

UNIVERSITY OF KWAZULU-NATAL

PARENTING IN THE TIME OF AIDS

2011

ZUBEDA PARUK

Parenting in the time of AIDS

ZUBEDA PARUK

Submitted in fulfillment of the degree of

Doctor of Philosophy

At the University of KwaZulu-Natal

Howard College

DECLARATION

I declare that this dissertation is my own work. It is being submitted in fulfillment of the degree Doctor of Philosophy at the University of KwaZulu-Natal. This research has not been submitted before for any degree or examination at any other University. The use of all sources consulted has been acknowledged in the text as per American Psychological Association guidelines. Research was carried out under the supervision of Professor Inge Petersen in the School of Psychology at the University of KwaZulu-Natal.

Signature_____

Date_____

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to the following people for their help and support:

Professor Inge Petersen for your patience, encouragement and guidance, and for staying with me along this long journey.

The participants in the study for your time, patience and enthusiasm.

All the people on the CHAMP (USA) and CHAMPSA (South Africa) team, especially Professor Arvin Bhana and all the CHAMPSA facilitators.

The National Institute of Mental Health in the United States for providing the funding that made CHAMPSA possible.

Ms Pat Mthimkhulu for your help in some of the translation.

All my relatives and friends, especially Cynthia Patel and Saroj Naidoo, for moral support and encouragement.

My daughter, Haseena and grandsons, Yusuf and Muhammad Raees who make it all worthwhile.

ABSTRACT

This thesis reports on a formative evaluation study conducted, firstly, to inform an adaptation of the Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP) so as to strengthen the adult protective shield in order to prevent high risk behaviour and HIV among children in the targeted community in Embo, Kwadedangendlale, KwaZulu-Natal (Study 1); and secondly, after a pilot intervention, to evaluate the adapted programme in order to understand the processes involved in strengthening the adult protective shield (Study 2). The research design for both Study 1 and Study 2 was qualitative in nature. More specifically, the two studies used a focused ethnographic case study approach. Thematic content analysis was used to analyse the data from both studies and three theoretical approaches facilitated the understanding of the data: Joffe's psychoanalytic extension of social representation theory, Carpiano's integrative theory of social capital, and Campbell and Murray's critical approach to community health psychology.

The participants in the first study were a volunteer convenience sample of parents of children aged 9-12 years from a school in the targeted community. Focus groups and in depth follow up interviews were conducted with the parents. Interviews were also conducted with key members of the community. At the community level, ***lack of containment*** emerged as an overarching theme, with *splitting* and *lack of trust* as subthemes interpreted as emerging to deal with anxiety. Anxiety was also linked to ***stigmatization*** of people suspected of being HIV positive or having AIDS. Coping mechanisms used to deal with stigmatization were *silence* and *denial*. Linked to the issue of stigmatization was that of *death and bereavement*. At the family level, ***disempowerment*** of caregivers emerged as an overarching theme creating anxiety for parents, one of the sources of which was the *generational knowledge gap*, with parents being generally less educated than their children. This was linked to two issues: that of *children's rights*; and parents' attempts to resort to severe forms of *authoritarian parenting*.

In the second study, in-depth semi-structured interviews, based on the themes that had emerged from the pre-intervention focused ethnographic study, were conducted with a volunteer convenience sample of nine mothers who had been part of the CHAMPSA intervention. Two broad themes emerged: ***Individual empowerment***, including the subthemes *parental empowerment*, *women empowerment*, and *social support and social leverage*; and ***collective empowerment***, including the subthemes *informal social control and community organisation*, and *HIV/AIDS stigma*. The findings of the second study contributed to the development of a model showing how improved parent child communication and parental HIV knowledge at the individual level as well as renegotiated, empowered parental identities facilitated through the group process restored parental authority at the individual level as well as collectively, strengthening social capital and restoring the adult and community protective shields.

Table of Contents	Page
Chapter One: Introduction	1
Chapter Two: Parenting	7
Validation of Maccoby and Martin's categories	9
Studies confirming authoritative parenting as optimal	9
Cross cultural validity	10
American studies	10
Other countries	11
Contradictory findings	13
Critique of studies on parenting style	16
Parenting style and risky behaviour	16
Parenting style and risk behaviours	17
Parental expectations and trust	19
Supervision and monitoring	21
Communication	23
Chapter Three: Family-based HIV prevention programmes	28
Youth HIV prevention interventions	28
The Collaborative HIV Prevention and Adolescent Mental Health Program	29
	(CHAMP)

Other family-based youth HIV prevention programmes	32
Family to Family	32
ImPACT	33
Keeping It R.E.A.L.	33
The Strong African American Families Program	34
The Parents Matter! Program	34
Mother/Daughter HIV Risk Reduction	34
PATH	35
Strengthening the Bond. The Mother-Son Health Promotion Project	35
Chapter Four: Methodology	37
Qualitative research	38
The quantitative versus qualitative debate	39
Trustworthiness	41
Ethnography	41
Focused ethnography	42
Case studies	42
Formative evaluation	43
The target community	43
Procedure and participants: CHAMPSA	45
Data collection	46
Focus groups	46

Interviews	47
Participants and procedure: Study 1	48
Participants and procedure: Study 2	49
Data analysis	50
Ethical issues	51
Informed consent	51
Anonymity and confidentiality	52
Offering inducements for participation	52
Institutional approval	52
Chapter Five: Theoretical Underpinnings	53
Social Representations Theory	53
Psychodynamic extension of social representations theory	58
Social representations theory, community health research, and power	59
Critique of social representations theory	60
Social representations and HIV/AIDS	62
Critique of research	68
Social Capital Theory	70
Bonding, bridging and linking social capital	75
Vertical and horizontal social capital	75
Cognitive and structural social capital	76
Anti-social capital	77

Criticisms of social capital	77
Carpiano's (2006) integrative theory of social capital	78
Research based on social capital theory	80
Social capital and youth/youth at risk	81
Social capital and sexual health	85
Social capital and HIV	86
Conclusions	89
Community Health Psychology	91
Chapter Six: Findings and Discussion of Study 1 and Development of CHAMPSA	93
Findings and discussion of Study 1	93
Community level	93
Splitting	96
Lack of trust	98
Stigmatisation	99
Silence	100
Denial	101
Death and bereavement	101
Family level	101
Generational knowledge gap	102
Children's rights	102
Authoritarian parenting	103

Implications for family and community level interventions	105
Development of CHAMPSA	108
Chapter Seven: Findings and Discussion of Study 2	112
Individual empowerment	113
Parental empowerment	113
Women empowerment	117
Social support	118
Collective empowerment	120
Informal social control	120
Social leverage and community organisation	122
HIV/AIDS stigma	124
Chapter Eight: Integrative Discussion, Reflections and Limitations,	126
Conclusion and Recommendations	
Integrative discussion	126
Reflections and limitations	130
Translation in research	130
The issue of generalizability	132
Payment of stipend	133
Socially desirable responses?	134
Study 2 participants	134
Conclusion and recommendations	134

References	137
-------------------	-----

Appendices

Appendix 1: Motivation and support: Durban Metropolitan Unicity Municipality	178
Appendix 2: Focus Group Guide: Study 1	179
Appendix 3: Individual Interviews: Study 1	180
Appendix 4: Follow Up Interviews: Study 2	181
Appendix 5: Human Participants Protection Education for Research Teams:	183
Completion certificate	
Appendix 6: University of Durban-Westville ethical clearance letter	184
Appendix 7: The AmaQhawe Family Project Facilitators' Manual	185

CHAPTER ONE

INTRODUCTION

The human immunodeficiency virus (HIV) was first identified in five gay men in the United States of America in 1981 (Gottlieb, 2006). Because of its association with marginalized populations, sexuality, drug use and death, HIV has been characterized by stigma, discrimination, and denial (Rotheram-Borus, Flannery, Rice & Lester, 2005; Merson, O'Malley, Serwadda, & Apisuk, 2008). It soon became apparent that HIV was not a "gay disease" but could be transmitted heterosexually, and by the end of the century the worldwide prevalence of HIV was almost 1%; in sub-Saharan Africa the prevalence among adults between 15 and 49 years was 6% (Merson et al., 2008). HIV/AIDS (Acquired Immune Deficiency Syndrome) has become a leading cause of mortality worldwide and the main cause of death in sub-Saharan Africa (Merson et al., 2008).

The apartheid government in South Africa did little to stem the tide of the epidemic in the 1980s and early 1990s. After the changeover in 1994 to a new democratic order, the Mandela-led government adopted an AIDS Plan which, despite the development of highly active antiretroviral therapy (HAART) in the mid 1990s, was characterized by a lack of progress (Schneider & Stein, 2000). The Mbeki presidency from 1999 to 2008 was marked by AIDS denialism and an active resistance to making antiretroviral therapy (ART) available to people living with AIDS (Natrass, 2006). However, the introduction of the National Strategic Plan 2007-2011 (NSP), initiated a multisectoral response to South Africa's AIDS epidemic, calling for treatment, care and support for 80% of HIV positive people by 2011 (Avert, 2010).

In advocating for greater prevention efforts, Merson et al. (2008) contend that despite the availability of antiretroviral drugs “we cannot treat our way out of this pandemic” (p. 285), and that for every two patients placed on antiretroviral drugs during 2007, five new HIV infections occurred. Furthermore, the search for an effective HIV vaccine faces many challenges, with some researchers wondering “whether an effective vaccine will ever be added to the HIV-prevention toolbox” (Johnstone & Fauci, 2008, p. 888). The focus has to therefore still remain on prevention. Despite the personal behaviour of current President Jacob Zuma, who has provided a poor role model for HIV prevention, his government launched a major counselling and testing campaign in April, 2010 with the aim of raising awareness of HIV and thereby reducing the HIV incidence rate by 50% by June 2011 (Avert, 2010).

The risk for HIV infection has been found to be most pronounced in adolescence and early adulthood given, inter alia, the developmental challenges facing this age group, with young people between the ages of 15 and 24 years accounting for half of all new cases of HIV infection worldwide (UNAIDS, 2004). Reducing the risk of HIV in youth is critical to slowing down the epidemic as young people continue to fuel it as new sexually active cohorts become part of the susceptible pool (Bradshaw, Pettifor, MacPhail & Dorrington, 2004).

South African youth in the 15 to 24 year age group have one of the highest prevalence rates in the world (UNAIDS, 2008). The most recent South African National HIV survey (Shisana et al., 2009) found a slight decrease in HIV prevalence from 10.3% in 2005 to 8.6% in 2008 in this age group; this was corroborated by decreases in HIV incidence as well. However, HIV prevalence in this age group increased in two provinces, one being KwaZulu-Natal where the increase was from 11.7% in 2002 to 15.8% in 2008. Furthermore, nationally, sexual debut before the age of 15

years among youth, which exposes them to vulnerability to HIV infection, declined among males from 13.1% in 2002 to 11.3% in 2008, but remained virtually the same among females from 8.9% in 2002 to 8.5% in 2008 (Shisana et al., 2009).

Shisana et al. (2009) attribute the decrease in national incidence and prevalence rates among 15 to 24 year olds to increased condom use and communication programmes. Since 1999 there has been a plethora of awareness and intervention strategies for decreasing infection rates in this age group including life skills programmes in schools, national campaigns such as Khomanani, Soul Buddyz, loveLife and Soul City, as well as peer education programmes, and HIV counselling and treatment (HCT), all of which seek to empower youth to make responsible choices. Despite the success of awareness messages, with 90% coverage reported, the national survey found a decline in knowledge regarding the use of condoms and the risks of multiple partners in the sexual transmission of HIV (Shisana et al., 2009). Shisana et al. (2009) conclude that there is clearly a need for more targeted interventions, especially in provinces such as KwaZulu-Natal.

Furthermore, there is general recognition that HIV prevention efforts should be accompanied by efforts to facilitate a social environmental context that is enabling of healthy choices on the part of youth. While a number of studies have attempted to understand these issues (e.g., Campbell, Foulis, Maimane & Sibiyi, 2005; Eaton, Flisher and Aaro, 2003; Kelly and Parker, 2000), they have not sought to understand the role of families in mitigating or facilitating healthy choices on the part of youth in South Africa in any great depth. This is concerning for two reasons: first, South Africa's apartheid past and transition to a new democratic order impacted on the traditional family system in a number of ways, including the erosion of family structures as a result of the migrant labour system; and second, there was increasing recognition that HIV prevention programmes for youth need to include interventions which involve families and local

communities (Lagerberg, 2004), and which empower parents and caregivers to provide a protective environment against high-risk behaviour in their children (Bhana, McKay, Mellins, Petersen, & Bell, 2010). The important role of families as a protective factor against risk behaviour in adolescence has also been highlighted in numerous studies (e.g., Bell, 2001; Paikoff, 1995).

In 2000, researchers from the United States of America (USA) approached South African researchers to pilot a community-based family programme called the Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP) in KwaZulu-Natal (Bhana, Petersen, Mason, Mahintsho, Bell, & McKay, 2004). CHAMP, originally developed in Chicago, focuses on improving parent-child relationships as a protective factor against HIV infection in children (Madison, McKay, Paikoff & Bell, 2000). Given the wide recognition that intervention programmes should be contextually and culturally appropriate, the researchers had to first establish if CHAMP could be adapted and effectively utilized in South Africa. Two recent studies (Karnell, Cupp, Zimmerman, Feist-Price, & Bennie (2006); Wechsberg, Luseno, Lam, Parry, & Morojele, 2006) have shown that behavioural intervention programmes developed in USA can be effectively adapted for use in the South African context.

CHAMP South Africa (CHAMPSA) was adapted for the South African context and pilot studies were initially conducted in three sites. Outcome data obtained from the pilot studies having been promising (cf. Bhana et al., 2004), the programme was more widely administered at 20 sites with significant differences being obtained between the intervention and control groups (cf. Bell et al., 2008). The focus of my thesis is a formative evaluation including the pre-pilot, focused ethnographic study which informed the adaptation of CHAMP, and a post-intervention process

evaluation study in one of the sites where CHAMPSA was piloted to understand how the programme had worked. While CHAMP works with families (that is, preadolescent children and parents/caregivers), one of its primary aims is to “~~a~~-establish the adult protective shield” (Bell et al., 2008). This aspect of CHAMP underpins the aim of this thesis; namely, to understand how to strengthen the adult protective shield in the time of HIV/AIDS in South Africa.

The objective of this formative evaluation study, therefore, was twofold:

- firstly, to conduct an ethnographic case study to inform an adaptation of CHAMP so as to strengthen the adult protective shield in the South African community in which it was administered (Study 1); and
- secondly, after an initial pilot intervention, to conduct a qualitative evaluation of the adapted programme to understand processes involved in strengthening the adult protective shield (Study 2).

More specifically, the research questions related to Study 1 were:

- How do people in the target community understand the relatively new phenomenon of HIV/AIDS?
- How do adults protect their children against the disease?
- Do they feel effective in protecting their children against the disease?

The research questions related to Study 2 were:

- How did the programme help to strengthen the adult and community protective shield to enhance safety of their children against HIV infection?

And leading from the first question:

- Did the programme facilitate a greater level of critical consciousness with regard to their role as parents among the participants after the intervention, and if so, how?
- Did the parents feel more empowered to parent effectively after the intervention, and if so, how?

As the focus of this thesis is parenting, in Chapter Two I present a review of the theory and research on parenting. Chapter Three comprises a description of youth HIV prevention programmes including a more detailed account of the US based CHAMP programme, as well as a brief examination of other family-based prevention interventions. Chapter Four describes the methodology for this project. Chapter Five contains a review of the theoretical underpinnings of the project, as well as research related to each theoretical approach. In Chapter Six I present a description and discussion of the findings of Study 1, how the findings from this study informed the adaptation of CHAMP, as well as a brief description of CHAMPSA. A description and discussion of the findings of Study 2 are presented in Chapter Seven. Chapter Eight includes an integrative discussion, reflections and limitations, and conclusion and recommendations.

CHAPTER TWO

PARENTING

Given that the focus of this thesis is parenting, in this chapter I present an overview of theory and research related to parenting.

Parenting has been conceptualized by Darling and Steinberg (1993) as the overall emotional climate within which socialization occurs. As early as 1939, researchers have shown that authoritative parents had children who tended to be competent, psychosocially mature and socially skilled (Symonds, 1939; Baldwin, 1949; 1955; Child, 1954; Sears, Maccoby & Levin, 1957; Schaeffer, 1959; Bronfenbrenner, 1961). The authoritative parenting style is one of three parenting styles identified by Baumrind (1966). Having assessed parenting on the dimensions of acceptance, control, demandingness, disciplinary practices, and encouragement of autonomy, she proposed that parenting styles could be authoritarian, authoritative, or permissive. Maccoby and Martin (1983) refined this categorization system by suggesting that within the permissive style a distinction could be made between indulgent and neglectful parenting. Their system analyzed parenting style along two orthogonal dimensions (Maccoby & Martin, 1983):

demandingness: the extent to which parents demand mature behaviour, supervise activities, and discipline transgressions, and

responsiveness: the extent to which parents are attuned to their children's physical, social and emotional needs, and support their increasing autonomy.

Authoritative parents (according to Maccoby and Martin, 1983) are high in both demandingness and responsiveness; they are warm, firm and fair, and this is a highly effective parenting style. Authoritarian parents are high in demandingness but low in responsiveness; they are firm and punitive, and this is a less effective parenting style. Permissive parents are high in responsiveness and low in demandingness; they are warm and laissez-faire, and this is also a less effective parenting style. Uninvolved parents are low in responsiveness and also in demandingness; they are emotionally absent. This parenting style is not effective.

According to Steinberg (1999), authoritative parenting has three main components: warmth, structure and autonomy support. A fourth component, considered by the Pan American Health Organization (PAHO) to be a key aspect of effective parenting, is development support (Breinbauer & Maddaleno, 2005). *Warmth* refers to the way a parent communicates to the child that s/he is loved and accepted; such parents maintain a positive emotional climate even during high environmental stress and parent-child disagreements. *Structure* (or demandingness) refers to the standards (consistent with the child's needs and capabilities) set by the parents. These standards maintain a balance between restrictiveness and autonomy, and include monitoring the child's behaviour and anticipating risky situations. To increase autonomy and teach responsibility, negotiable limits are set and communication is encouraged. However, to protect the child from harm, some limits are non-negotiable. Parents who provide *autonomy support* accept and encourage their child's individuality. They afford the child opportunities to develop self-reliance, but with clear standards and limits for behaviours. *Development support* fosters capacities for emotional and logical thinking. Discussions between parents and children help the child to develop reasoning abilities, role-taking, emotional thinking, empathy, and moral judgment (Breinbauer & Maddaleno, 2005).

Validation of Maccoby and Martin's categories

Maccoby and Martin's (1983) categorization system has been widely cited and extensively used in research on parenting style and a wide range of child and adolescent outcome variables.

Lamborn, Mounts, Steinberg and Dornbusch (1991) tested Maccoby and Martin's (1983) revision of Baumrind's conceptual framework on a large sample of adolescents from varying ethnic and socioeconomic backgrounds in the USA. Their study confirmed the validity of the four parenting styles, and a follow-up study a year later (Steinberg, Lamborn, Darling, Mounts & Dornbusch, 1994) corroborated the earlier findings. These two studies also supported earlier findings (e.g., Baumrind, 1967, 1971) that the authoritative parenting style was optimal for youth outcomes. Slicker (1998) also confirmed the validity of the four classic parenting styles even with a sample of older adolescents.

Studies confirming authoritative parenting as optimal

Subsequent studies also confirmed these results. Radziszewska, Richardson, Dent and Flay (1996) found that adolescents with authoritative parents had the best outcomes on measures of depressive symptoms, smoking, and academic grades compared to those with permissive, autocratic or unengaged parents. This was true across ethnicity (White, Hispanic, African-American, and Asian adolescents), gender and socioeconomic status. Weiss and Schwarz (1996) obtained similar results with college students on measures of personality, academic achievement, adjustment and substance abuse; although the differences between adolescents with authoritative parents and others were not as great as for previous research studies, they explained this as probably being due to the restriction of their sample. Dominguez and Carton (1997) investigated the relation between self-actualization and parenting style among college students and found support for their hypothesis that an authoritative parenting style may facilitate self-actualization.

Gray and Steinberg (1999) found that authoritative parenting was positively associated with various aspects of adolescent adjustment. Research by Gunnoe, Hetherington and Reiss (1999) showed a positive relationship between authoritative parenting and religiosity, and these two variables were positively related to adolescent social responsibility among a sample of Caucasian middle class adolescents. A positive relationship between an authoritative parenting style and student academic adjustment among 17-19 year old college students was found by Hickman, Bartholomae and McKenry (2000). Another study, by Carlson, Uppal and Prosser (2000), demonstrated that authoritative parenting predicted higher self-esteem among a sample of early adolescent Hispanic, African-American and White schoolgirls. Using mothers' reports, Kaufmann, Gesten, Santa Lucia, Salcedo, Rendina-Gobioff and Gadd (2000) showed that authoritative parenting was predictive of children's competence regardless of the child's gender, grade level, ethnicity and family income. The authoritative parenting style was also found to be positively correlated with resilience in adolescents (Ritter, 2005), and among a sample of at-risk, economically disadvantaged preschool children (Soward, 2006).

Cross-cultural validity

American studies

Querido, Warner and Eyberg (2002) found strong support for the cross-cultural validity of the authoritative parenting style which was most predictive of fewer child behaviour problems in a sample of African-American preschool children. These findings support those of Bluestone and Tamis-LeMonda (1999) who obtained similar results with school-age African-American children. A study by Hall and Bracken (1996) also showed no significant racial differences: adolescents with authoritative mothers had better interpersonal relations than those with authoritarian or permissive mothers. Calzada (2001), using a sample of immigrant or first generation Hispanic

American mothers and their preschool children, found that authoritative parenting behaviors were associated with fewer child behavior problems compared to authoritarian and permissive parenting. A significant positive relationship between the authoritative parenting style and students' self-reported school performance in a sample of Armenian-American adolescents was demonstrated by the research of Ayrapetyan (2006). Adolescents who perceived their immigrant Vietnamese fathers as using an authoritative parenting style reported higher levels of self-esteem and lower depression scores compared to those who perceived their fathers as using an authoritarian parenting style (Nguyen, 2008).

Other countries

Studies conducted in many other countries also showed that the authoritative parenting style was associated with optimum youth outcomes on a range of variables. Shucksmith, Hendry & Glendinning (1995), using measures of school integration and mental well-being in a United Kingdom sample of young adolescents, demonstrated that the most effective parenting style was an authoritative one which is characterized by high levels of both acceptance and control. Chen, Dong & Zhou (1997) also found an association between authoritative parenting and children's school and social adjustment in a sample of second grade Chinese children. A study by Herz and Gullone (1999) showed that high levels of control and overprotection similar to an authoritarian parenting style was negatively related to self-esteem, confidence and resilience among a sample of Vietnamese-Australian and Anglo-Australian adolescents. In Finland, Aunola, Stattin and Nurmi (2000) found that adolescents from authoritative families applied most adaptive achievement strategies compared to adolescents from neglectful families. Adalbjarnardottir and Hafsteinsson's (2001) study among adolescents in Iceland showed that those who characterized their parents as authoritative were more protected against substance use than those adolescents

who perceived their parents as neglectful. Vucina and Becirevic (2007) also found the authoritative parenting style to be a protective factor against substance use among a sample of high school students in Mostar (Bosnia and Herzegovina). Boon (2007), using a sample of grade 8-10 Australian students, showed that an authoritative parenting style predicted higher achievement via enhanced mastery goals and self-efficacy. Using a sample of Chinese families with 6-9 year old children, Xu (2008) found a positive relationship between authoritative parenting and child social competence.

With the weight of evidence from research findings, Steinberg (2001) asserted that despite the focus of earlier work on White, middle class families, the benefits of authoritative parenting transcended the boundaries of ethnicity, socioeconomic status, and household composition. He maintained that studies such as Baldwin and Baldwin (1989), Baumrind (1972), Deckerd, Dodge, Bates and Pettit (1986), and McLeod, Kruttschnitt and Dornfield (1994) which are often cited as demonstrating that African American and Asian American adolescents fare better with authoritarian parents, show in fact, that these groups are not as negatively affected by authoritarian parenting as are White adolescents, but that in fact research (Steinberg et al., 1991) has shown that minority children raised in authoritative homes fare better than those raised in non-authoritative ones. Steinberg (2001) did concede, however, that authoritative parenting does not particularly benefit African American and Asian American students in the area of school performance, and that some developmental outcomes of authoritative parenting may not be adaptive in all contexts. Steinberg (2001) also underscored the importance of adolescents' social networks, stating that studies such as Cauffman and Steinberg (1995) and Darling, Steinberg and Gringlas (1993) have shown that authoritative parenting works better when other parents in the community are also authoritative.

Contradictory Findings

Despite Steinberg's (2001) claims, however, the concepts of authoritarian and authoritative parenting styles have been questioned as possibly being ethnocentric (Chao, 1994), and that the authoritarian parenting style is not universally associated with negative adolescent outcomes (Ang & Goh, 2006). While Asian parents may score high on authoritarianism, Chao (1994) believes that "strictness" and "control" that are reflected in measures of authoritarianism may be equated with parental concern, caring and involvement in Asian cultures. She maintains that the concepts of authoritarian and authoritative parenting do not capture the feature of "training" that is an important feature of Chinese child rearing and that may explain Chinese school success. McBride-Chang and Chang (1998) found that an authoritative parenting style was negatively associated with autonomy among their sample of Hong Kong Chinese adolescents; they concluded, however, that conceptualizing parenting as permissive, authoritative, or authoritarian may be less relevant for Chinese families than for those in the West. Leung, Lau and Lam (1998) demonstrated that authoritarianism was positively related to academic achievement among Hong Kong adolescents. Leung et al. (1998) found in fact, that while the authoritative parenting style was positively associated with academic achievement among European American and Australian adolescents, this was not the case among Hong Kong adolescents. Blair and Qian (1998) also found a positive relationship between parental control and school performance among Chinese adolescents. Similarly, Park and Bauer (2002) demonstrated from three follow up studies that while the European American parents in their sample were more authoritative than other ethnic groups (African American, Asian American and Hispanic), the relationship between an authoritative parenting style and academic achievement did not extend to all ethnic groups.

Odubote (2008), in a comparative study of European American, African American and Nigerian families, found that Nigerian parents were more authoritarian than the other groups, and this parenting style has a positive developmental outcome for Nigerian adolescents.

Even within the United States, it has been hypothesized that because poor ethnic minority families are more likely to live in dangerous communities, authoritarian parenting may not be as harmful and may even carry some protective benefits (Furstenberg, Cook, Eccles, Elder & Sameroff, 1999). Having obtained mixed findings regarding the advantages of an authoritative parenting style over an authoritarian one in their sample of juvenile offenders, Steinberg and Blatt-Eisengart (2006) suggest that it is not that authoritarian parenting is good for poor, urban, ethnic minority adolescents, but, rather, that authoritarian parenting may not be as bad for these adolescents as it has been shown to be for their middle-class, suburban, white counterparts.

Another set of studies has shown that the indulgent style of parenting may be just as effective in some cultures. Kim and Rhoner (2002) showed that there was no difference in the academic achievement of Korean American adolescents raised by authoritative and indulgent fathers. A study by Wolfradt, Hempel and Miles (2003) found that German adolescents with indulgent parents had better psychosocial adjustment than others. Studies in Spain (e.g. Martinez & Garcia, 2007), Turkey (Turkel & Tezer, 2008), Mexico (Villalobos, Cruz & Sanchez, 2004 cited in Garcia & Gracia, 2009), and Brazil (Martinez & Garcia, 2008; Martinez, Garcia & Yubero, 2007) also demonstrated that children of indulgent parents performed either better or just as well as other children on various outcomes. Garcia and Gracia (2009) found that, in Spain, the optimum style of parenting is the indulgent one.

Garcia and Gracia (2009) have suggested that the disparate findings regarding the relationship between parenting styles and youth outcomes could be understood in terms of two explanatory models: the *Person-Environment Fit*, and the concepts of *Collectivism and Individualism*, both vertical and horizontal.

The Person-Environment fit model is based on Bronfenbrenner's (1986) ideas of the ecology of human development. It suggests that people fare better in environments that are similar to their attitudes, values and experiences (Swanson & Fouad, 1999). Therefore, children from authoritative homes perform better in school because the school environment is an authoritative one (Sabo, 1995). In dangerous environments such as those of poor ethnic minority groups, the authoritarian parenting style may be beneficial as it provides a level of protection (Furstenberg, Cook, Eccles, Elder & Sameroff, 1999). A study by Wintre and Ben-Knaz (2000) showed that the authoritative parenting style did not best prepare adolescents in Israel for military training which is an authoritarian context. Mayseless, Scharf and Sholt (2003) on the other hand, having found that adolescents with authoritative parents did cope well in the Israeli military context, have questioned the person-environment fit model with regard to parenting style.

Singelis, Triandis, Bhawuk and Gelfand (1995) explain vertical collectivism as perceiving oneself as part of a collective but accepting the idea of inequality, while horizontal collectivism stresses equality. Similarly vertical individualism involves the concept of an autonomous individual with the acceptance of inequality, and horizontal individualism implies autonomy with equality. In vertical collectivist cultures such as some Asian cultures, authoritarian parenting with its strict discipline is perceived to be beneficial for children (e.g. Shek, 2008). Garcia and Gracia (2009) suggest that in horizontal collectivist cultures like some South American (Brazil,

Mexico) and South European (Spain, Italy) countries affection, acceptance and involvement in children's socialization are emphasized. Strictness and control are perceived as negative (Rudy & Grusec, 2001). Therefore, the optimum parenting style in these cultures would be the indulgent one.

Critique of Studies on Parenting Style

Newman, Harrison, Dashiff and Davies (2008), in a review of studies on parenting styles and risk behaviours in adolescents, suggest that such studies have various limitations. Many of them use single informants, don't differentiate the rating of mothers and fathers, nor consider differences in relationships based on parents' and children's gender or ethnicity. Studies also use different measures and typologies of parenting style. Another problem is that families cannot always be classified neatly into one of the four parenting style categories. In addition, most of the studies are cross-sectional and not longitudinal. Another methodological limitation of these studies is that it is difficult to identify the effects of confounding and contextual factors that shape youth behaviour, such as parental risk behaviours (e.g. alcohol consumption, smoking, etc).

Parenting Style and Risky Behaviour

In a review of the literature, DeVore and Ginsburg (2005) concluded that various aspects of parenting have demonstrated immediate and long-term protective effects on adolescent risk behaviour, and that positive parenting practices not only delay risk behaviour in risk-naïve youth, but moderate behaviour in risk-experienced youth, and promote optimal youth development. Studies have examined not only the link between sexual risk taking and the broad construct of parenting style, but also between sexual risk taking and specific dimensions of parenting style, including parental expectations and trust, supervision and monitoring, and communication.

Parenting style and risk behaviours

Small and Kerns (1993) found that, in a sample of 1,149 early and middle adolescent females, those who had parents who did not monitor their behavior closely or use an authoritative parenting style, were more vulnerable to unwanted sexual contact initiated by their peers. Similarly, in a Canadian study, Petersmeyer (1997) showed that adolescents parented authoritatively, reported the lowest level of interest in risk behaviours, whereas teens from permissive indifferent families reported the highest. This was particularly so for maternal demandingness and responsiveness.

A study by Taris and Semin (1998), using a sample of British adolescent-mother dyads, examined maternal parenting and adolescent sexual behaviour. Their findings indicated that, for younger adolescents (15-16 years), maternal support and control was associated with the delay of first sexual experience, but this was not so for older adolescents, suggesting that parental influence on adolescents' sexual attitudes decreases as they grow older.

Pittman and Chase-Lansdale (2001) examined the relationship between parenting style and adolescent functioning in a sample of 302 African American adolescent girls and their mothers living in impoverished neighborhoods. Parenting style was significantly related to adolescent outcomes; teens whose mothers were disengaged (low on both parental warmth and supervision/monitoring) were found to have the most negative outcomes. While there was no significant difference between authoritative and authoritarian parenting, girls with authoritative mothers were less likely to have ever had sex or to have been pregnant.

Crosby et al. (2001) found that for African American female adolescents, living in a perceived supportive family with the mother was protective against HIV/STD. They suggest that including mothers in prevention programs may promote positive and lasting effects.

Rose, Koo, Bhaskar, Anderson, White, and Jenkins (2005) examined parental factors associated with sexual risk behaviours among fifth graders. Parental factors associated with fewer risk behaviors included higher levels of monitoring, fewer communication barriers, less permissive attitudes regarding adolescent sexual behavior, and higher relationship quality with the child. The authors suggest that, to delay early sexual activity, prevention efforts must begin during the elementary school years and include those who raise and care for the adolescent.

Cox (2006) investigated parenting style as a determinant of risk behaviour using the two distinct parenting dimensions of demandingness and responsiveness. Her sample consisted of African American and White adolescent-mother dyads. Maternal demandingness predicted an increased likelihood of condom use among African American adolescents, but a decreased likelihood among White adolescents. Maternal responsiveness did not predict condom use. There were no gender differences. Another longitudinal study (Cox, 2007) with 2,030 adolescents and their mothers found that maternal demandingness and maternal responsiveness independently predicted adolescent abstinence from sex. Jackson and Foshee (1998), on the other hand, suggest that parental responsiveness is a stronger protective factor for girls and parental demandingness is more protective for boys. Cox (2007) advocates a dimensional approach to measure parenting in examining adolescent sexual behavior.

Coley, Medeiros, and Schindler (2008) used rigorous statistical methodology and a large representative sample of youth to establish that regular family activities and less negative and hostile parenting during mid-adolescence predicted lower sexual risk behaviors during late adolescence.

In conclusion, the studies on parenting style and adolescent risk behaviour found that an authoritative parenting style, particularly maternal demandingness and maternal responsiveness, protected adolescents from risky sexual behaviour. Jackson and Foshee (1998) suggest that parental responsiveness is more protective for girls and parental demandingness is more protective for boys. The protective effects were greatest with younger adolescents, with Rose et al. (2005) suggesting that prevention efforts should begin in elementary school years. Rose et al. (2005) and Crosby et al. (2001) recommend that prevention programmes should include caregivers. While most of the studies were cross-sectional, one (Cox, 2007) was a longitudinal study.

Parental expectations and trust

Jaccard, Dittus and Gordon (1996), in a survey of 751 black youths, found that adolescent perceptions of maternal disapproval of premarital sex, and satisfaction with the mother-child relationship, were significantly related to abstinence from adolescent sexual activity and to less-frequent sexual intercourse and more consistent use of contraceptives among sexually active youths. Resnick et al. (1997), having analyzed data obtained from 12,118 adolescents in a national study of adolescent health in the USA, demonstrated that parent-family connectedness and parental disapproval of early sexual debut was associated with later sexual debut among

adolescents. A study by Lammers, Ireland, Resnick and Blum (2000), using a sample of 26,023 adolescents aged 13 to 18 years, also showed that high parental expectations were strongly associated with postponement of sexual activity.

A prospective study (Dittus & Jaccard, 2000) revealed that the more disapproving adolescents perceived their mothers to be toward their engaging in sexual intercourse and the more satisfied adolescents were with their relationship with their mothers, the less likely the adolescents were to initiate sexual activity or to become pregnant. Sieving, McNeely and Blum (2000), in a longitudinal study over 9 to 18 months, with 12,105 students in grades 7 through 12, also found that adolescents' perceptions of maternal disapproval and high levels of mother-child connectedness were associated with delays in first sexual intercourse. Another study of mother-adolescent dyads (McNeely, Shew, Beuhring, Sieving, Miller, & Blum (2002) obtained similar results: strong maternal disapproval of their daughters having sex was associated with later sexual debut at one year follow-up in 14-15 year old girls who had originally reported to be virgins. Mothers' values and beliefs did not, however, have a similar influence on their adolescent sons. Another longitudinal study (Ford et al., 2005) found that adolescents who perceived that their parents more strongly disapproved of their having sex during adolescence were less likely to have STIs 6 years later.

Borawski, Ievers-Landis, Lovegreen, and Trapl (2003) used self report measures with a sample of adolescents (mean age: 15.7 years) to examine the role of parental monitoring, negotiated unsupervised time and trust in protecting against risky behaviour. They found that perceived parental trust was a strong deterrent against risky behaviour for females but not for males.

To summarize, in both cross-sectional and longitudinal studies high parental expectations and parental disapproval of sexually risky behaviour were found to be associated with delayed sexual debut, abstinence from sex, or with safer sex among sexually active adolescents. Two studies (Borawski et al., 2003; McNeely et al., 2002) showed a gender difference: while maternal values or parental trust were a deterrent against risky behaviour for girls, they were not for boys.

Supervision and monitoring

Resnick et al. (1997) found that supervision in the form of increased parental presence in the home was associated with a reduction in risk behaviours. This was confirmed by two studies (Cohen, Farley, Taylor, Martin, & Shuster, 2002; DiLorio, Dudley, Soet, & McCarty, 2004), both of which showed that unsupervised time was associated with sexual risk behaviours. Cohen et al. (2002) found that participation in after-school activities was not protective against sexual activity; they suggest that it may be contact with parents, in addition to reduced opportunities for risk that may be crucial. Even negotiated unsupervised time was found to lead to increased experimentation with sexuality among adolescents, albeit in a more responsible way (Borawski et al., 2003).

Studies of female African American adolescents from poor urban communities have shown that high levels of perceived parental supervision were associated with less sexually risky behaviour (DiClemente et al., 2001; Hogan & Kitagawa, 1985; Romer, Stanton, Galbraith, Feigelman, Black, & Li, 1999). A prospective (18 month follow-up) study with a similar sample (Crosby, DiClemente, Wingood, Lang, & Harrington, 2003) found that perceived parental monitoring levels predicted the acquisition of sexually transmitted infections.

Studies with both males and females have confirmed these findings. Rodgers (1999) showed in her sample of primarily White sexually active male and female adolescents, that parental monitoring significantly decreased the odds that they would be high risk takers. Li, Feigelman, and Stanton (2000) found that among urban, low-income, African-American children and adolescents (9-17 years) low levels of perceived parental monitoring were associated with participation in risky sexual behaviour; females perceived themselves to be more monitored than did males, and perceived parental monitoring tended to decrease with advancing age of the youth. In a 4 year longitudinal study among 383 low-income, urban African Americans aged 9 to 15 years, Stanton, Li, Pack, Cottrell, Harris, and Burns (2002) explored the long-term contributions of perceived parental influences on adolescent risk and protective behaviors. Having found that perceived parental monitoring was inversely correlated with sexual involvement, they concluded that perceptions of parental behaviors influence long-term risk and protective behaviours of adolescents, and that parents should be included in adolescent risk reduction intervention efforts. Similarly, Li, Stanton, and Feigelman (2000) in a prospective, longitudinal follow-up (4 years) study showed that perceived parental monitoring had a long-term effect on risk behaviors among urban, low-income African-American children and adolescents. They contend that these findings reinforce the importance of parental monitoring and that intervention efforts to reduce adolescent risk behaviors should be directed at strengthening parental monitoring.

In another (decade-long) longitudinal study with 1279 low income African-American youth aged 13 to 16 years at baseline, Rai et al. (2003) also found that despite a rapid increase in sexual activity during mid-adolescence parental monitoring had a protective influence on sexual activity. Two prospective studies with young adolescents from low income urban environments (Coley, Morris & Hernandez, 2004; Roche, Ellen and Astone, 2005) revealed that parental/adult

supervision during out-of-school hours was protective against high risk behaviour. Similarly, Huebner and Howell (2003), using adolescent self report, found among rural high school students in the United States, that closely supervised adolescents were less likely to engage in sexual risk taking. The study did not differentiate between the gender of either the adolescents or the parents, nor did it examine the parents' perspective. While the authors found no direct effect for parenting style on level of sexual risk-taking, they suggest that this might have been due to their use of a single-item measure for parenting style. Lower perceived parental monitoring was also found to be associated with increased sexually transmitted disease (STD) risk behaviour in a sample of detained female adolescents (Voisin, DiClemente, Salazar, Crosby, Yarber, & William, 2006).

To summarize, both cross-sectional and longitudinal studies, including both male and female, and African American and White adolescents - and children from 9 years of age in one study (Li et al., 2000) - found that parental supervision and monitoring was protective against risky sexual behaviour, and that perceived parental monitoring had a long-term effect on risk behaviours. Furthermore, even negotiated unsupervised time and participation in after-school activities increased the risk of sexual activity. Li et al. (2000) advocate that intervention efforts to reduce adolescent risk behaviours should strengthen parental monitoring.

Communication

A Swedish study (Stattin & Kerr, 2000), using both child and parent reports, concluded that, rather than monitoring per se, it is parent-child relationships that facilitate communication that prevent deviant behaviour among adolescents.

In the United States, a study (Holtzman & Rubinson, 1995) using data from a 1989 national probability sample of 8,098 high school students found that discussions about HIV with parents tended to decrease the likelihood that adolescents would engage in risky behavior. Kotchick, Dorsey, Miller, Kim, and Forehand (1999) examined the relationship between mother-adolescent communication about sex, and maternal attitudes about adolescent sexuality to adolescent sexual risk-taking behavior in a sample of 397 Black and Hispanic families headed by single mothers. They showed that when sexual communication between a mother and an adolescent was open and receptive, less adolescent risk-taking behavior was reported. Two studies with mother-adolescent dyads in economically disadvantaged urban communities (Dilorio, Kelley & Hockenberry-Eaton, 1999; Guilamo-Ramos, Jaccard, Dittus & Bouris, 2006) revealed that increased communication predicted delayed sexual initiation and lower levels of adolescent risk behaviour. Dilorio et al. (1999) conclude that this points to the importance of fostering good communication and comfort between parents and adolescents about sexual issues.

Stanton et al. (2002) found that positive parental communication was correlated with increased condom use among adolescents. Crosby, Wingood, DiClemente, and Rose (2002) showed that, among 170 pregnant African American adolescents attending prenatal care clinics, infrequent mother-daughter communication about AIDS was significantly correlated with having had at least one STD. Miller, Levin, Whitaker and Xu (1998), using self reports from sexually active adolescents, demonstrated that mother-adolescent discussions about condoms that occurred prior to sexual debut, were strongly associated with greater condom use during first intercourse. Whitaker, Miller, May and Levin (1999) found with a sample of sexually active black and Hispanic adolescents, that parent-teenager discussions about sexuality and sexual risk were associated with an increased likelihood of teenagers' condom use. The authors stress, however,

that parents' influence on adolescents' sexual behaviour depends on what parents say and how they say it. Whitaker and Miller's (2000) study revealed that parent-adolescent communication about initiating sex and condoms was related to adolescent sexual behaviour, and that adolescents who had not discussed sex or condoms with a parent were more likely to be influenced by peer norms regarding sexual behaviour. Increased parent-child communication was also found to be related to increased self-efficacy regarding condom use and refusal of sex (Blake, Simkin, Ledsky, Perkins, & Calabrese, 2001; DiClemente, Wingood, Crosby, Cobb, Harrington, & Davies, 2001).

On the other hand, other studies (Bettinger, Celentano, Curriero, Adler, Millstein, & Ellen, 2004; Huebner & Howell, 2003) did not find a relationship between high levels of parent-adolescent communication and reduction in risk behaviour. Bettinger et al. (2004) suggest that differences in findings could be because they measured perceived parental communication rather than content, style and delivery of the message. The problem is that parent-adolescent communication is difficult to measure (Newcomer & Udry, 1985); communication varies by sex of the adolescent and parent (Darling & Hicks, 1982; Dutra, Miller & Forehand, 1999; Jaccard & Dittus, 1993); and depends on parental style of communication (Whitaker, Miller, May & Levin, 1999).

In summary, the study of parent-adolescent communication has to deal with many challenges. Notwithstanding these difficulties, studies have shown that open parent-adolescent communication about sexual risk-taking behaviour or HIV were related to delayed sexual initiation and lower levels of adolescent risk behaviour. With sexually active adolescents parent-

adolescent discussions about sexuality and sexual risk were associated with an increased likelihood of teenagers' condom use. When parents did not discuss sex or condoms adolescents were more likely to be influenced by peer norms regarding sexual behaviour. However, what parents say and how they say it is likely to influence adolescent behaviour (Whitaker et al., 1999). DiLorio et al. (1999) underscore the importance of fostering good communication and comfort between parents and adolescents about sexual issues.

Many of the studies on parenting style and adolescents' risky sexual behaviour are based on the perceptions of adolescents and use adolescents' self-reports. One problem with the use of self-report measures with adolescent samples is that the validity of the data is questionable. Zenilman et al. (1995) found in a study of condom use, that self-report measures may be subject to substantial reporting bias. A more recent South African study (Palen, Smith, Caldwell, Flisher, Wegner, & Vergnani, 2008) discovered that, of the sexually active adolescent participants in their sample, nearly 40% reported being virgins after sexual activity had been reported at an earlier assessment.

On the whole, research on parenting style and adolescent risk behaviour suggests that an authoritative parenting style with high levels of supervision and monitoring, high parental expectations, and open communication between parents and children, is optimum for protecting children against risky sexual behaviour. However, there is some evidence that children from a vertical collectivist culture (such as the target community for this research) fare better with authoritarian parents, and that this style of parenting may provide protection in dangerous and/or

poor environments (Furstenburg et al., 1999). As is apparent from this literature review, the majority of studies on parenting style and adolescent outcomes have been conducted in the West, and more specifically, in the United States of America. The few ~~non~~-Western” studies have been mainly with Chinese samples in Hong Kong and these, having obtained contradictory findings, have questioned the ~~Western~~” conceptualization of parenting styles. I was able to locate only one African study (Odubote, 2008) that found that an authoritarian parenting style had a positive developmental outcome for Nigerian adolescents. The literature search did not reveal any studies that have established which parenting style would be best in the South African context.

CHAPTER THREE

FAMILY-BASED HIV PREVENTION PROGRAMMES

The literature review in Chapter Two indicated the importance of parents in the protection of children against high risk behaviour. In this chapter I present family-based youth HIV programmes, with a special focus on CHAMP.

Youth HIV Prevention Interventions

Kumpfer & Alvarado (2003), having reviewed family interventions in the United States, recommend that effective family interventions should be comprehensive and multi-component rather than single component; should include strategies for improving parent child relations, communication and monitoring; and be developmentally appropriate. They are of the opinion that interventions that are culturally appropriate and focus on collaborative empowerment could improve recruitment, retention and effectiveness. They also believe that incentives such as food, childcare and other rewards could enhance recruitment and retention of participants; and that interactive rather than didactic methods are more effective particularly with parents from low socioeconomic circumstances (Kumpfer & Alvarado, 2003).

Many of the recommendations of Kumpfer and Alvarado (2003) are echoed by DiClemente et al. (2008) in their review of youth HIV prevention programmes. They conclude that contextual influences that affect disease acquisition must be addressed in any prevention effort. They emphasize the role of the family, and more specifically, communication between parents and children and parental monitoring of their children's activities and whereabouts. In addition, they

advocate tailored interventions, delivered in a group format with the opportunity for social networking that would encourage adolescents to adopt and maintain HIV prevention practices.

On the basis of their South African study, Kaufman, Clark, Manzini and May (2004), who found a strong association between household members' education and adolescents' risk avoidance, also recommend that programmes promoting risk reduction for adolescents should emphasize family and households. Harrison et al. (2010) concur with the opinion regarding the merits of group-based interventions. Having reviewed eight South African intervention programmes (specifically excluding CHAMPSA because it is a family-based programme), they conclude that group-based interventions provide the opportunity for participants to engage in collective critical thinking, leading to positive shifts in social norms, increased self-esteem and empowerment. They also advocate the adoption of structural approaches to change the context of youth HIV risk.

The Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP)

The CHAMP Family Program was developed in Chicago in 1994 and was originally targeted specifically to African American inner city youth. It is a family-focused, developmentally timed programme targeting pre- and early adolescents (9-13 years) who may not be sexually active, but are often exposed to situations of sexual possibility. CHAMP's developmental perspective maintains that a successful HIV prevention programme needs to intervene prior to the initiation of sexual and other risky behaviour, specifically pre- and early adolescence, and also address social and psychological factors that impinge on adolescent sexual decision making (Bhana al., 2010).

The theoretical approach underpinning CHAMP is the Triadic Theory of Influence (TTI) (Flay, Snyder & Petraitis, 2009) which is both a theory of the problem, focusing on explaining and predicting health behaviour change; and a theory of action, guiding the development of health-promoting interventions. The TTI suggests that people are influenced by three distinct streams of influence: intra-personal influences that contribute to feelings of *self-efficacy* regarding specific behaviours; interpersonal social influences that contribute to *social normative beliefs* about specific behaviours; and cultural-environmental influences that shape *attitudes* about specific behaviours. According to the TTI, some variables (e.g. intentions) are causally proximal, having a direct effect on behaviour, while others (e.g. motivation to comply) are causally distal as their effects are mediated through numerous other variables, such as social normative beliefs.

The development of CHAMP was also informed by basic research studies that found that risk behaviour in youth was associated with: family processes (e.g., communication, decision making, conflict, supervision/monitoring, support); outside family parental support network resources; youth and family HIV/AIDS knowledge and comfort discussing sensitive issues; and youth communication, social problem solving, and refusal skills (Paikoff, Truabe, & McKay, 2007).

CHAMP adopts a two-pronged approach. Firstly, it strengthens families' abilities to prevent youth spending time in sexual possibility situations; this includes parental monitoring, discipline, conflict resolution, support, and communication about sensitive topics between parents and youth. Secondly, it targets youth social problem-solving abilities such as recognition of risk, and refusal skills in order to reinforce abstinence from sexual intercourse (Baptiste et al., 2006; McKay et al., 2004). CHAMP also recognises the importance of social networks in supporting

parents so that the “adult protective shield” is strengthened by the “re-established village” (Bell, Flay & Paikoff, p. 20).

An important aspect of CHAMP is community participation including: links between researchers and people within the community; the formation of a stakeholder advisory group to monitor the program; inclusion of indigenous knowledge and perspectives when designing each programme; and recruitment of people to implement interventions in their own neighborhoods (Baptiste et al., 2006). These, according to Baptiste et al. (2006), are likely to increase sustainability of the programme and participants’ engagement in the process. Cultural and contextual relevance of the programme also helps to navigate barriers within targeted communities (Bhana, et al., 2010).

CHAMP is a 12 week programme with each meeting lasting about 90 minutes. In the United States, the meetings were facilitated by trained programme leaders who were mental health interns, with community consultant/parent co-facilitators. A specific topic for discussion is introduced to groups of ten families. At the beginning of each session, separate parent and child groups explore the topic. In the last 30 minutes parents and children come together in a multi-family group format for families to practise activities. Structured games and activities are used throughout the programme to ensure the interest and engagement of both parents and children.

The topics for each of the 12 sessions are as follows:

- | | |
|-------------|---------------------------------------------------------------------------------------|
| Session 1: | Getting to know the CHAMP Family Program:
Working together to keep our kids safe!! |
| Session 2: | Where are we going? Paperwork!! |
| Session 3: | Talking and listening to each other. |
| Session 4: | Keeping track of kids – Part 1. |
| Session 5: | Keeping track of kids – Part 2. |
| Session 6: | Who can help us raise our children? |
| Session 7: | Rules keep kids safe. |
| Session 8: | Growing up: Talking about puberty. |
| Session 9: | What we need to know about HIV/AIDS. |
| Session 10: | Growing up: Preparing kids for adolescence. |
| Session 11: | Where are we ending up? Paperwork and more paperwork!! |
| Session 12: | A celebration!! Where we have been and where we go from here (McKay et al., 2004). |

Other Family-based Youth HIV Prevention Programmes

Without exception, all the family-based youth HIV prevention programmes located by means of a literature search have been developed in the United States of America. All the programmes focus on similar issues such as HIV/AIDS knowledge, risky behaviour, open and effective communication between parents and their children, and family strengthening. A brief description of each of the programmes follows.

Family to Family (Fullilove, Green & Fullilove, 2000)

Family to Family was not specifically designed to prevent HIV, but to strengthen bonds within and between families in an African American community in Harlem, New York, develop the social capital of the community, and thereby reduce individual risk behaviour. Monthly

community meetings of about 40-50 people strengthen neighbourhood bonds and connect children to other adults in the community. The group meetings also underscore the importance of families and the value of each family member, especially children. Fullilove et al. (2000) believe that Family to Family is a structural intervention because it seeks to alter the social milieu, not just individual behaviours.

ImPACT (Stanton et al., 2000)

Informed Parents and Children Together (ImPACT) is a home-based 60-90 minute intervention in which a facilitator shows a 20 minute video to the parent and youth (12-16 yrs). The video emphasizes several concepts of parental monitoring and communication. The facilitator then leads a role-play of a vignette in which a parent is confronted with evidence of a child's involvement in a sexual relationship. A critique and discussion of the role-play and the video follow. Finally, the facilitator conducts a condom demonstration.

Keeping it R.E.A.L. (Dilorio et al., 2002)

Keepin' it R.E.A.L.! (Responsible, Empowered, Aware, Living) is designed to promote delay of sexual intercourse among 11-14 year old adolescents and to teach mothers to support their adolescents in postponing sexual debut and developing HIV risk-reduction behaviors. Keepin' it R.E.A.L.! comprises two separate HIV prevention interventions: a social cognitive intervention (focusing on HIV prevention) and a problem behavior (or lifeskills) intervention. Each intervention involves seven fortnightly sessions lasting two hours each. The sessions are interactive, with mothers and adolescents being together for some sessions and then breaking away for part of the session.

The Strong African American Families Program (Brody et al., 2004)

The Strong African American Families (SAAF) Program is designed to enhance family protective processes and communicative parenting to reduce substance use, antisocial behavior, and early sexual involvement among rural African American adolescents. The programme, which works with 11-year-olds and their mothers, consists of seven weekly meetings held at community facilities, and involves separate parent and youth skill-building curricula and a family curriculum. Each meeting lasts two hours and includes separate, concurrent training sessions for parents and children, followed by a joint parent-child session during which the families practice the skills they learned in their separate sessions.

The Parents Matter! Program (Dittus, Miller, Kotchick, & Forehand, 2004)

The Parents Matter! Program (PMP) is a community-based family intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction with the ultimate goal of reducing sexual risk behavior among adolescents. PMP targets African American parents with a 9-12 year old child. Parents attend two hour sessions over five weeks. During the interactive sessions, they receive instruction and guidance in general parenting skills related to decreased sexual risk behaviour among youth, including sexual communication skills. The targeted child joins the parent for the last session which includes a video, role plays and discussions between the child and parent.

Mother/Daughter HIV Risk Reduction (Dancy, Crittenden & Talashek, 2006)

The Mother/Daughter HIV Risk Reduction (MDRR) programme is a community-based approach to reducing HIV risk among African American low income adolescent girls. It is based on the behavioural models of Bandura (1982) and Fishbein and Ajzen (1975), and Collin's (1991)

community-other-mothers, African American mothers who mentor non biological children (Dancy, Crittenden & Talashek, 2006). MDRR consists of six weekly two hour classes delivered in a group format. The curriculum focuses on sexual abstinence, but also includes information and practice with the use of condoms. All mothers receive prior training and each class is facilitated by one of the mothers who serves as a model and teacher to her own daughter as well as others in the group (Dancy, Crittenden & Talashek, 2006).

Two programmes that work only with the parent or parents are the PATH Program (developed by Krauss et al., University of Illinois) and Strengthening the Bond (developed by Jemmott et al., University of Pennsylvania)

PATH (Krauss et al., 2000)

The Parent/Preadolescent Training for HIV Prevention Program (PATH) aims to enable parents of boys and girls between the ages of 10 and 13 years, to be effective HIV educators for their children. PATH works with parents in six group sessions of three hours once a week covering such issues as HIV infection and transmission, parent-child communication, recognizing, avoiding and negotiating risk, socializing with persons with HIV/AIDS, and maintaining children's safety. While not working directly with children, PATH does provide several opportunities for parents to practice teaching their children about HIV in the presence of a PATH staff member as a passive observer.

Strengthening the Bond. The Mother-Son Health Promotion Project. (Jemmott et al., 2000)

This programme is based on Bandura's (1986) social cognitive theory, Ajzen and Fishbein's (1980) theory of reasoned action, and Ajzen's (1985) theory of planned behavior (Jemmott et al.,

2000). It was initially developed to prevent sexually transmitted HIV infection among adolescent sons of African American single mothers from low-income urban areas. Facilitators work with the mothers over four 4-hour sessions delivered weekly, with two 3-hour booster sessions 3 months and 6 months after the initial sessions. The small-group sessions are interactive and designed to heighten mothers' awareness of the developmental challenges faced by their sons, foster positive mother-son communication, enhance their skills in encouraging their sons to make positive sexual and life choices, and help mothers to be positive role models for their sons.

To summarize, all the programmes stress the importance of the role of the family in protecting their children against the risk of HIV infection. In addition, they underscore the significance of knowledge about HIV and AIDS as well as open communication between parents and children. The majority of the programmes work with groups, highlighting the importance of support networks within the community. Some of the programmes work with adolescents, but others (Keeping it R.E.A.L.; PMP; SAAF; PATH) like CHAMP recognize the importance of working with preadolescents in order to delay sexual debut. While there are many similarities among all the programmes, CHAMP not only works with preadolescent children in a group context, but also emphasizes community participation, and cultural and contextual relevance, making it one of the most comprehensive of the family-based HIV prevention programmes.

CHAPTER FOUR

METHODOLOGY

The following brief outline locates my project within the broader CHAMPSA programme.

Having been approached by researchers from the USA, South African researchers agreed to pilot CHAMP in KwaZulu-Natal, with the aim of developing it for more extensive use in South Africa. A qualitative, focused ethnographic formative evaluation study (Study 1) was conducted, the findings of which informed the adaptation of CHAMP, and CHAMPSA was developed. Pilot studies were conducted in three sites. A qualitative formative evaluation study (Study 2) was conducted in one of the sites where CHAMPSA was piloted. The focus of my thesis is the pre- and post-pilot formative evaluations i.e. Study 1 and Study 2.

Beyond the scope of this project, outcome data obtained from the pilot studies having been promising (cf. Bhana et al., 2004), the programme was more widely administered in randomized control trials with significant differences being obtained between the intervention and control groups (cf. Bell et al., 2008).

As the research design for both Study 1 and Study 2 was qualitative in nature, and more specifically, formative evaluations of CHAMP using a focused ethnographic case study approach, in this chapter, I examine the qualitative approach to research, and briefly consider ethnography, case studies and formative evaluation. A description of the target community, procedure, data collection methods, and data analysis, as well as a consideration of relevant ethical issues, follows.

Qualitative Research

Vidich and Lyman (1998) ascribe the origins of qualitative research to the early ethnographic studies of 17th, 18th, and 19th century explorers who studied and reported on the strange and foreign “other”. Denzin and Lincoln (2005) on the other hand, locate the origin of qualitative research in early twentieth century colonialism when the reports of unfamiliar, exotic cultures produced by sociologists and anthropologists were used by the colonial powers to subjugate and control them. Anthropological methods were adapted by sociologists at the University of Chicago in the 1920s and 1930s to study cultural groups in the United States, and around midcentury there was a reassertion of an alternative post-positivist paradigm in the social sciences (Devers, 1999). However, by the 1960s, researchers from the positivist quantitative approach, regarded as the foundational paradigm, had consigned qualitative research to an inferior status within the scientific field (Denzin & Lincoln, 2005). More recently (since the 1990s), the postmodernists contend that multiple causes and effects interact in complex non-linear ways in the world, and these cannot be adequately understood by means of the dualism inherent in Western thought (Lather, 1991). The quantitative versus qualitative debate continues today.

Denzin and Lincoln (2005, p. 3) define qualitative research as:

a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level qualitative research involves an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.

Qualitative research is used in many disciplines and does not have a distinct set of methods or practices. It is shaped by diverse ethical and political positions and accepts that inquiry is always value-laden (Denzin & Lincoln, 2005). The researcher has her/his own perspective, and will adopt a particular view of the “Other” who is under study. Qualitative researchers also accept that we cannot capture objective reality which is socially constructed, but can only know phenomena through their representations. However, in an effort to obtain an in-depth understanding of the subject matter, multiple interconnected interpretive practices, each providing a different perspective, are used (Denzin & Lincoln, 2005). This is triangulation, which, according to Flick (2002, p. 229), “adds rigor, breadth, complexity, richness and depth to any inquiry”. Flick (2002) maintains that triangulation is an alternative to, rather than a strategy for, validation.

The quantitative versus qualitative debate

Positivism declares that the scientific method is suitable to all forms of knowledge, natural and social (Devers, 1999). Positivist, quantitative research assumes that science is value-free and objective, that reality is out there to be studied and understood, and that truth can transcend opinion and bias (Carey, 1989; Schwandt, 1997). The quantitative approach uses the deductive method to test theories; it isolates causes and effects, measures and quantifies phenomena, and allows generalisation of findings (Flick, 2002). Quantitative researchers abstract from the world and seldom study it directly; they use an etic, nomothetic approach (Denzin & Lincoln, 2005).

Qualitative researchers, on the other hand, follow an emic, idiographic case-based approach examining specifics of particular cases. Having been confronted with new social contexts as a result of rapid social change, and finding the traditional deductive approaches not always useful, they use inductive methods and study local knowledge and practice, believing it to be a

humanistic way of studying group processes. They also believe that class, race, gender and ethnicity shape inquiry, making it a multicultural process (Denzin & Lincoln, 2005).

Positivists allege that qualitative researchers write fiction or criticism rather than theory or science. They also claim that qualitative researchers have no way of verifying their results; and that their work is exploratory, subjective, and descriptive. However, post-positivist qualitative researchers have challenged the criteria of internal and external validity, reliability, and objectivity that have traditionally been used to evaluate both qualitative and quantitative research (Devers, 1999). They assert that positivist criteria produce a science that silences too many voices and are irrelevant for evaluating their work, and they seek alternative methods of evaluation (Denzin & Lincoln, 2005). These include clarification and justification; procedural rigour; representativeness; interpretative rigour; reflexivity and evaluative rigour; and transferability (Kitto, Chesters & Grbich, 2008, p. 243). Others have suggested other lists of sometimes overlapping criteria (e.g. Creswell & Miller, 2000; Porter, 2007). Kvale (1995, p. 35) who talks derisively about the scientific holy trinity of reliability, validity and generalization, questions the “validity of the validity question”, maintaining that “the more one validates, the greater the need for further validation”. Some qualitative researchers (e.g. Rolfe, 2006) go as far as to insist that there is no coherent ‘qualitative’ research paradigm and that individual studies should be judged for quality on their own merits. The issue of reliability and validity in qualitative research remains a matter of debate.

Trustworthiness

Despite the ongoing debate regarding reliability and validity in qualitative research, Guba and Lincoln (2001) suggest that good qualitative research should have “trustworthiness” (p. 6) which includes the criteria of:

- *Credibility*, roughly parallel to internal validity, and including triangulation, prolonged engagement, persistent observation, peer debriefing, member checks, continuous testing and reworking of hypotheses.
- *Transferability*, roughly parallel to external validity or generalizability; the extent to which the findings are viable in other similar contexts. Strategies for transferability include *thick description* and purposive sampling.
- *Dependability*, roughly parallel to reliability, and established through a dependability audit.
- *Confirmability*, roughly parallel to objectivity, and established by means of an “audit trail” including raw data, process notes and summaries, initial themes, etc. (Guba & Lincoln, 2001).

Ethnography

Qualitative research is associated with a variety of philosophical and theoretical perspectives, one of which is ethnography. Ethnography originated in anthropology, and its goal is to describe and interpret a culture, social group, or system (Devers, 1999). Ethnographic researchers are interested not only in what happens differently in different groups or cultures, but also why (Kelly & Gibbons, 2008). Swanson and Chapman (1994) are of the opinion that ethnography is an appropriate methodological approach for knowledge building and theory generation. Geertz (2000) coined the term “*thick description*” which, according to Kelly & Gibbons (2008),

underscores the importance of symbols in context in ethnographic research. While ethnographic studies mainly use interviews and participant observation, focus groups can provide the opportunity to observe interaction on a topic, as well as evidence about similarities and differences in the participants' opinions and experiences (Babbie & Mouton, 2001).

Focused ethnography

While ethnography is generally associated with long-term field studies, Knoblauch (2005) suggests that short-term or focused ethnographies can be useful for an intensive and rapid collection of information on a specific, focused aspect of a field. Focused ethnographies are short-ranged and are often criticized as being superficial. They are, however, emic in nature, attempting to obtain the perspective of the community under investigation. Because data are collected in a relatively short time period, they require intensive analysis (Knoblauch, 2005).

Case Studies

In designing a case study, the researcher must set boundaries with regard to what is to be described (Stake, 1994). During data collection, triangulation, or the use of more than one source for information, provides support for the conclusions reached (Yin, 1994). One of the most important sources of case study information is the interview (Tellis, 1997). In analyzing the data, the case study researcher considers alternative interpretations before reaching conclusions (Stake, 1994).

Although case methodology has been widely used to investigate the effects of community-based prevention programmes, a common criticism is that because it depends on a single case, one

cannot generalize from its findings (Tellis, 1997). Hamel, Dufour and Fortin (1993) argue, however, that if the parameters of the study are established, and the established objectives are met, then a single case could be considered acceptable.

Formative Evaluation

Evaluation is an ongoing process to determine whether or not a programme is appropriate, effective, and efficient (Deniston, & Rosenstock, 1970). According to Stetler et al. (2006), there is no single definition of formative evaluation (FE), and even some disagreement on the term itself, with variations including *process evaluation* and *formative research*. However, Stetler et al. (2006, p. S2) define FE as “an rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts”; it helps to answer questions related to context, adaptations, and response to change. Formative evaluation is generally used when a new programme is being developed or an existing program is being modified (Mallonee, 2000). Related data may be collected before, during, and after implementation of the intervention to determine its effectiveness and whether there is a need for refinement. FE does not test hypotheses as it is a descriptive assessment activity (Stetler et al., 2006). Hawe, Shiell, and Riley (2004) advise that one should endeavor to understand the intervention and if formative modifications are made, consider whether the FE has facilitated a functional adaptation of the intervention.

The Target Community

The target community for this study was KwaDedangendlale, a formal semi-rural area 40 kilometers outside of the city of Durban, KwaZulu-Natal, South Africa. The people in this area were Zulu-speaking members of the Nguni tribe. This community was chosen because the South

African CHAMP researchers had worked on various community projects in the area and had already established access and ties with the people there.

At the time of the study, the area was relatively underdeveloped with a general lack of piped water and electricity. Furthermore, a significant proportion of the population was unemployed and lived below the poverty datum line. Most women who were employed worked as live-in domestic workers and came home only on weekends; most men who were employed worked in the industries in Metropolitan Durban or even outside the province of KwaZulu-Natal, and came home on weekends or at month-end. As is common in most rural and semi-rural areas in South Africa, households were made up of multi-generational families. In addition, a significant number of individuals rented or lived with families who were unrelated to members of the household. Some of these individuals, particularly women, sometimes lived with unrelated families to increase their own level of protection or to help ease the financial burden of the host household (Hosegood & Solarsh, 2002).

As with many semi-rural and rural areas in South Africa, the transition to a new democratic order was not without tensions. Of particular importance in the target community was the division of loyalties, with some members still owing allegiance to hereditary traditional chiefs, who in KwaZulu-Natal were primarily affiliated to the Zulu-based Inkatha Freedom Party (IFP), while others were generally loyal to elected party political councilors often affiliated to the historically Xhosa-based African National Congress (ANC), the party that controls political power in South Africa. A dual leadership system of elected party political leaders and traditional chiefs or *indunas* thus existed, and community members generally held allegiance to one or the other. In addition to larger political power struggles that existed between these two leadership structures,

as found by Campbell, Foulis, Maimane, and Sibiya (2005), their value systems and beliefs were likely to pull in different directions. Traditional chiefs tended to promote traditional values and the party political leaders were more likely to support Western-dominated value systems aligned with ANC government policies.

Procedure and Participants: CHAMPSA

When the prospect of using CHAMP in South Africa was first proposed to the South African researchers by those in the USA, the South African researchers, having identified the target site approached the relevant (traditional and political) leaders in the community for permission to conduct the programme there (Appendix 1 is a letter of support from the Director of Community Services). Once permission was obtained, a steering committee was formed to oversee the entry of the CHAMP programme into the community. The steering committee, comprising researchers and traditional and political leaders from the target site, identified a school in the Embo area of Kwadedangendlale for the pre-intervention study (Study 1), the findings of which were to be used to adapt CHAMP for the local context. This school was to be one of three sites for the pilot interventions, and the site for the post-intervention evaluation (Study 2). (My research focuses only on this school site, the other two being part of the broader CHAMPSA project.)

Notices were sent home with children aged 9–12 years attending the identified school. Families were invited to attend an informational meeting and were deemed eligible (for CHAMPSA) if at least one adult caregiver and preadolescent child aged 9–12 were able to attend the 13-week intervention. The parents were informed at the first meeting that the intervention would be free of charge, while a stipend of R50 (and lunch) would be given to each family for attending each

CHAMPSA session and an additional R250 for attending all 10 sessions. A volunteer, convenience sample was recruited thereafter.

Some of the parents had some high school education and at least one individual in each family was employed. Almost all of the families spoke the Zulu dialect at home and belonged to an organized church or group of Christian faith. Relatively equal numbers of boys and girls participated in the broader CHAMPSA study and averaged about 10 years. Most children lived with adult caregivers (e.g., mother, grandparent, or adult sibling), with some living with only one caregiver (Baptiste et al., 2006). While families participated in CHAMPSA, the participants of my project were the parents (NB. While I use the term “parent/s”, this includes caregivers who might not have been the biological parent/s of the children).

Data Collection

Common methods of qualitative data collection are interviews (unstructured and semi-structured), focus groups, and participant observation (Fossey, Harvey, McDermott & Davidson, 2002). The following discussion is confined to focus groups and semi-structured interviews which were the methods used in the current project. Although focus groups and individual interviews are independent data collection methods, Lambert & Loiselle (2008) assert that combining them, a form of triangulation, can yield complementary views and a more comprehensive understanding of the phenomenon under consideration.

Focus Groups

Focus groups are facilitated group discussions that use the group interaction to explore the research issue. Focus groups have been extensively used and popularized by the field of

marketing (Kreuger & Casey, 2000). Participants in focus groups are selected because of their shared social or cultural experiences, or concerns related to the study focus (Rice & Ezzy, 1999). Data collected from focus groups reflect the collective views of group members rather than an aggregation of individual interviews (MacDougall & Fudge, 2001). In considering the validity of focus groups, Reed and Payton (1997, p. 770) argue that focus groups reflect “the process of developing a group perspective” rather than facts about the real world external to the focus group, but that members of focus groups do have particular ideas that they have developed previously. More detail about the focus groups, which were used as part of data collection for the pre-intervention Study 1, is presented below where the participants and procedure of Study 1 are described.

Interviews

Qualitative research interviews, which may be unstructured or semi-structured, endeavor to obtain the participants’ perspective of their experiences, feelings and social worlds (Fossey et al., 2002). Semi-structured interviews use an interview guide, containing a list of questions, to facilitate focused exploration of a specific topic in a flexible and conversational, manner (Minichiello, Aroni, Timewell & Alexander, 1990).

The focus groups and interviews for this project were conducted by black African Zulu-speaking psychology interns trained in interviewing skills. These interns were also the facilitators for CHAMPSA. The focus group instructions and semi-structured interview schedules were translated into Zulu by one of the facilitators and then back translated by another facilitator to ensure that they had been adequately translated. All focus groups and interviews were audio-taped, transcribed and translated. Transcription and translation was done by a Zulu-speaking

research assistant with extensive experience in transcription and translation for researchers at the University of KwaZulu-Natal. Parts of the translated data were back translated by one of the facilitators to determine accuracy. A discussion about translation in research is presented in Chapter Eight as part of my reflections about the project.

Participants and Procedure: Study 1

The sample for Study 1 was a volunteer convenience sample of parents from families that were deemed eligible for CHAMPSA who chose to participate. Four parent focus group discussions were conducted at the identified school in Zulu, by trained facilitators. Each focus group comprised 8-10 participants with a roughly even mix of men and women, yielding a total number of 38 participants in the four groups. The groups were conducted over approximately ninety minutes each. The participants were informed about the research project; asked about their perspective on the problem of HIV/AIDS; what role they, as parents, could play in protecting their children; and whether they encountered problems in parenting their children. (See Appendix 2 for the schedule including probe questions).

The focus groups were followed up with in-depth individual interviews with six adults (three females and three males) from the same sample. Given the iterative nature of qualitative research, four key community members were also interviewed to further interrogate issues emerging from the focus groups and individual interviews with parents, totaling 10 in-depth semi-structured individual interviews.

The interview schedule was based on an initial analysis of the data obtained from the focus group discussions. The final schedule was drawn up after discussions with the CHAMPSA team and

was based on themes that had emerged from the focus groups, and that were considered to require further interrogation. The interview schedule is included in Appendix 3. While I am not fluent in Zulu, I attended all focus groups and interviews in order to address any queries that might arise.

A stipend of R50 was paid to each person who participated in a focus group and/or an interview.

Participants and Procedure: Study 2

Efforts were made to contact and invite all the parents who had participated in the original pilot intervention of CHAMPSA. While there had been 21 parents in the original pilot group, of whom three were men, only nine women were available for the follow-up interviews. They made up the volunteer convenience sample for Study 2.

The in-depth semi-structured interviews were based on the themes that had emerged from the pre-intervention focused ethnographic study (see Appendix 4 for the interview schedule), and were conducted in Zulu by a black African psychology intern, trained in interviewing skills. He had been part of the team that had administered the original pilot intervention. I was present at the first two interviews, which were used as pilot interviews. Minor changes were made to the interview schedule for the subsequent interviews. The two pilot interviews were included in the data analysis. Each interview was conducted over about 60-90 minutes. Each participant was paid a stipend of R50 for participation in the interview.

Data Analysis

According to Morse (1994) all qualitative analysis involves the following: comprehending of the phenomenon being studied; synthesizing of relations and linkages into a coherent portrait; theorizing about the relations and linkages; and recontextualizing the new knowledge into what is already known.

The aim of data analysis is to establish patterns and connections among segments of texts that contain some particular meaning (Tesch, 1990). In thematic content analysis which was used in both studies, these are coded, sorted and organized. Constant comparisons are made in a progressive process of classifying, comparing, grouping and refining groupings of text segments to create and then clarify the definition of categories, or themes, within the data (Lincoln & Guba, 1985). While this inductive approach derives and develops categories from the data (Tesch, 1990), Malinowski (1992, cited in Hammersley & Atkinson, 1995, p. 24) who maintained that “preconceived ideas are pernicious”, recommended that the qualitative researcher approach the field of study with “foreshadowed problems” based on her/his theoretical background. While the researcher is informed by these foreshadowed problems she/he is also informed by the emergent data, refuting or developing new hypotheses where necessary (Hammersley & Atkinson, 1995).

Through reading and re-reading the transcriptions, I immersed myself in the data in order to become familiarized with it. The data were then coded and themes were induced. With further reading and familiarization, the themes were elaborated and interpreted.

Ethical Issues

According to Babbie and Mouton (2001), if one is going to do social scientific research, then one should be aware of what is proper or improper in the conduct of social scientific inquiry. Some of the ethical issues that should be considered are:

Informed consent

This term includes both the concept of *voluntary participation* and *no harm to participants*.

As social research can be an intrusion into people's lives, requiring revelation of personal information and a disruption of their regular activities, the social scientific researcher should, as far as possible, ensure not only that participation is voluntary, but also that there will be no physical or psychological harm to the participants (Babbie & Mouton, 2001). For the CHAMPSA project, including the pre- and post-intervention studies, all participants were fully informed about the programme, and consent was obtained by all participants. There was no question of deception; participation was entirely voluntary, and was not likely to cause harm.

Anonymity and confidentiality

Anonymity in this project was not possible as CHAMPSA is delivered in a group format.

However, where individual interviews were conducted, anonymity regarding the identity of each participant, as well as confidentiality with regard to information they provided, was maintained.

Offering inducements for participation

One of the ethical issues addressed by the Professional Board for Psychology of the Health Professions Council of South Africa (HPCSA) is the offering of "excessive or inappropriate financial or other inducements" (HPCSA, 2002, p. 19). People participating in the focus groups

and interviews for Studies 1 and 2 were paid a stipend of R50 each, but this was neither excessive nor inappropriate, considering the poverty of the participants, the time that they invested in participating, and sometimes the cost to them of travelling to the school where the focus groups and interviews were conducted.

Institutional approval

At the onset of negotiations regarding the use of CHAMP in South Africa, my colleagues and I completed an online course on Human Participation Protection Education for Research Teams sponsored by the National Institutes of Health (Appendix 5). Ethical clearance for my project was also obtained from the then University of Durban-Westville (Appendix 6). (University of Durban-Westville and University of Natal merged in 2004 and is now called University of KwaZulu-Natal).

CHAPTER FIVE

THEORETICAL UNDERPINNINGS

Given that this project used a qualitative ethnographic case study approach, I had no ~~per~~ pernicious preconceived ideas” (Malinowski, 1992, cited in Hammersley & Atkinson, 1995, p. 24), but as data emerged, my concurrent exploration of the literature revealed three key theoretical approaches that assisted in understanding the dynamics occurring within the community and the programme participants. These approaches constitute the theoretical underpinnings of my thesis. Social representations theory and more specifically, Joffe’s (1996a) psychodynamic extension of this theory helped to understand the representations of the threat of HIV/AIDS and the related anxieties among the people in the target community especially in relation to the safety of their children. Social capital theory helped to explain the erosion of trust, reciprocity and social networks in the community. Community health psychology elucidated the role of critical reflection and dialogue of social issues in collective empowerment to facilitate health enhancing social contexts and thereby increasing social capital.

A description of social representations theory, social capital theory, and community health psychology, together with related research, follows.

SOCIAL REPRESENTATIONS THEORY

Given that one of the objectives of Study 1 was to understand how people in the Embo community understood the relatively new phenomenon of HIV/AIDS, social representations theory (SRT) provided a useful theoretical framework for understanding the targeted

community's collective representations of this phenomenon. Joffe's (1996a) psychoanalytic expansion of social representations theory, which explains how communities and individuals cope with new and what they perceive to be threatening phenomena, was deemed an appropriate "foreshadowed problem" to inform the interpretation of the Study 1 data.

The theory of social representations was developed by Moscovici (1961, cited in Voelklein & Howarth, 2005) and was based on his study of the diffusion of the scientific concept of psychoanalysis among the French public in the 1960s (Voelklein & Howarth, 2005). Moscovici was influenced by Durkheim's (1898, cited in Voelklein & Howarth, 2005) notion of collective representations, a form of knowledge that is produced by a single source of authority, that is strongly resistant to change and that functions to bind societies together (Voelklein & Howarth, 2005). However, Moscovici (1988) differs from Durkheim, in that he does not consider representations to be homogeneous. As Howarth (2001) points out, the concept of collective representation does not reflect the mobile and heterogeneous nature of contemporary societies. Moscovici (1988) maintains that there is a plurality and diversity of representations within any group, and that all human beings have the power and agency to develop and negotiate representations.

Moscovici defined social representations as

systems of values, ideas and practices which....enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history (Moscovici, 1973, p. xiii).

In other words, social representations are "ways of world making" (Moscovici, 1988, p. 231).

Social representations are a specific way of understanding and communicating what we know already. Moscovici (1984) distinguishes between the consensual and the reified universes: the consensual universe is the world of common sense where social representations are created, negotiated and transformed; the reified universe, on the other hand, is the world of experts and scientists whose judgements of reality are based on experimentation, logic and rational choice. Social representations deal with the consensual in that they explain objects and events so that they become accessible to everyone. According to Moscovici (1984, cited in Voelklein & Howarth, 2005), every social representation has a triadic relationship that creates an inter-subjective reality: the object that is represented, the subject that undertakes the representation, and the social group of the subject.

Social representations are also prescriptive in that they influence the mind of the individual so that representations, while shared by a group, are not thought by individuals but re-thought, re-cited and re-presented. Present experiences and ideas are controlled by the past through social representations, and the less aware we are of representations, the greater is their influence (Moscovici, 1984).

According to Moscovici (1984), the primary function of social representations is to make the unfamiliar familiar. The unfamiliar threatens to disrupt the established order and social representations make the unusual usual so that the unknown can be included in an acknowledged category. The objects, persons, and events we encounter are “conventionalized”, so that each new experience is added to a reality that is shared by a group of people (Moscovici, 1984, p.7). This is achieved through socio-cognitive activity and this process is neither cognitive nor social, but both simultaneously (Voelklein & Howarth, 2005).

The way in which the unfamiliar is made familiar, according to Moscovici (1984), is through two mechanisms based on memory and foregone conclusions: *anchoring* and *objectification*.

Anchoring involves comparing what is foreign and disturbing or threatening with existing known categories and thus classifying and naming it, and assigning it a positive or negative value (Moscovici, 1984). The new events, pieces of information, and so on are molded in such a way that they appear continuous with existing ideas. Importantly, anchoring is not an individual process but one in which group members make the unfamiliar familiar through shared ideas, images and language. Thus community beliefs, myths and norms become codified. Scientific knowledge is also anchored by transmission through various media forms and lay thinkers; ‘facts’ are interpreted in lay terms and these become reality for the recipient, rendering that which is unfamiliar (and initially inherently threatening), familiar (Joffe, 1996a).

Objectification is a more active process than anchoring. Through the use of image, symbol and metaphor (Wagner, Lahnsteiner, & Elejebarrieta, 1995), objectification transforms the abstract links to past ideas that are set up by anchoring into concrete mental content thus making them easier to grasp (Joffe, 1996b). Images become elements of reality rather than elements of thought (Moscovici, 1984). The use of symbolization helps people to feel that they understand complicated issues (Joffe, 1996b). This, according to Joffe (1996b), is the essential difference between SRT and more cognitive or discursive frameworks (Joffe, 1996a). When unfamiliar ideas are objectified, individuals draw on ways of thinking that are acceptable to the groups with which they identify, and that are a response to a fear of powerlessness in the face of a social object that cannot be controlled (Joffe, 1996a). Thus, social representations have a calming function, and serve to defend individuals and the collective identity of the group against threat (Moscovici, 1984), or in Joffe’s (1996a) words ‘the shock of the new’ (p. 197).

In a review of two studies (Foster, 2001; Dorrer, 2002), Howarth, Foster and Dorrer (2004) underscore three aspects of social representations theory:

First, it recognises competing systems of knowledge without privileging one form of knowledge over another, especially lay and professional knowledge. Knowledge systems have a purpose and value within their own contexts. Competing and sometimes contradictory versions of reality can coexist within one community, culture, or even within an individual as found by Gervais and Jovchelovitch (1998), Wagner, Duveen, Verma, and Themel (2000) and Foster (2001).

Moscovici (1961) called this *cognitive polyphasia* which sometimes occurs because social representations can be bound to social contexts as demonstrated by the work of Mugny and Carugati (1989, cited in Wagner et al., 2000), where parents had competing representations of their children's intelligence depending on the context in which it was being discussed.

Secondly, social representations defend and maintain stigmatising practices in conjunction with wider social, economic and political factors, and can play a role in maintaining unequal inter-group relations and social exclusion (Howarth, 2001). However, while representations can take on their own ontological reality (Markova, 1996), they can be resisted and transformed by individuals and groups (Moscovici, 1984). Krause (2002) demonstrated the transformation of social representations among a group of people with Crohn's Disease and Ulcerative Colitis. By instituting a program to expand information and social support in the group, sensitize the mass media to the conditions, and promote the public image of the group, she found that after a year, participants' representations of their disease were less stigmatizing, and it posed less of a threat to their identities.

Thirdly, while one of the functions of social representations is identity protection, they can have an impact on identity and well-being when others have negative representations of us. While people do resist and reject others' negative representations of them in order to protect a sense of self (Howarth, 2006), Joffe (1996) describes the concept of *spoiled identity*, where some people internalize dominant representations of them.

Psychodynamic extension of social representations theory

Joffe (1996a) suggests a psychodynamic extension of SRT in order to understand how an individual copes with the knowledge of a serious threat. She suggests that defences are employed when fears are not contained, such as with the HIV epidemic. An individual uses defence mechanisms of splitting and projection to create distance between her/himself and the perceived threat. Splitting involves the differentiation of feelings into good and bad components in order to obtain relief from fears. It is often accompanied by projection, which involves locating negative feelings in others rather than in the self in order to retain a sense of safety (Joffe, 1996a). These coping strategies may alternate with a more "mature" position characterized by tolerance of ambivalence and recognition of both "good" and "bad" aspects within the self and others (Halton, 1994).

Thus social representations often serve to distance people from threat and protect the positive identity of the self as well as the in-group. To account for the protective nature of social representations of threat at a community level, Joffe (1996a) draws on Social Identity Theory (SIT) (Tajfel & Turner, 1979) to make the critical transition from the inter-personal to the inter-group level. SIT posits that social identity is a part of personal identity. Further to this is a body of literature attesting to the mirroring of individual processes within group situations (cf.

Hinshelwood, 1987; Obholzer & Roberts, 1994). Central to bringing psychoanalytic concepts to understanding groups, is the understanding that, as individuals utilize defences to cope with anxieties, so do groups of people. Given that people are intrinsically resistant to change, anxieties are likely to be most pronounced in contexts of social change. Defences of splitting and projection are likely to come into play between groups; identification with an ‘in-group’ that one regards favourably provides safety from an ‘outgroup’ (such as those suffering from AIDS) that is perceived to be deviant (Joffe, 1996a). Understanding these unconscious processes at play at a community level would facilitate greater understanding of how to put in place measures to contain group anxieties and obviate the need for unhealthy defences (Obholzer, 1997).

Social Representations Theory, Community Health Research, and Power

The potential of social representations theory in community health approaches has been suggested by Campbell and Jovchelovitch (2000) and Howarth et al. (2004). Campbell and Jovchelovitch (2000) maintain that in the lay knowledge embedded in representations are the practical and symbolic resources of the community. They warn, however, that while recognising local knowledges expressed in the social representations held by a community, these can be open to ideological distortions and the same representations can be both adaptive and harmful as found by Campbell (1997). Campbell and Jovchelovitch (2000) stress that participation in community health research allows for social representations to be expressed and reaffirmed, and for dialogue and negotiation between different representations within and between communities.

According to Jovchelovitch (1997), community health researchers should consider the power differential between and within communities since not all representations are equally recognized. Dominant social representations can be hegemonic, and can be used to naturalise and legitimise

exclusion and othering (Howarth, 2006). Howarth (2006) maintains that social representations theory needs to examine the role of power in the reification and legitimisation of ‘expert’ knowledge systems, and to interrogate the aim of research within a social representations perspective. “Is it to support or to criticise the social order? Is it to consolidate or transform it?” Howarth (2006, p. 1) asks.

However, social representations are not simply impressed upon us without the possibility of debate, opposition and refusal. Even extremely disparaging representations of a community (or individual) can be reworked to challenge stereotypes and marginalizing practices (Howarth, 2001). “Re-presentation” provides the space for contestation and dialogic reflection and transformation of representations (Howarth et al, 2004, p.19).

Critique of Social Representations Theory

In a review of criticisms of SRT, Voelklein and Howarth (2005) examined four major controversies related to the theory.

One of the main criticisms has been that SRT is too broad and vague and has little substance or originality, with some authors (e.g. Billig, 1988; Potter & Litton, 1985; Valsiner, 1998) maintaining that it is not a theory at all, but a “pseudo-explanation” (Jahoda, 1988, p. 206).

Voelklein and Howarth (2005) contend that while Moscovici has provided definitions of SRT, he has deliberately advocated an inductive and descriptive approach rather than an hypothetico-deductive model that formulates clear guidelines for testing and operationalising a theory. One of the reasons for this is that social representations are volatile and will change over time. Voelklein and Howarth (2005) also assert that another problem is one of misunderstanding because the

theory was originally elaborated in French and Moscovici's original work was not available in English.

Another criticism of SRT is that of social determinism (e.g. Jahoda, 1988; Parker, 1987, both cited in Voelklein & Howarth, 2005), that there is little scope for social change and that all individuals have a consensual view of reality with the same images and explanations. Voelklein and Howarth (2005) argue that consensus is not the sole defining feature of social representations; it is the product of collaboration and negotiation; representation is not simply a repetition or replication of some idea presented by a dominant social group that is synonymous with uniformity; it involves the deliberate action of those involved.

A third criticism is that SRT overemphasizes cognition (Jahoda, 1988; Parker, 1987; Semin, 1985, all cited in Voelklein & Howarth, 2005), and that the two key processes of anchoring and objectification are similar to the concepts of categorization and schemata of cognitive psychology. According to Voelklein and Howarth (2005) research (e.g. Jodelet, 1991; Voelklein, 2004; Wagner, Elejabarrieta & Lahnsteiner, 1995) has shown that anchoring and objectification are not only cognitive but also social, cultural and ideological. According to Markova (2000), cognition from a social representations perspective is socio-cultural and dynamic and cannot be reduced to an individual level.

Finally, SRT has been accused of being acritical and of not addressing issues of power and ideology (Ibañez, 1992; Jahoda, 1988; Parker, 1987, all cited in Voelklein & Howarth, 2005). Moscovici has been criticized for making a distinction between the consensual and reified

universes; that is, separating the world of science from the world of common sense (Jahoda, 1988; McKinlay & Potter, 1987; Potter & Billig, 1992; Wells, 1987, all cited in Voelklein & Howarth, 2005). As the critics argue, science is also subject to historical and social influences, and also relies on social representations. Furthermore, critics assert that while the relationship between the reified and the consensual is often described and researched as a one-way process, little attention is given to how common sense influences the content and structure of science. As Voelklein and Howarth (2005, p. 21) declare, “if all knowledge is socially constructed, so is scientific knowledge”. They propose, however, that the reified and the consensual could co-exist as two interacting forms of knowledge.

Voelklein and Howarth (2005, p. 2) conclude that many of the criticisms of SRT are due to a “difficulty in understanding and integrating the complex, dynamic and dialectical relationship between individual agency and social structure that forms the core of social representations theory”. They contend, however, that engagement with the critics would provide clarification and initiate critical dialogue, which would be crucial for theoretical development.

Social Representations and HIV/AIDS

There is a wealth of research on SRT. Howarth (2006) refers to an extensive range of topics from Moscovici’s seminal study of psychoanalysis (1961/1976) to the public understanding of science and new technology (e.g., Bauer & Gaskell, 1999; Gaskell, Bauer, Durant & Allum, 1999; Wagner & Kronberger, 2001), popular ideas of health and illness (Campbell & Jovchelovitch, 2000; Gervais & Jovchelovitch, 1998; Herzlich, 1973; Jodelet, 1991; Joffe, 2002), constructions of identities (Breakwell, 2001; Duveen, 2001; Howarth, 2002a) and human rights (Doise, 2001; Doise, Staerkle, Clemence and Savory, 1998; Doise, Clemence & Lorenzi-Cioldi, 1993; Le Duc, 2001). However, this

literature review has been limited to those studies that have examined social representations of HIV/AIDS.

Paez et al. (1991) interviewed 813 respondents in a Spanish study of the social representations of AIDS. They found that the sample could be clustered into those with liberal or conservative beliefs. Those with greater contact with homosexuals (believed to be a high risk group) and seropositive individuals, tended to have liberal beliefs and less negativistic attitudes towards AIDS. They also found that people distort or alter their recall of original information in accordance with their social representations. The authors believe that representations maintain their stability in this way.

Joffe (1996b) used semi-structured in-depth interviews (conducted in 1990/1991) to explore the social representations of the origin and spread of AIDS in their country, among a sample of young, urban, sexually active adults in Britain and South Africa, with the aim of comparing the representations in the two cultures. She found that both groups used *anchoring* of the incurable illness to the 'other'. In both groups, White respondents believed that AIDS originated in Africa, while black respondents ascribed its origin to the West. Furthermore, respondents denied that HIV/AIDS affected their in-group. Joffe (1996b) maintains that this projection allows the individual to preserve a positive individual and group identity, and deny one's own vulnerability to threat. Both groups also used *objectification* to concretize abstract 'othering' to sinful and perverse practices of the other. This, according to Joffe (1996b), would have implications for behaviour, because if the in-group is not perceived as vulnerable, then there is no need to change one's behaviour. Social representations are not always identity protective, however, and evidence of *spoiled identity* was found where despite 'othering', some members of the sample internalized

the dominant representations of them. These were gay or black persons who were often held responsible for AIDS, and were regarded by the wider society as out-groups. Joffe (1996b) believes that the incentive for change lies with members of blamed groups who should be given a central role in AIDS policy-making.

Joffe and Bettega (2003), using semi-structured interviews, explored social representations of AIDS among 60 urban adolescents in Zambia. They specifically investigated conceptualizations of the origin and spread of AIDS, and perceived personal risk. AIDS was believed to have originated in the West, and to be God's punishment for immoral sexual behaviour; both representations being identity protective by associating this threat with the 'other'. Adolescent girls, in this patriarchal society, were largely blamed for the spread of the disease, and this was often linked to poverty and girls exchanging sex for money. Male identity was protected, with males being represented as not having control over sexual desire and thus inadvertently spreading AIDS. In this way existing norms, values and power relations are perpetuated, with women being derogated and consigned to a disadvantaged position. The majority of the participants believed that they were not at risk of contracting HIV, mainly because of abstention or because of their knowledge of how it is spread. Joffe and Bettega (2003) conclude that their data reflect a sense of powerlessness among both boys (sexual drive and peer pressure) and girls (need for money) that compromises the active choice that must be made in decisions to abstain.

Goodwin et al., (2003) interviewed 511 business people and health professionals in five Central and Eastern European countries to examine social representations of HIV/AIDS in these post-Communist countries. The respondents completed a free association task with the stimulus word *AIDS*, as well as answering questions derived from social representation theory. The findings

indicated a general negative set of associations around AIDS and the threat it poses, but beliefs about the origins and spread of HIV, prevailing conceptualizations of moral responsibility and blame, and attitudes towards the role of the government varied across countries. The authors conclude that these variations reflect differences in testing regimes, disparities in media portrayals of HIV/AIDS, and the varying influence of religious beliefs on the growth of the epidemic in different cultures.

In a similar study, Goodwin et al. (2004) explored the social representations of HIV/AIDS amongst 494 business people and health professionals in the same Central and Eastern European countries. Having analyzed free associations around the term *HIV/AIDS*, the authors found two major factors underlying representations of the stimulus: they termed them *Sex* and *Deadly disease*. Respondents tended to perceive those at risk from contracting HIV/AIDS as belonging to an ‘out-group’ that included prostitutes, those engaging in casual sexual activity and those that carried condoms. The authors recommend that this psychological “distancing” that allows a sense of detachment from those perceived to be at risk, requires a community-focused approach to address prevailing representations in these conservative cultures with strong religious sensibilities.

In a Brazilian study, Brasileiro and Freitas (2006) interviewed nine HIV positive people over 50 years of age, to explore their representations about AIDS. Their analysis revealed that the central representation of AIDS was that it is a constant death threat. Other representations were that being old and having AIDS means being discriminated against twice; AIDS isn’t cancer; and that doctors don’t think, at first, that they (older people) can have AIDS. The authors conclude that HIV positive people over 50 years are socially isolated, and recommend policies that would lead

to the reconstruction of representations and remove attitudes of rejection, prejudice and abandonment.

Caramlau and Goodwin (2007) used SRT to explore: the content of publicly available safer sex promotion leaflets; how young people in Romania depict HIV/AIDS; and whether the leaflets' content is reflected in young people's social representations of HIV/AIDS. A free-association task using the stimulus term *HIV/AIDS*, and a semi-structured questionnaire were used to elicit social representations of HIV/AIDS among a sample of 186 students aged 18 to 24 years. The participants' social representations of HIV/AIDS corroborated the health promotion leaflets. However, they did not see themselves as being at risk, but anchored the risk of infection on *other* 'at risk' groups: drug users, careless people, homosexuals, promiscuous people, and those practising unprotected sex. These social representations helped in protecting their identity by associating the illness with an out-group who were unfortunate' or 'out-of-control'. The authors conclude that while health promotion messages were successful in conveying AIDS-related knowledge, they seemed to have failed in influencing people's perception of their own vulnerability.

Campbell, Skovdal, Mupambireyi, and Gregson (2010) examined Zimbabwean children's stories and drawings to understand how children represent AIDS and AIDS affected children, and whether and how they stigmatise AIDS-affected peers. They found that the impact of AIDS on children was overwhelmingly presented as negative. Children were depicted as deprived, discriminated against, rejected, 'children with no childhood' and as children with reduced educational opportunities impacting negatively on their future life chances. AIDS was represented as a deadly and contagious disease which could be transmitted through casual social

contact. Some of the representations were more complex and ambiguous, and included feelings of admiration, respect and empathy. There was empathy and admiration for AIDS-affected children who supported and cared for ailing parents. Campbell et al. (2010) recommend that stigma reduction programmes should go beyond simple information provision, to facilitating social spaces in which groups of children could engage in critical thinking and dialogue regarding different ways of thinking about the stigmatised situation of their AIDS-affected peers. The authors suggest that stigmatising representations held by children may be more malleable and open to contestation and transformation than adult stigma.

Schoeneman, Schoeneman-Morris, Obradovic, and Beecher-Flad (2010) examined 94 abnormal psychology textbooks published from 1984 to 2005 in the United States to explore iconic social representations of AIDS in pictures in the first quarter century of the disease. Schoeneman et al. (2010) wished to interrogate whether there was a balance between sympathy and the use of established anchors of AIDS in the pictures in their sample. The authors identified 129 pictures relating to AIDS/HIV. They maintain that abnormal psychology textbooks, by definition, focus on a basic category of Otherness, the mentally ill; and put the viewer and the viewed on opposite sides of the boundary between health and illness. Including AIDS/HIV in a textbook of abnormal psychology links AIDS/HIV status or risk with mental disorder, a potential double stigmatisation. They conclude that authors, editors, and publishers of abnormal psychology textbooks unwittingly and unavoidably use social representations of AIDS that illustrate and reinforce the anchoring of the disease in concepts such as otherness, death, victimisation, and culpability.

In a study in Lalitpur, a district in India, Sharma, Singh and Mishra (no date) explored social representations of HIV/AIDS among 639 respondents aged 10 to 24 years, using both qualitative

and quantitative data gathering methods. The paper was part of a report for UNICEF on the district's vulnerability to HIV/AIDS. They found that the level of knowledge about HIV/AIDS, particularly among women, was poor; a large percentage of the sample had heard of the disease; their main sources of information were TV and radio; only 28% of the sample believed that HIV could not be treated; only a very small percentage believed that people with HIV/AIDS should be exiled, but others believed that extra caution was required when living closely with them.

In conclusion, the reviewed studies indicate that social representations about HIV/AIDS tend to be negative. The disease tends to be anchored in 'others', reducing the sense of personal vulnerability and protecting in-group or self identity. However, social representations are not always identity protective and Joffe (1996b) describes the concept of *spoiled identity*, where some people internalise dominant negative representations of themselves. Social representations may also be used to perpetuate power relations. Greater contact with people with HIV/AIDS seems to reduce stigmatising negative beliefs and attitudes. While social representations can change they do remain relatively stable. Goodwin et al. (2003) showed that social representations also vary across cultures. One of the recommendations emerging from these studies is that addressing social representations requires a community-focused approach (Goodwin et al., 2004).

Critique of Research

In criticising the social representational approach in AIDS research, Fife-Shaw (1997) maintains that it is too broad, not predictive of behaviour, involves tautological reasoning, and no different from lay theories. In her rejoinder, Joffe (1997) describes how findings from non-predictive research have been used to inform AIDS prevention campaigns in Britain. Regarding breadth and tautology, Joffe (1997, p. 79) asserts that SRT is not a causal approach; it is a reciprocal model

rather than a linear one: “representations are hypothesized to underpin, but not to cause, thought and action”. SRT is different from other lay theories in that it involves the transfer of information between social institutions and minds and the transfer of older ideas to new phenomena (Joffe, 1997).

On a broader level, Campbell and Jovchelovitch (2000) believe that SRT has the potential to promote social participation and community development in the research process. However, Howarth, Foster and Dorrer, (2004) caution that research within this perspective needs to be culturally sensitive and self-consciously reflective. The researcher needs to be sensitive to the possibility that inviting participants to share their representations may expose feelings of anger, resentment, pain and shame. Therefore a relationship of trust, openness and rapport must be developed with the researched community. Howarth et al. (2004, p. 21) believe that researchers using the social representations approach should take heed of the criticisms of critical psychologists who question the rights of researchers to “parachute” into a group, treat people as the objects of research, from an omnipotent, omniscient position, and then leave to analyse the data”. Such an approach, they warn, has rightly been criticised as imperialist and exploitative.

Howarth (2006) cautions that while SRT appears to have the conceptual tools to criticise the social order, there are few studies that have demonstrated this potential empirically. She questions whether social representations research should simply describe what is happening in the social world, thereby supporting the status quo of social inequalities, or develop a more critical perspective. An uncritical description of representations, she maintains, will render social psychologists susceptible to claims that they “ignore social inequalities, political violence, wars, underdevelopment and racial conflict” (Moscovici, 1972, p. 21, quoted in Howarth, 2006, p. 3).

Potter and Edwards (1999) maintain that researchers using the social representations approach are likely to be affected by their own representations, and therefore ‘biased’ in any research situation. Howarth et al. (2004) suggest that collaborative, open discussions of representations between the researcher and researched could address such criticisms.

SRT and Joffe’s psychoanalytic expansion of the theory promised a useful way to understand the social representations of, and the anxieties related to, the threatening “new” phenomenon of HIV/AIDS among the targeted community of Embo.

SOCIAL CAPITAL THEORY

As study data emerged, the feasibility of utilizing social capital theory to understand social cohesion and social networks, and how they can strengthen the adult protective shield in the targeted community, appeared increasingly promising. An examination of social capital theory and related research follows.

The term *social capital* has been used in many different fields including economic theory, social control, family behaviour, community life, and democracy and governance (Hawe & Shiell, 2000). Kreuter & Lezin (2000) attribute one of the earliest uses of the term to Hanifan in 1920, who described it as good will, fellowship, sympathy, and social intercourse among the individuals and family that make up a social unit. Schuller, Baron and Field (2000) ascribe an early use of the term to Dube, Howes, and McQueen (1957, cited in Schuller et al., 2000) who defined social capital in terms of the public physical infrastructure, but credit them with foreshadowing more recent debates regarding the concept. Portes (1998, p. 2) traced the idea of social capital to the 19th-century foundations of sociology, and claimed that the idea is implicit in

Marx's concept of the "atomized class-in-itself" versus a "mobilized class-for-itself" and in Durkheim's "emphasis on group life as an antidote to anomie and self-destruction". Woolcock (1998) traced the concept's intellectual origins to the 18th Century philosophers David Hume, Edmund Burke, and Adam Smith.

The three people who are usually credited with increasing the current interest in social capital are Pierre Bourdieu, James Coleman and Robert Putnam who each approached social capital from a different perspective (Schuller et al., 2000).

Bourdieu (1997, p. 49) defined social capital as ~~the~~ aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition....which provides each of its members with the backing of collectively owned capital". Bourdieu perceived social capital as created and maintained by cultural and especially economic capital which, he argued, was at the root of all other types of capital (Schuller et al., 2000). Bourdieu (1986) conceptualized social capital as stemming from individuals' association with a ~~er~~edential" rich class, family, or other institutionalized network. Wakefield and Poland (2005) regard Bourdieu's definition as a critical one, in which social capital is seen as a resource that accrues to individuals and groups, who can leverage it to achieve particular goals that may or may not be beneficial to society as a whole. In Bourdieu's view, the credentials provided by social capital can be used by elite groups for benefit, but can also have detrimental effects through the exclusion of individuals who lack access to these credentials (Wakefield and Poland 2005). According to Pevalin (2003), one of Bourdieu's main insights is that people consciously participate to build various forms of capital and then use them to their advantage. While social capital may be acquired through group participation, it is a property of

the individual, and is implicated in the production and reproduction of the very inequalities it is generally thought to mediate against (Pevalin, 2003). Macinko and Starfield (2001) contend that Bourdieu was clear in his conception of the origin of social capital, but was ambiguous as to where exactly social capital resides.

According to Coleman (1988) social capital is defined by its function. It consists of social structures and facilitates certain actions of actors within the structure. It exists in the relations among people. Like other forms of capital, social capital is productive and makes possible the achievement of certain ends that would not be possible without it. Social relations, according to Coleman, are capital resources that establish obligations, expectations and trustworthiness; they set norms backed by sanctions and create channels for information. (Schuller et al., 2000).

Where there is extensive trust and trustworthiness within a group, it will be able to achieve much more than one without such qualities (Coleman, 1988). Coleman (1988) highlighted the importance of social capital within the family for the development of children. Whether a child has access to the parents' human capital depends both on their physical presence as well as on the attention given to the child. The physical absence of parents is, according to Coleman (1988), a structural deficiency in family social capital.

Following Coleman (1990) and Bourdieu (1991), Macinko and Starfield (2001) describe social capital as the available resources (capital) that accrue to people by virtue of their mutual acquaintance and recognition (social) and that can be used for a variety of productive activities.

Putnam (1995) defines social capital as ~~features~~ of social life - networks, norms, and trust - that enable participants to act together more effectively to pursue shared objectives" (pp. 664-665).

These social connections or networks are likely to enhance cooperation by linking substantial sectors of the community, and correlate with generally desirable social conditions; however, some networks (e.g. youth gangs), which also have high social capital, could be detrimental to the wider community. Putnam (1993, p. 4) believes that the criterion of social capital, is trustworthiness which “lubricates social life” and reinforces norms of reciprocity. Putnam’s concept of social capital was broader and less individually focused than both Bourdieu’s and Coleman’s definitions (Schuller et al., 2000), but centred on geographical locales, according to Carpiano (2006). Putnam conceived of social capital as a collective resource that could be possessed by communities or even nations (Dominguez & Arford, 2010).

Apart from the definitions of Bourdieu, Coleman and Putnam, there have been a plethora of definitions of social capital by various authors including Loury (1992), Portes (1998), Baum (1999), Fukuyama (1999), Veenstra (2000), Kreuter, Lezin, Young, and Koplan (2001), and Lin, Cook, and Burt (2001).

Woolcock (1998) contends that it is widely accepted that the concept of social capital is poorly defined and hotly contested. Similarly, Lochner, Kawachi and Kennedy (1999), having reviewed the concept of social capital conclude that there is no single definition of social capital. Szreter and Woolcock (2004) contend that social capital is, like ‘class’, ‘gender’, and ‘race’, an essentially contested concept of the social sciences; one where there is consensus on the broad nature of the phenomenon and its great importance, without any agreement on its definition. However, Baum (1999) maintains that there is broad agreement that social capital concerns the levels of social and civic trust, the presence of both thick and thin, or embedded and autonomous networks and that these factors lead to coordination and cooperation for mutual benefit.

Similarly, Hean, Cowley, Forbes, Griffiths & Maben (2002), drawing from a variety of sources, conclude that the main dimensions of social capital are trust; rules and norms governing social action e.g. norms of reciprocity; types of social interaction; network resources; and other network characteristics. They believe that social capital is a multidimensional concept, with each dimension contributing to the meaning of social capital without fully capturing the concept in its entirety.

Unlike tangible assets such as labour and human capital, social capital is largely invisible and intangible (Moser, 1998). In certain situations, social capital may substitute for other forms of capital and, unlike other forms of capital, it is a resource that accrues through use and is depleted through lack of use (Putnam, 1993). Social capital is a dynamic commodity and it may have persistent effects if it induces investment in other forms of physical or human capital (Collier, 1998).

Kreuter & Lezin (2000, p. 231), having reviewed various definitions of social capital (Bourdieu, 1985; Coleman, 1990; Portes, 1995; Putnam, 1996; and Fukuyama, 1999) concluded that the following central themes emerge:

- It is defined by its function.
- It is lodged neither in individuals nor in physical implements of production but instead is a property of the individual's set of relationships with others.
- It facilitates certain actions of the individuals who are within the structure to pursue shared objectives.
- It is expressed by networks, norms, and trust that enable participants to act together more effectively.

- It is able to command scarce resources by virtue of membership in networks or broader social structures.

Bonding, Bridging and Linking Social Capital

Putnam (2000) distinguished between two types of social capital: *bonding* social capital and *bridging* social capital. Bonding social capital refers to social cohesion within group structures. It creates and nurtures group solidarity in close neighborhoods and intensifies existing support networks. Bonding capital provides social and psychological support. Bridging social capital is analogous to institutional infrastructure, at an organisational level where norms, values and social structures facilitate macroconnections. It cuts across different communities or groups and extends potential opportunities through the support network (Harpham et al, 2002).

Woolcock (2001) added a third distinction: *linking* social capital which refers to ties to people outside of one's own community and social situation, but where the networks are between unequal agents. It can be democratic and empowering where, despite the inequality, there is a mutually agreed beneficial goal (or set of goals) based on mutual respect, trust, and equality of status. It is like a special case of bridging social capital but with vertical power relations (Szreter, 2002). Dominguez and Arford (2010) use the term *leveraging* to refer to linking capital. It opens up opportunities to individuals and groups, giving them access to resources normally outside of their own context (Dominguez & Arford, 2010)

Vertical and Horizontal Social Capital

Researchers have used the terms *horizontal* and *vertical* social capital. According to Veenstra (2000), social capital is generated as a by-product of social interaction and has benefits that can

accrue - often incidentally - to those not directly involved in the interaction. Social interaction usually takes two forms: social support, identified as the interactions with close friends and family, and social involvement in formal and informal voluntary associations (Veenstra, 2000). These appear to be analogous to bonding and bridging social capital respectively. Social involvement has been further classified into two distinct types: horizontal and vertical (Collier, 1998). Horizontal interaction, or reciprocal involvement, takes two forms: networks (spontaneous free associations) that lack the capacity for decision making and clubs (organized associations) which have the infrastructure to make decisions and act collectively. Collaboration among horizontally-based associations is thought to increase the stocks of social capital at community level (Putnam, 1993). Vertical interaction, or one-way involvement, on the other hand, is an extremely organized system of interaction that is usually defined by the presence of a hierarchy. Differences may exist in the quality of the social capital generated by horizontal and vertical associations (Collier, 1998).

Cognitive and Structural Social Capital

According to Thomas (2008), other useful concepts in social capital ‘theory’ are the *cognitive* (personal) dimension of social capital and the *structural* dimension of capital in society. Krishna and Shrader (1999) describe cognitive capital as the aspects such as values, norms and behaviour that impact on trust. For Bain and Hicks (1998) cognitive social capital includes perceptions of support, reciprocity, sharing and trust. Cognitive social capital predisposes people to mutually beneficial collective action (Uphoff, 2000). Structural social capital refers to the activities, organisational structure and democratic principles that underpin collective action and decision making (Krishna & Schrader, 1999). It facilitates mutually beneficial collective action leading to predictable and beneficial outcomes from interaction (Uphoff, 2000).

Anti-social Capital

While high levels of social capital are usually regarded as being beneficial, some authors (e.g. Bourdieu, 1986; Portes & Landolt, 1996) have warned about the negative aspects of social capital, leading to the notion of *anti-social capital*. Kolankiewicz (1996) maintained that dense ties provide an effective defensive or coping resource, but could lead to amoral familism and clientelism, which do not necessarily have positive consequences. Similarly, Baum (1999) warned that tightly-knit, cohesive communities could be unhealthy for outsiders as well as insiders who disagree with the majority. Such communities can be exclusionary, and characterized by distrust, fear, racism, and could demand conformity (Baum, 1999). Campbell (1999), commenting on a study (Campbell & Mzaidume, 1999) of social capital and sexual health promotion, also cautioned that social capital might be closely linked to unequal and exploitative power relations, with individual members within a community having different degrees of access to the benefits of social capital. As Kreuter & Lezin (2002) maintain, social capital is a powerful social force that can propel action for social good or social disruption.

Criticisms of Social Capital

Lenci (1998) declared that the literature on social capital was confusing, and lacked terminological precision and theoretical rigour. The debates about its importance in health research have been compromised by a lack of adequate conceptualization, operationalisation and measurement (Poortinga, 2006). However, Baum (1999) maintained that given the complexity and subjectivity of the fundamental building blocks of social capital such as participation, trust, networks, and cooperation, the confusion was understandable.

In a review of the criticisms of social capital, Semaan, Sternberg, Zaidi and Aral (2007, p. 2334) summarize them as follows:

- Its definition, conceptualization, and dimensions are not clear.
- It incorporates elements, such as trust and civic engagement, that generate social capital and that are also produced by social capital.
- It is not uniquely different from other concepts such as collective efficacy, and community capacity.
- It is not measured by instruments with reliable and valid psychometric properties.
- The mechanisms by which it influences health, including STD rates, are not empirically evaluated.
- Its positive association with public health outcomes, while supported by many (Kawachi & Berkman, 2000; Poundstone et al., 2004; Putnam, 2002), is debated by others (Caughy, O'Campo, & Muntaner, 2003; Lynch, Due, Muntaner, & Smith, 2000; Muntaner & Smith, 2001; Muntaner et al., 2002; Navarro, 2002).

Despite the criticisms of social capital, Bhattacharya (2005) maintains that the social capital approach has potential in HIV prevention programmes. Pronyk et al. (2008) suggest that a balanced and cautious application of social capital to HIV prevention is warranted, and that a better understanding of where and how to work with communities is essential for effective policy and programme development.

Carpiano's (2006) Integrative Theory of Social Capital

In defining social capital as “consisting of actual or potential resources that inhere within social networks or groups for personal benefit”, Carpiano (2006, p.166) draws upon Bourdieu's (1986)

conceptual model of neighborhood social capital and Putnam's (1993) definition of social capital to propose what he calls "a broader theory of neighborhood social processes as health determinants". Carpiano (2006) conceptualises social capital as including factors at both the neighbourhood and individual level, and as emerging out of social networks that provide the basis for developing socially cohesive communities that are characterised by strong social organisations, common norms and social trust, and which facilitate coordination and cooperation for mutual benefits. Acknowledging Portes' (1998) conclusion after a review of the literature on social capital that no distinction is made between the social processes that lead to social capital (such as collectivity and trust), social capital itself, and the outcomes of social capital, Carpiano (2006) distinguishes between the causes, correlates and consequences of social capital as:

- Structural antecedents to social cohesion and social capital: the structural characteristics of a neighbourhood and its surrounding area that influence the type and strength of social ties and resources available within the neighbourhood.
- Social cohesion: patterns of social interaction and values (such as network formation and ties, familiarity, and mutual trust) that lead to social capital; while they serve as intermediaries between structural antecedents and social capital, they are necessary foundations for establishing social capital within neighbourhoods.
- Social capital: actual or potential resources that are rooted in neighbourhood social networks.
- Outcomes of social capital: goals or benefits that social capital can provide for neighbourhood network members or the neighbourhood as a whole. (Carpiano, 2006, p. 168)

Carpiano (2006) further identifies four “forms” of social capital:

- Social support, a critical component for health, consisting of emotional, instrumental, appraisal and informational components that an individual can draw upon to cope with daily problems.
- Social leverage, which helps individuals to access information to maintain or improve their quality of life and advance socio-economically.
- Informal social control, which is the ability of individuals to collectively maintain social order and keep their neighbourhood safe.
- Community organisation participation, which refers to involvement in formally organised groups for addressing neighbourhood issues. (Carpiano, 2006, p. 170).

Carpiano’s (2006) model addresses many of the criticisms of social capital. By distinguishing between the causes, correlates and consequences of social capital, he addresses the problem of conceptualization; and his separation of social capital into four “forms” could be useful in operationalising social capital, thereby making the theory empirically testable.

Carpiano’s (2006, p. 165) “neighbourhood resource-based theory of social capital” informed the understanding of processes and dynamics within the targeted community.

Research Based on Social Capital Theory

Research on social capital has examined its relationship to a wide array of variables in the health field. According to Veenstra et al. (2005), the research on social capital and health has tried to link an amorphous group of indicators of social capital (e.g., social networks and support, involvement in associations, measures of trust) through various theoretical and empirical means

(e.g., the character of political governance, economic growth, the quality of health care, stress, social support) to numerous health outcomes (e.g., self-rated health, mortality rates, life expectancy). The breadth of this dialogue, they claim, makes it difficult to conceptualize and investigate empirically how social capital might influence health (Veenstra et al., 2005). The vast literature on social capital and health is beyond the scope of this review which is limited to that on social capital and youth/youth at risk, as well as social capital and sexual health and HIV.

Social Capital and Youth/Youth at Risk

The studies reviewed below explored the relationship between social capital and outcomes for children and youth, and those at risk.

Coleman's (1988) study in the United States on youth who dropped out from high school, identified five indicators of social capital which predicted dropping out among sophomores: 1) the presence of both parents in the household, 2) one versus four siblings, 3) fewer changes of school since fifth grade, 4) regular attendance at religious services and 5) mother's high expectations for a child's educational attainment. According to Coleman, if a family consists of a single parent or too many siblings, parents do not have enough time to give attention to their children, which can reduce the social capital among individual children.

Runyan et al. (1998) defined social capital as benefits that accrue from social relationships in communities and families. In a case-control study of 667 at-risk children in four communities across the country, Runyan and colleagues measured social capital as an index of five factors: presence of two parents or parent-figures in the household, maternal care giver's perception of social support, number of children in the household, neighborhood support, and regular church

attendance by the family. When foster care placement, maternal depression, family income, maternal education, and site differences were controlled, data showed that adding a single social capital indicator to a child's situation increased the odds of "doing well" by 29%. Adding two indicators increased a child's odds of doing well by 66%. Runyan et al. (1998) conclude that social capital constructs, singly and in combination, have a direct impact on individual level health outcomes. They maintain further that social capital may be most crucial for families who have fewer financial resources and that those who are interested in the healthy development of children who are most at risk, must search for new and creative ways of supporting interpersonal relationships and strengthening the communities in which families live.

Morrow (1999, 2001) explored health and social capital among the youth in a deprived community in England. She concluded that local community life undermined their development of a sense of health-enhancing "perceived citizen power" (Campbell, Wood & Kelly, 1999, p. 144). The youth felt excluded and devalued, and were skeptical of what they perceived as ineffective school councils and of their token rather than meaningful representation on community councils. Morrow (2001) finds it ironic that while schools should be developing young peoples' freedom of expression and capacity for decision-making, schools are often structured in a formal and authoritarian way, with young people having little real input into school governance.

Weitzman and Kawachi (2000) found that social capital had a protective effect on binge drinking among 18 to 26 year old college students in the United States. They operationalised social capital as engagement in voluntary activities and argue that this reflects the construct's core features; i.e. its "public good" element and expression of commitment to the group or collective.

Wright, Cullen and Miller (2001) used data from the National Youth Survey in the United States to explore whether family social capital is associated with prosocial development in adolescents. They found that, not only does family capital produce other forms of social capital, but that adolescents from families that are high in social capital are protected against delinquent involvement, do better in school, and are less likely to acquire delinquent friends.

Gold, Kennedy, Connell, and Kawachi (2002) explored the relationship between income inequality, poverty, teen (15-17 years) birth rate and social capital in 39 states of USA. As social capital measures, they used *group membership* and *social mistrust*. They found that teen birth rate was associated with both poverty and income inequality, but that income inequality appeared to affect teen birth rate mainly through its impact on social capital. Gold et al. (2002) suggest that decreased social capital could weaken informal social support systems thereby causing adolescents to feel socially disconnected. Lower social capital might also lead to less emphasis on pregnancy prevention services and have a detrimental effect on economic structures resulting in fewer educational or occupational opportunities that might prevent early pregnancy.

In an exploratory study, Crosby, Holtgrave, DiClemente, Wingood, and Gayle (2003) assessed the state-level association between social capital, poverty, and income inequality and adolescents' sexual risk and protective behaviors. They used Putnam's measure of social capital which is a combination of 14 variables including community organisational life, involvement in public affairs, volunteerism, informal sociability and social trust. Social capital was inversely correlated with sexual risk behaviours and positively correlated with protective sexual behaviors. Poverty and income inequality were relatively less influential than social capital with regard to sexual risk

and protective behaviours. Crosby et al. (2003) concluded that their findings provided evidence that social capital might have a profound influence on adolescents' sexual risk and protective behaviours. In a similar study, Crosby and Holtgrave (2006) found that social capital was an exceptionally strong predictor of teen pregnancy rates. They suggest that social capital may play an important role in the prevention of teen pregnancy.

As indicators of social capital, Verner and Alda (2004) used the variables of trust in local, municipal, and other organisations in the neighborhood, trust in other dwellers, and own level of organisation, in a survey focusing on Brazilian youth of 10-24 years of age. They found that low social capital among the youth predicted early pregnancy and fatherhood, violence, crime, and drug use.

In a study of homeless youth in an urban area in the United States, Bantchevska, Bartle-Haring, Dashora, Glebova and Slesnick (2008), using certain indicators of social capital (mutual aid; connection with social institutions; family structure - single versus two parent; number of siblings; years participant was raised by both biological parents; education of participant and parent/s), found that lower levels of social capital were associated with higher levels of delinquency, depression, substance use, days spent on the street, as well as HIV risk.

In a Swedish study, Bolin, Lindgren, Lindstrom and Nystedt (2003) developed a model of the family as a producer of health capital and social capital; they found that social capital was positively related to the level of health capital.

According to Fukuyama (1995) the family, the smallest and most basic of groups, is an essential source of social capital. The studies reviewed above show that social capital is important for the development of children, and that low levels of social capital, whether personal or family social capital, could render children susceptible to risk.

Social Capital and Sexual Health

Campbell and Mzaidume (2001), using a qualitative case study, examined the role of grassroots participation in sexual health promotion in a South African mining community. Having analyzed 30 in-depth interviews with sex workers in terms of social capital, empowerment, and identity, they concluded that in structural conditions of poverty and sexual inequality where existing norms and networks are inconsistent with ideal criteria for participatory health promotion, there is a strong challenge to theories of the role of social capital in community development in general and in sexual health promotion in particular.

In another study in the same community Williams, Gilgen, Campbell, Taljaard, & MacPhail, (2000) explored the link between social capital and sexual health. The indicators of social capital that they used were trust, the feeling of having a lot in common with one's neighbours, finding the neighbourhood a pleasant place to live in, perceiving people as helpful and belonging to formal or informal groups and associations. While membership of some associations was protective, membership of other groups (that is, those that were associated with a higher number of casual partners, less condom use, increased alcohol consumption or a combination of these mediating behavioural factors) seemed to increase the risk of HIV infection. HIV prevalence was generally lower in men and women who trusted others. For the other variables the findings varied depending on gender and environmental factors.

Semaan, Sternberg, Zaidi and Aral (2007) assessed five dimensions: informal sociability, social trust, community volunteerism, community organisational life, and engagement in public affairs, as a measure of social capital in their study of the state-level association between social capital and rates of gonorrhea and syphilis in the United States. They found that states with higher social capital had lower STD rates.

Social Capital and HIV

Higgins (1997) found that those with high social capital scores also had higher involvement in the community, were more likely to seek screening for HIV, and had enlarged their social networks through participation in a community-based intervention project, and participation itself may have furthered or fostered social capital.

In a study among young women in Zimbabwe, Gregson, Terceira, Mushati, Nyamukapa and Campbell (2004) operationalised social capital in terms of civic engagement or participation determined by levels of membership of a range of community and social groups. They found that young women with secondary education were more likely to be members of well-functioning community groups, and these were associated with increased chances of having avoided HIV infection.

Campbell, Williams and Gilgen (2002) operationalised social capital in terms of civic participation, and investigated whether group membership was associated with HIV infection, or behaviour that put people at risk of HIV infection. They found that participation in certain types of organisations (e.g., churches, sports clubs, and youth groups) was protective, while membership in other social groups (e.g., groups with high levels of social drinking) increased

HIV risk. They concluded that the complexity of their findings suggests that the relationship between sexual health and social capital is not easy to generalize and should be treated with caution.

Using a case study approach to examine the impact of the social context on the effectiveness of HIV-prevention programmes among youth in a peri-urban poor community in KwaZulu-Natal, Campbell, Foulis, Maimane and Sibiya (2005a) found that there was virtually no bridging social capital, with a total lack of support from outside people or agencies whether locally, regionally or nationally. Those bonding capital networks that existed within the community were narrowly focused on physical survival and usually adult-dominated, with minimal opportunities for youth involvement or development. They conclude that exclusion of youth will undermine the likelihood of effective HIV prevention on the assumption that sexual behaviour change is facilitated not only by knowledge about HIV/AIDS, but also by youth solidarity, empowerment, critical thinking and the presence of bonding and bridging social capital.

Pronyk et al. (2008) examined associations between social capital and HIV risk among 14 to 35-year-old residents of 750 poor households in rural Limpopo province in South Africa. Their measure of social capital included structural social capital (group membership and level or intensity of membership) and cognitive social capital (Perceived levels of reciprocity and community support, solidarity in response to crisis, and participation in collective action). Their findings suggest that strong community relations, with mutual support, reciprocity, and collective mobilization around common concerns, are linked to lower levels of HIV risk among men and to a lesser extent among women. However, higher levels of structural social capital as reflected in expanded social group membership could increase HIV risk in females. They concluded that not

all social capital is protective or health promoting, and that there is a complex and nuanced relationship between social capital and HIV risk in the rural African context.

Diaconu (2008) defined social capital as including human, family, emotional, physical, economic, community and education factors. She found that social capital elements were significant factors in increasing HIV/AIDS knowledge, attitudes, and related behaviors among young people aged 16-24 years in Tanzania.

Sivaram et al. (2009), using ethnographic interviews with 41 men and women in Chennai, India, explored the associations between social capital and HIV stigma. Their measure of social capital comprised the following: participants' membership in formal and informal groups in the community; reported number of close friends; availability of financial assistance in times of need; and trustworthiness of community members. They found that reports of social capital indicators were associated with reduced fear of transmission of HIV/AIDS; lower levels of feelings of shame, blame and judgment; and lower levels of personal support and perceived community support for discriminatory actions against people living with HIV/AIDS.

In a Namibian study, Smith and Rimal (2009) examined the link between social capital and HIV-related behaviours and intentions. Their measure of bonding, bridging and linking social capital included group centrality, information sources, knowledge, use of HIV services, condom-use intentions and monogamy intentions. They concluded that their study found support for the link between social capital and greater HIV-related efficacies.

Sen, Aguilar, and Goldbach (2010) explored levels of social capital among migrant labourers in Angola, hypothesizing that movement away from their villages would diminish their social capital in terms of social support, norms, and networks while stresses from migration could prove to be conducive to the spread of HIV. Their measure of social capital was a combination of social engagement, social support, and person-to-person contact. They found that migrants had a lower level of social capital and migrants with lower social capital tended to have higher risky behavior.

Conclusions

While the majority of the studies reviewed above show that higher levels of social capital are associated with more positive outcomes with regard to children's development, and with sexual health and HIV, some (e.g. Campbell et al., 2002; Pronyk et al., 2004) have warned that this relationship is not as clear cut as it may seem, and that particularly in poorer communities in South Africa, the relationship is complex and nuanced. Birdsall and Kelly (2005) conclude from their multi-community survey in South Africa, that the “directionality” of the relationship between HIV/AIDS and social capital is not firmly established. While HIV/AIDS may undermine social cohesion leading to lower levels of social capital, social capital may help to prevent large-scale AIDS epidemics and mitigate the impact of HIV/AIDS in areas of high prevalence.

One problem with the research on social capital and health in general, and HIV in particular, is that each researcher defines social capital differently. De Silva, McKenzie, Harpham, and Huttly (2005) argue that social capital is a multidimensional concept encompassing both bridging, bonding and linking aspects of social relationships and that none of the studies included in their review of research measure any aspect of bridging or linking social capital; that in fact, the

majority of the studies measure either only one dimension of social capital (structural or cognitive), or combine these two dimensions into one score.

Macinko and Starfield (2001), in their review of the research, assert that the social capital measures used in the health literature are not consistently based on any one major theoretical tradition, nor do they explain why certain social capital measures were chosen over others. This lack of consistency and clarity, they maintain, leads to limited comparability between studies. Furthermore, some studies use social capital as an individual-level concept, while others use it as a community or state-level concept which is measured at the individual level and then aggregated to community or state level.

Another problem with measures of social capital that have been utilised in the research is that there is little or no empirical justification for the validity and reliability of the different measures (Macinko & Starfield, 2001). Harpham, Grant and Thomas (2002) maintain that the problem of how to validate social capital tools remains one of the important challenges facing this research.

All of the studies reviewed above are cross-sectional, and as De Silva et al. (2005) note, cross sectional studies call into question the direction of association between social capital and health outcomes.

Despite the criticisms and problems related to research that utilised social capital theory, this approach, specifically Carpiano's (2006) concept of social capital, promised to be useful in understanding social networks and social cohesion, with its associated concepts of trust,

reciprocity and norms within the community, especially as one of the aims of CHAMPSA was to ~~re~~build the village”.

COMMUNITY HEALTH PSYCHOLOGY

In addition to social capital theory, Campbell and Murray’s (2004) critical approach to community health psychology was used to understand how the CHAMP programme strengthened collective empowerment to facilitate increased community control of a more protective environment for youth.

According to Campbell and Murray (2004), many determinants of individual health are social. Therefore, a crucial aspect of community health psychology is to understand what constitutes a ~~health~~ enabling community context”. Campbell and Murray (2004) draw on Paulo Freire’s (1993) concept of *conscientisation*, which refers to the development of critical social analysis of adverse individual and social conditions inhibiting change; they believe that conscientisation is a vital psychosocial mediator between group participation and health. Campbell and Murray (2004) suggest that critical reflection and dialogue of social issues that impede health within the context of social groups can facilitate individual and collective ownership of the problem. They assert that the social support networks (a form of social capital) that emerge from the group process provide the necessary dialogical space to renegotiate empowering social identities as well as facilitate collective empowerment to take action and address issues of a social and material nature (Campbell & Murray, 2004). Ideally, these renegotiated identities would also lead to associated social representations that would influence health related behaviour change among group members.

While work on a critical perspective on health issues is increasing, there is little research using this approach (Murray, Nelson, Poland, Matlicka-Tyndale, & Ferris, 2004). However, McPhail (2006) did use the concepts of social capital, empowerment and critical consciousness to examine the different experiences of two youth HIV prevention initiatives in a community in South Africa. One was situated in a youth-initiated public clinic facility for the treatment of adolescent sexually transmitted diseases, and the other a school-based peer education programme. McPhail (2006) believes that, compared to the clinic-based programme, the school-based programme, in spite of being peer-based, failed to build on existing bonding social capital among adolescents in the community because it was under the control and authority of educators. Control by the educators also limited opportunities for the youth to build bridging, and specifically linking capital, with local stakeholder committees where the youth were not directly represented. Furthermore, peer educators lacked both the critical thinking skills, as well as the social insights, to promote critical discussions in order to promote critical consciousness that might form the basis of critical action. McPhail (2006) maintains that for youth HIV prevention programmes to succeed, adolescents should be empowered, and have autonomy, and access to resources and alliances.

CHAMPSA's group format creates the necessary dialogical spaces for conscientisation and renegotiation of social identities and social representations, making Campbell and Murray's critical approach to community health psychology an appropriate theory to guide an understanding of the data in the second study.

CHAPTER SIX

FINDINGS AND DISCUSSION OF STUDY 1

AND DEVELOPMENT OF CHAMPSA

FINDINGS AND DISCUSSION OF STUDY 1

The aim of this study was to explore how people in the community understood the relatively new phenomenon of HIV/AIDS; how they protected their children against the disease; and whether they perceived themselves as being effective in their role as protectors of their children's safety, especially against the threat of HIV. The findings of the study were to be used to adapt CHAMP in order to make it more contextually relevant and appropriate.

In analyzing the data I identified a number of themes which, with further analysis were grouped together under the two broad themes: community and family.

Community level

At the community level, a *lack of containment* emerged as an overarching theme. This was seen to be related to two broad issues: a lack of leadership; and the breakdown of traditional customs in raising children. The lack of containment was understood to create anxiety for the participants, with coping patterns such as *splitting* and *lack of trust* emerging to deal with these anxieties.

Anxiety at the community level was also linked to the negative representations of HIV/AIDS and stigmatization of people suspected of being HIV positive or having AIDS. Coping mechanisms used to deal with stigmatization were *silence* and *denial*. Linked to the issue of stigmatization was that of *death and bereavement* as a result of AIDS.

Tensions between the leaders in political and traditional structures had led to a lack of strong unified leadership in the target site as described very vividly in the following excerpt:

There is no head leading, it's only the body and the neck existing. There is no chief. When you have a problem you don't know whether you should go to the induna... They are working for their families and not the community... there are many things that should be happening here (that are not)... They (the indunas and councillors) need to come together and cooperate because a country is being built... (instead) everyone works for himself.

(Individual interview: Community member)

The void created by the lack of strong unified leadership was likely to result in poor containment of the anxieties emerging from political, social, economic and cultural shifts. According to Joffe's (1996a) psychoanalytic extension of SRT, the ability to assimilate new events into the old through anchoring and objectification is dependent on the extent to which a dominant group, more likely to be found within unified leadership, is able to assert its view of what constitutes acceptable norms and standards of behaviour. The tension between leadership structures in this community was likely to exacerbate feelings of fear and uncertainty among the community. In this climate of anxiety and uncertainty the community was trying to deal with the then relatively new threat of HIV/AIDS. Carpiano (2006) identifies structural characteristics of the neighbourhood as an antecedent of social capital. The above quotation suggests the erosion of these antecedents and of social cohesion, leading to low levels of social capital within the community.

Another source of anxiety among parents was their perception of a void resulting from a breakdown in traditional customs, related to the upbringing of adolescents, which had previously served to educate and exert social controls around sexual and other behavioural practices. To quote:

In the good and golden days ... head girls were nominated for the sole purpose of educating girls about womanhood. In the past the initiation of children into adulthood was not a parental role...Once there was an indication that there was a man who was interested in you, they (head girls) would advise you in terms of what you should and should not do... there are no head girls in this community today and their duties have been handed over to mothers who are expected to educate girls. (Focus Group One: Mother)

In the old days when boys reached a stage of entering manhood, adult people would get them to fight with each other as a matter of instilling a sense of discipline and respect for those above you. Now this does not happen and it makes all males think that they are all powerful and cannot take orders from anyone. (Focus Group Two: Father).

In the absence of the development of renegotiated acceptable sexual and other behavioural practices related to the upbringing of adolescents, parents indicated that they felt confused and helpless as to how to respond as indicated in the quote below:

I become confused because people say if you tell your children everything, you are

actually encouraging them to experiment with sex and making them even more curious...but at the same time some people say if you tell your child everything, you are helping them ... I end up being confused. (Focus Group One: Father)

This void provided space for the development and propagation of myths and misinformation as demonstrated in the following quote:

We often warn girls that they will fall pregnant if they allow boys to touch them. We do this out of desperation. (Focus Group One: Mother).

Without a strong leadership to contain anxieties associated with the new and threatening phenomenon of HIV/AIDS and to facilitate the renegotiation of health enhancing norms and standards of behaviour, two types of coping mechanisms emerged in the community in an effort to deal with their anxiety.

Splitting

In the first instance, to cope with and reduce anxiety generated by the threat of HIV/AIDS, community members utilized the defence mechanism of *splitting* whereby “bad” parts of the self are split off and projected onto an external “other” in an effort at identity protection. “Othering” as an effort at psychological distancing from those perceived to be at risk of HIV/AIDS was also found by Goodwin et al. (2004) and Caramlau and Goodwin (2007). Splitting is illustrated by the following excerpt from an individual interview with a parent, where “others”, in this case “white people”, are blamed for spreading the disease.

This is where I pose a question on where do the elderly people get AIDS if they no longer have life or love partners, since AIDS is contracted through sexual intercourse? Someone did say that AIDS is no longer contracted through sex. Something is being done by white people to spread it. (Individual interview: Father).

Females were also identified as being responsible for spreading and containing the disease.

My opinion is that it is OK to exclusively look after female children. We need to talk to them, because a female child holds the key. She is the one who gives consent ultimately. (Focus Group Three: Mother).

Joffe (1996b) states that pre-existing representations are important in terms of who is chosen as the representative of the “bad other”. Joffe and Bettega (2003) found in Zambia that existing norms, values and power relations were perpetuated, with women being derogated and consigned to a disadvantaged position. Given the apartheid history of South Africa as well as the dominant patriarchal culture, it is not surprising that convenient “others” for the projection of unwanted anxiety were ‘whites’ and females. Females were also identified as being responsible for any mishap that might occur, including rape and unwanted pregnancy.

Every burden and responsibility is given to the women. Even if the girl is pregnant, the woman has to answer. Even if the boy has made a girl pregnant, the people will come and fight with the woman. (Focus Group Two: Mother)

Lack of trust

The second response to the absence of containment at a community level manifested in a general *lack of trust* between community members, especially in relation to possible sexual molestation of children. To quote:

Female children are generally not safe in the community. Most people are unemployed and you find them molesting children as young as eight years old out of frustration of being unemployed. We are then compelled to advise our children to be always in the company of other children when they are coming back from school – we do that out of being unsafe in the community. (Focus Group Three: Mother)

This lack of trust even extended to relatives.

It is necessary to be cautious and not assume that children are safe from relatives and that the danger is always from outside. (Focus Group Two: Mother)

Carpiano (2006) identifies trust as part of social cohesion and an intermediary between neighbourhood resources and social capital. Lack of trust impacted on supportive networks that community members could draw on, particularly with respect to raising their children. The consequence was that there were low levels of social cohesion and little informal social control of youth behaviour at a community level, a clear erosion of social capital within the community. To quote:

In the past, we knew that if you were ever caught misbehaving, you could be beaten up

indiscriminately by any old person. You could not report him when you got home because they (your parents) would continue where he left off. That's no longer the case. (Focus Group Two: Father).

And

Now let's suppose I take a shortcut, a child is having a love affair with a man and they kiss in front of you as you are coming ... (now) you cannot tell the parent of the child and you won't warn the child about what she is doing and say: "My child what you are doing is incorrect because you are a schoolchild" ... You see because her parent may respond to you by saying: "Why are you bothered because it's not your child". Now most of the time, you must look after your own. Yes somebody else's property cannot be helped by you. (Individual interview: Father).

Social cohesion is a multidimensional concept at the heart of which is social connectedness, which is concerned with how people derive social support and a sense of identity that engenders cooperation and trust in one another (Forrest & Kearns, 2001). An outcome of social connectedness is greater willingness of individuals to cooperate with one another to reach common goals of social order through increased informal social controls. The building blocks of social cohesion are located in common values and a civic culture, which a strong unified leadership structure can provide, but which was absent in the target community.

Stigmatisation

One of the ways that community members dealt with anxiety created by the threat of HIV/AIDS was to stigmatise not only the person suspected of being HIV positive, but also the family of the person. Stigmatization or "othering", a form of "identity protection", produces a sense of

invulnerability to threats and dangers that might otherwise appear overwhelming (Campbell et al., 2005b). The following quote is illustrative of the general feeling around the issue:

Once a person has AIDS, that thing cannot be cured. Now once certain people know that he died of AIDS, the one who is surviving at home is treated like an animal. (Individual Interview: Father).

The fear of contamination often led to the family isolating the person who would experience stigmatization from both the community and the family:

Let's say there is a person who is sick whose family is discriminated against. Perhaps they will make him reside behind the house in one of the rooms. You find that if they bring him food, it is not brought properly; it's just thrown to him. Even if that person could live longer, his life is shortened by abuse. (Focus Group Four: Father).

Responses to the fear of stigmatization ranged from silence about the disease to denial of knowing anyone with HIV/AIDS. As Brown, Trujillo and Macintyre (2001, p. 5) suggest, –Silence and denial may be the most pervasive reactions to stigma”.

Silence

The following quotation conveys succinctly the fear and apprehension within the community:

There is silence in this community as far as HIV/AIDS is concerned. People only gossip about it. It does exist in the community though you can never be certain – you can only suspect. (Focus Group Two: Mother).

Denial

Denial ranged from outright declarations as in the following quote,

I have never heard that there is a person who died of AIDS (Focus Group Two: Father),
to not referring to the disease by name

We refer to people living with HIV/AIDS as suffering from Amagama Amathathu [the
three letters, i.e. HIV]. (Focus Group Three: Mother).

Death and Bereavement

Notwithstanding the silence and denial about HIV/AIDS, the community was experiencing increasing numbers of deaths due to AIDS, and appeared to be unable to cope with the resulting bereavement, as exemplified by the following:

People are afraid to come any closer to the person who died of AIDS because they believe that the virus is still alive in the corpse. This is, therefore, difficult and a burden for the relatives, not knowing what to do. (Individual Interview: Female community member).

Family Level

At the family level, **disempowerment** of caregivers emerged as an overarching theme creating anxiety for parents. Parents expressed an intense sense of disempowerment in relation to their capacity to parent effectively. One of the sources of this feeling of disempowerment was the **generational knowledge gap**, with parents being generally less educated than their children. This was linked to two issues: that of *children's rights*; and parents' attempts to resort to severe forms of *authoritarian parenting*.

Generational knowledge gap

The generational knowledge gap eroded respect for adults and inhibited parents' ability to parent effectively as it impacted on parent-child power relations, as illustrated in the following excerpt from an interview with a key informant within the community.

They are giving the message because they are saying, "You go to school. I don't want you to be like me, as an illiterate somebody and...somebody who knows nothing because I am uneducated; then you must go and learn and become something." At the back of their [children's] minds they know that "my mother is nothing, my father is nothing; they are both uneducated. I know better than them because I am educated." (Individual interview: Community member).

A consequence was that children regarded their parents' advice as inferior, and were more likely to follow the advice of their peers, compromising parents' ability to protect their children from HIV infection. As one parent stated:

The child learns more about such issues [sexuality] from other children. S/he [the child] follows the advice of her/his friends and tries to make you [the parent] a fool. This is what has been my observation in this community. (Focus Group Two: Mother)

Children's rights

In the face of this power imbalance created by better educational opportunities for Black youth under the current democratic dispensation, and in the absence of renegotiated parental practices,

parents complained of their parental authority being further emasculated by government and media messages about children's rights which inserted Western cultural formations into the lives of both adults and children, but particularly children through school and media exposure. These messages empowered children and conflicted with traditional practices of corporal punishment, a last remaining vestige of parental authority. To quote:

It's difficult to raise children ... it's the government and the media. This makes it difficult for a parent to exercise any disciplinary acts because the media and the government tell the children to lay charges of child abuse. (Focus Group One: Father)

and

I complain about rights of children – that children know that they have a right. If you hit him/her, he/she has a right to open a case against you even if you are his/her parent. In that way it is difficult to advise your child because in the past we knew that if you did not do as you were told you would be reprimanded. In modern times, they [children] do wrong knowing that there is nothing you can do... the eradication of culture [has] led directly to a loss of respect, as the government outlawed corporal punishment ... at home, even if parents set rules, a child knows that whether he/she sticks by the rules or not, there is nothing that is going to happen. (Focus Group Three: Mother)

Authoritarian parenting

In an attempt to compensate for feelings of disempowerment in relation to being able to adequately parent their children, caregivers in desperation tended to resort to punitive parenting

styles involving physical violence. While authoritarian parenting styles, sometimes involving corporal punishment are characteristic of traditional approaches to parenting in the Zulu culture, anxieties related to parents' feeling disempowered in relation to their children appear to have exaggerated this form of parenting as the following excerpt illustrates

I think we need to improve the relationship between parents and male children. We need to talk to male children and discipline them if they do not listen. Corporal punishment is very appropriate in male children because they do not listen. (Focus Group Two: Father)

and

I even authorized her teacher to beat her up. It is unfair to say that we are abusing children when we use corporal punishment. Corporal punishment was the order of the day during our days. (Focus Group One: Mother)

This traditional parenting style advocates that children should speak only when spoken to. Communication with children is often directive and admonishing rather than discursive (Mbambo & Msikinya, 2003). The need for new behavioural parenting practices on the part of parents was, however, identified by some parents.

We could benefit from parenting and communication skills so that we are empowered to talk to our children. (Focus Group Two: Mother)

While some research (e.g. Furstenberg et al., 1999) shows that in certain risky environments an authoritarian parenting style can be protective for adolescents, and that an authoritarian parenting style had positive developmental outcomes for Nigerian adolescents (Odubote, 2008), several of the parents recognised that traditional authoritarian parenting styles were no longer appropriate or effective in assisting their children to cope in the current context of the threat of HIV/AIDS, and where traditional customs relating to the upbringing of adolescents had broken down. There is also evidence that children from a vertical collectivist culture (where individuals are perceived to be part of a collective but the idea of inequality is accepted [Singelis et al., 1995]) such as the target community, fare better with authoritarian parenting with its strict discipline (e.g. Shek, 2008). However, research (albeit in Western contexts) on parenting style and adolescent risk behaviour suggests that an authoritative parenting style with high levels of supervision and monitoring, high parental expectations, and open communication between parents and children, is optimum for protecting children against risky sexual behaviour.

Implications for Family and Community Level Interventions

Joffe (1999, 2003) used a psychoanalytic extension of social representations theory to understand how people deal with risk. Of particular import for this study was her use of this theory to understand how people, when confronted with a new and threatening disease such as HIV/AIDS develop social representations which defend the collective identity of the group, with splitting and projection of risk onto ‘others’ or ‘outgroups’ being a common defense against the anxiety of risk of infection. This theoretical framework was used to understand HIV risk influences for youth at community and family levels with the view to informing an adaptation of CHAMP.

The emergent themes suggested that in the context of political, economic, social and cultural change, dealing with the threat of HIV/AIDS for youth was an enormous challenge. Parents expressed a profound sense of disempowerment with regard to the protection of their children. They ascribed this in the first instance, to a power imbalance created by children having better educational opportunities than themselves. Second, a breakdown in traditional norms and social practices associated with protective parenting had left them emasculated as to how to parent effectively, with media and government messages suggesting that traditional methods of parenting were inappropriate. Parents attempted to compensate for this sense of disempowerment by exacerbating the traditional authoritarian parenting styles. This approach could only serve to further distance and alienate their children who, exposed to Western dominated cultural formations on appropriate discipline, challenged their parents' right to use corporal punishment. From a Freirein (1993) perspective of conscientisation, parents needed to engage in a process of critical reflection of the social issues and renegotiating of parenting practices that were deemed to impede their parental authority. Empowering parents with knowledge about HIV/AIDS as well as with parenting skills, including communication, and monitoring, which would promote greater parental authority, would be important interventions at the family level. In addition, parents needed to engage in critical reflection of the rights and responsibilities of both parents and children.

In the absence of a containing leadership, that could assist with anchoring the unfamiliar and rendering it manageable, parents felt anxious, helpless and unsupported. Within this context, it was not surprising that 'outgroups' such as 'Whites' and 'females' were identified as being responsible for spreading HIV. According to Joffe (1996b), "such changes make for insecurity... people perceive their world to be out of control, with their protection compromised" (p. 209). The

insecurity and fear of contamination also led to stigmatization of people suspected to be living with HIV/AIDS.

Using Carpiano's (2006) model of social capital, mistrust and suspicion among community members and erosion of traditional values (and social networks) had resulted in little social cohesion in the community. In addition to feeling disempowered as parents, they felt unsupported both by other community members as well as community leaders. Informal social control of children was virtually non-existent in this climate of suspicion and mistrust. Sampson, Raudenbush & Earls (1997) found that high levels of social cohesion can be a protective factor for adolescent risk behaviour and that communities with greater support networks are able to work collectively to implement social controls to protect community members from negative social influences. The lack of connectedness within the community also compromised participation in community organisations and opportunities to socially enhance protection of their children.

The network provided by the CHAMP group process had the potential to establish an organized group, one of the "forms" of Carpiano's (2006) social capital. The group could be the impetus, as a result of renegotiation of health enhancing social representations, for social support and informal social control for the protection of children. Empowerment stemming from participation in the group could lead to increased community participation and social leverage, all aspects of social capital. In general, and despite the warnings of some researchers (e.g. Campbell et al., 2002; Pronyk et al., 2004) that the relationship between social capital and positive health outcomes is not as clear cut as it may seem, particularly in poorer communities in South Africa,

research shows that higher levels of social capital are associated with more positive outcomes with regard to children's development, and with sexual health and HIV.

The group could also provide the dialogical space for renegotiating social representations of people living with HIV/AIDS, thus addressing issues of silence and denial linked to stigmatization. Additionally, the group could provide an opportunity for addressing issues related to death and bereavement.

These findings guided the adaptation of CHAMP to render it contextually appropriate. While details of the adaptation process are beyond the scope of this thesis, a brief description is presented here to show how the findings of Study 1 were used, and to provide a comprehensive perspective of the broader project within which this thesis is located.

DEVELOPMENT OF CHAMPSA

The Triadic Theory of Influence (TTI) (Flay, Snyder & Petraitis, 2009) on which CHAMP was based, was translated into seven community field principles to provide a conceptual framework for the adaptation of CHAMP for the South African context (Bell, 2001). The seven field principles included: (1) reestablishing the village (social networks); (2) providing access to health care (referral service); (3) improving bonding, attachment and connectedness dynamics (parenting styles and communication skills); (4) improving self-esteem (developing self-understanding and knowledge); (5) increasing social skills; (6) re-establishing the adult protective shield through monitoring (parental monitoring); and (7) minimizing residual effects of trauma (promoting supportive community networks) (Bhana, et al., 2010, p. 3).

The CHAMPSA steering committee (that had been established prior to initial entry into the community) oversaw the adaptation of CHAMP into CHAMPSA. At the suggestion of the committee, the sessions were redesigned as an open-ended, cartoon-based story line running throughout the program (Petersen et al., 2006). Families were required to reflect on their own experiences to close each narrative, using the characters in the narrative as a springboard. Key informants, such as health care workers, social workers, and teachers were asked to review the adapted version. In addition, adult caregivers and youth who participated in the pilots of each session gave feedback that informed the final manualized programme, The AmaQhawe (Champions) Family Programme (the name was another suggestion of the committee) (Bhana, Petersen, Mason, Mahintsho, Bell, & McKay, 2004). A copy of the manual is included as Appendix 7.

The AmaQhawe Family Programme comprises ten 90-minute sessions delivered over 10 weekends to multiple family groups. Given the amount of time families were required to devote to the program, they were paid a stipend of R50 for each session attended, as well as a R250 incentive for attending all 10 sessions.

CHAMP deals with information about HIV/AIDS, and this was believed to be essential for Amaqhawe as part of the process of parental empowerment. A significant addition that was unique to Amaqhawe was a session on HIV/AIDS related stigma which was found to be a major concern in the community. Communication and monitoring, as well as setting rules for children as part of authoritative parenting, are part of the CHAMP programme. These are also included in the Amaqhawe sessions, with the addition of children's rights and responsibilities, an issue that

was found to be especially important within the community. As in CHAMP, a session of Amaqhawe deals with the onset of puberty. Also unique to Amaqhawe is a session on death and bereavement which was considered necessary, given the finding that the community was striving to cope with increasing numbers of deaths due to AIDS. Similar to CHAMP's session on community parenting (~~Who~~ "Who can help us raise our children?"), Amaqhawe included sessions on connectedness with caregiver social networks; decreased neighborhood disorganisation, and increased social control and cohesion. In addition to addressing feelings of anxiety provoked by a lack of containment as well as lack of trust among community members, these were envisaged to help to reestablish community parenting and the adult protective shield at a community level.

The AmaQhawe Family Programme provides the necessary group context for caregivers collectively to renegotiate caregiver norms and practices towards health-enhancing alternatives. This provides bonding social capital to facilitate the processes of dialogue, collaborative participation, reflection and social debate (Campbell & Jovchelovitch, 2000; Howarth, Foster & Dorrer, 2004), which are considered necessary to facilitate ~~eritical~~ "critical consciousness" and empower parents to renegotiate health enabling social representations and parenting practices in order to protect their children against high risk behaviour and HIV. As part of a social network, the parents are provided with the opportunity to strengthen the ~~community~~ "community protective shield" and ~~rebuild the village,~~ "promoting ownership and sustainability of these efforts on completion of the project. (Bell et al., 2008; Petersen, Mason, Bhana, Bell, & McKay, 2006).

The adapted Amaqhawe Family Programme was piloted in three sites. The post-intervention formative qualitative evaluation (Study 2), however, was conducted only with participants from

the community where the pre-intervention study had been implemented. The findings and discussion of Study 2 are presented next in Chapter Seven.

CHAPTER SEVEN

FINDINGS AND DISCUSSION OF STUDY 2

This chapter reports on the post-intervention formative qualitative evaluation of the AmaQhawe Family Programme in the site in which it was initially piloted. In a randomized control trial of the intervention, Bell et al. (2008) found that there were significant differences between the experimental group and a control group. There was an improvement among parents in AIDS transmission knowledge; less-stigmatizing attitudes towards people who were HIV positive; increased comfort and frequency in talking about sensitive issues such as HIV, AIDS, sexuality and substance abuse with their children; improved caregiver monitoring and control of children's whereabouts and behaviour; and a strengthening of primary support networks (Bell et al., 2008; pp. 941-942). Given that the randomized controlled trial showed *that* the Amaqhawe Family Programme had made a difference, Study 2 was concerned with developing an understanding of *how* the programme had addressed family and community issues that had been identified in the pre-intervention exploratory study as having placed youth at risk. Study 2 was conducted two years after the intervention so that the effects related to the immediacy of the programme would have dissipated; if the programme was health enabling in the Freirian sense, then this should emerge in what the participants said about their lives and health-enabling supportive social networks.

The responses of all nine women who participated in Study 2 were overwhelmingly positive, with all the participants expressing a sense of empowerment both at individual and community levels. McPhail (2006, p. 178) defines empowerment as ~~the~~ the mechanism through which

successful community-based programme operation is derived from the successful involvement of local people in the process of participation”. She maintains that one of the aims of programme participation is involvement in community networks leading to collective problem solving and increased community power and control.

The findings are discussed under two broad themes: **Individual empowerment**, including the subthemes *parental empowerment*, *women empowerment*, and *social support*; and **Collective empowerment**, including the subthemes *informal social control*, *social leverage and community organisation*, and *HIV/AIDS stigma*.

Individual empowerment

Parental empowerment

One of the most striking positive outcomes was that those parents who had participated in the programme clearly felt empowered, having greater confidence in themselves as parents. In particular they felt that the programme had helped them deal with what they perceived as the erosion of their rights as parents by government and media messages which they perceived as having encouraged children’s disrespect by affirming children’s rights and undermining parents’ rights. The following two quotations are good examples of what was expressed by all participants:

CHAMP coming in the area was very helpful. In fact it was a relief to us; we as parents were then powerless; we couldn’t talk to our children the way we wanted, since we used to get these comments from the children when you were instructing the child or smacking the child for something that she/he had done wrong, the child would tell you that she/he is

going to take you to court. Whatever you did, the child would threaten you by saying that she/he is going to take you to court. Well then it made us feel like we were useless and not a parent. You wouldn't feel like a parent to the child, but felt that the child was more powerful than you. So CHAMP was able to solve that problem by teaching us parents how far children's rights go and how far parents' rights go. So in that sense we were able to have a proper discussion with our children and there was good communication, and we felt like real parents, and the child was able to realize that she/he is still a child and this is a parent. (Interview 6)

I would say that I was very scared to talk to my child though my child is still young but I was scared to talk to her/him. But having attended the CHAMP programme, I was then able to talk to my child without hiding information. We now chat and discuss things. Sometimes my child would ask questions and I would tell her/him straight away without being scared like before. (Interview 2)

This sense of empowerment on the part of parents can be attributed to a number of programmatic interventions. First, the programme had assisted parents to engage in critical reflection regarding their authority as parents, and to develop a level of critical consciousness regarding their own rights and responsibilities as parents. The importance of critical reflection and dialogue for the development of critical consciousness was underscored by Campbell and Murray (2004). The following excerpt illustrates the kind of critical consciousness that had developed among programme participants:

Okay, we realized that our rights were not taken away from us. But the problem was that sometimes when we thought that we were using our rights, maybe we were abusing the authority that we had over our children, or abusing our position as parents to our children. We were aware that it was our right to take care of our children, especially when a child has gone and you don't know where she/he has gone to, [we believed that] it is your right to shout at your child or to give your child a hiding. But we have learnt that we were abusing our authority over our children. We learnt that the treatment we gave our children sometimes had bad results. (Interview 4)

This critical consciousness also promoted the understanding that just as parents expect respect from their children, children also deserve respect from their parents as the following excerpt illustrates:

If you ask the child [to do a task, rather than instruct her/him], the child feels respected and acknowledged that she is being treated like a human being. Same like an adult, if a child says "please", you are touched by those words.
(Interview 5)

Furthermore, parents felt empowered by their children's awareness that rights are balanced with responsibilities.

We had a problem, a serious problem, since when you were talking to a child, s/he would tell you that I know that there are now rights for the children. But now they know that their rights do not come alone. It does not mean that just because the child has got a right

s/he must not respect the parent. Now they know that their rights come with conditions that this and that should be done, and the rights work here and there. (Interview 7).

In addition to the development of a critical consciousness around the rights and responsibilities of parents and children, parents' sense of empowerment and self-efficacy also appeared to be associated with improved HIV knowledge and communication skills. Campbell et al. (2007) identify knowledge and skills necessary to avoid HIV-infection as one of six psychosocial resources that facilitate AIDS competence. Increased HIV knowledge empowered parents with protective information that they could pass on to their children, as illustrated by the following quote:

But we have enough information, as I can now tell my child from the start to the end how HIV/AIDS is acquired, what happens from the first up to the end. The child also adds information if she/he attended the programme, and you have a discussion. (Interview 5)

Communication skills empowered parents to enter into dialogue with their children about sensitive issues as reflected in the following quote:

CHAMP gave us ways of proper communication within the family. That was the key in most issues. Now we find it easier to talk about anything, and it's also easier for my child to say, "Mom, I'm not clear on this and that". And so, matters of relationships, including HIV issues, are now easy to talk about since we now talk as friends, you see! (Interview 4)

The outcome of this sense of empowerment in parents had been a shift in parenting styles. Prior to programme implementation participants had reflected an awareness that the old authoritarian ways were no longer effective, and part of the feelings of helplessness emanated from not knowing how to assert their authority as parents. Critical consciousness of their roles and responsibilities as parents coupled with enhanced HIV knowledge and communication skills translated into parents adopting a more democratic, authoritative parenting style that involved greater negotiation as opposed to the previous authoritarian style of parenting. Steinberg (2001) asserted that an authoritative parenting style has been shown to be definitively optimal, despite some contradictory evidence (e.g. McBride-Chang and Chang, 1998; Furstenberg et al, 1999). In addition to adopting this new parenting style, the participants also appeared to have infused humour into their interactions with their children, indicating that the sense of empowerment had enabled parents to feel relaxed and enjoy their role as parents:

[Before] I have attended the programme, ... I notice[d] that what I have said has not been heeded by my children. I now have a saying which goes like this: "Did I swear you or embarrass you, or did I use unacceptable language?" Then they would laugh and say: "No, mama, it's just that you said this and that, while I was thinking about this and that". Then I would say: "Oh, I said that because of this and that". They now find it funny when I say: "Have I embarrassed you or sworn at you?" In that way I would then get feedback.
(Interview 5)

Women empowerment

The majority of participants in the programme were women who not only felt empowered as parents, but had also clearly been empowered as women. This was despite the fact that the pre-

intervention study had found that women were regarded as one of the “outgroups” who were blamed for the spread of HIV/AIDS and for any other problems within the family. However, participation in the group was not the only source of the women’s sense of affirmation; structural factors promoting women’s empowerment such as the appointment of a woman (at the time) as the deputy president of the country was also mentioned as indicating that women are equally as capable as men. Campbell et al. (1999, p. 144) argue that this kind of “perceived citizen power” is a most important dimension of health-enhancing social capital:

We now have a deputy president as a woman and we are also noticing it in the community. We have a large number of women holding high positions, ya. Even here in our area, there are women holding positions and working very hard and doing very well. Before, we thought that it was only men that worked hard and could hold positions. Well, everywhere now you find women holding high positions and fitting in perfectly. (Interview 3)

Howarth (2006, p. 28) maintains that “when others’ representations of us are negative - perhaps positioning us as dangerous, deviant and “other”, we find strategies that resist and reject such representations and so protect our sense of self”.

Social support

In addition to empowerment as parents and women, participation in the programme appeared to have empowered the participants individually through increased social capital in the form of social support. Participants reported feeling far more supported than before in being able to give and receive help. While some participants indicated that this sense of support had disseminated

beyond the boundaries of those participating in the programme, others mentioned that it was mainly limited to the group participants.

I wouldn't say that it [trust] developed in the community, but I would say that with people that attended the programme, friendship and trust did develop. Since we met, we bonded so much that it came to a point where when you have a problem, you don't just sit down but you go to your friend that you met when you attended the programme. We are now able to help each other and phone each other as neighbours. But with regard to the community, I feel that this issue of trust is going very slow. (Interview 4)

For others, social capital in the form of social support was more widespread. Although trust, part of social cohesion and contributing to social capital according to Carpiano (2006), was admittedly “going very slow”, increased levels of reciprocity among community members was reported, albeit strongest among group members:

Now you know that if you ask for help from your neighbour, you will get help. Another person in need of help will come to you and ask for help. There is that spirit of trust and longing to help one another. Even when you meet a person: “Hey, I have not seen you for ages!”; and you feel that you are still part of this person and she/he misses you. (Interview 5)

Literature on the health enhancing potential of social support abounds (e.g. Ray, 2004). For the participants, this increased social support was an important resource at an individual level, providing them with social support for protecting their children and reinforcing their empowered

social identities. There was, however, the risk that increased levels of social capital among participants of the programme might lead to negative social capital in the form of exclusion (Portes, 1998).

With regard to individual empowerment, it would appear that through critical reflection and dialogue of issues related to parenting, the programme was effective in challenging negative parental identities and facilitating more empowered ones. These empowered identities were supported by structural transformations in the external environment, which promoted women empowerment. Further, the social network afforded by the group intervention provided the participants with much needed social support, which also empowered them to provide greater protection to their children.

Collective empowerment

Informal social control

Strengthened networks with increasing levels of trust was an important outcome among group participants. However, this influence also appeared to extend beyond group participants in the form of increased informal social controls. Thus, most participants stated that if they encountered a child engaging in unacceptable behaviour, they would intervene without the apprehension that they had had before, that the parents of the child would remonstrate with them for ~~interfering~~. Although some participants did say that there were still some instances of parents who saw this kind of intervention as interference, one parent said that most parents would often thank the person who had disciplined the child. This illustrates how the programme assisted in enabling ~~community parenting~~ and ~~reestablishing the village~~.

You find a child [who is not in school] and you send or accompany her/him to school and the child goes to school. And then the mother comes to you and says: “I heard that you sent my child to school. Thank you very much, that was very helpful.” Before, the mother would have said: “What is the matter with you, that was not your business. It is my child and you are not paying the school fees, but I pay it”. Now there is that spirit of togetherness, that I have seen the child doing wrong, and let me correct her/him. (Interview 5)

Furthermore, when it was suspected that drugs were being sold at a particular house, community members grouped together and successfully compelled the residents to stop doing so.

There was a rumour that the house that was near the school used to sell drugs, but the community met and advised them to stop doing that. They stopped. The level of drug abuse has dropped. Parents are taking responsibility to keep the area clear from all forms of corruption. (Interview 3)

Participants also reported that community members had rallied together and organised to have local unlicensed stores formally stopped from stocking alcohol and selling it to children.

Some of the parents informed the police about the taverns since they were the cause of all this trouble. The people that are selling liquor to them, they are drinking with them, and the child learns to drink liquor and to smoke and learns about everything in the process. We are grateful to the police since they are closing down these taverns so we know our children won't be able to go there. (Interview 7)

Incidents of rape, especially of young girls in the community, were also reported to have dropped. For example:

Well, here I have noticed that there are changes and the rate or level of children being raped is not as high as it was before. (Interview 8)

The emergence of community parenting which increases the potential for protection of children, informal ‘policing’ of residents who engage in activities that increase risk for children, as well as organising to have police close down taverns selling alcohol to children illustrates how the programme assisted in facilitating collective action in the form of informal social controls to enable the community’s “adult protective shield” (Bell, Flay & Paikoff, 1993). Carpiano (2006) argues that while informal social controls are a form of social capital that is network based, it also serves to benefit those who are not part of the network. In the present case, the strengthened community norms and values with their consequent benefits had accrued not only to children of group participants but to children in the community generally.

Social Leverage and Community Organisation

Social leverage and community organisation participation, two forms of social capital emerging from improved community networks are important for increasing access to resources and facilitating structural and material changes at a community level. According to Carpiano (2006), community organisation refers to formally organized groups for addressing neighbourhood issues. While the AmaQhawe parents were not reported to have developed any formal organisational groups, the participants had increased their participation in community organisations concerned with addressing community issues. Participants reported that they had

become actively engaged in community development initiatives as reflected in the following quote:

parents who attended the programme are very active when something needs to be done, and if there is a leader of the community that is not in a meeting, they would suggest that that person is called to attend the meeting since all leaders are [supposed to be] serving the community. (Interview 6)

Furthermore, one woman subsequent to participation in the group, became involved with the school governing body, the Area Development Project and the Independent Electoral Commission. Participation in organisations outside of regular social networks can help to bring resources into the community and is an example of social leverage (Carpiano, 2006).

Participants also recognized that men were potential resources who needed to be harnessed to assist in the protection of children. The women participants felt sufficiently empowered to begin to encourage men to be more involved in protecting and raising their children. This is a further example of social leverage:

At the cultural day at the school, I was there and there were so many men. I got that time to explain, uh, that we need support from men. It is not just only women to look after the child, but both. We are just inviting them, now they are still lacking but we are just trying, we are trying. (Interview 1)

Individual empowerment clearly translated into collective empowerment, with participants acting collectively through informal social controls to improve the safety of their neighbourhood for children as well as engaging in community organisation activities to facilitate greater access and control of resources.

HIV/AIDS stigma

The majority of the participants asserted that HIV/AIDS was no longer stigmatized in the community as the following excerpt exemplifies:

I just feel that stigmatization has just been put aside since many people now come forward and confess their status and say they are infected with the disease. (Interview 4)

They ascribed this to the programme:

As I attended the Amaqhawe programme, I realized that you don't have to discriminate against a person who has this disease. Before, I used to be scared of people suffering from this disease. I was even more scared to come close to the person, scared to even touch the person, but no more. I am, no longer like that now. And even in the community a person with this disease is visited. (Interview 7)

However, one participant believed that some stigmatization with its associated silence still remained:

It may happen that people still feel scared to share it [HIV+ status] because of stigmatization. When a person dies of the disease people do help but they try to hide it in one way or the other. (Interview 9)

Brown et al. (2001), having reviewed studies on stigma conclude that while stigma can be reduced with intervention strategies such as information, counseling, coping skills and contact, it may not be possible to eliminate it completely; and that changes in stigma-related attitudes are probably not sustained over the long term.

In conclusion, this post-intervention, qualitative formative process evaluation aimed to explore how the pilot study of the Amaqhawe Family Programme had helped participants to address issues that had emerged from the pre-intervention exploratory study. In the next chapter, I present an integrative discussion with a model of how adult and community protective shields can be developed in order to protect children against the risk of HIV. Following that are my reflections about this project, including some limitations. Finally, I discuss my conclusions and recommendations for the way forward.

CHAPTER EIGHT

INTEGRATIVE DISCUSSION; REFLECTIONS AND LIMITATIONS; CONCLUSION AND RECOMMENDATIONS

Integrative Discussion

At the time of this project, the community of Embo in Kwadedangendlale, KwaZulu-Natal was undergoing political, economic, social and cultural change. Superimposed on these changes was the then new and threatening disease of HIV/AIDS. Using Joffe's (1999, 2003) psychoanalytic extension of social representations theory, the community were understood to have developed social representations that would defend the collective identity of the group. These included the defence mechanisms of splitting and projection of risk onto 'others' or 'outgroups'. The insecurity and fear of contamination also led to stigmatization of people suspected to be living with HIV/AIDS. A climate of mistrust and suspicion had developed within the community, leading to the erosion of social networks and resulting in little social cohesion. The lack of connectedness within the community also compromised participation in community organisations and opportunities to socially enhance protection of their children. In addition, informal social control of children was virtually non-existent. According to Carpiano's (2006) model, there was a severe decline in social capital.

In the absence of a containing leadership, that could assist with anchoring the unfamiliar and rendering it manageable, parents felt anxious, helpless and unsupported with regard to the protection of their children against the threat of HIV/AIDS. Parents ascribed their feelings of disempowerment to a generational knowledge gap as well as a breakdown in traditional norms

and social practices regarding parenting. Parents attributed these to media and government messages that emphasized children's rights and suggested that traditional methods of parenting were inappropriate. In attempting to cope with their helplessness, parents admitted to resorting to severe forms of traditional authoritarian parenting practices which they acknowledged were not working.

From a Freirein (1993) perspective of conscientisation, parents needed to engage in a process of critical reflection of the social issues and renegotiating of parenting practices that were deemed to impede their parental authority. Empowering parents with knowledge about HIV/AIDS as well as with parenting skills, including communication, and monitoring, which would promote greater parental authority, would be important interventions at the family level. In addition, parents needed to engage in critical reflection of the rights and responsibilities of both parents and children.

The network provided by the CHAMP group process had the potential to establish an organized group, one of the "forms" of Carpiano's (2006) social capital. The group could be the impetus, as a result of renegotiation of health enhancing social representations, for social support and informal social control for the protection of children. Empowerment stemming from participation in the group could lead to increased community participation and social leverage, all aspects of social capital.

The group could also provide the dialogical space for renegotiating social representations of people living with HIV/AIDS, thus addressing issues of silence and denial linked to

stigmatization. Additionally, the group could provide an opportunity for addressing issues related to death and bereavement.

These findings of Study 1 guided the adaptation of CHAMP to render it contextually appropriate. CHAMP became CHAMPSA and finally the Amaqhawe Family Programme.

The pilot study of the AmaQhawe Family Programme was designed to work with groups of parents and their children to strengthen the “adult protective shield” at both an individual and collective level through a process of critical reflection and dialogue of social barriers to healthy functioning to achieve social change (Campbell & Murray, 2004). At the individual level, the programme was reported to promote individual empowerment of the participants as parents and women to protect their children against HIV risk. This was achieved through the development of a critical consciousness of their rights and responsibilities as parents which facilitated the renegotiation of empowered parental identities, as well as increased HIV knowledge and communication skills. This empowered identity was supported by wider socio-political structural changes promoting women’s empowerment as well as increased support both materially and socially which reinforced the participants’ renegotiated identities.

At the community level, collective empowerment enabled participants to begin exerting more informal social controls as well as engage in community organisational activities to increase resources and create a more protective neighbourhood for their children.

Considered from the perspective of Carpiano's (2006) model, increased social networks facilitated the development of social capital in the form of social support, social leverage, informal social controls and community organisation participation. The participants perceived an improvement in social support, which they could draw on to protect their children against high-risk behaviour. Participation also clearly increased their social leverage and facilitated increased informal social controls within the community with regard to community parenting. Community organisation participation by some of the participants also increased their potential to engage collectively in organisational activities to reduce negative risk influences and strengthen protective influences at a community level.

These findings suggest that interventions involving families and communities to facilitate health enabling social contexts for youth are possible. The model in Figure 1 shows how improved parent child communication and parental HIV knowledge at the individual level as well as renegotiated, empowered parental identities facilitated through the group process restored parental authority at the individual level as well as collectively through increased social capital, thereby restoring the adult and community protective shields.

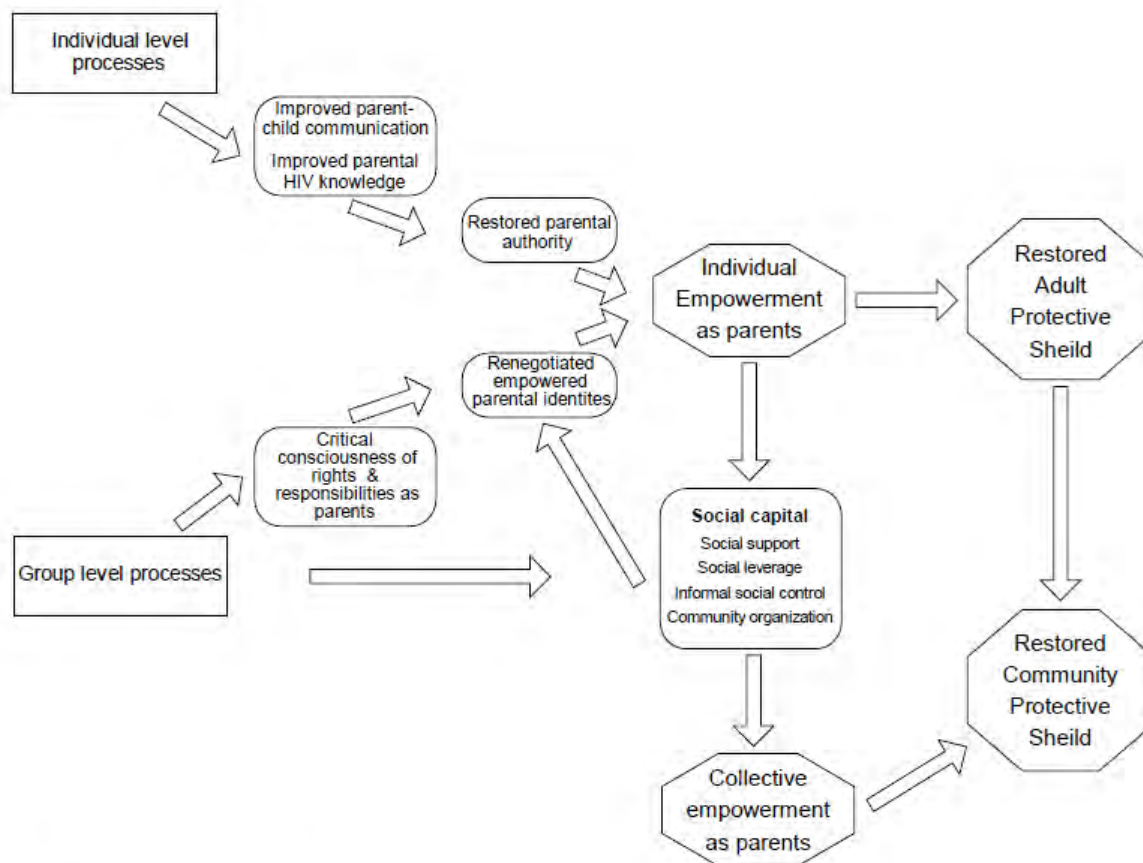


Figure 1: Model for restoring the adult/community protective shield

Reflections and Limitations

Translation in research

This research project was conducted in Zulu, necessitating translation of the original questionnaires into Zulu, and then translation of the data obtained back into English for analysis. While every effort was made to ensure the validity of data by translation and back translation, and by employing facilitators and translators who were familiar with research processes, and experienced in translation of research data, I must acknowledge that it is impossible to obtain complete objectivity and eliminate all bias; translations will always be flawed and therefore the

findings may be questionable. However, Mclean (2007) advocates that language not be identified only as a barrier in cross-cultural research, but also as a resource to try to understand the social reality of participants.

Nonetheless, the issue of translation in research is fraught with problems. Crane, Lombard and Tenz (2009) maintain that translation is a subjective, open and imperfect process. Even when qualitative research is conducted in one language, requiring no translation, the researcher produces an understanding of the text that is filtered through her own experiences (Phillips, 1960). As Mclean (2007, p. 786) suggests, “understanding is always an act of construction and creation”. When dealing with translated text, the researcher’s understanding is filtered through the understanding of the translator (Riessman, 2000). With my project, not only were the questionnaires translated into Zulu and administered by Zulu speaking facilitators, but the audio recorded data were then transcribed and translated back into English by another Zulu speaking translator. An additional challenge was that Study 1 explored the understanding, or social representation, of HIV among the targeted community. It could be argued that the data obtained were a social construction of a social representation twice removed, and therefore susceptible to “triple subjectivity” (Temple & Edwards, 2002, p. 6).

However, in a rare exploratory study using English translations of Chinese data, Twinn (1997) examined the influence of translation on the validity and reliability of qualitative data analysis. She found that similar categories and themes were developed during the analysis of the qualitative data, whether using Chinese or English as the medium for analysis. She emphasized

the importance of having only one translator working with the data to maximize reliability of the data sets.

Another issue in translation in research is that of power relations (Crane et al., 2009; Muller, 2007). Muller (2007) contends that translation is complex, political and subjective. There is a power differential between the researcher, the facilitator/s, the translator/s and the research participants. Translation, according to Temple and Young (2004), makes the source language invisible. Furthermore, the translator is not neutral, but makes her own constructions of meaning, making her an analyst and cultural broker, and this must be acknowledged. In qualitative semi-structured interviews and focus group discussions, facilitators using a language other (in this case Zulu) than the source language (in this case English) wield the power to explore issues beyond the semi-structured questionnaire as they see fit, with the researcher having little control over the direction of exploration. However, Crane et al. (2009) suggest that these issues encourage greater awareness and reflexivity. At a personal level, the inability to work directly with participants and explore and probe around issues that I might have regarded as warranting further clarification proved to be frustrating.

The issue of generalizability

–Generalizability refers to the extent to which one can extend the account of a particular situation or population to other persons, times or settings than those directly studied” (Maxwell, 1992, p. 293). One of the aims of research is to produce information that can be applied beyond the study setting, and while no study can be universally transferable, findings from qualitative studies are generally believed by positivists to be applicable only within a specified setting because they are not based on random sampling and statistical probability (Malterud, 2001). However, Johnson

(1997) suggests that it would be reasonable to generalize to similar populations, settings and time; what Stake (1978, p. 6) calls *naturalistic generalization*.

Of relevance to the current research is external generalizability (Maxwell, 1992), and what Firestone (1993) termed case-to-case transfer in which the findings from a case study in one setting may be applied in another. For the Amaqhawe Family Programme to be rolled out to other communities in South Africa, it had to be externally generalizable or transferable. Firestone (1993) recommends the use of thick description which would assist in determining the applicability of the findings in a different context, i.e. comparability and translatability (leCompte & Goetz, 1982). According to Lincoln & Guba (1985, p. 124), the similarity or congruence between the two cases would determine the degree of transferability or the “fittingness.” Transfer of the Amaqhawe Family Programme to other communities would require careful determination of their similarity to the pilot site.

Payment of stipend

Each person who participated in the focus groups and/or interviews was paid a stipend of R50. Dickert, Emanuel, and Grady (2002), having reviewed guidelines for payment to research participants, recommend that undue inducement be minimized. Given the poverty of the majority of people in the target community, these amounts represented a substantial sum. One may speculate on the extent to which participation was influenced by these inducements. However, considering the time that participants invested in participating, and sometimes the cost to them of travelling to the school where the focus group and interview sessions were conducted, these inducements were not believed to be excessive or inappropriate.

Socially desirable responses?

Responses of participants in Study 2 were overwhelmingly positive. While the pilot intervention may indeed have had a considerable impact on the adult and community protective shield, I reflect on how much of the optimism of the women was due to their need to convey their appreciation and gratitude for the programme in which they had been paid to participate. At the time of the intervention, there had also been a general sentiment among participants that they were “Champions” (Amaqhawé) and they perceived themselves to be special within the broader community. Although Study 2 was conducted two years after the intervention, perhaps some of that feeling of being privileged persisted and needed to be conveyed in responses that they believed would please the interviewer from the Amaqhawé Programme.

Study 2 participants

Despite all efforts, to contact all participants of the pilot intervention, of whom three had been men, only nine women were available for Study 2. When notices were first sent home with children from the targeted school inviting parents to attend an informational meeting, there had been an approximately even mix of men and women who attended. The focus groups for Study 1 had also consisted of both men and women in equal numbers. For the pilot intervention, however, only three men attended, with only one father attending all sessions. It seemed that having attended the original meetings and determined that the programme was about child rearing, the men from this patriarchal community decided that this was “women’s work” and lost interest.

Conclusion and Recommendations

This focused ethnographic, formative case study was conducted, firstly, to inform an adaptation of CHAMP so as to strengthen the adult protective shield in the Embo community in

Kwadedangendlale, KwaZulu-Natal, and secondly, after a pilot intervention, to evaluate the adapted programme in order to understand the processes involved in strengthening the adult protective shield.

The findings, which suggest that interventions involving families and communities to facilitate health enabling social contexts for youth are possible, culminated in the model depicted in Figure 1. By improving parent child communication and parental HIV knowledge at the individual level, as well as renegotiated, empowered parental identities facilitated through the group process, parental authority can be restored at the individual level as well as collectively through increased social capital, thereby restoring the adult and community protective shields.

Researchers have repeatedly underscored the importance of including parents in HIV prevention programmes for children and adolescents, and of addressing social and environmental factors that place children at risk. In South Africa, while there have been many HIV prevention interventions targeted at the youth, most of them have been individual programmes that encourage young people to make healthy choices. These programmes have had some success, with the third national HIV survey in 2008 showing an overall decline in HIV prevalence among 15-19 year olds. However, there has been an increase in two provinces, KwaZulu-Natal and Mpumalanga, with a large increase in KwaZulu-Natal making it the province with the highest HIV prevalence of HIV among youth. Furthermore, the national incidence estimates for HIV among 15-20 year olds is still high, ranging from 0.5% to 1.7%. As the most common mode of transmission of HIV in South Africa is through heterosexual sex, in order to reduce incidence, it is important to prevent early sexual debut by targeting preadolescent children. My research suggests that children can be protected from risky sexual behaviour by empowering parents using a group-

based intervention that establishes community control by adult community members, thereby strengthening the adult and community protective shield.

CHAMP and CHAMPSA (Amaqhawwe) were funded by the National Institute of Mental Health (NIMH) in the United States and were very cost intensive. Since the three initial pilot projects, CHAMPSA (Amaqhawwe Family Programme) has been rolled out at 20 sites. As one of the aims of CHAMP is community collaboration and community ownership, participants from the pilot programmes were recruited and trained as co-facilitators to implement the programme in other communities. This type of task shifting has been recommended by the World Health Organization (WHO, 2008) for scarce resource contexts, and could be utilized for a more cost-effective scaling up of the implementation of the programme on a provincial and possibly national scale. A review by Callahan et al. (2010) concluded that task shifting is an effective strategy where programme rollouts are threatened by shortages in health personnel, but they caution that task shifting must be accompanied by adequate and sustainable training and support.

My review of the literature revealed no empirical research using family-based HIV prevention programmes with preadolescent children in Africa, and more specifically in South Africa. All family-based prevention programmes located originated in the United States, and the majority of the literature on parenting was from the wealthier developed countries. More research is required in order to establish not only which parenting styles are optimum for the protection of children against high risk behaviour and HIV, but also which family-based interventions work best in South African contexts.

REFERENCES

- Adalbjarnardottir, S., & Hafsteinsson, L.G. (2001). Adolescents' perceived parenting styles and their substance use: Concurrent and longitudinal analyses. *Journal of Research on Adolescence, 11*, 401-423.
- Amon, J.J. (2002). Preventing HIV infections in children and adolescents in sub-Saharan Africa through integrated care and support activities: a review of the literature. *African Journal of AIDS Research, 1*, 143-149.
- Ang, R.P., & Goh, D.H. (2006). Authoritarian parenting style in Asian societies: a cluster-analytic investigation. *Contemporary Family Therapy, 28*(1), 131-151.
- Asheber, T. (2005). Social capital as a survival mechanism: the case of some street children and youth in Addis Ababa. MA Thesis. Addis Ababa University. Retrieved from <http://etd.aau.edu.et/dspace/handle/123456789/846> on 14/06/10.
- Astone, N. A., Nathanson, C. A., Schoen, R., & Kim, Y. J. (1999). Investment in social capital. *Population and Development Review, 25*, 1-31.
- Aunola, K., Stattin, H., & Nurmi, J. (2000). Parenting styles and adolescents' achievement strategies. *Journal of Adolescence, 23*, 2, 205-222.
- Avert (2010). HIV and AIDS in South Africa. Retrieved from <http://www.avert.org/AIDSouthafrica.htm>
- Ayrapetyan, V. (2006). Parenting styles and self-efficacy beliefs in Armenian-American families and their relationship to their children's school performance. Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 66(7-B), 2006.

- Babbie, E., & Mouton, J. (2001). *The practice of social research*. Oxford: Oxford University Press.
- Baldwin, A.L. (1948). *Behavior and Development in Childhood*. New York: Dryden Press.
- Baldwin, A.L. (1948). Socialization and the parent-child relationship. *Child Development*, 19, 121-136.
- Baldwin, C., & Baldwin, A. (1989). *The role of family interaction in the prediction of adolescent competence*. Paper presented at the meeting of the Society for Research in Child Development, Kansas City, MO.
- Ball, J., Pelton, J., Forehand, R., Long, N., & Wallace, S.A. (2004). Methodological overview of the Parents Matter! Program. *Journal of Child and Family Studies*, 13(1), 21–34.
- Bantchevska, D., Bartle-Haring, S., Dashora, P., Glebova, T., & Slesnick, N. (2008). Problem behaviors of homeless youth: A social capital perspective. *Journal of Human Ecology*, 23(4), 285-293.
- Baptiste, D.R., Bhana, A., Petersen, I., McKay, M., Voisin, D., Bell, C., & Martinez, D.D. (2006). Community collaborative youth-focused HIV/AIDS prevention in South Africa and Trinidad: Preliminary findings. *Journal of Pediatric Psychology*, 31(9), 905–916.
doi:10.1093/jpepsy/jsj100
- Baptiste, D.R., Blachman, D., Cappella, E., Dew, D., Dixon, K., Bell, CC., ... & McKay, M.M. (2007). Transferring a university-led HIV/AIDS prevention initiative to a community agency. *Social Work in Mental Health*, 5(3 & 4), 269 – 293.
- Baron, S., Field, J., & Schuller, T. (2000). *Social Capital. Critical Perspectives*. Oxford: Oxford University Press.

- Barrett, M. (1992). Words and Things: Materialism and Method. In M. Barrett & A. Phillips (Eds.) *Contemporary Feminist Analysis. In Destabilizing Theory: Contemporary Feminist Debates* (pp. 201–219). Cambridge: Polity Press.
- Baum, F. (1999). Social capital: is it good for your health? Issues for a public health agenda. *Journal of Epidemiological Community Health, 5*, 195-196.
- Baumrind, D. (1967). Child care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs, 75*, 43-88.
- Baumrind, D. (1971). Current theories of parental authority. *Developmental Psychology, 4*, 1-103.
- Baumrind, D. (1972). An exploratory study of socialization effects on black children: some black-white comparisons. *Child Development, 43*, 261-267.
- Bell, C. (2001). Cultivating Resiliency in youth. *Journal of Adolescent Health, 29*, 375-381.
- Bell, C. C., Flay, B. & Paikoff, R. (2002). Strategies for Health Behavior Change. In J. C. Chunn (Ed.) *The Health Behavioral Change Imperative: Theory, Education and Practice in Diverse Populations*. New York: Springer,
- Bell, C., Bhana, A., McKay, M., & Petersen, I. (2007). A commentary on the triadic theory of influence as a guide for adapting HIV prevention programs for new contexts and populations: The CHAMP South Africa story. In M. McKay, & R. Paikoff (Eds.) *Community collaborative partnerships and empirical findings: The foundation for youth HIV prevention* (pp. 243–268). New York: Haworth Press.

- Bell, C.C., Bhana, A., Petersen, I., McKay, M.M., Gibbons, R., Bannon, W., & Amatyia, A. (2008). Building protective factors to offset sexually risky behaviors among Black youths. A randomized control trial. *Journal of the National Medical Association*, 100(8), 936–944.
- Bettinger, J.A., Celentano, D.D., Curriero, F.C., Adler, N.E., Millstein, S.G., & Ellen, J.M., (2004). Does parental involvement predict new sexually transmitted diseases in female adolescents? *Archives of Pediatrics and Adolescent Medicine*, 158, 666-670.
- Bhana, A., McKay, M.M., Mellins, C., Petersen, I., & Bell, C. (2010). Family-based HIV prevention and intervention services for youth living in poverty-affected contexts: the CHAMP model of collaborative, evidence-informed programme development. *Journal of the International AIDS Society*, 13 (Suppl2): S8. Retrieved from <http://www.jiasociety.org/content/13/S2/S8>
- Bhana, A., Petersen, I., Mason, A., Mahintsho, Z., Bell, C. & McKay, M.M. (2004). Children and youth at risk. Adaptation and pilot study of the CHAMP (AmaQhawe) program in South Africa. *African Journal of AIDS Research*, 3, 33-41.
- Bhattacharya, G. (2005). Social capital and HIV risks among acculturating Asian Indian men in New York City. *AIDS Education and Prevention*, 17(6), 555-567.
- Bigombe, B., & Khadiagala, G.M. (2003). Major trends affecting families in sub-Saharan Africa. Retrieved from <http://www.un.org/esa/socdev/family/Publications/mtrendsbf.htm/>
- Billig, M. (1988). Social representations, objectification and anchoring: A rhetorical analysis. *Social Behaviour*, 3, 1-16.

- Birdsall, K. & Kelly, K. (2005). Community responses to HIV/AIDS in South Africa. Findings from a multi-community survey. Centre for AIDS Development, Research and Evaluation (CADRE). Downloaded from the internet 29/07/10.
- Blake, S.M., Simkin, L., Ledsy, R., Perkins, C., & Calabrese, J.M. (2001). Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. *Family Planning Perspectives*, 33, 2, 52-61.
- Bluestone, C., & Tamis-LeMonda, C. S. (1999). Correlates of parenting styles in predominantly working- and middle-class African-American mothers. *Journal of Marriage and the Family*, 61, 881-893.
- Bolin, K. Lindgren, B, Lindstrom, M, & Nystedt, P. (2003). Investments in social capital—implications of social interactions for the production of health. *Social Science & Medicine* 56, 2379–2390.
- Boon, H.J. (2007). Low- and high-achieving Australian secondary school students: Their parenting, motivations and academic achievement. *Australian Psychologist*, 42, 3, 212-225.
- Borawski, E.A., Ievers-Landis, C.E., Lovegreen, L.D., & Trapl, E. (2003). Parental monitoring, negotiated unsupervised time, and parental trust: the role of perceived parenting practices in adolescent health risk behaviors. *Journal of Adolescent Health*, 33, 60-70.
- Bourdieu, P. (2004). The Forms of Capital. In J.E. Richardson (Ed.), *Handbook of Theory of Research for the Sociology of Education*. (pp. 241-258). Westport, Connecticut: Greenword Press.

- Bradshaw, D., Pettifor, A., MacPhail, C. & Dorrington, R. (2004). Trends in Youth Risk for HIV. Johannesburg: Reproductive Health Research Unit, University of Witwatersrand.
- Brasileiro, M., & Freitas, M.I.F. (2006). Social representations about AIDS in people over 50, infected by HIV. *Rev Latino-am Enfermagem*, 14, 5, 789-95. Downloaded from the internet 01/09/10.
- Breakwell, G.M. (1993). Social representations and social identity. *Papers on Social Representations*, 2(3), 198-217.
- Breinbauer, C., & Maddaleno, M. (2005). *Youth: Choices and Change*. Washington, D.C.: Pan American Health Organization.
- Brody, G.H., McBride Murry, V., Gerrard, M., Gibbons, F.X., Molgaard, V., McNair, L., Brown, A.C., Wills, T.A., Spoth, R.L., Luo, Z., Chen, Y., & Neubaum-Carlan, E. (2004). The Strong African American Families Program: Translating research into prevention programming. *Child Development*, 75, 3, 900-917.
- Bronfenbrenner, U. (1961). Some familial antecedents of responsibility and leadership in adolescents. In M. Petrullo & B.M. Bass (Eds.), *Leadership and interpersonal behavior*. (pp. 239-271). New York: Holt Rinehart & Winston.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22, 723-742.
- Brough et al

- Brown, L., Trujillo, L., & Macintyre, K. (2001). Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? New York: The Population Council Inc. Retrieved from http://pdf.usaid.gov/pdf_docs/PNACR088.pdf
- Calzada, E. J. (2001). Normative and optimal parenting in Dominican and Puerto Rican mothers of young children. Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 61(8-B).
- Camargo, B.V., & Bousfield, A.B.S. (2009). Social representations, risk behaviors and AIDS. *The Spanish Journal of Psychology*, 12(2), 565-575.
- Campbell, C. & Murray, M. (2004). Community health Psychology: Promoting analysis and social change. *Journal of Health Psychology*, 9(2), 187-195.
- Campbell, C. (2003). *Letting them die: How HIV/AIDS prevention programs often fail*. Cape Town: Double Storey Books.
- Campbell, C., Foulis, C. A., Maimane, S., & Sibiya, Z. (2005a). The impact of social environments on the effectiveness of youth HIV prevention: A South African case study. *AIDS Care*, 17(4), 471- 478.
- Campbell, C., Foulis, C.A., Maimane, S., & Sibiya, Z. (2005b). "I Have an Evil Child at My House": Stigma and HIV/AIDS Management in a South African Community. *American Journal of Public Health*, 95(5), 808-815. DOI: 10.2105/AJPH.2003.037499

- Campbell, C., & Jovchelovitch, S. (2000). Health, community, and development: towards a social psychology of participation. *Journal of Community and Applied Social Psychology*, 10, 255-270.
- Campbell, C., & Mzaidume, Z. (2001). Grassroots participation, peer education, and HIV prevention by sex workers in South Africa. *American Journal of Public Health*, 91, 12, 1978-1986.
- Campbell, C., Skovdal, M., Mupambireyi, Z., & Gregson, S. (2010). Exploring children's stigmatisation of AIDS-affected children in Zimbabwe through drawings and stories. *Social Science & Medicine* 71, 975-985.
- Campbell, C., Williams, B., & Gilgen, D. (2002). Is social capital a useful conceptual tool for exploring community level influences on HIV infection? An exploratory case study from South Africa. *AIDS Care*, 2002, 14, 41–54.
- Campbell, C., Wood, R., & Kelly, M. (1999). *Social capital and health*. London: Health Education Authority.
- Caramlau, I., & Goodwin, R. (2007). Evaluating health promotion leaflets' impact on young people in Romania. *Cognition, Brain, Behavior*, XI, 2, 279-297.
- Carey, J.W. (1989). *Communication as culture: Essays on media and society*. Boston: Unwin Hyman.
- Carlson, C., Uppal, S., & Prosser, E.C. (2000). Ethnic differences in processes contributing to the self-esteem of early adolescent girls. *Journal of early adolescence*, 20, 44-68.
- Carpiano, R. M. (2006). Toward a neighborhood resource-based theory of social capital for health: Can Bourdieu and sociology help? *Social Science and Medicine*, 62, 165-175.

- Cattell, V. (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social Science & Medicine* 52, 1501–1516.
- Cauffman, E., & Steinberg, L. (1995). *Moderating effects of neighbourhood parenting on family socialization processes*. Paper presented as part of a symposium entitled “Community Effects on Adolescent Development: New Approaches to the Study of Neighborhoods and Their Impact” at the biennial meetings of the Society for Research in Child Development, Indianapolis, IN.
- Chao, R. K. (1994). Beyond parental control and authoritarian parenting style: Understanding Chinese parenting through the cultural notion of training, *Child Development*, 65, 1111-1120.
- Chao, R. K. (2001). Extending research on the consequences of parenting style for Chinese Americans and European Americans. *Child Development*, 72, 6, 1832-1843.
- Chen, X., Dong, Q., & Zhou, H. (1997). Authoritative and authoritarian parenting practices and social and school performance in Chinese children. *International Journal of Behavioral Development*, 21, 855-873.
- Chenail, R.J. (2010). Getting specific about qualitative research generalizability. *Journal of Ethnographic & Qualitative Research*, 5, 1-11. Retrieved from <http://www.cedarville.edu/event/eqrc/journal/vol5issue1abstract.pdf#page=6>
- Cheung, Y.W., & Cheung, N.W.T. (2003) Social capital and risk level of posttreatment drug use: Implications for harm reduction among male treated addicts in Hong Kong. *Addiction Research and Theory*, 11, 3, 145–162.
- Child, I.L. (1954). Socialization. In G. Lindzey (Ed.). *Handbook of Social Psychology* (Vol 2, pp 655-692). Reading, MA: Addison-Wesley.
- Choi, Cheung & Chen 2006

Cohen, D.A., Farley, T.A., Taylor, S.N., Martin, D.H., & Shuster, M.A. (2002). When and where do youths have sex? The potential role of adult supervision. *Pediatrics*, 110, e66.

Coleman 1990

Coleman, J.S. (1988), Social capital in the creation of human capital. *American Journal of Sociology*, 94 (Supplement), S95–S120.

Coley, R. L., Medeiros, B. L., & Schindler, H. S. (2008). Using sibling differences to estimate effects of parenting on adolescent sexual risk behaviors. *Journal of Adolescent Health*, 43(2), 133-140.

Coley, R.L., Morris, J.E., & Hernandez, D. (2004). Out-of-school care and problem behavior trajectories among low-income adolescents: individual, family, and neighborhood characteristics as added risks. *Child Development*, 75, 3, 948-965.

Collier, P. (1998). *Social Capital and Poverty*. Washington D.C.: World Bank.
condom use. *Sexually Transmitted Diseases*, 22, 15-20.

Cox, M. (2007). Maternal demandingness and responsiveness as predictors of adolescent abstinence. *Journal of Pediatric Nursing*, 22, 3, 197-205.

Cox, M. (2006). Racial differences in parenting dimensions and adolescent condom use at sexual debut. *Public Health Nursing*, 23, 1, 2-10.

Crane, L.G., Lombard, M.B., & Tenz, E.M. (2009). More than just translation: challenges and opportunities in translingual research. *Social Geography*, 4, 39–46. Retrieved from www.soc-geogr.net/4/39/2009/

Crosby, R.A., DiClemente, R.J., Wingood, G.M., Cobb, B.K., Harrington, K., Davies, S.L., Hook, E.W., & Oh, M.K. (2001). HIV/STD-protective benefits of living with mothers in

perceived supportive families: A study of high-risk African American female teens.

Preventive Medicine, 33, 3, 175-178.

Crosby, R.A., DiClemente, R.J., Wingood, G.M., Lang, D.L., & Harrington, K. (2003).

Infrequent parental monitoring predicts sexually transmitted infections in low-income African American female adolescents. *Archives of Pediatrics and Adolescent Medicine*, 157, 169-173.

Crosby, R.A., Wingood, G.M., DiClemente, R.J., & Rose, E.S. (2002). Family-related correlates of sexually transmitted disease and barriers to care: A pilot study of pregnant African American adolescents. *Family & Community Health*, 25, 2, 16-27.

Crosby, R.A., Holtgrave, D.R., DiClemente, R.J., Wingood, G.M., & Gayle, J.A. (2003). Social capital as a predictor of adolescents' sexual risk behavior: a state-level exploratory study. *AIDS and Behavior*, 7, 3, 245-252.

Dancy, B.L., Crittenden, K.S., & Talashek, M. (2006). Mothers' effectiveness as HIV risk reduction educators for adolescent daughters. *Journal of Health Care for the Poor and Underserved*, 17, 218-239.

Darling, C.A., & Hicks, M.W. (1982). Parental influence on adolescent sexuality: implications for parents as educators. *Journal of Youth and Adolescence*, 11, 231-245.

Darling, N., & Steinberg, L. (1993). Parenting style as context: an integrative model. *Psychological Bulletin*, 113, 487-496.

Darling, N., Steinberg, L., & Gringlas, M. (1993). *Community integration and value consensus as forces for adolescent socialization: a Test of the Coleman and Hoffer hypothesis*. Paper presented as part of a symposium entitled "Community and Neighborhood Influences on

Adolescent Behavior” at the biennial meetings of the Society for Research in Child Development, New Orleans.

- De Silva, M.J., McKenzie, K., Harpham, T., & Huttly, S.R.A. (2005). Social capital and mental illness: a systematic review. *Journal of Epidemiology and Community Health, 59*, 619-627.
- Deckerd, K., Dodge, K., Bates, J.E., & Pettit, G.S. (1986). Physical discipline among African-American and European American mothers: Links to children's externalizing behaviours. *Developmental Psychology, 32*, 1065-1072.
- Deniston, O.L., & Rosenstock, I.M. (1970). Evaluating health programs. *Public Health Reports, 85*, 835-840.
- Denzin, N.K., & Lincoln, Y.S. (2005). Introduction: The Discipline and Practice of Qualitative Research. In N.K. Denzin & Y.S. Lincoln (Eds.) (2005). *The Sage Handbook of Qualitative Research*, (3rd ed., pp. 1-32). Thousand Oaks: Sage.
- Department of Health. (2004). *Summary Report. National HIV and syphilis sero-prevalence survey, 2002*. Pretoria, Department of Health.
- Devers, K.J. (1999). How will we know "good" qualitative research when we see it? Beginning the dialogue in health services research. *Health Services Research 34, 5, Part II*, 1153-1188.
- DeVore, E.R., & Ginsburg, K.R. (2005). The protective effects of good parenting on adolescents. *Current Opinion in Paediatrics, 17, 4*, 460-465.
- Diaconu, M. (2008). Social capital: The missing link between HIV/AIDS knowledge, attitudes, and related behaviors among young women in Tanzania. Ph.D. Thesis, University of Texas at Arlington. Downloaded from the internet 14/06/10.
- Dickert, N., Emanuel, E., & Grady, C. (2002). Paying research subjects: An analysis of current policies. *Annals of Internal Medicine, 136(5)*, 368-373.

- DiClemente, R.J., Crittenden, C.P., Rose, E., Sales, J.M., Wingood, G.M., Crosby, R.A., & Salazar, L.F. (2008). Psychosocial predictors of HIV-associated sexual behaviors and the efficacy of prevention interventions in adolescents at-risk for HIV infection: What works and what doesn't work? *Psychosomatic Medicine*, 70, 598–605.
- DiClemente, R.J., Wingood, G.M., Crosby, R., Cobb, B.K., Harrington, K., & Davies, S.L. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *The Journal of Pediatrics*, 139, 3, 407-412.
- DiClemente, R.J., Wingood, G.M., Crosby, R., Sionean, C., Cobb, B.K., Harrington, K., Davies, S., Hook, E.W., & Oh, M.K. (2001). Parental monitoring: association with adolescents' risk behaviors, *Pediatrics*, 107, 6, 1363-1368.
- DiLorio, C., Dudley, W.N., Soet, J.E., McCarty, F. (2004). Sexual possibility situations and sexual behaviors among young adolescents: the moderating role of protective factors. *Journal of Adolescent Health*, 35, 6, e511-e520.
- DiLorio, C., Kelley, M., & Hockenberry-Eaton, M. (1999). Communication about sexual issues: mothers, fathers, and friends. *Journal of Adolescent Health*, 24, 3, 181-189.
- Dilorio, C., Resnicow, K., Thomas, S., Wang, D.T., Dudley, W.N., Van Marter, D.F., & Lipana, J. (2002). Keepin' it R.E.A.L.!: program description and results of baseline assessment. *Health Education and Behavior*, 29, 1, 104-123.
- Dittus, P., & Jaccard, J. (2000) Adolescents' perceptions of maternal disapproval of sex: relationship to sexual outcomes. *Journal of Adolescent Health*, 26, 4, 268-278.
- Dittus, P., Miller, K.S., Kotchick, B.A., & Forehand, R. (2004). Why Parents Matter!: The conceptual basis for a community-based HIV prevention program for the parents of African American youth. *Journal of Child and Family Studies*, 13, 1, 5–20.
- doi: 10.1080/02533950608628731

doi:10.1177/1359105304040897

- Dominguez, M.M., & Carton, J.S. (1997). The relationship between self-actualization and parenting style. *Journal of Social Behavior & Personality*, 12, 4, 1093-1100.
- Dominguez, S. & Arford, T. (2010). It is all about who you know: Social capital and health in low-income communities. *Health Sociology Review*, 19, 1, 114–129.
- Dorrer, N. C. (2002). *Women, body and eating: a social representational analysis of meanings in British and Tobagonian cultural contexts*. Paper presented at the 6th International Conference on Social Representations, 27th - 1st September, 2002.
- Dutra, R., Miller, K.S., & Forehand, R. (1999). The process and content of sexual communication with adolescents in two-parent families: associations with sexual risk-taking behavior. *AIDS and Behavior*, 3, 59-66.
- Eaton L., Flisher A. J. & Aaro, L. E. (2003). Unsafe sexual behaviour in South African youth. *Social Science and Medicine*, 56, 149-165.
- Everatt, D. (n.d.). Exploring the opaque: Working with young people: The Joint Enrichment Project 1986-2000. Retrieved from <http://66.10.../opaque.pdf+David+Everatt+%2Bjoint+Enrichment+Project&hl=en&ie=UTF->
- Ewart, C.K. (1991). Social action theory for a public health psychology. *American Psychologist*, 46, 931-936.
- Feagin, J., Orum, A., & Sjoberg, G. (Eds.), (1991). *A case for case study*. Chapel Hill, NC: University of North Carolina Press.
- Firestone, W. A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher*, 22, 16-23. doi: 10.3102/0013189X022004016

- Fitzpatrick, K.M., Piko, B.F., Wright, D.R., & LaGory, M. (2005). Depressive symptomatology, exposure to violence, and the role of social capital among African American adolescents. *American Journal of Orthopsychiatry* 75, 2, 262–274.
- Flay, B.R., Snyder, F.J., & Petraitis, J. (2009). The theory of triadic influence. In: *Emerging theories in health promotion practice and research*. R.J. DiClemente, R.A. Crosby, & M. Kegler (eds.). San Francisco, CA: John Wiley & Sons. (Pp 451-509).
- Flick, U. (2002). *An introduction to quantitative research*. (2nd ed.). London: Sage.
- Ford, C.A., Pence, B.W., Miller, W.C., Resnick, M.D., Bearinger, L.H., Pettingell, S., & Cohen, M. (2005). Predicting adolescents' longitudinal risk for sexually transmitted infection: results from the National Longitudinal Study of Adolescent Health. *Archives of Pediatrics & Adolescent Medicine*, 159, 657-664.
- Forrest, R., & Kearns, A. (2001). Social cohesion, social capital and the neighbourhood. *Urban Studies*, 38, 2125-2143. DOI: 10.1080/00420980120087081
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry*, 36, 717–732.
- Foster, J. L. H. (2001). Unification and differentiation: A study of the social representations of mental illness. *Papers on Social Representations*, 10, 3.1-3.18. Downloaded from the internet on 30/08/2010.
- Freire, P. (1993). *Education for critical consciousness*. New York: Continuum.
- Fukuyama, F. (1995). *Trust: The social virtues and the creation of prosperity*. New York: Free Press.
- Furstenberg, F.F., Cook, T., Eccles, J., Elder, G., & Sameroff, A. (1999). *Managing to make it: Urban families and adolescent success*. Chicago: University of Chicago Press.

- Garcia, F., & Gracia, E. (2009). Is always authoritative the optimum parenting style? Evidence from Spanish families. *Adolescence*, 44, 173, 101-131.
- Geertz, C. (2000). *The Interpretation of Cultures*. Basic Books: Oxford.
- Gervais, M., & Jovchelovitch, S. (1998). Health and identity : the case of the Chinese community in England. *Social Science Information*, 37, 4, 709-729.
- Gold, R., Kennedy, B., Connell, F., & Kawachi. I. (2002). Teen births, income inequality, and social capital: developing an understanding of the causal pathway. *Health & Place*, 8, 2, 77-83.
- Goodwin, R., Kozlova, A., Kwiatkowska, A., Luu, L.A.N., Nizharadze, G., Realo, A., Kulvet, A., & Rammer, A. (2003). Social representations of HIV/AIDS in Central and Eastern Europe. *Social Science & Medicine*, 56, 1373–1384.
- Goodwin, R., Kwiatkowska, A., Realo, A., Kozlova, A., Luu, L.A.N., & Nizharadze, G. (2004). Social representations of HIV/AIDS in five Central European and Eastern European countries: a multidimensional analysis. *AIDS Care*, 16, 6, 669-680.
- Gray, M., & Steinberg, L. (1999). Unpacking authoritative parenting: Reassessing a multidimensional construct. *Journal of Marriage and the Family*, 61, 574-587.
- Gregson, S., Terceira, N., Mushati, P., Nyamukapa, C., & Campbell, C. (2004). Community group participation: can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe. *Social Science & Medicine*, 58, 2119-2132.
- Guba, E.G., & Lincoln, Y.S. (2001). Guidelines and checklist for constructivist (a.k.a. fourth generation) evaluation. Downloaded from www.wmich.edu/evalctr/checklists
- Guilamo-Ramos, V., Jaccard, J., Dittus, P., & Bouris, A.M. (2006). Parental expertise, trustworthiness, and accessibility: parent-adolescent communication and adolescent risk behavior. *Journal of Marriage and Family*, 68, 1229-1246.

- Gunnoe, M.L., Hetherington, E.M., & Reiss, D. (1999). Parental Religiosity, Parenting Style, and Adolescent Social Responsibility *The Journal of Early Adolescence*, 19, 2, 199-225.
- Hagan, J., McCarthy, B., Parker, P., & Climenhage, J. (1997). *Mean streets: Youth crime and homelessness*. New York: Cambridge University Press.
- Hall, W.N., & Bracken, B.A. (1996). Relationship between maternal parenting styles and African American and white adolescents' interpersonal relationships. *School Psychology*, 17, 253-267.
- Halton, W. (1994). Some unconscious aspects of organizational life: contributions from psychoanalysis. A. Obholzer, A. & Roberts, V.G. (eds.) *The unconscious at work. Individual and organizational stress in the human services* (pp.11-18). London, Routledge.
- Hamel, J., Dufour, S., & Fortin, D. (1993). *Case study methods*. Newbury Park, CA: Sage Publications.
- Hammersley, M. & Atkinson, P. (1995). *Ethnography. Principles in practice*. London, Routledge.
- Harpham, T., Grant, E., & Thomas, E. (2002). Measuring social capital within health surveys: key issues. *Health Policy and Planning*, 17, 1, 106-111.
- Harrison¹, A., Newell, M., Imrie, J., & Hoddinott, G. (2010). HIV prevention for South African youth: which interventions work? A systematic review of current evidence. *BMC Public Health*, 10:102. <http://www.biomedcentral.com/1471-2458/10/102>
- Hawe, P., Shiell, A., & Riley, T. (2004). Complex interventions: how __out of control__ can a randomized controlled trial be? *British Medical Journal*, 328, 1561-1563.
- Hean, S., Cowley, S., Forbes, A., Griffiths, P., & Maben, J. (2002). The M-C-M' cycle and social capital. *Social Science and Medicine*, 56, 1061-1072.

- Herz, L., & Gullone, E. (1999). The relationship between self-esteem and parenting style: A cross-cultural comparison of Australian and Vietnamese Australian adolescents. *Journal of Cross-Cultural Psychology, 30*, 742-761.
- Hickman, G. P., Bartholomae, S., & McKenry, P. C. (2000). Influence of parenting style on the adjustment and academic achievement of traditional college freshmen. *Journal of College Student Development, 41*(1), 41-54.
- Higgins, D.L. (1997). *Social capital and HIV intervention*. Unpublished Doctor of Philosophy thesis, University of Nottingham.
- Hinshelwood, R.D. (1987). *What happens in groups*. London, Free Association Books.
- Hogan, D.P., & Kitagawa, E.M. (1985). The impact of social status, family structure, and neighborhood on the fertility of black adolescents. *American Journal of Sociology, 90*, 825-855.
- Holtzman, D. & Robinson, R. (1995). Parent and peer communication effects on AIDS related behavior among U.S. high school students. *Family Planning Perspectives, 27*, 6, 235-268.
- Hosegood, V & Solarsh, G. (2002). Population mobility and household dynamics in rural SA: implications for demographic and health research. Unpublished article.
- Howarth, C. (2001). Towards a social psychology of community: a social representations perspective. *Journal for the Theory of Social Behaviour, 31*, 2, 223-238.
- Howarth, C. (2006). A social representation is not a quiet thing: exploring the critical potential of social representations theory. *British Journal of Social Psychology, 45*, 1, 65-86.
- Howarth, C., Foster, J. & Dorrer, N. (2004). Exploring the potential of the Theory of Social Representations in community-based health research – and vice versa? *Journal of Health Psychology, 9*(2), 229-243.
- Huebner, A.J., & Howell, L.W. (2003). Examining the relationship between adolescent sexual

- risk-taking and perceptions of monitoring, communication, and parenting styles. *Journal of Adolescent Health*, 33, 71-78.
- Jaccard, J., & Dittus, P. (1993). Parent-adolescent communication about premarital pregnancy. *Family in Society*, 74, 329-343.
- Jaccard, J., Dittus, P.J., & Gordon, V.V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives*, 28, 4, 159-185.
- Jackson, C., & Foshee, V. (1998). Violence-related behaviors of adolescents. Relations with responsive and demanding parenting. *Journal of Adolescent Research*, 13, 3, 343-359.
- Jahoda, G. (1988). Critical notes and reflections on 'social representations'. *European Journal of Social Psychology*, 18, 3, 195-209.
- Jemmott, L.S., Outlaw, F.H., Jemmott III, J.B., Brown, E.J., Howard, M., & Hopkins, B.H. (2000). Strengthening the bond: The mother-son health promotion project. In W. Pequegnat & J. Szapocznik (Eds.), *Working with Families in the Era of HIV/AIDS*. (pp. 133-151). Thousand Oaks: Sage Publications, Inc.
- Jodelet, D. (1991). Madness and social representations. Hemel Hempstead: Harvester-Wheatsheaf.
- Joffe, H. (1996a). The shock of the new: a psychodynamic extension of social representational theory. *Journal for the Theory of Social Behaviour*, 26, 2, 197-219.
- Joffe, H. (1996b). AIDS research and prevention: A social representational approach. *British Journal of Medical Psychology*, 69, 169-190.
- Joffe, H. (1997). Juxtaposing positivist and non-positivist approaches to social scientific AIDS research: Reply to Fife-Schaw's commentary. *British Journal of Medical Psychology*, 70, 75-83.
- Joffe, H. (1999). *Risk and ,the other''*. Cambridge University Press: Cambridge.

- Joffe, H. (2003). Risk: From perception to social representation. *British Journal of Social Psychology*, 42, pp. 55-73.
- Joffe, H., & Bettega, N. (2003). Social representation of AIDS among Zambian adolescents. *Journal of Health Psychology*, 8, 5, 616-631.
- Johnson, R.B. (1997). Examining the validity structure of qualitative research. *Education*; 118(2), 282-292. Retrieved from <http://www.dralessandro.com/subpages/PDFfiles/Validity%20Structure.pdf>
- Karnell, A.P., Cupp, P.K., Zimmerman, R.S., Feist-Price, S., & Bennie, T. (2006). Efficacy of an American alcohol and HIV prevention curriculum adapted for use in South Africa: Results of a pilot study in five township schools. *AIDS Education and Prevention*, 18, 4, 295–310.
- Kaufman, C.E., Clark, S., Manzini, N., & May, J. (2004). Communities, opportunities, and adolescents' sexual behavior in KwaZulu-Natal, South Africa. *Studies in Family Planning*, 35, 4, 261-274.
- Kaufmann, B.A., Gesten, E., Santa Lucia, R.C., Salcedo, O., Rendina-Gobioff, G., & Gadd, R. (2000). The relationship between parenting style and children's adjustment: The parents' perspective. *Journal of Child and Family Studies*, 9, 2, 231-245.
- Kawachi & Berkman (2000)
- Kawachi, I., Kennedy, B.P., & Glass, R. (1999). Social capital and self-rated health: A contextual analysis. *American Journal of Public Health*, 89, 8, 1187-1193.
- Kawachi, I., Kennedy, B.P., Lochner, K., & Prothrow-Stith, D. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health*, 87, 9, 1491-1498.
- Kelle, U. (1993). Theories as heuristic tools in qualitative research. Paper presented at the Openness in Research Congress. Utrecht, Holland.

- Kelly, D., & Gibbons, M. (2008). Ethnography: The good, the bad and the ugly. *Journal of Medical Marketing*, 8, 4, 279–285.
- Kelly, K., & Parker, W. (2000). Communities of practice. Contextual mediators of youth response to HIV/AIDS. *Report published by the Sentinel Site Monitoring and Evaluation Project*.
- Kim, K., & Rhoner, R.P. (2002). Parental warmth, control, and involvement in schooling: Predicting academic achievement among Korean American adolescents. *Journal of Cross-Cultural Psychology*, 33, 127-140.
- Kirst, M. (2007). Social networks and harm reduction: The influence of social capital on substance-use-related health behaviours. In J.C. Cohen-Kohler & M. B. Seaton (2007) (eds.). *Comparative Program on Health and Society, Lupina Foundation Working Papers Series 2006-2007*. University of Toronto. Downloaded from the internet 10 July, 2010.
- Kitto, S.C., Chesters, J. & Grbich, C. (2008). Quality in qualitative research. Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia. *Medical Journal of Australia*, 188, 4, 243-246
- Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research*, 6, 3, Art. 44. Downloaded from <http://www.qualitative-research.net/fqs/>
- Kolankiewicz, G. (1996). Social capital and social change. *The British Journal of Sociology*, 47, 3, 427-441.
- Kotchick, B.A., Dorsey, S., Miller, K.S., & Forehand, R. (1999). Adolescent sexual risk-taking behavior in single-parent ethnic minority families. *Journal of Family Psychology*, 13, 1, 93-102.
- Krause, M. (2002). Social representations of psychological problems: Contents and transformations. *Social Science Information*, 41, 4, 603-623.

- Krauss, B.J., Godfrey, C., Yee, D., Goldsamt, L., Tiffany, J., Almeyda, L., ... & Velez, R. (2000). Saving our children from a silent epidemic. The PATH program for parents and preadolescents. In W. Pequegnat & J. Szapocznik (Eds.), *Working with Families in the Era of HIV/AIDS*. (pp. 89-112). Thousand Oaks: Sage Publications, Inc.
- Kremers, S.P.J., Brug, J., de Vries, H., & Engels, R.C. (2003). Parenting style and adolescent fruit consumption. *Appetite*, 41, 1, 43-50.
- Kreuter, M.W., & Lezin, N. (2000). Social Capital Theory. Implications for Community-Based Health Promotion, in R.J. Di Clemente, R.A Crosby, & M.C. Kegler (eds), *Emerging Theories in Health Promotion Practice and Research*. (228-254).
- Kreuter, M.W., Lezin, N., Koplan, & Young, (2001).
- Krishna, A., & Schrader, E. (2000). Cross-cultural measures of social capital: a tool and results from India and Panama. *Social Capital Initiative Working Paper no. 21*. Washington DC: World Bank. Downloaded from the internet 10 July, 2010.
- Krueger, R.A., & Casey, M.A. (2000). *Focus groups. A practical guide for applied research*. Thousand Oaks, CA: Sage Publications.
- Kumpfer, K.L., & Alvarado, R. (2003). Family-strengthening approaches for the prevention of youth problem behaviors. *American Psychologist*, 58, 6/7, 457-465. DOI: 10.1037/0003-066X.58.6-7.457
- Kvale, S. (1995). The social construction of validity. *Qualitative Inquiry*, 1, 1, 19-40.
- Lagerberg, D. (2004). Sexual knowledge and behaviour in South African students: a case for prevention with focus on behaviour. *Acta Paediatrica*, 93(2), 159-161.
- Lambert, S.D., & Loiselle, C.G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, 62, 2, 228-237.
- Lamborn, S.D., Mounts, N.S., Steinberg, L., & Dornbusch, S.M. (1991). Patterns of competence

- and adjustment among adolescents from authoritative, authoritarian, indulgent and neglectful families. *Child Development*, 62, 1049-1065.
- Lammers, C., Ireland, M., Resnick, M., & Blum, R. (2000). Influences on adolescents' decision to postpone onset of sexual intercourse: a survival analysis of virginity among youths aged 13 to 18 years. *Journal of Adolescent Health*, 26, 42-48.
- Lather, P. (1991). *Getting Smart: Feminist Research and Pedagogy with/in the Postmodern*. New York: Routledge.
- Leana, C. R., & Van Buren III, H. J. (1999). Organisational social capital and employment practices. *Academy of Management Review*, 24, 538-555.
- LeCompte, M.D., & Goetz, J.P. (1982). Problems of reliability and validity in ethnographic research. *Review of Educational Research*, 52(1), 31-60. Downloaded from <http://rer.aera.net>
- Lenci, S. (1998). Social capital? From pizza connection to collective action. An inquiry into power, culture and civil society. The Hague: Netherlands Institute of Social Studies, 24.
- Leung, K., Lau, S., & Lam, W. (1998). Parenting styles and academic achievement: a cross-cultural study. *Merrill-Palmer Quarterly*, 44, 1998.
- Li, X., Feigelman, S., & Stanton, B. (2000). Perceived parental monitoring and health risk behaviors among urban low-income African-American children and adolescents *Journal of Adolescent Health*, 27, 1, 43-48.
- Li, X., Stanton, B., & Feigelman, S. (2000). Impact of perceived parental monitoring on adolescent risk behavior over 4 years. *Journal of Adolescent Health*, 27, 1, 49-56.
- Lin (2001)
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*. California: Sage.

- Lochner, K., Kawachi, I., & Kennedy, B.P. (1999). Social capital: a guide to its measurement. *Health & Place*, 5, 259-270.
- Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent–child interaction. In P. H. Mussen (Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (4th ed., pp. 1-101). New York: Wiley.
- MacDougall, C., & Fudge E. (2001). Planning and recruiting the sample for focus groups and in-depth interviews. *Qualitative Health Research*, 11, 117–126.
- Macinko, J., & Starfield, B. (2001). The utility of social capital in research on health determinants. *The Milbank Quarterly*, 79, 3, 387-427.
- Maclean, K. (2007). Translation in cross-cultural research: an example from Bolivia. *Development in Practice*, 17(6) DOI: 10.1080/09614520701628287
- MacPhail, C. (2006). Youth-driven HIV prevention programmes in South Africa: Social capital, empowerment and conscientisation. *Social Dynamics*, 32, 2, 170-196. DOI: 10.1080/02533950608628731
- Madison, S.M., McKay, M.M., Paikoff, R., & Bell, C.C. (2000). Basic research and community collaboration: Necessary ingredients for the development of a family-based HIV prevention program. *AIDS Education and Prevention*, 2(4), 281-297.
- Mallonee, S. (2000). Evaluating injury prevention programs: The Oklahoma City smoke alarm project. *The Future of Children. Unintentional injuries in childhood*, 10, 1, 164-174.
<http://www.futureofchildren.org>
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *Lancet*, 358, 483–88. Retrieved from http://www.allgemeinmedizin.med.uni-goettingen.de/literatur/qual/qual_stand_chall_01.pdf

- Marková, I. (1996). Towards an epistemology of social representations. *Journal for the Theory of Social Behaviour*, 26, 2, 177-193.
- Markova, I., & Wilkie, P. (1987). Representations, concepts, and social change: the phenomenon of AIDS. *Journal of the Theory of Social Behaviour*, 17, 388-409.
- Martinez, I., & Garcia, J.F. (2007). Impact of parenting styles on adolescents' self-esteem and internalization of values in Spain. *Spanish Journal of Psychology*, 10, 338-348.
- Martinez, I., & Garcia, J.F. (2008). Internalization of values and self-esteem among Brazilian teenagers from authoritative, indulgent, authoritarian, and neglectful homes. *Adolescence*, 43(169), 13-29.
- Martinez, I., Garcia, J.F., & Yubero, S. (2007). Parenting styles and adolescents' self-esteem in Brazil. *Psychological Reports*, 100, 731-745.
- Maxwell, J.A. (1992). Understanding and validity in qualitative research. *Harvard Educational Review*, 62(3), 279-300. Retrieved from the internet.
- Mayseless, O., Scharf, M., & Sholt, M. (2003). From authoritative parenting practices to an authoritarian context: Exploring the person–environment fit. *Journal of Research on Adolescence*, 13, 427-456.
- Mbambo, B. & Msikinya, N. (2003). Are children's rights underminig parents? ChildrenFIRST, Special Issue. Reviewing the Status of Children's Rights, 61-63.
- McKay, M.M., Chasse, K.T., Paikoff, R., McKinney, L.D., Baptiste, D., Coleman, D., Madison, S., & Bell, C.C. (2004). Family level impact of the CHAMP Family Program: A community collaborative effort to support urban families and reduce youth HIV exposure. *Family Process*, 43, 1, 79-93.
- McLeod, J.D., Kruttschnitt, C., & Dornfield, M. (1994). Does parenting explain the effects of structural conditions on children's antisocial behavior? A comparison of Blacks and

- Whites. *Social Forces*, 73, 575-604.
- Mcneely, C., Shew, M., Beuhring, T., Sieving, R., Miller, B., & Blum, R. (2002). Mothers' influence on the timing of first sex among 14- and 15-year-olds. *Journal of Adolescent Health*, 31, 3, 256-265.
- Miller, K.S., Levin, M.L., Whitaker, D.J., & Xu, X. (1998). Patterns of condom use among adolescents: The impact of mother-adolescent communication. *American Journal of Public Health*, 88, 10, 1542-1544.
- Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-depth Interviewing: Researching People*. Melbourne: Longman Cheshire.
- Morrow, V. (1999). Conceptualizing social capital in relation to the health and well-being of children and young people: A critical review. *Sociological Review*, 47, 4, 744–765.
- Morrow, V. (2001). *Networks and neighborhoods: Children's and young people's perspectives*. London: Health Development Agency.
- Morse, J.M. (1994). "Emerging from the data": the cognitive processes of analysis in qualitative inquiry. In J.M. Morse (ed.). *Critical Issues in Qualitative Research Methods*. Thousand Oaks, CA: Sage (Pp. 23–43).
- Moscovici, S. (1973). Foreword. In C. Herzlich (Ed.). *Health and Illness: A Social Psychological Analysis*. London: Academic Press.
- Moscovici, S. (1984). The phenomenon of social representations. Farr, R.M. & Moscovici, S. (eds.), *Social Representations* (pp. 3-69). Cambridge, Cambridge University Press.
- Moscovici, S. (1988). Notes towards a description of social representations. *European Journal of Social Psychology*, 18, 211-250.
- Moser, C. (1998). The asset vulnerability framework: reassessing urban poverty reduction strategies. *World Development*, 26, 1, 1.

- Mullen, P.D., Ramirez, G., Strouse, D., Hedges, L.V., Sogolow, E. (2002). Meta-analysis of the effects of behavioral HIV prevention interventions on the sexual risk behavior of sexually experienced adolescents in controlled studies in the United States. *Journal of AIDS* 30, S94-S105.
- Muller, M. (2007). What's in a word? Problematizing translation between languages. *Area*, 39(2), 206–213.
- Murray, M., Nelson, G., Poland, B., Maticka-Tyndale, E., & Ferris, L. (2004). Assumptions and values of community health psychology. *Journal of Health Psychology*, 9, 2, 323–333.
- Narayan, D. (1999). Bonds and bridges: social capital and poverty. Mimeo. Washington DC: World Bank.
- Narayan, D., & Kapoor, S. (2005). Beyond ideologies: Creating wealth for the poor. *Paper presented at the Arusha Conference, "New Frontiers of Social Policy"*, Arusha, Tanzania.
- Newcomer, S.F., & Udry, J.R. (1985). Parent-child communication and adolescent sexual behavior. *Family Planning Perspectives*, 17, 169-174.
- Newman, K., Harrison, L., Dashiff, C., & Davies, S. (2008). Relationships between parenting styles and risk behaviors in adolescent health: an integrative literature review. *Rev. Latino-Am. Enfermagem*, 16,1, 142-150.
- Nguyen, P. V. (2008). Perceptions of Vietnamese Fathers' Acculturation Levels, Parenting Styles, and Mental Health Outcomes in Vietnamese American Adolescent Immigrants. *Social Work*, 53, 4, 337-346.
- Obholzer, A. (1997). The contribution of psychodynamic understanding to the management of institutions. *Psycho-analytic Psychotherapy in South Africa*, 5(2), 65-72.
- Obholzer, A., & Roberts, V.G. (eds.) 1994. *The unconscious at work. Individual and organizational stress in the human services*. London, Routledge.

- Odubote, B.A. (2008). Parenting style, race and delinquency: A comparative study of European American, African American and Nigerian families. U Minnesota, US. Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 69 (1-A), pp. 393.
- Paez, D., Echebarria, A., Valencia, J., Romo, I., San Juan, C., & Vergara, A. (1991). AIDS social representations: Contents and processes. *Journal of Community and Applied Social Psychology*, 1, 89-104.
- Paikoff, R. L. (1995). Early heterosexual debut: Situations of sexual possibility during transition to adolescence. *Am J Orthopsychiatry*, 65(3), 369-393.
- Palen, L., Smith, E., Caldwell, L., Flisher, A., Wegner, L., & Vergnani, T. (2008). Inconsistent reports of sexual intercourse among South African high school students. *Journal of Adolescent Health*, 42, 3, 221-227.
- Paikoff, R. L., Truabe, D. E., & McKay, M. (2007). Overview of the community collaborative partnerships and empirical findings: The foundation for youth HIV prevention. *Social Work Mental Health*, 5, 3-26.
- Park, H., & Bauer, C. (2002). Parenting practices, ethnicity, socioeconomic status and academic achievement in adolescents. *School Psychology International*, 23, 4, 386-396.
- Petersen, I., Mason, A., Bhana, A., Bell, C. & McKay, M. (2006). Mediating social representations using a cartoon narrative in the context of HIV/AIDS. *Journal of Health Psychology*, 11(2), 197-208.
- Petersmeyer, C. (1997). Adolescent risk behaviour as related to parenting styles. Ph.D. thesis U Victoria, Canada UMI Dissertation Services, 2003 (Abstract shortened by UMI.)
- PsycINFO Database Record (c) 2009 APA, all rights reserved)
- Pevalin, D. (2003). More to social capital than Putnam. *British Journal of Psychiatry*, 182, 172-173.

- Phillips, H. (1960) Problems of Translation and Meaning in Fieldwork. In R.N. Adams & J.J. Preiss (Eds.) *Human Organisation Research: Field Relations and Techniques*. Homewood, IL: Dorsey Press Inc.
- Pittman, L.D., & Chase-Lansdale, P.L. (2001). African American adolescent girls in impoverished communities: Quality of parenting and adolescent outcomes. *Journal of Research on Adolescence*, 11, 199-224.
- Poortinga, W. (2006). Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science & Medicine*, 63, 255–270.
- Poortinga, W. (2006). Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science and Medicine*, 63(1), 255-270.
- Portes, A. & Landolt, P. (1996). The downside of social capital. *The American Prospect*, 26, 18–22
- Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology*, 24, 1-24.
- Potter, J., & Edwards, D. (1999). Social representations and discursive psychology: From cognition to action. *Culture and Psychology*, 5, 4, 447-458.
- Potter, J., & Litton, I. (1985). Some problems underlying the theory of social representations. *British Journal of Social Psychology*, 24, 81-90.
- Pronyk, P.M., Harpham, T., Morison, L.A., Hargreaves, J.R., Kim, J.C., Phetla, G., Watts, C.H., & Porter, J.D. (2008). Is social capital associated with HIV risk in rural South Africa? *Social Science & Medicine*, 66, 1999-2010.
- Putnam, Leonardi, & Nanetti (1993)
- Putnam, R.D. (1993). The prosperous community. *The American Prospect*, 4, 13, 1-11.

- Putnam, R.D. (1995). Tuning in, tuning out: The strange disappearance of social capital in America. *Political Science and Politics*, 28, 4, 664-683.
- Querido, J.G., Warner, T.D., & Eyberg, S.M. (2002). Parenting styles and child behavior in African-American families of preschool children. *Journal of Clinical Child Psychology*, 31, 2, 272-277.
- Radziszewska, B., Richardson, J.L., Dent, C.W., & Flay, B.R. (1996). Parenting style and adolescent depressive symptoms, smoking and adolescent achievement: Ethnic, gender and SES differences. *Journal of Behavioral Medicine*, 19, 289-305.
- Rai, A., Stanton, B., Wu, Y., Li, X., Galbraith, J., Cottrell, L., Pack, R., Harris, C., D'Alessandri, D., & Burns, J. (2003). Relative influences of perceived parental monitoring and perceived peer involvement on adolescent risk behaviors: an analysis of six cross-sectional data sets. *Journal of Adolescent Health*, 33, 2, 108-118.
- Ray, O. (2004). How the mind hurts and heals the body. *American Psychologist*, 59, 1, 29-40.
- Reed, J., & Payton, V.R. (1997). Focus groups: issues of analysis and interpretation. *Journal of Advanced Nursing* 26, 765-771.
- Resnick, M.D., Bearman, P.S., Blum, R.W., Bauman, K.E., Harris, K.M., Jones, J., ... & Udry, J.R. (1997). Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA*, 278, 10, 823-32.
- Rhee, K.E., Lumeng, J.C., Appugliese, D.P., Kaciroti, N., & Bradley, R.H. (2006). Parenting styles and overweight status in first grade. *Pediatrics*, 117, 2047-2054.
- Rice P.L., & Ezzy, D. (1999). *Qualitative research methods, a health focus*. Melbourne: Oxford University Press.

- Riessman, C. (2000) "Even If We Don't Have Children [We] Can Live": Stigma and Infertility in South India. In C. Mattingly & L.C. Garro (Eds.) *Narrative and the Cultural Construction of Illness and Healing*. Berkeley, CA: University of California Press.
- Ritter, E. Neiley. (2005). Parenting styles: Their impact on the development of adolescent resiliency. [Dissertation Abstracts International: Section B: The Sciences and Engineering](#), Vol 66(1-B), 2005. pp. 621.
- Robin, L., Dittus, P., Whitaker, D., Crosby, R.A., Ethier, K., Mezoff, J., Miller, K., Pappas-Deluca, K. (2004). Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *Journal of Adolescent Health*, 34, 3-26.
- Roche, K.M., Ellen, J., & Astone, N.M. (2005). Effects of out-of-school care on sex initiation among young adolescents in low-income central city neighborhoods. *Archives of Pediatrics & Adolescent Medicine*, 159, 68-73.
- Rodgers, K.B. (1999). Parenting processes related to sexual risk-taking behaviors of adolescent males and females. *Journal of Marriage and the Family*, 61, 1, 99-109.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53, 3, 304-310.
- Romer, D., Stanton, B., Galbraith, J., Feigelman, S., Black, M.M., & Li, X. (1999). Parental influence on adolescent sexual behavior in high-poverty settings. *Archives of Pediatrics & Adolescent Medicine*, 153, 1055-1062.
- Rose, A., Koo, H., Bhaskar, B., Anderson, K., White, G., & Jenkins, R. (2005). The influence of primary caregivers on the sexual behavior of early adolescents. *Journal of Adolescent Health*, 37, 2, 135-144.
- Rose, R. (2000). How much does social capital add to individual health? A survey study of Russians. *Social Science & Medicine*, 51, 1421-1435.

- Rudy, D., & Grusec, J.E. (2001). Correlates of authoritarian parenting in individualist and collectivist cultures and implications for understanding the transmission of values. *Journal of Cross-Cultural Psychology*, 32, 202-212.
- Runyan, D. K., Hunter, W., Socolar, R., Amaya-Jackson, L., English, D., Landsverk, J., ... & Mathew, R. (1998). Children who prosper in unfavorable environments: The relationship to social capital. *Pediatrics*, 101, 12-18.
- Sabo, D.J. (1995). Organizational climate of middle schools and the quality of student life. *Journal of Research and Development in Education*, 28, 150-160.
- Sampson, R., Raudenbush, S., & Earls, F. (1997). Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science*, 277, 918-924.
- Schaeffer, E.S. (1959). A circumplex model of maternal behavior. *Journal of Abnormal and Social Psychology*, 59, 226-235.
- Schoeneman, T.J., Schoeneman-Morris, K.A., Obradovic, J., & Beecher-Flad, L. (2010). Social representations of AIDS: Pictures in Abnormal Psychology textbooks, 1984–2005. *Journal of Applied Social Psychology*, 40, 1, 13–35.
- Schuller, T., Baron, S., & Field, J. (2000). Social Capital: A Review and Critique. In S. Baron, J. Field & T. Schuller (Eds.), *Social Capital. Critical Perspectives* (pp. 1-38). Oxford: Oxford University Press.
- Schwandt, T.A. (1997). Textual gymnastics, ethics and angst. In W.G. Tierney & Y.S. Lincoln (Eds.), *Representation and the text: Re-framing the narrative voice* (pp. 305-311). Albany: State University of New York Press.
- Sears, R.R., Maccoby, E., & Levin, H. (1957). *Patterns of Child Rearing*. Evanston, Ill: Row, Peterson.

- Semaan, S., Sternberg, M., Zaidi, A., & Aral, S.O. (2007). Social capital and rates of gonorrhea and syphilis in the United States: Spatial regression analyses of state-level associations. *Social Science & Medicine*, 64, 2324–2341.
- Sen, S., Aguilar, J.P., & Goldbach, J. (2010). Does social capital act as a buffer against HIV risk among migrant men in sub-Saharan Africa? *Journal of HIV/AIDS & Social Services*, 9, 2, 190-211.
- Sharma, A.K., Singh, R., & Mishra, A.K. (n.d.). Report for UNICEF. Retrieved from [the internet](#) 03/09/2010.
- Sharma, M. (2004). Viable methods for evaluation of community-based rehabilitation programmes. *Disability and Rehabilitation*, 26, 6, 326–334.
- Shek, D.T. (2008). Predictors of perceived satisfaction with parental control in Chinese adolescents: A 3-year longitudinal study. *Adolescence*, 43, 169, 153-164.
- Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., Pillay-van-Wyk, V., ... & the SABSSM III Implementation Team (2009). *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town: HSRC Press.
- Shucksmith, J., Hendry, L.B., & Glendinning, A. (1995). Models of parenting: Implications for adolescent well-being within different types of family contexts. *Journal of Adolescence*, 18, 253-270.
- Sieving, R.E., McNeely, C.S., & Blum, R.W. (2000). Maternal expectations, mother-child connectedness, and adolescent sexual debut. *Archives of Pediatrics & Adolescent Medicine*, 154, 809-816.
- Simbayi, L.C., Chaveau, J., & Shisana, O. (2004). Behavioural responses of South African youth to the HIV/AIDS epidemic: a nationwide survey. *AIDS Care*, 16, 605-618.

- Singelis, T.M., Triandis, H.C., Bhawuk, D.P.S., & Gelfand, M.J. (1995). Horizontal and vertical dimensions of individualism and collectivism: A theoretical and measurement refinement. *Cross-Cultural Research*, 29, 240-275.
- Sivaram, S., Zelaya, C., Srikrishnan, A.K., Latkin, C., Go, V.F., Solomon, S., & Celentano, D. (2009). Associations between social capital and HIV stigma in Chennai, India: Considerations for prevention intervention design. *AIDS Education and Prevention*, 21, 3, 233-250.
- Slicker, E.K. (1998). Relationship of parenting style to behavioral adjustment in graduating high school seniors. *Journal of Youth and Adolescence*, 27, 345-372.
- Small, S. A., & Kerns, D. (1993). Unwanted sexual activity among peers during early and middle adolescence: Incidence and risk factors. *Journal of Marriage & the Family*, 55(4), 941-952.
- Smith, R.A., & Rimal, R. (2009). (2009). The impact of social capital on HIV-related actions as mediated by personal and proxy efficacies in Namibia. *AIDS Behavior*, 13, 133–144.
- Soward, K. W. (2006) Resilience and self-control in at-risk preschool children: Influences of maternal parenting style and self-control. [Dissertation Abstracts International: Section B: The Sciences and Engineering](#), Vol 67(2-B).
- Sperber, E., McKay, M.M., Bell, C.C., Petersen, I., Bhana, A., & Paikoff, R. (2008). Adapting and disseminating a community-collaborative, evidence-based HIV/AIDS prevention programme: Lessons from the history of CHAMP. *Vulnerable Children and Youth Studies*, 3, 2, 150-158.
- Stake, R.E. (1994). Case studies. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236 – 247). Thousand Oaks, CA: Sage Publications.
- Stake, R.E. (1995). *The art of case research*. Thousand Oaks, CA: Sage Publications.

- Stake, R.E. (2005). Qualitative Case Studies. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed.) (pp. 443-466). Thousand Oaks, CA: Sage Publications.
- Stanton, B., Li, X., Pack, R., Cottrell, L., Harris, C., & Burns, J.M. (2002). Longitudinal influence of perceptions of peer and parental factors on African American adolescent risk involvement. *Journal of Urban Health*, 79, 4, 536-548.
- Stanton, B.F., Li, X., Galbraith, J., Cornick, G., Feigelman, S., Kaljee, L., & Zhou, Y. (2000). Parental underestimates of adolescent risk behavior: A randomized, controlled trial of a parental monitoring intervention. *Journal of Adolescent Health*, 26, 18–26.
- Stattin, H., & Kerr, M. (2000). Parental monitoring: A reinterpretation. *Child Development*, 71, 4, 1072–1085.
- Steinberg, L. (1999). **Reference from Inge.**
- Steinberg, L. (2001). We know some things: parent-adolescent relationships in retrospect and prospect. *Journal of Research on Adolescence*, 11(1), 1-19.
- Steinberg, L., & Blatt-Eisengart, I. (2006). Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent, and neglectful homes: a replication in a sample of serious juvenile offenders. *Journal of Research on Adolescence*, 16(1), 47-58.
- Steinberg, L., Elmen, J.D., & Mounts, L.S. (1989). Authoritative parenting, psychosocial maturity and academic success among adolescents. *Child Development*, 60, 1424-1436.
- Steinberg, L., Lamborn, S.D., Darling, N., Mounts, L.S., & Dornbusch, S.M. (1994). Over-time changes in adjustment and competence among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development*, 65, 754-770.
- Steinberg, L., Lamborn, S.D., Dornbusch, S.M., & Darling, N. (1992). Impact of parenting

- practices on adolescent achievement: Authoritative parenting, school involvement and encouragement to succeed. *Child Development*, 63, 1266-1281.
- Steinberg, L., Mounts, N.S., Lamborn, S.D., & Dornbusch, S.M. (1991). Authoritative parenting and adolescent adjustment across varied ecological niches. *Journal of Research on Adolescence*, 1, 19-36.
- Stephenson, S. (2001). Street children in Moscow: Using and creating social capital. *The Sociological Review*, 49, 4, 530-547.
- Stetler, C.B., Legro, M.W., Wallace, C.M., Bowman, C., Guihan, M., Hagedorn, H., Kimmel, B., Sharp, N.D., & Smith, J.L. (2006). The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine*, 21, S1-S8.
DOI: 10.1111/j.1525-1497.2006.00355.x
- Swanson, J.L., & Fouad, N.A. (1999). Applying theories of person-environment fit to the transition from school to work. *Career Development Quarterly*, 47, 337-347.
- Swanson, J.M., & Chapman, L. (1994). Inside the black box: Theoretical and methodological issues in conducting evaluation research using a qualitative approach. In J.M. Morse (Ed.) *Critical issues in qualitative research methods* (pp. 67-93). London: Sage.
- Switzerland 2008.
- [http://data.unAIDS.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf]. Accessed 17 October, 2010.
- Symonds, P.M. (1939). *The Psychology of Parent-Child Relationships*. New York: Appleton-Century-Crofts.
- Szreter, S. (2002). The state of social capital: Bringing back in power, politics, and history. *Theory and Society*, 31, 5, 573-621.

- Szreter, S., & Woolcock, M. (2004). Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33, 650–667.
- Tajfel, H. & Turner, J. C. (1979). An integrative theory of intergroup conflict. W. Austin, & S. Worchel (eds.), *The social psychology of intergroup relations*. (pp. 33-47). Monterey, CA, Brooks/Cole.
- Taris, T.W., & Semin, G.R. (1998). How mothers' parenting styles affect their children's sexual efficacy and experience. *Journal of Genetic Psychology*, 159, 68-81.
- Tellis, W. (1997). Introduction to case study. *The Qualitative Report*, 3, 2, no page numbers.
- Downloaded from <http://www.nova.edu/ssss/QR/QR3-2/tellis1.html>
- Temple, B., & Edwards, R. (2002). Interpreters/translators and cross-language research: Reflexivity and border crossings. *International Journal of Qualitative Methods*, 1(2), 1-12.
- Downloaded from <http://creativecommons.org/licenses/by/2.0>
- Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, 4(2), 161-178.
- Temple, B., & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, 4, 2, 161-178.
- Terre Blanche, M., & Kelly, K. (1999). Interpretive methods. In M. Terre Blanche & K. Durrheim (Eds.), *Research in Practice*. Cape Town: UCT Press.
- Tesch, R. (1990). *Qualitative research: analysis types and software tools*. New York: Falmer.
- The Professional Board for Psychology, Health Professions Council of South Africa (2002). *Ethical Code of Professional Conduct*. Downloaded from the internet
- <http://web.uct.ac.za/depts/psychology/resources/EthicsCode.doc>
- Thomas, E.P. (2002). Local participation in development initiatives: The potential contribution of an understanding of social capital. *Urban Forum*, 13, 2, 116-131.

- Thomas, E.P. (2008). Local participation in development initiatives: the potential contribution of an understanding of social capital. *Urban Forum*, 13, 2, 116-131.
- Turkel, Y.D., & Tezer, E. (2008). Parenting styles and learned resourcefulness of Turkish adolescents. *Adolescence*, 43(169), 143-152.
- Twinn, S. (1997). An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced Nursing*, 26, 418–423.
- UNAIDS (2004). *2004 Report on the global AIDS Epidemic*. Geneva: UNAIDS.
- UNAIDS: AIDS Epidemic. Update. Joint United Nations Programme on HIV/AIDS. Geneva,
- V Morrow - International Journal of Sociology and Social Policy 2001**
- Valsiner, J. (1998). *The Guided Mind*. Cambridge, MA: Harvard University Press.
- Veenstra, G., Luginaah, I., Wakefield, S., Birch, S., Eyles, J., & Elliott, S. (2005). Who you know, where you live: social capital, neighbourhood and health. *Social Science & Medicine*, 60, 2799–2818.
- Verner, D., & Alda, E. (2004). Youth at risk, social exclusion, and intergenerational poverty dynamics: A new survey instrument with application to Brazil. World Bank Policy Research Working Paper 3296. Downloaded from internet 01.07.10.
- Vidich, A.J., & Lyman, S.M. (2000). Qualitative methods: Their history in sociology and anthropology. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 37-84). Thousand Oaks, CA: Sage.
- Voelklein, C., & Howarth, C. (2005). A review of controversies about social representations theory: A British debate. *Culture and Psychology*, 11, 4, 431-454.

- Voisin, D.R., DiClemente, R.J., Salazar, L.F., Crosby, R.A., & Yarber, W.L. (2006). Ecological factors associated with STD risk behaviors among detained female adolescents. *Social Work, 51, 1*, 71-79.
- Vucina, T., & Becirevic, I. Z. (2007). Risk factors and protective factors for adolescent substance use. *Review of Psychology, 14, 1*, 59-72.
- Wagner, W., Duveen, G., Verma, J., & Themel, M. (2000). 'I have some faith and at the same time I don't believe' — cognitive polyphasia and cultural change in India. *Journal of Community & Applied Social Psychology, 10, 4*, 301–314.
- Wagner, W., Lahnsteiner, I., & Elejbarrieta, F. (1995). How the sperm dominates the ovum: objectification by metaphor in the social representation of conception. *European Journal of Social Psychology, 25*, 671-688.
- Wakefield & Poland (2005). Family friend or foe? *Social Science and medicine, 60*, 2819-2832.
- Wechsberg, W.M., Luseno, W.K., Lam, W.K.K., Parry, C.D.H., & Morojele, N.K. (2006). Substance use, sexual risk, and violence: HIV prevention intervention with sex workers in Pretoria. *AIDS and Behavior, 10, 2*, 131-137. DOI: 10.1007/s10461-005-9036-8
- Weiss, L.H., & Schwarz, J.C. (1996). The relationship between parenting types and older adolescents' personality, academic achievement and substance use. *Child Development, 67(5)*, 2101-2114.
- Weitzman, E.R. & Kawachi, I. (2000). Giving means receiving: The protective effect of social capital on binge drinking on college campuses. *American Journal of Public Health, 90, 12*, 1936–1939.
- Whitaker, D.J., & Miller, K.S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behavior. *Journal of Adolescent Research, 15, 2*, 251-273.

- Whitaker, D.J., Miller, K.S., May, D.C., & Levin, M.L. (1999). Teenage partners' communication about sexual risk and condom use: the importance of parent-teenager discussions. *Family Planning Perspective*, 31, 117-121.
- WHO (2008). Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines. Geneva.
- Wilkinson 1996, 1997 – SC & Health
- Williams, B., Gilgen, D., Campbell, C., Taljaard, D., & MacPhail, C. (2000). *The Natural History of HIV/AIDS in South Africa. A biomedical and social survey in Carletonville*. Downloaded from the internet 23/07/10.
- Williams, K.M., Wingood, G.M., DiClemente, R.J., Crosby, R.A., Hubbard McCree, D., Liao, A., Harrington, K., Davies, S., Hook, E.W., & Kim Oh, M. (2002). Prevalence and correlates of *Chlamydia trachomatis* among sexually active African-American adolescent females. *Preventive Medicine*, 35, 6, 593-600.
- Wintre, M.G., & Ben-Knaz, R. (2000). It's not academic, you're in the army now: Adjustment to the army as a comparative context for adjustment to university. *Journal of Adolescent Research*, 15, 145-172.
- Wolfradt, U., Hempel, S., & Miles, J.N.V. (2003). Perceived parenting styles, depersonalization, anxiety and coping behavior in adolescents. *Personality and Individual Differences*, 34, 521-532.
- Wright, D.R., & Fitzpatrick, K.M. (2006). Social capital and adolescent violent behavior: Correlates of fighting and weapon use among secondary school students. *Social Forces*, 64, 3. Downloaded from Internet on 01/07/10.
- Wright, J.P., Cullen, F.T., & Miller, J.T. (2001). Family social capital and delinquent involvement. *Journal of Criminal Justice*, 29, 1- 9.

- Xu, C. (2008). Direct and indirect effects of parenting style with child temperament, parent-child relationship, and family functioning on child social competence in the Chinese culture: Testing the latent models. [Dissertation Abstracts International Section A: Humanities and Social Sciences](#), Vol 68(8-A), 2008. pp. 3274.
- Yin RK. Case study research, design, and methods. Thousand Oaks, CA: Sage Publications, 1994.
- Yin, R. (1994). *Case study research: Design and methods* (2nd ed.). Beverly Hills, CA: Sage Publishing.
- Zenilman, J.M., Weisman, C., Rompalo, A.M., Elish, N., Upchurch, D.M., Hook, E.W. & Celentano, D. (1995). Condom use to prevent incident STDs: the validity of self-reported condom use. *Sexually Transmitted Diseases*, 22, 1, 15-21.

APPENDIX 1

R.2001 10:42

COMMUNITY SERVICES
COMMUNITY SERVICES

NO. 402 P.2

DURBAN METROPOLITAN UNICITY MUNICIPALITY Outer West Operational Entity Community Services



OUR REF DCS 341.99
YOUR REF
ENQUIRIES M. Mthembu

16th March 2001

TO WHOM IT MAY CONCERN

MOTIVATION AND SUPPORT: CHAMP PROGRAMME IN THE KWADEDANGENDLALE AREA OF THE OUTER WEST DISTRICT

Council has a Constitutional Mandate I Section 152 and 153a and 153b to promote socio-economic development of its residents. This is further emphasised in the White Paper on Local Government Development role of Local Government (Chapter 7).

It is for the above reason that Council is actively involved in mobilising and organising communities around self-development initiatives.

Further more, Council supports organised community structures and community based service providers in terms of capacity building, operational facilities and linking them with relevant sources and information to assist them.

Council therefore appeals to the private sector, NGO's and CBO's and Community structures to embrace worthy initiatives that benefit broader communities, as groups, sectors and individuals.

Council through its Community Services Directorate supports the CHAMP programme by the University of Durban-Westville, School of Psychology. They will focus on this area due to their familiarity of the area through other involvement in providing psychological services to this area through the NICHE programme.

Council will support, monitor its activities to ensure that its aims and objectives are achieved and participate on a CHAMP Board which would comprise of the US partners, School of Psychology at the University of Durban-Westville, Community partners & service partners.

Your active support and participation in this initiative will be highly appreciated for effective social partnerships to improve health, socio-economic status and quality of lives for our unemployed communities, particularly the youth.

Thanking you in advance for your support on behalf of the Outer West communities.

Kind regards


M. Mthembu (Mrs)
DIRECTOR COMMUNITY SERVICES
MM/nnc

8 Link Road
Waterfall
P O Box 36
Kloof
3640

Tel: (031) 762 1224
Fax: (031) 763 3738

APPENDIX 2

FOCUS GROUP GUIDE: STUDY 1

HIV/AIDS has become a major problem worldwide, but especially in South Africa. We are doing research to see how we can protect children against HIV. We need help from you to understand the problem from your perspective. What role can you as parents play in protecting children? What are some of the problems you encounter in parenting your children?

Probe questions

1. What would help you to become more effective parents?
2. How do you currently control your children?
3. What kind of relationship do you have with your children?
4. What is your role in the sex education of your children?
5. What is your understanding of what is happening, and why?
6. How does the community help in protecting the children?
 - Has that broken down?
 - If so, how?
7. How do people in your community respond to someone who is HIV+?
 - What would you do if your child became HIV+?
 - Why would you deal with it in this way?
 - What do you think about people's response to those who are HIV+?
8. Do you think that community leaders should play a role in helping to protect children against HIV/AIDS? If so, how?

APPENDIX 3

INDIVIDUAL INTERVIEWS: STUDY 1

1. In extended families, who provides the discipline and guidance to the children? Who is the head of the family? How do families operate around rules?
2. Why is there anxiety around communication with the children? Is it because you feel that you are not well enough informed?
3. Do you think that with more information you would feel more empowered to communicate with you children?
4. How do you think the children are influenced by their friends?
5. Why do you feel so ineffective in your parenting roles? There was a clear sense of fear of the children expressed during the focus groups. Who is afraid? Is it mothers/fathers? Who are they afraid of? Is it of the boys/ Is the fear linked to lack of information, of a sense of losing control, of being “left behind” by your children; or is it also of physical violence? How are your fears and anxieties contained? By the use of physical punishment? But adolescent boys are too strong to be physically punished by their mothers. Does the fear arise because of this?
6. Do you try to contain your anxieties by reverting to old cultural traditions? With the “new ways” that the children are adopting, what do you think you need to do to bridge the gap between yourself and your child/ren?
7. It seems that the old concept of “ubuntu” is no longer operating; there is no community parenting and parents become angry when a community member reports the misbehavior of a child; there is also a lack of trust of anyone in the family/community. Why is this happening?
8. Community leaders don’t seem to be playing their role as leaders as they did in the past. Has the role of leaders changed?
9. What is the role of the male in the household? What do they do as “head” of the household?
10. It seems that men are abdicating responsibility for disciplining male children. What is happening?
11. It also seems that women are being blamed for lack of control over children. Why is this happening?
12. Why is there stigma around HIV/AIDS?
13. It seems that men feel disempowered and yet this is not so with young males. Why?

APPENDIX 4

FOLLOW UP INTERVIEWS: STUDY 2

It has been some time since the AmaQhawe programme was first implemented here. You may recall that before AmaQhawe started, we conducted some group discussions and individual interviews with some of the parents of children in Gwadu Zenex school, as well as some community members, to get an idea of how people in this community were protecting their children against HIV. This interview is a follow-up of the issues that emerged from those discussions and interviews. We would also like to find out whether you think that the AmaQhawe programme helped this community, and if so, how.

1. One issue that emerged from those initial groups and interviews was that parents felt that their children had more power than themselves; parents felt unable to guide and protect their children because children seemed to have more rights than parents. Do you think the programme was successful in making parents feel more empowered to be effective in parenting their children? If yes, how? If no, why not?
2. The programme also aimed to help parents feel more empowered by providing knowledge about HIV/AIDS. Was it successful in this regard? Did more knowledge about HIV/AIDS make you feel better equipped to protect your children?
3. Parents also felt that the traditional parenting practices of the past had fallen away or become ineffective, with the result that they felt confused as to how to bring up their children. What are your thoughts on this issue? Did the programme help parents to agree on new ways to bring up their children?
4. At that time community members also felt that the leadership structures were not really providing unified leadership to the community. Has there been any change? If so, what has contributed to the change?

5. Before the programme, people in this community believed that outsiders, such as white people were responsible for corrupting the children and for spreading AIDS in the community. What do you think about this? If yes, how does this happen? If no, what has changed?
6. Another issue that emerged at that time was that women and girls were blamed for anything that went wrong, and that females were mainly responsible for the spread of HIV/AIDS. What is your opinion about this issue now?
7. During the discussions before the programme was implemented, people felt that they could not trust other people in the community. Has the programme helped in any way to increase trust among community members?
8. People also felt that they could not tell other people's children anything even if they saw them doing something wrong. There was very little "parenting" provided by community networks and therefore, very little social control over children. Has the programme changed this in any way?
9. Has there been any improvement in community networks? Can people rely on other community members to help them, especially to ensure that their children are safe/
10. Do you think that the programme was successful in empowering the community and making it more competent in keeping the children safe and protected against HIV/AIDS?
11. Before the programme there was a great deal of stigma related to HIV/AIDS. No one would talk about it or admit that they knew anyone who was HIV positive, or had died of AIDS. Has the programme made any difference on this issue?

APPENDIX 5



Human Participant Protections Education for Research T

Completion Certificate

This is to certify that

Zubeda Paruk

has completed the **Human Participants Protection Education for Research Teams** online course, sponsored by the National Institutes of Health (NIH), on 09/19/2001.

This course included the following:

- key historical events and current issues that impact guidelines and legislation on human participant protection in research.
- ethical principles and guidelines that should assist in resolving the ethical issues inherent in the conduct of research with human participants.
- the use of key ethical principles and federal regulations to protect human participants at various stages in the research process.
- a description of guidelines for the protection of special populations in research.
- a definition of informed consent and components necessary for a valid consent.
- a description of the role of the IRB in the research process.
- the roles, responsibilities, and interactions of federal agencies, institutions, and researchers in conducting research with human participants.

National Institutes of Health
<http://www.nih.gov>

APPENDIX 6



University of
Durban-Westville

PRIVATE BAG X54001 DURBAN
4000 SOUTH AFRICA
TELEGRAMS: 'UDWEST'
TELEX: 6-23228 SA
FAX: (031)204-4383
☎ (031)204-4111

RESEARCH ADMINISTRATION



ALL CORRESPONDENCE TO BE ADDRESSED
TO THE HEAD - RESEARCH ADMINISTRATION

08 JANUARY 2004

MRS. Z. PARUK
PSYCHOLOGY

Dear Mrs. Paruk

ETHICAL CLEARANCE - NUMBER 03253A

I wish to confirm that ethical clearance has been granted for the following project :

*"Containment and contagion: coping with the spread of HIV/AIDS in South Africa.
A study in the community of Kwadedangendale, KwaZulu-Natal"*

Thank you

Yours faithfully

MS. PHUME XIMBA
(for) HEAD: RESEARCH ADMINISTRATION

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc: Director of School
cc: Supervisor

THE AMAQHAWE FAMILY PROJECT

FACILITATORS' MANUAL



Facilitators' Manual

The AmaQhawe

FAMILY PROJECT

SESSION ONE

Parents' and children's rights and responsibilities

Caregivers, parents and children

This programme is for parents and children, but we are aware that in many families the people who are caring for the children may not be their parents. CHAMP realises that there are different types of families. There are families with both a mother and a father, there are single parent families, and there are children who are raised by grand parents, uncles and aunts and some are adopted. CHAMP works with all these different kinds of families. Explain to the participants that, for convenience, we have used the word 'parent' to refer to all caregivers who are looking after children. Even if they are not blood relations, all caregivers and children face similar problems and difficulties.

Ice breaker

An example of an icebreaker would be as follows: THROW THE BALL.

Explain to the participants that we are going to play a game that will facilitate the introductory process. Explain to them that we know that they will not remember every ones names but as we interact and with time they will get to know each other's names. Explain to the group that you have a ball in your hands, you are going to say your name and will throw the ball to anyone in the room and that person will catch the ball and say his or her name and they will throw the ball to some one else and that person will follow the same process until every one in the room has had a chance to catch the ball and tell the group his or her name.

Introduction

The interviews held with community members found that many parents feel disempowered when it comes to parenting children. This is because children are often not respectful of their parents. Often this is because the parents are poorly educated and are not able to buy the children all the things that they want.

Some parents cope with this situation by using a very strict and authoritarian parenting style, which may border on abuse. In this session we are going to focus on the rights and responsibilities of parents and children. Parents have the right to parent their children, but they also have the responsibility of doing this in a *balanced* way. Children have the right to be protected from abuse by parents, but they also have the responsibility of abiding by the rules set by their parents.

Children should respect their parents no matter what educational level their parents have or whether they have the money to buy them the things they want or not.

Session objectives

At the end of this session, parents and children should:

- understand and have accurate information about their constitutional rights and responsibilities as parents and children;
- understand how the constitutional rights of parents and children impact on parenting tasks, and what the Constitution has to say about parent-child relationships;
- be aware of other issues that may make it difficult for parents to parent effectively;
- be encouraged to try and improve parent-child relationships.

Outline of the session

- The session will consist of separate groups for parents and children, followed by a combined parents'/children's group.
- Both groups will discuss issues related to parents' and children's rights and responsibilities and how these impact on their relationships and family functioning.
- Then they will form into family groups where they will discuss these issues as a family.

Procedure

1. Hand out the workbooks to the participants.
2. Using the **Maqhawe Family Chart**, introduce the whole group to the Maqhawe family.
3. Read through the **Story Chart No. 1**, with the whole group, while they read the story in their workbooks. Read the dialogue out loud and dramatise it as you read it so that everyone can enjoy the story. More than one facilitator can take part in dramatising the story.

SESSION ONE



*Dramatise the story as you read it while the participants look at their workbooks.
In this way everyone can understand and enjoy the story.*

Story summary

Story Chart No. 1: The cheeky son

Note to the facilitator: Explain that this is a comic and how speech bubbles are used. Also explain that in comics the characters always wear the same clothes. This helps us recognise the character.

S'bu plays soccer at school and comes home after dark. He knows that the family rules do not allow him to be out so late. When his mother reprimands him, he is rude to her. He is also very rude to his grandmother and his father. His father gives him a hiding and he protests that he is being abused. He threatens to report the matter to Childline.

SESSION ONE

The AmaQhawe ^{Session 1} CHAMP FAMILY PROJECT

THE CHEEKY SON



CONTINUED ...

SESSION ONE



Parents' group

Procedure

1. Divide participants into buzz groups of five to six people.
2. Provide each group with the **Story Chart No.1** and the list of **Parents' Discussion Questions**.
3. Allow 30 minutes of discussion and ask for volunteers from each group to report back on each buzz group's discussion.

Parents' discussion questions

1. What do you think of S'bu's behaviour?
2. Do you think he had the right to behave this way? Give reasons.
3. What do you think of ma Maqhawe's behaviour?
4. Do you think she had the right to shout at S'bu like that? Give reasons.
5. What do you think of baba Maqhawe's behaviour?
6. Do you think he had the right to hit S'bu like that? Give reasons.
7. What children's rights do you know of?
8. Have these rights influenced the way you do things in your family? Give reasons.
9. What other factors do you think have influenced your ability to parent effectively?
10. What are your rights as a parent?
11. What are your responsibilities as a parent?
12. What do you think children's responsibilities are in the parent-child relationship?
13. What do you think parents can do to gain respect from their children?

Children's group

Procedure

1. Divide participants into buzz groups of five to six children.
2. Provide each group with **Story Chart No.1** and the list of **Children's Discussion Questions**.
3. Allow 30 minutes of discussion and ask for a volunteer from each group to report back on the group's discussion.

Children's discussion questions

1. What do you think of S'bu's behaviour?
2. Do you think he had the right to behave this way? Give reasons.
3. What do you think of ma Maqhawe's behaviour?
4. Do you think she had the right to shout at S'bu like that? Give reasons.
5. What do you think of baba Maqhawe's behaviour?
6. Do you think he had the right to hit S'bu like that? Give reasons.
7. What children's rights do you know of?
8. What do you think their purpose is?
9. Do parents have rights too? Give reasons.
10. If parents have rights what rights do they have?
11. Rights go with responsibilities. What responsibilities do parents have?
12. What responsibilities do children have?

Family group

Procedure

- Provide the family groups with **Story Chart No. 1**.
- Ask the family groups to suggest ways of how the Maqhawe family could have handled the situation differently to ensure that the rights and responsibilities of both parents and children are maintained.

Notes for facilitators

- The Bill of Rights, which includes children's rights and human rights, aims to protect the rights of all people in our country and acknowledge the democratic values of human dignity, equality and freedom.
- The Bill of Rights states that everyone has dignity no matter who they are and that everyone has the right for their dignity to be respected and protected.
- While everyone has these rights, they also have responsibilities. These include acknowledging and respecting the rights of others. Rights and responsibilities go together.
- Children having rights does not mean that parents lose their dignity or responsibilities as parents. Children must respect their parents and caregivers.
- Defending one's rights, either as a parent or as a child, also requires respect for the rights of others.
- Parents who allow their rights and responsibilities to be interfered with by children also play a role in their own disempowerment as parents.
- Parental disempowerment may result from parents feeling inferior to their children because they have a lower educational level and/or because they feel that they are unable to provide for the child's material needs and desires.
- When this happens, parents sometimes give up their rights and responsibilities as parents to children, who they view as more knowledgeable. This is wrong.
- Parents should always demand respect from their children no matter what their educational level and/or financial status is. Respect does however, demand that parents act responsibly in their parental role and do not abuse their parental power.
- The Bill of Rights protects parents and children and requires that parents act on their rights and responsibilities in order to protect their children.

The children's Bill of Rights

Every child has a right:

- To a name and a nationality from birth
- To family care or parental care, or to appropriate alternative care when removed from the family environment
- To basic nutrition, shelter, basic health care services and social services
- To be protected from maltreatment, neglect, abuse or degradation
- To be protected from exploitative labour practices
- Not to be permitted to perform work or provide services that are inappropriate for a child; or that threaten the child's well-being, education, physical or mental health or spiritual, moral or social development
- Not to be detained except as a measure of last resort, in which case, the child may be detained only for a short period of time
- To be kept separately from detained persons of over the age of 18 years
- To have a legal practitioner assigned to the child by the state
- Not to be used directly in armed conflict and to be protected in times of armed conflict.



SESSION ONE

RIGHTS AND RESPONSIBILITIES OF PARENTS AND CHILDREN

Parents...	Children...
should respect children as developing individuals who sometimes make mistakes	should respect parents as adults who have had more experience of the world and its dangers
should be responsible for providing children with food and shelter, teaching them how to behave and keeping them safe	should be responsible for making use of all the opportunities provided by parents, however big or small they may be.

Home assignment

Give each of the families one copy of the **Session 1 workbook**. Explain to them that this is a fun way to learn together as a family. Children must do the puzzle. Parents must read the children's rights with their children.

The AmaQhawe FAMILY PROJECT

SESSION TWO

Parenting styles

Review of home assignment

For last weeks home assignment families were asked to read children's rights and children were asked to do the puzzle. Ask families to feedback on this task. Also ask families for feedback on the workbook.

Introduction

The last session covered the rights and responsibilities of both parents and children. Parents have the right to discipline their children but need to do so in a balanced and responsible way. All parents want to bring up their children to be responsible and respectful and to be safe as they are growing up. However, children should respect parents not because they are afraid of them, but because they know that they love them, that they can come to them whenever they have a problem, and that they will do their best to help them solve it in a positive way.

This session is about parenting styles. Parenting styles refers to the way in which caregivers express their beliefs about how to be a good or bad parent. All parents want to be good parents and avoid being bad parents.

Session objectives

By the end of the session the following should have been achieved:

- Both parents and children should be aware of the way parenting styles impact on the relationship between parents and their children.
- Both parents and children should understand the different parenting styles and how

SESSION TWO

each style impacts on children's responses.

- Parents should understand the influences (including children's responses) that impact on parenting styles.
- Parents should have reflected on their own parenting style and how this impacts on their relationships with their children.
- Both parents and children should understand how parenting styles could impact on risky behaviour among children.

Outline of the session

Explain that the session will consist of separate groups for adults and children, and then a combined parents'/children's group.

Procedure

1. Read through **Story Chart No. 2(a),(b)** with the whole group. Read the dialogue out loud and dramatise it as you read it so that everyone can enjoy the story.
2. Ask the participants to separate into the parents' and children's groups.

SESSION TWO



Dramatise the story as you read it so that everyone can understand and enjoy it.

Story summary

Story Chart No. 2a:

S'bu goes to see his friends and finds them sniffing glue. They try to persuade him to try. He knows it makes people get high and says no. His friends make fun of him and call him a mama's boy. S'bu feels confused and runs away from his friends wishing he had someone to talk about this.

Story Chart No. 2b

Zodwa has been chosen to enter a school dance competition, which will be taking place at 6 o'clock in the evening. She asks her mother. Ma Maqhawe refuses to let her go, not giving her a chance to explain about the dance. Zodwa is angry and rude to her mother and decides to disobey her mother and go anyway.

The AmaQhawe

Session 2

CHAMP

FAMILY PROJECT

THE TEMPTATION



CONTINUED ON BACK PAGE

SESSION TWO



SESSION TWO

FROM PAGE ONE...



Story Chart No. 2c

Aunt Ntombi finds S'bu looking glum. She ask him if there is something he needs to talk about. He tells her about how his friends were trying to get him to sniff glue and how because he didn't want to, they made fun of him. Aunt Ntombi says he did the right thing not to try. She retells the story when they are all having dinner. All the adults support S'bu and he feels better about himself.

Parents' group

Procedure

- In plenary explain what is meant by parenting styles.
- Separate participants into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back
- Provide each group with **Story Chart No.2(a) and (b)** and a list of Parents' Discussion Questions.

Discussion questions

1. What do you think makes ma Maqhawe refuse to give Zodwa permission to go to the dance?
2. What makes Zodwa angry and rude and want to defy her mother?
3. Why do you think S'bu cannot talk to his parents?
4. What would be the pros and cons of talking to his parents?
5. What would be the pros and cons of talking to his friends?
6. What different parenting styles are used in this community?
7. Which parenting style is most often used, and why?
8. Discuss the pros and cons of the different parenting styles.
9. How does this common parenting style impact on parent-child relationships and children's behaviour?
10. Does the commonly used parenting style encourage children to talk to their parents if they have problems?

Children's group

Procedure

- Have the children break up into buzz groups of 5-6 children.
- Provide each group with **Story Chart No. 2(a) and (b)** and the list of Children's Discussion Questions.
- Ask the groups to elect one child to take notes and report back.
- Get the groups to examine the cartoons and discuss the questions posed.
- Bring the groups back together and report back.
- Explain the different parenting style and how they could impact differently on children's risky behaviour.

Discussion questions:

1. What is happening in these two situations?
2. What do you think makes ma Maqhawe refuse to give Zodwa permission to go to the dance?
3. What makes Zodwa angry and rude and want to defy her mother?
4. Why do you think S'bu cannot talk to his parents?
5. What would be the pros and cons of talking to his parents?
6. What would be the pros and cons of talking to his friends?

Family group

Procedure

- In plenary provide feedback on the outcomes of the child and parent groups
- Read through **Story Chart No. 2(c)** with the whole group. Read the dialogue out loud and dramatise it as you read it so that everyone can enjoy the story.
- Ask the participants to separate into their family groupings.
- Provide each family group with **Story Chart Chart No. 2(c)** and the list of Family Discussion Questions.
- Return to plenary and ask families for feedback on their discussions. Lead a group discussion on their responses highlighting the following issue:

SESSION TWO

Children are more likely to be respectful and protected from risky behaviour if they feel that they can discuss their problems with their parents who will listen to their point of view. Refer back to **Story Chart No.2(a) and (b)**.

Discussion questions

- What helped S'bu to talk to aunty Ntombi about the glue sniffing incident?
- What are the advantages of resolving the problem through discussion?
- Have S'bu's aunt and parents' lost his respect by not scolding or beating him for mixing with children who sniff glue?
- What do you think may have happened if S'bu was not able to talk to aunt Ntombi and his parents about his problem.

Notes for the facilitator

Parenting styles

All parents incorporate both love and limits in their style of parenting. It is the balance of love and limits that determine parents' particular style.

Parents who use love as their primary style (permissive caregivers) consider love to be more important than limits. They also use attachment and their bond with their child to teach right from wrong. They spend a lot of time with the child communicating, negotiating, and reasoning so that children learn to do this in return when they need to express themselves to their parents. Parents provide role models. Their value is on 'increasing their child's self-esteem' or 'making them feel special.'

Parents who use limits as their primary style (authoritarian caregivers) consider limits as more important than love (relationship). They use external control to teach right from wrong and are quick to act on a discipline problem. Consequently, children are usually quick to react and rarely get their parents to negotiate. The value is on 'teaching respect' and 'providing structure.'

Communicate to the participants that being a single parent does not mean one is a bad parent. Single parents are faced with a big challenge of raising children alone. However being a single parent does not mean that your child will behave badly or have problems. Just as with children from two headed households, the parent-child relationship and support from other people, such as grandparents, neighbours and other factors influence a child's behaviour.

If and when facilitators notice parents who seem to be experiencing difficulty in raising their children, talk to them after the session and refer them for support either to a social worker, psychologist and other people that might be of assistance.

The four styles of parenting

Rejecting/Neglecting

The Rejecting/Neglecting style of parenting is low on both love and limits. It is generally thought of as uncaring and inadequate to meet the needs of children. Sometimes, it is referred to as the 'indifferent parenting style' due to its lack of emotional involvement and supervision of children.



Authoritarian

The Authoritarian parenting style is high on limits and low on love. That doesn't mean that an authoritarian parents do not love their child. They do love their child but their parenting strengths are in the area of action discipline (limits) and not relationship discipline (love).

Most children of authoritarian parents do not feel they have a close, warm relationship with their parents.

Consequently, they are not someone they feel they can turn to for empathy and problem solving. Authoritarian parents value obedience and respect. They do not negotiate rules and chores. And they believe in a family hierarchy, with dad usually at the top, mom next in line, and children last.



Permissive

The Permissive parenting style is high on love (relationship discipline) and low on limits (action discipline). Permissive parents are highly attuned to their child's developmental and emotional needs but



SESSION TWO

have difficulty setting firm limits. In fact, the biggest telltale sign of a permissive caregiver is their inconsistent discipline. Bedtime is at 7 pm one night and 10 pm the next. They use reason and negotiation to gain their child's compliance. They use their attachment and bond with their child to teach right from wrong.

This is not to say that the permissive parent is an abusive or ineffective parent. Children often do comply with permissive parents as a result of the relationship. It is a little known fact that children do want to please their parents and are more likely to follow the directions of someone they know, love, and trust versus someone they do not.

Democratic or balanced

The democratic or balanced parenting style is high on both love and limits. It is based on the democratic concepts such as equality and trust. Parents and children are equal in terms of their need for dignity and worth but not in terms of responsibility and decision making. In large families, where there are more children than adults, parents would easily be outvoted, for example, on whether ice-cream should be served before or after dinner. Parents, like the president in a democratic society, have veto-power over decisions that may affect the health and well-being of younger family members



Only the democratic or balanced parenting style has both high love and high limits. In addition, each style has strengths and weaknesses inherent in them and is learned mainly from the important parental figures in our lives. These figures are usually our own parents.

Parents adopt the styles of parenting learned from their parents because:

1. They don't know what else to do.
2. They feel that this is the way to be good parent.

Home assignment

The home assignment is in the workbook.

There is information for parents to read on page 3.

On page 4 and 5, there is a quiz for both parents and children. Parents should identify their own parenting style and children should identify which parenting style fits their parents and which one they would ideally like their parents to adopt.

On page 6, children should try to make their own cartoons by first matching the feelings with the faces and then drawing their own cartoons. It is important for children to do this before doing the exercise on page 7.

The exercise on page 7 should be done by parents and children together. It uses the same story about Zodwa asking to go to the dance competition. Tell the parents that they should fill in the speech bubbles for both Zodwa and her mother in a way that would reflect a balanced parenting style. Ask children to draw in the faces to reflect the feelings of both Zodwa and her mother in this new conversation.

The AmaQhawe

FAMILY PROJECT

SESSION THREE

Talking and listening

Review of last week's home assignment

Ask for feedback on last week's home assignment. Ask whether both parents and children were able to identify the parenting style that was most commonly used in the home. Families were also asked to complete the story of Zodwa asking to go to the dance in a way which would reflect a balanced parenting style. Parents were asked to fill in the words and children were asked to draw in the faces. Ask whether they were able to do this task and whether they had any difficulties.

Introduction

The last session was about the need to parent in a balanced way. This involves listening and talking through problems with one's child. Parents and children need to learn how to communicate effectively to prevent any misunderstanding from occurring, and to ensure that each member of the family feels listened to. This would help parents to parent in a balanced way which preserves the rights of both children and adults.

Session objectives

By the end of the session the following objectives should be achieved:

- Communication between parents and children should be enhanced.
- Parents and children should be aware of the roles of each person in the family with regard to communication and discussion.

Outline of the session

Explain that the session will consist of separate groups for adults and children, and then a combined parents'/children's group.

Procedure

1. Read through **Story Chart No. 3(a),(b), (c) and (d)** with the whole group. Read the dialogue out loud and dramatise it as you read it so that everyone can enjoy the story. Explain that parents are going to be using **Story Charts Nos 3 (a) and (b)** while children will use **Story Charts Nos 3 (c) and (d)** in their discussions.
2. Ask the participants to separate into the parents' and children's groups.

Story summary

Story Chart No. 3a: Ma Maqhawe tells Zodwa that she has spoken to her father and decided that she can go to the Dance competition after all. Zodwa tells her mother that she is required to buy a special dancing dress for the competition which costs R50.

Story Chart No. 3b: Gogo Qhawe thinks she sees Gugu kissing her boyfriend Nkosinathi. She tells ma Maqhawe that she thinks he is a bad influence on Gugu. Ma Maqhawe says she will speak to her husband. Gogo Qhawe says that baba Maqhawe likes Nkosinathi because he buys drinks for him. When baba Maqhawe comes home, ma Maqhawe says that she is worried about Gugu's boyfriend Nkosinathi. Baba Maqhawe responds by telling her not to worry and that he is a 'good kid'.

Story Chart No. 3c: Zodwa diligently does all her homework. When she gets to school the next day, her friend Nomsa asks her if she can copy her homework as she has not done hers.

Story Chart No. 3d: Ma Maqhawe asks S'bu to go and buy some bread but be sure to bring the change back. On the way S'bu meets his friends who pester him to buy sweets with the change. When he says he can't as his mother asked him to bring the change back, they call him names. He gives in and buys them sweets. When he gets home, ma Maqhawe asks for the change.

SESSION THREE

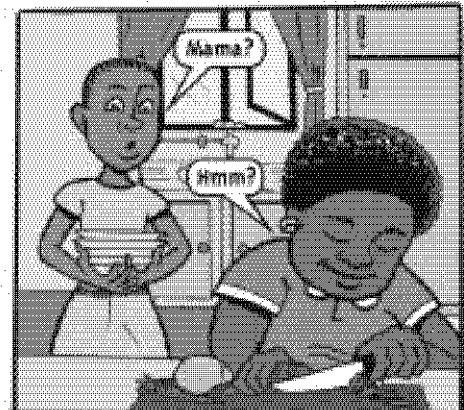
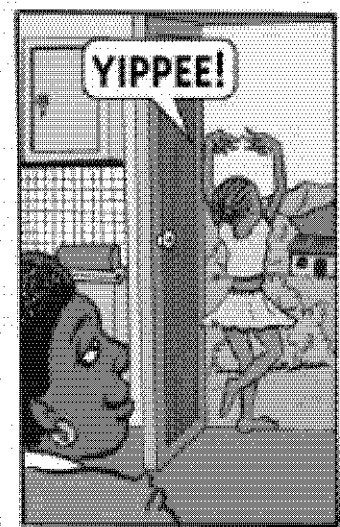
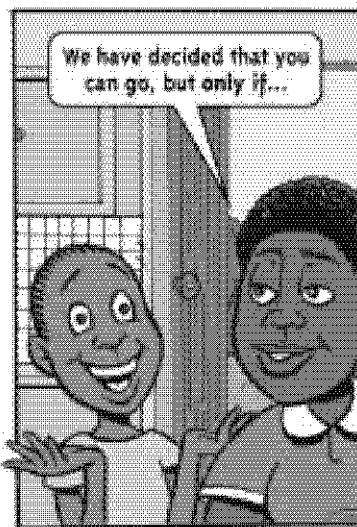
The Session 3

CHAMP

AmaQhawe

FAMILY PROJECT

THE DANCING DRESS



SESSION THREE



WHAT DOES MAQHAWWE SAY TO HER HUSBAND?

SESSION THREE



CONTINUED ON THE BACK PAGE

SESSION THREE

FROM PAGE ONE...



Parents' group

Procedure

1. In plenary, discuss with parents what they understand by the term 'communication' within the family and what is each person's role in this communication process. Discuss the four response styles, giving examples of each. In explaining the assertive style of communication, emphasise the importance of 'I' statements.
2. Have participants separate into two buzz groups.
Provide each group with **Story Chart No. 3 (a) and (b)** and a list of parent's discussion questions.
Ask the group to elect people who are going to take on the characters of Zodwa, baba Maqhawe and ma Maqhawe.
3. Return to plenary and have parent pairs report back on the responses that were generated, according to each of the four response style categories and their discussion of the effect of each response style on Zodwa and baba Maqhawe.

Discussion questions

1. Using **Story Chart 3(a)**, act out four different responses that ma Maqhawe could give to Zodwa using the four different response styles.
2. What effect does each of these different responses have on Zodwa.
3. Using **Story Chart 3(b)**, act out four different responses that ma Maqhawe could give to baba Maqhawe using the four different response styles.
4. What effect does each of these different responses have on baba Maqhawe.

Children's group

Procedure

1. In plenary, discuss with the children what they understand by the term 'communication' within the family and what is each person's role in this communication process.
2. In discussing the term 'communication' explain the verbal and the non-verbal communications and what impact these components of communication have on the person one is speaking to.
3. Discuss the four response styles, giving examples of each.
4. Facilitators are to act out these response styles highlighting the verbal and the non-verbal.
5. Discuss the "I" statement and emphasis it's importance in assertive communication.
6. Divide the children into buzz groups of 5-6 people. Provide each group with **Story Chart 3 (c) and (d)** and a list of children's discussion questions.
7. Ask the group to elect people who are going to take on the characters of Zodwa, Nomsa, S'bu and, ma Maqhawe.

Discussion questions

1. Using **Story Chart 3(c)**, act out four different responses that Zodwa could give to Nomsa using the four different response styles.
2. What effect does each of these different responses have on Nomsa.
3. Using **Story Chart 3(d)**, act out four different responses that S'bu could give to ma Maqhawe using the four different response styles.
4. What effect does each of these different responses have on ma Maqhawe.

Family discussion

Procedure

- In plenary provide feedback from adult and children's discussions.
- Break up into family groups.
- Provide families with the prepared scenario.
- Ask families to role play the scenario with a child role playing Gugu and an adult role playing ma Maqhawe.

SESSION THREE

Scenario

Gugu has been invited to a party. She goes to ma Maqhawe to ask for permission to go to the party. Role play this scenario with (a) Gugu requesting permission in an assertive way, (b) ma Maqhawe saying YES in an assertive way, and (c) ma Maqhawe saying NO in an assertive way.

Notes for the facilitator

Facilitators should explain that communication and discussion within the family requires parents to talk to their children, as well as to LISTEN to them.

Parents need to be aware that talking down to their children, or not listening to them, results in children feeling alienated (unimportant) and alone. As a result, they would be reluctant to talk to their caregivers, and would rather keep quiet about their problems or talk to someone else.

Parents need to be aware that children, like adults, need to be given explanations for decisions made. For example, an explanation for rules around coming home late is based on a concern for the child's safety, and not a challenge to the adult's decision-making right or authority.

Parents should be made aware that whenever they respond to a particular situation, the outcome of the situation must be borne in mind. Certain response styles may violate the integrity of a relationship, i.e., damage a relationship or cause a relationship to deteriorate.

They should also be made aware that communication is not only verbal. Non-verbal communications such as tone of voice, gestures, facial expressions also convey messages that may not be consistent with out verbal message. Refer participants to page 6 of the workbook.

Children are more likely to talk to their caregivers if the following conditions for communication exist:

- A caring and open environment.
- Mutual trust and respect.
- Honesty.
- A non-judgemental attitude.
- Understanding and compassion.

The following tips tend to enhance effective communication between caregiver and child:

- Speak frankly. If you don't know the answer, say that you will find out and let them know. Don't lecture.
- You do not have to be a specialist, with highly detailed information. Give simple, direct answers that you know are accurate.
- Don't get upset or become agitated when your children confront you with a problem.

SESSION THREE

- Your attitude is extremely important. Let your child know that no question is 'wrong' to ask, and that even topics that are embarrassing are good to talk over with you.
- If you feel that there are subjects that your child needs to know about but are finding it difficult to ask, introduce it to them. The child needs to understand that you are open to talking about anything, even difficult topics.
- Don't perpetuate a double standard, for e.g., responding differently to boys and girls when they ask questions, or providing boys and girls with different kinds of information. However, boys and girls might feel comfortable talking to the same-sex parent, and it is important that they know that it is okay for them to do that.
- Open lines of communication early and keep them open. Encourage a culture of openness and honesty in the family, so that even if the child has done something wrong or is uncertain about something, they feel free to talk about it.
- Use everyday events, such as what happened in school etc., to initiate conversation.
- Facilitators should highlight the differences between the response styles using an example of a child who asks his/her parent if they can go out at night to a place that is well known to be unsafe. Refer the participants to the examples in the workbook on pages 4-5.



Passive

- put others first at your expense.
- give in to what others want.
- remain silent when something bothers you.
- apologise a lot.

Example: 'Okay, whatever you want to do..'



SESSION THREE

Aggressive

- stand up for your own rights.
- put yourself first at the expense of others.
- overpower others.
- achieve your own goals, but at the expense of others.

Example: 'Definitely not...you're stupid even to ask!'

Manipulative

- try to make the other person feel guilty.
- Put your feelings first at the expense of others' feelings.
- Being 'pushy'.
- Achieving own goals, at the expense of others.

Example: 'Okay, you can go...but don't come crying to me when things go wrong'

Assertive

- stand up for your own rights without ignoring other's rights.
- respect yourself as well as the other person.
- listen and talk.
- express positive and negative feelings.
- be confident, but not 'pushy'.

Example: 'I know you want to go...but these are my concerns.'

- Explain the importance of 'I' statements in helping to give an assertive response.
- An 'I' statement is a way of expressing clearly your point of view about a situation. It includes an expression of how it is affecting you, and how you would like to see it change. The best 'I' statement is free of specific demands and blame. It opens up the area for discussion and leaves the next move to the other person.
- We should aim for our 'I' statement to be clear (that is, to the point) and non-judgmental.



SESSION THREE

- We should beware of 'you' statements which place blame on someone else, hold them responsible, demand change from them or hold a threat.

'I' statement formula

The action: 'When...' Make it as specific and non-judgmental as possible

e.g. 'When you come home at night...'

My response: 'I feel...' Say 'I feel...' rather than 'I think...' and refer specifically to your own feelings.

e.g. 'I feel hurt/sad/happy/disappointed/ignored...'

NOT 'I feel that you are being mean!'

Reason: '... because...' If you think an explanation helps, you can add one here. But make sure it is still not blaming the other person.

e.g. '... because I like to spend time with you.'

Suggestions: 'What I'd like is...' A statement of the change you would like. It is OK to say what you want, but do not demand it of the other person, e.g., 'What I'd like is for us to discuss this' NOT 'You must stop being so lazy!'

Home assignment

Parents and children to read the information on communication in the workbook and to complete the task on body language on page 6. They are to identify in which pictures the body language is telling us something different from what the person's words are saying. Ask parents and children to practice communication skills during the week with their peers as well as between children and parents. Tell them that they will be required to report back on examples that they used and any problems they encountered in doing this exercise in the next session.

The AmaQhawe

FAMILY PROJECT

SESSION FOUR

Puberty

Review of the last session

For last week's home assignment, families were asked to complete the task on body language on page 6 of the workbook. They were asked to identify in which pictures the body language was saying something different from what the person's words were saying. Ask families for feedback on this task. Parents and children were also asked to practice assertive communication skills during the week with their peers as well as between children and adults. Ask for feedback on this task.

Introduction

The last session was about communication. The importance of listening to the other person as well as communicating in a way which is respectful of our own feelings and opinions as well that of others was discussed.

Remind families that CHAMP is a family based intervention that centres on development during adolescence. Explain to them that CHAMP raises awareness of how families can help prevent HIV exposure by providing them with information related to parenting and family life that has been linked to HIV risk. This session is about puberty. Puberty is a difficult time for both parents and children. Open communication between parents and children about puberty ensures that children obtain the correct information and support that will help them grow up to be healthy adults. Explain to them that we realise that this is not a comfortable topic for most families to talk about due to a number of reasons, e.g. culture. However communication within families regarding sexual development has been identified as an important aspect in preventing our children from HIV exposure. Today we are going to talk about puberty and ways in which we can talk to each other about puberty.

Session objectives

At the end of the session, the following should have been accomplished:

- Both parents and children should have accurate information about the changes children go through during puberty and the effects it has on their emotions and behaviour.
- Parents and children should be able to communicate about puberty.
- Children should know that they are not the first or the only ones to go through puberty. Therefore there are people to talk to about difficulties that they come across.
- Children should have some practical coping skills for dealing with puberty.

Session outline

Explain that the session will consist of separate groups for adults and children, and then a combined parents' and children's group.

Story summary

Story Chart No. 4a

Zodwa asks Nomsa and Bongi if they can keep a secret. She tells them that Cynthia told her that she had started her periods. Nomsa says that Cynthia must be sleeping with a boy because that is when you start getting your periods. When Cynthia arrives, her three friends are embarrassed and say they have to go, leaving Cynthia confused and hurt.

Story Chart No. 4b

S'bu goes to one of his friend's houses to try to find Themba. When he opens the door the naughty boys tease him, saying that he sounds like a girl because of his high voice. They suggest that he tries smoking to make his voice huskier. He runs away feeling mortified.

Story Chart No. 4c

Themba visits the Maqhawe house looking for S'bu. He finds Zodwa who shows him her drawings. Ma Maqhawe comes into the room and suggests that they are doing something naughty. She comments on the fact that Themba is starting to grow facial hair and says he should go home. As he is leaving she tells Zodwa that she doesn't want Themba to visit anymore.

Story Chart No. 4d

Zodwa is starting to develop breasts and she is very shy about it. She does not want anyone at home to know that she is starting to grow breasts, especially not her brother S'bu. She gets very angry when he comes into the room while she is changing. When some naughty boys tease her about her breasts, she becomes even angrier. She is no longer comfortable sharing her room with S'bu.

The Session 4 CHAMP AmaQhawe FAMILY PROJECT

BROKEN SECRET



SESSION FOUR

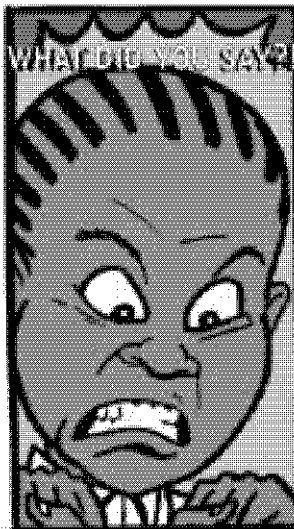
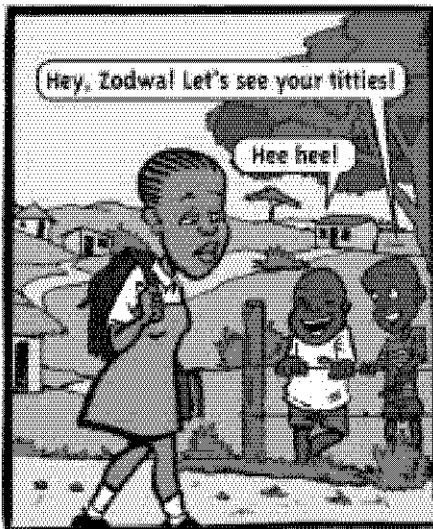
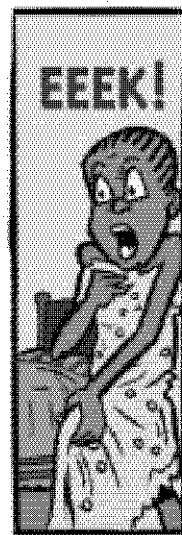


SESSION FOUR

A FEW MONTHS LATER...



SESSION FOUR



SESSION FOUR

Parents' group

Procedure

- In plenary, brainstorm with parents the emotional and cognitive changes that occur during puberty. To facilitate this process, ask parents to reflect on their experiences of puberty, so they can identify with what their children are going through.
- Separate participants into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with **Story Chart No 4 (a) and (b)** and a list of **Parents' Discussion Questions**.
- Return to plenary for feedback and discussion.
- The facilitator should emphasise the importance of giving children information on puberty in the pre-adolescent phase of development so that children are prepared for the developmental changes they are going to experience.

Discussion questions

1. Why do you think Nomsa gives Zodwa and Bongi incorrect information about why Cynthia has started her periods?
2. What effect does this have on Cynthia, Zodwa and Bongi?
3. Why do you think S'bu's friends suggest that he should try smoking to make his voice break?
4. What effect does this have on S'bu?
5. What could be the effect of children hearing about puberty from their peers and not adults?
6. What could you as parents do to ensure that your children have the correct information about puberty?
7. Why do parents not always give their children the correct information about puberty?
8. What could help you to give your children the correct information about puberty?

Children's group

Procedure

- Separate participants into gender specific groups.
- Separate gender specific groups into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with **Story Chart No 4 (c) (for boys) and (d) (for girls)** and a list of **Children's Discussion Questions** for girls and boys.
- Ask each buzz group to draw the physical changes that happen to them during puberty.
- Ask them to write down the questions that they have for adults about puberty.
- Return to gender specific plenary groups for feedback and discussion.

Discussion questions (boys)

1. What physical changes are happening to Themba?
2. How does Themba feel when ma Maqhawe points out the hair growing on his face?
3. Why do you think ma Maqhawe doesn't want Themba to visit Zodwa anymore?
4. How do you think this makes Themba feel about himself?
5. What would help Themba feel better about himself?

Discussion questions (girls)

1. What physical changes are happening to Zodwa?
2. Why do you think Zodwa doesn't want S'bu in the room when she is getting changed anymore?
3. How do you think this makes Zodwa feel about herself?
4. What would help Zodwa feel better about herself?

SESSION FOUR

Family discussion

Procedure

- In plenary provide feedback on the outcomes of the parent and child groups.
- Break up into adult/child buzz groups of 5-6 participants. Children should choose adult groups with whom they are most comfortable.
- Each group should discuss the questions children have about puberty.

Notes for the facilitator

Changes	Possible crises	Tips for parents
Intellectual development leads to the ability to solve more difficult problems, to think abstract, etc.	The pressure and demands of school may lead to truancy (non-attendance), obstinacy (stubbornness/inflexibility) rebelliousness.	If your child is not doing well at school, approach your school counsellor or principal for help with the problem.
Social development leads to more intense involvement with the peer group and establishing one's own identity among friends. ("Am I accepted or rejected?")	Negative peer pressure can lead to antisocial or criminal behaviour in a child.	Talk to your children each day about their day and their worries. Children who feel they can talk to their parents about their problems feel supported at home and will be less influenced by negative peer pressure.
Emotional development leads to attraction to the opposite sex and the need to be loved and appreciated.	Lack of love may lead the child to be involved in sexual activities to feel love or maintain relationship.	Show your children that, even though they are growing up, you love and care for them and that they can still talk to you about their problems.
Spiritual development wanting to believe in something greater than oneself, God or gods; to feel safe and have strong religious connections.	If positive spiritual guidance is not given, children sometimes become victims of evil practices (i.e Satanism).	Involve your children in religious activities such as going to church.

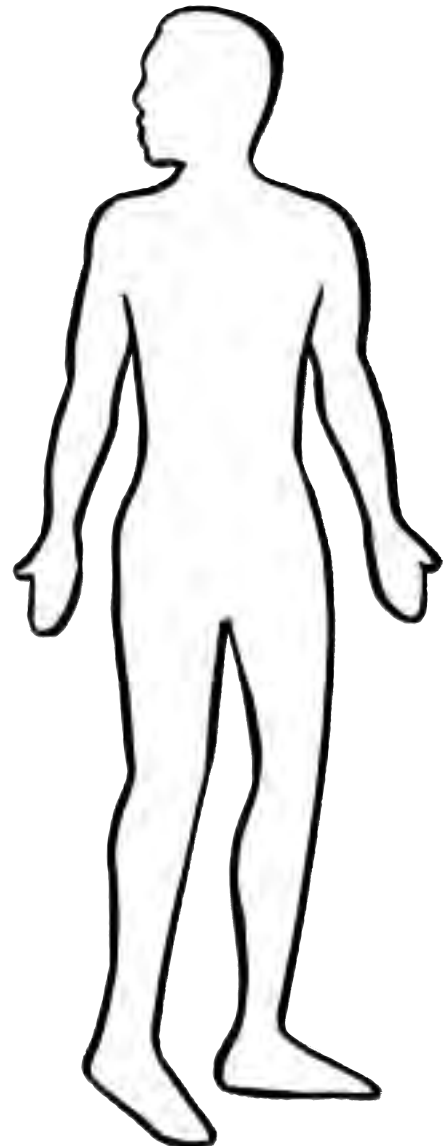
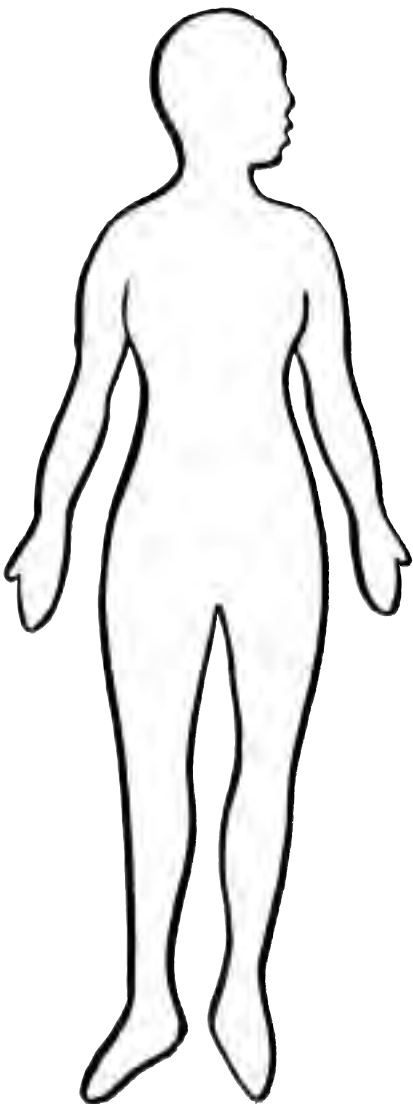
People may be uncomfortable communicating sexual related topics using Zulu words. If you find that participants are also experiencing this problem encourage them to use English words.

SESSION FOUR

- Note that physical changes such as growth of body hair in boys or the development of breasts in girls may also cause embarrassment.
- Cultural beliefs can hinder certain communication between caregivers and children.
- Lack of communication can lead to inaccurate information with regard to rules of conduct.
- Adults are the best people for children to talk to as they have also gone through the experiences of growing up.
- As we are all different, puberty takes places differently in each individual.
- Puberty occurs at varying pace and may be different from one person to the next.
- Growing up brings about a lot of responsibility.

Home assignment

Boys and girls have to draw in the parts of the body that are changing and fill in the words that describe their feelings about that part of their body. If they are embarrassed to do it with the rest of their family members, they can do it on their own or on a separate piece of paper.



The AmaQhawe

FAMILY PROJECT

SESSION FIVE

Hard to tell stuff

Review of last session

Ask participants to comment on the home assignment. Ask the children whether they were able to complete the body mapping exercise. Ask parents if they practised talking to their kids about puberty and whether they had any difficulties.

Introduction

The last session covered issues related to puberty and how this affects children both physically and emotionally. We discussed how important it was for parents to be open in their communication with their children about puberty in order to give them the necessary information and emotional support so that they can cope better with this stage in children's development. Because puberty involves sexual development some parents do not feel comfortable talking about this issue with their children. It is, however, a natural developmental process that we shouldn't be embarrassed about. All human beings go through it and it is important that children get the correct information so that they can grow up healthy. This session aims at assisting parents and children to talk to one another about difficult things like puberty.

Session objectives

By the end of the session, the following objectives should be achieved:

- Parents and children should have identified topics that are difficult to talk about.
- Parents and children should feel more comfortable and able to talk about these difficult issues.

Outline

Explain that the session will consist of separate groups for adults and children, and then a combined parents'/children's group.

Procedure

1. Read through **Story Chart No. 5(a),(b), (c) and (d)** with the whole group. Read the dialogue out loud and dramatise it as you read it so that everyone can enjoy the story. Explain that parents are going to be using **Story Charts Nos. 5 (a) and (b)** while children will use **Story Charts Nos. 5 (c) and (d)** in their discussions.
2. Ask the participants to separate into the parents' and children's groups.

Story summary

Story Chart No 5(a)

Ma Maqhawe notices that Zodwa has a blood stain on her panties when she is doing the laundry. She realises that Zodwa must have started menstruating. How does ma Maqhawe talk to Zodwa about menstruation?

Story Chart No 5(b)

S'bu feels shy about showering in front of baba Maqhawe. How does baba Maqhawe talk to S'bu about the bodily changes associated with puberty?

Story Chart 5(c)

Zodwa's history teacher made a pass at her at school. How does she talk to ma Maqhawe about this?

Story Chart 5(d)

Gugu's boyfriend, Nkosinathi, has offered some dagga to S'bu to try. How does S'bu talk to his father about this?

The Session 5

CHAMP

AmaQhawe

FAMILY PROJECT

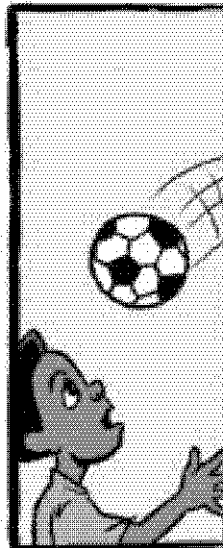
HARD TO TELL STUFF



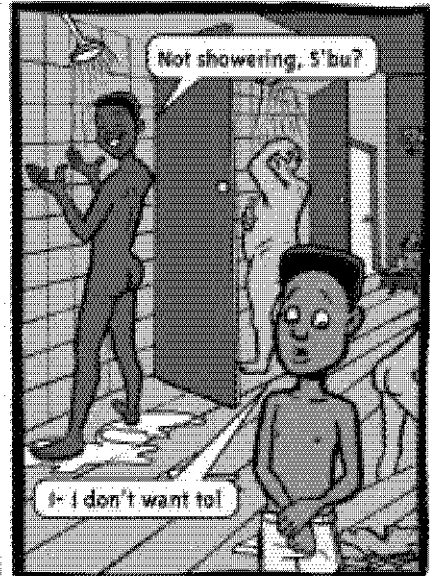
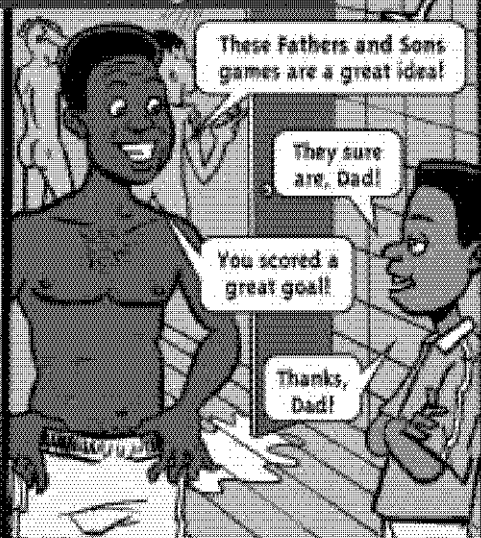
SESSION FIVE

LET'S TALK ABOUT IT...

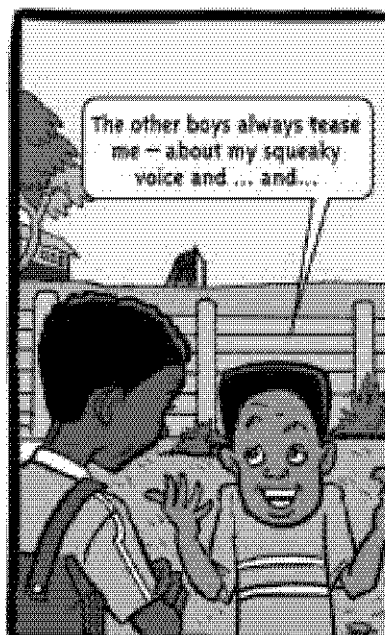
The Fathers and Sons Soccer Match



In the change room...



On the way home...



SESSION FIVE



SESSION FIVE



Parents' group

Procedure

- In plenary ask the parents to brainstorm topics that are difficult to talk about with their children.
- Ask them to think of strategies of how to talk with their children about these topics.
- Ask participants to pair off and role play responses to questions for **Story Chart No. 5 (a) and (b)** using suggested strategies.

Parent discussion questions

1. Using **Story Chart 5(a)**, role play how ma Maqhawe would talk to Zodwa about menstruation.
2. Using **Story Chart 5(b)**, role play how baba Maqhawe would talk to S'bu about the physical changes he is experiencing as he enters puberty.

Children's group

Procedure

- In plenary ask the children to brainstorm topics that are difficult to talk about with their parents.
- Ask them to think of strategies of how to talk with their parents about these topics.
- Ask participants to pair off and role play responses to questions for **Story Chart No 5 (c) and (d)** using suggested strategies.

Children discussion questions

1. Using **Story Chart 5(c)**, role play how Zodwa would talk to ma Maqhawe about her history teacher making a pass at her.
2. Using **Story Chart 5(d)**, role play how S'bu would talk to baba Maqhawe about Nkosingathi offering him some dagga to try.

Family group

Procedure

- In plenary provide feedback on the outcomes of the child and parent groups.
- Ask the participants to separate into their family groupings.
- Ask families share and compare their 'hard to tell' lists, and the strategies for talking about it.
- Ask families pick one scenario from their 'hard to tell' list, and role play the possible ways of talking about this as a family.

Notes for the facilitator

Facilitators should encourage caregivers to be honest in their list of difficult topics. The caregivers can then suggest strategies that may have worked for them, or that they would like to try bringing up these topics with their children. Remind caregivers about session on Talking and Listening. The emphasis in that session was on talking with and listening to your child.

The 'hard to tell' list is an opportunity for children to indicate to caregivers what children would like to talk to them about. It is also an opportunity for children to indicate to their caregivers how they would like this to happen.

During family discussions, new information about children's behaviour, friends, whereabouts is likely to emerge. Both facilitators and group members should support families that obtain difficult information and problem-solve about what steps need to be taken.

Caregivers bear equal responsibility in dealing with 'hard to tell stuff'.

Home assignment

Families play the **Know your Family Game** involving questions related to knowledge about both parents and children contained in the workbook. Parents and children need to interview each other to find out answers to the questions and should write down the answers in the back of the workbook. Families may include more questions to the list that they would like to know the answers to.



The AmaQhawe

FAMILY PROJECT

SESSION SIX

Identifying risk

Review of the last session

In the previous session, we worked on how to talk about issues that were hard to talk about. For the home assignment, parents and children were asked to try to talk about these issues. In the workbook you were also asked to play a game of getting to know one another. Ask families for feedback on these tasks.

Introduction

Talking about issues that are hard to talk about helps to reduce children's risks to negative influences. Parents can help children to deal with difficult issues so that they are less likely to be vulnerable to negative social influences. In this session we are going to look at other ways to reduce risk and harm to our children starting by identifying areas and situations that we consider as risky in our community. Explain to the families that we realise that because of the high rate of crime and other things that put our lives at risk at times we feel helpless to do anything to protect our families and ourselves. However this session aims at assisting us to develop strategies to be safe. The long walk home assignment in session one was one exercise to help people to identify risk and keep safe.

Session objectives

At the end of the session, the following should have been accomplished:

- Parents and children should have a common understanding of what/who is risky (areas, situations and friends).
- Parents and children should understand how to respond to risky situations, and be able to develop strategies to be safe.

- Parents should understand the importance of keeping track of their kids.
- Children should understand the importance of informing parents of their whereabouts.

Outline

Explain that the session will consist of separate groups for adults and children, and then a combined parents' and children's group.

Story summary

Story Chart No. 6a

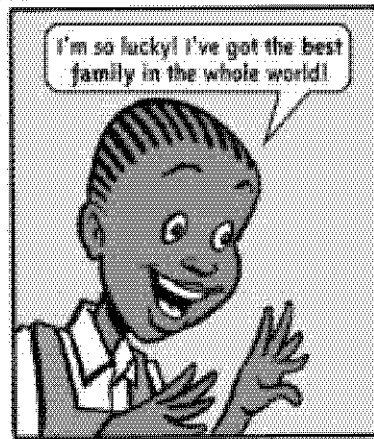
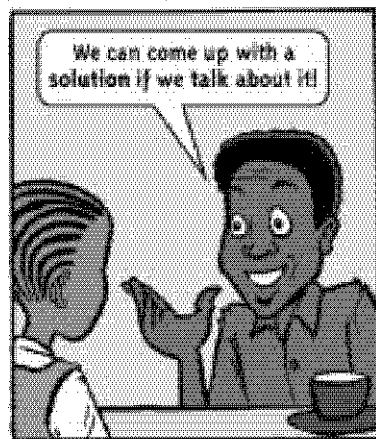
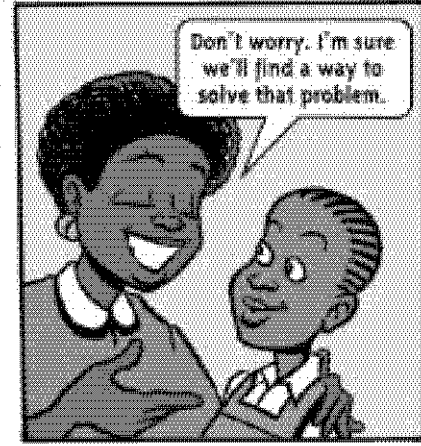
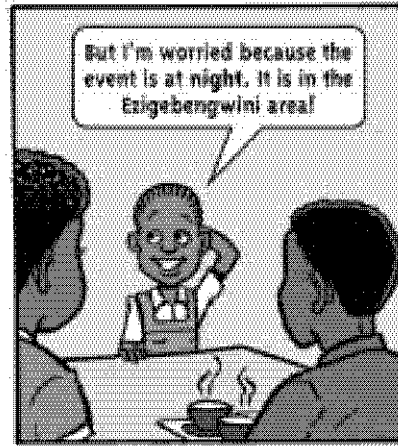
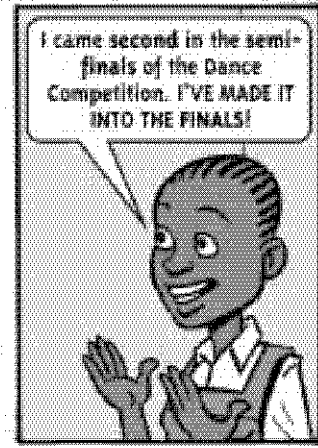
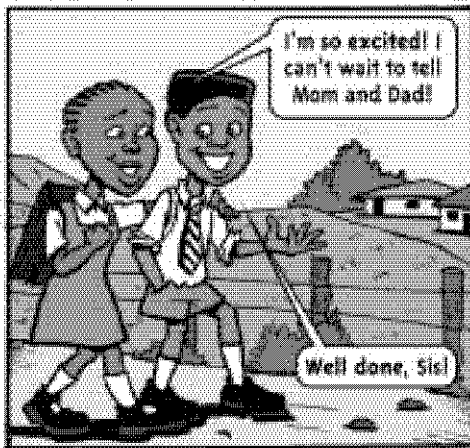
Zodwa has been selected for the finals of the dance competition which is to be held at night in a dangerous area. Baba Maqhawe and ma Maqhawe are worried about her safety. The family sits down to talk about finding a solution.

Story Chart No. 6b

Ma Maqhawe, baba maqhawe and Gogo have to go to Bergville for the weekend to attend a funeral. They need to find an adult to look after S'bu and Zodwa while they are away. Gugu suggests that Nkosinathi stays over for the weekend and helps her to look after S'bu and Zodwa. Ma Maqhawe does not think this is a good idea, because she knows that Nkosinathi offered dagga to S'bu (see the last session). Now the family has to find a solution to the problem.

The Session 6 **CHAMP** AmaQhawe FAMILY PROJECT

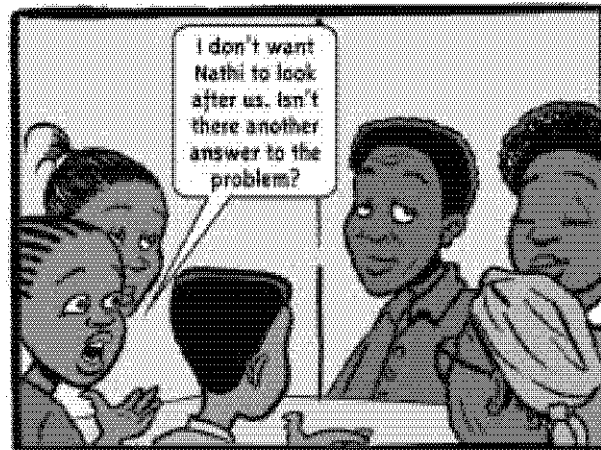
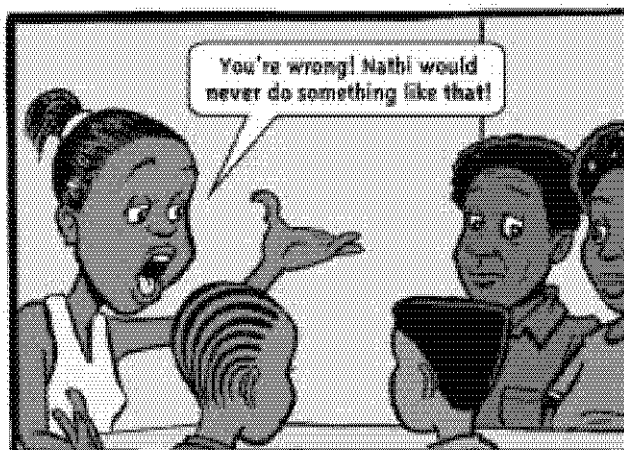
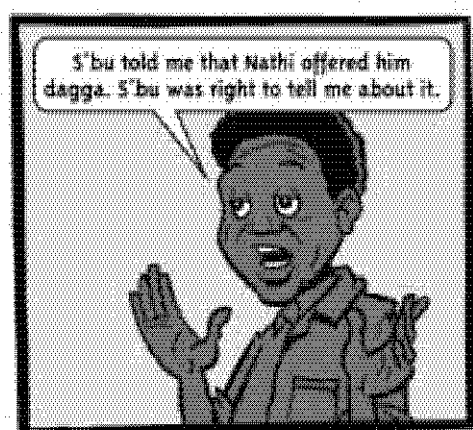
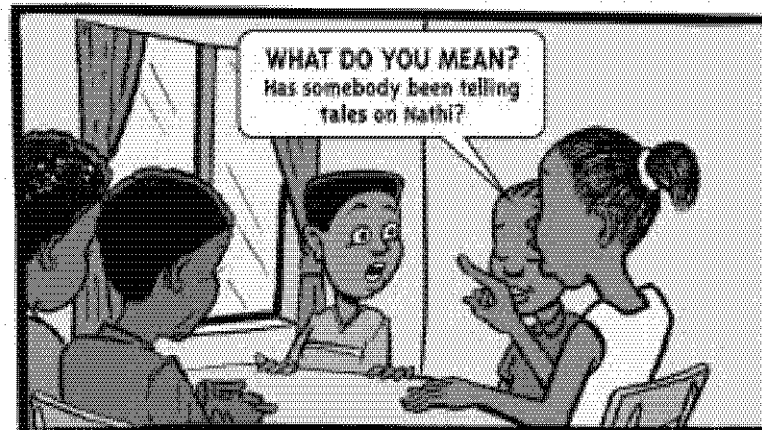
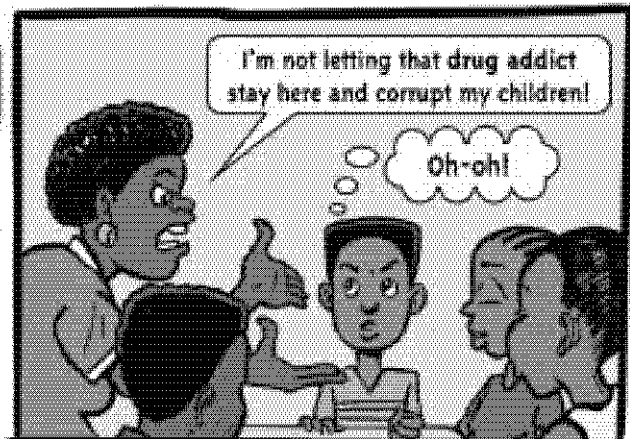
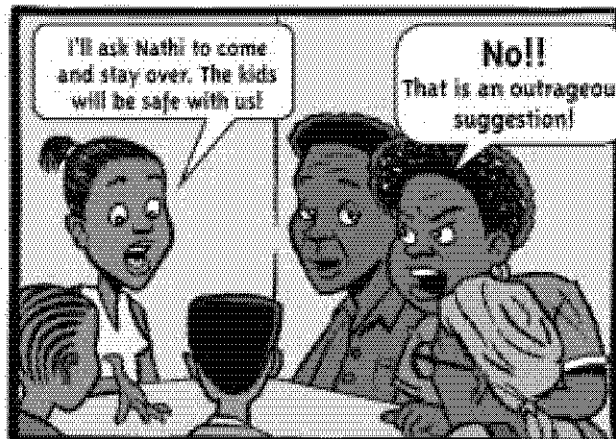
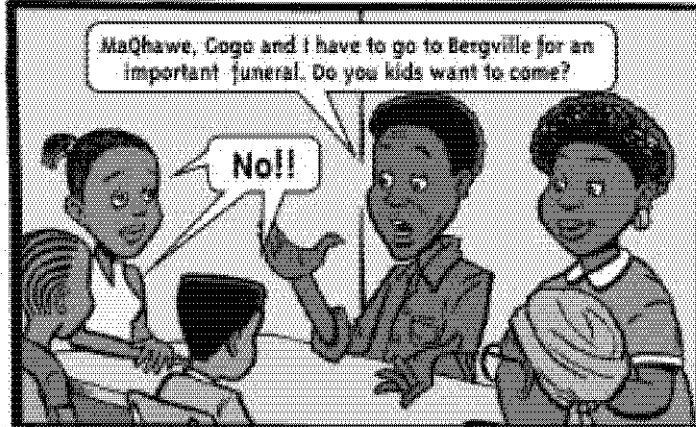
HAPPY FAMILY



HOW CAN THE AMAQHAWWE FAMILY SOLVE THIS PROBLEM?

SESSION SIX

A few weeks later...



Parents' group

Procedure

1. In plenary, brainstorm the following:
 - Parents' understanding of the term risk.
 - The importance of keeping track of your children.
 - Areas in the neighbourhood that parents consider to be risky. (Draw up separate lists for boys and girls).
 - Situations that they consider to be risky.
 - Qualities of good and bad friends for their child.
2. Ask caregivers to pair up.
 - Provide each pair with the **Story Chart No. 6(a)** and the **Parent Discussion Question**.

Discussion question

1. What strategies could baba Maqhawe and ma Maqhawe put in place to ensure Zodwa's safe return home?

Children's group

Procedure

1. In plenary, brainstorm the following:
 - The areas in the neighbourhood that are risky.
 - Situations that are risky.
 - The qualities of a good and a bad friend.
 - When they should stop being friends with someone.
2. Ask children to pair up.

Provide each pair with the **Story Chart No. 6 (a)** and the **Children's Discussion Question**.

Discussion question

1. What strategies can you think of that would ensure Zodwa's safe return home and convince her parents to let her go to the finals of the dance competition?

Family discussion

Procedure

In plenary, provide feedback on the outcome of the child and parent groups.

- Ask parents and children to compare their lists of risky areas in the neighbourhood and discuss what makes these areas risky.

SESSION SIX

Ask families to roleplay the Maqhawe family finding a strategy which would ensure that Zodwa and S'bu are safe while ma Maqhawe, baba Maqhawe and Gogo go to the funeral in Bergville for the weekend.

Notes for the facilitator

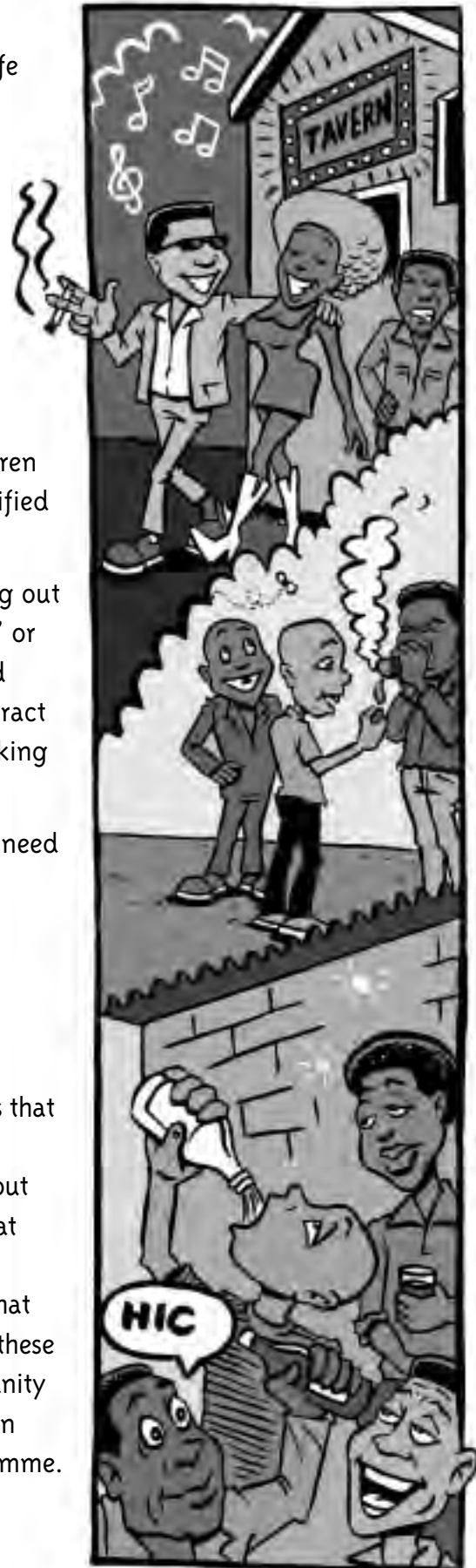
Facilitators should emphasise to parents that children (especially in this age group) may not have a concrete understanding of what 'risk' is. Parents should therefore approach risk from the perspective that it is 'cool' or 'streetwise' to stay away from situations that might be dangerous. In this way, parents can appeal to their children to stay away from areas and people that they have identified as 'risky'.

Facilitators should encourage children to see that hanging out in 'risky' areas with people that may be considered 'bad' or 'risky' is not 'cool' and 'streetwise'. The facilitator should emphasise that it is cool to look after oneself, to not contract any STIs, and to be assertive – rather than seeing risk-taking as an adventure.

Facilitators should remind families of the conditions that need to exist for children to feel safe to disclose information (especially being non-judgemental).

Facilitators should reinforce 'good' communication skills in families, and guide families that are struggling to communicate.

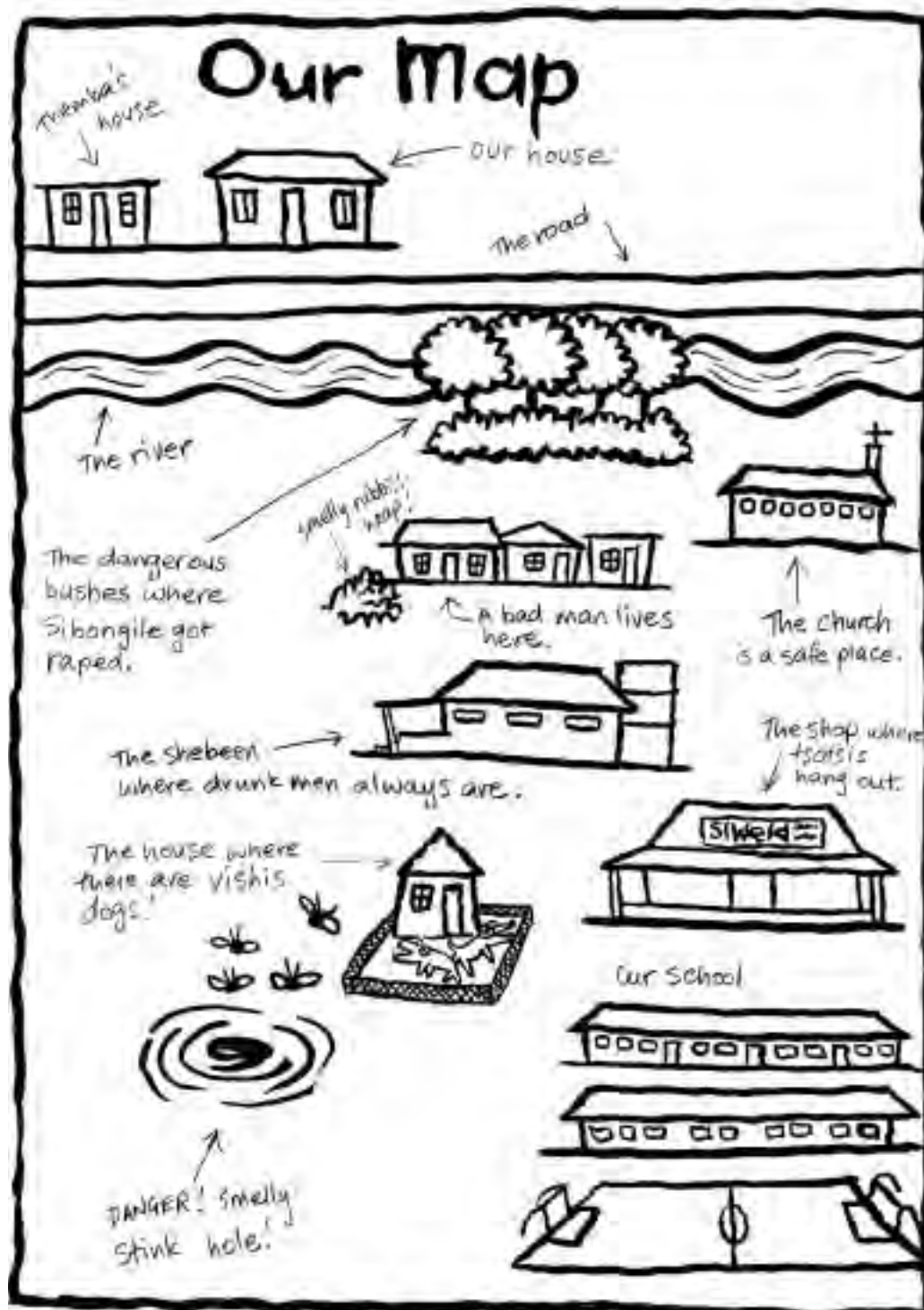
People may be uncomfortable naming areas and situations that are risky in their communities fearing that the people responsible for these areas being unsafe could find out about the discussion and that would put them and their families at risk. Explain to them that you are not asking for names of people responsible or suspected of such acts but of areas that are thought to be unsafe. Explain to them that identifying these areas will help us take steps to keep safe. Take this opportunity to remind people of confidentiality that they agreed upon when they consented to participate in the CHAMP programme.



SESSION SIX

Home assignment

- Ask parents and children to compare their list of risky situations and discuss what makes these situations risky.
- Ask parents and children to compare their lists of the qualities of good/bad friends.
- Provide each family with **Story Chart No. 6(b)**.



The AmaQhawe

FAMILY PROJECT

SESSION SEVEN

What is HIV/AIDS?

Review of the last session

In the previous session, we worked on identifying risky situations, areas and friends. We also worked on identifying safety strategies. As part of the home assignment, parents and children were asked to compare their lists of risky situations, areas and friends. Ask families for feedback on this task. Children were also asked to draw their neighbourhood and to draw in risky areas. Ask families for feedback on this task.

Introduction

The previous session dealt with identifying risk and developing strategies to minimise risk for children. One of the major risks that confront children as they grow up is the threat of becoming infected with the HI virus. South Africa has one of the highest prevalence rates of HIV/AIDS in the world. It is estimated that 23% of the population is infected with the virus, with KwaZulu-Natal having the highest estimated rate of 36%. Myths about the origin and transmission of the virus still abound in our communities and add to risk of infection. This session is aimed at ensuring that participants have the correct information and knowledge about the transmission of the virus and how it affects the body.

Session objectives

At the end of the session, the following should have been accomplished:

- Parents and children should have a good understanding of STIs and HIV/AIDS.
- Parents and children should have a good understanding of the modes of HIV transmission.
- Parents and children should have a good understanding of the mechanisms by which

body fluid transmission occurs and how the HI virus attacks the body.

- Myths and misconceptions about the origins and transmission of HIV should have been dispelled.
- Parents and children should have a good understanding of how to protect themselves from contracting HIV/AIDS.

Outline of the session

Explain that the session will consist of separate groups for adults and children, and then a combined parents' and children's group.

Procedure

- Read through **Story Chart 7(a)** with the whole group. Read the dialogue out loud and dramatise it so that everyone can enjoy the story.
- Ask the participants to separate into the parents' and children's groups.

Story summary

Story Chart No 7a

Zodwa and S'bu hear Themba's baby sister crying incessantly. They climb over the fence to investigate and find that Themba's mother is seriously ill. The Xakekile house is in a mess and Themba is unable to quieten the baby. Zodwa goes home and asks her mother to help MaXakekile. Ma Maqhawe refuses and says that MaXakekile has AIDS and she does not want to go there for fear of being infected.

Story Chart No 7b

A group of educators have come to Zodwa and S'bu's school to give them a lesson on HIV/AIDS. When Zodwa and S'bu get home, they discuss what they have learned with the rest of the family.

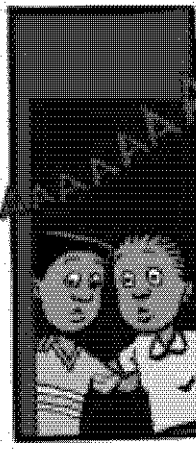
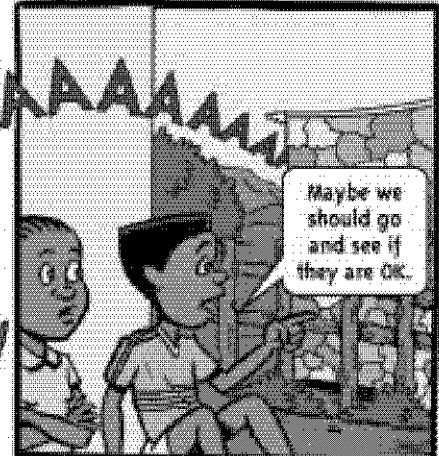
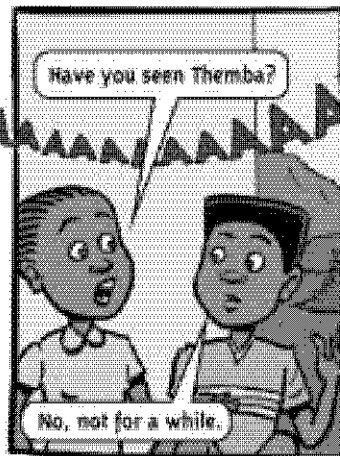
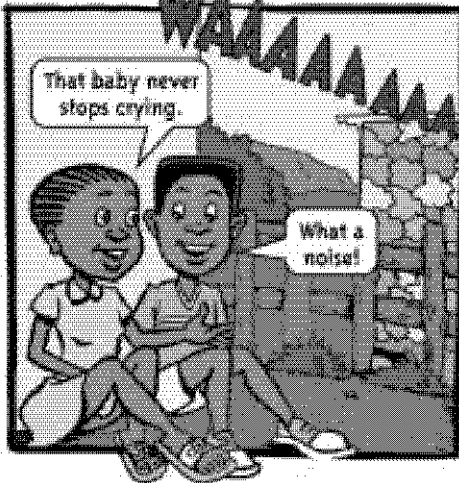
The Session 7

CHAMP

AmaQhawe

FAMILY PROJECT

A SHOCKING DISCOVERY



SESSION SEVEN

The next day...



SESSION SEVEN

After a mighty battle, the invaders are destroyed and the Guards and the T-Team withdraw, leaving the Clean-up Squad to restore order and repair the damage.



Peace reigns once more. New, specially trained Guards are put on duty.



They make sure that the same invaders do not get into the castle again.



But one day a new kind of invader threatens the castle...



This invader is invisible and very dangerous.



The invader sneaks through a crack in the wall..



...and overcomes the Guards by stealth.



The Guards don't understand what's happening to them...



The Guards can't do their job properly anymore. They start to die...



The Castle's defences start to break down. All sorts of invaders break through the unguarded walls and start to camp out in the castle grounds. The Castle can't function properly anymore... Its life is threatened...



SESSION SEVEN



Parents' group

Procedure

- Divide the participants into buzz groups of five to six participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of the **Parents' Discussion Questions**.
- Return to plenary and discuss answers to questions relating to transmission of HIV and how the HI virus affects the body. Use the story chart of the castle to explain how the virus enters the body and attacks the immune system.

Parents' discussion questions

1. What do you understand by the terms STI and HIV/AIDS?
2. Is ma Maqhawe correct when she says that she may get infected if she helps Xakekile?
3. In what ways is HIV transmitted? Provide examples.
4. What is the most common way in which HIV is transmitted from one person to another?
5. What is the relationship between HIV and STIs?
6. How does the HI virus attack the immune system?
7. What myths relating to AIDS do you know of and why do you think these exist?

Children's group

Procedure

1. In plenary ask the kids if they know of this disease called HIV/AIDS.
- Divide the participants into buzz groups of five to six people.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Children's Discussion Questions**.
- Return to plenary and explain to participants how the HI virus is different from other germs/viruses. Use the story chart of the castle to explain how the virus enters the body and attacks the immune system.

Children's discussion questions

1. List the kinds of germs you know of.
2. How do people get germs?
3. What do you understand by the terms STI and HIV/AIDS?
4. What do you think causes AIDS?

Notes for the facilitator

Information for adult facilitators

STIs stand for **Sexually Transmitted Infections**. **HIV** stands for **Human Immunodeficiency Virus** and **AIDS** for **Acquired Immuno Deficiency Syndrome**. Explain how these names came about: Immunodeficiency means that a person's immune system is compromised. The HI virus attacks the immune system of humans and is thus called the Human Immunodeficiency virus. The virus weakens a person's immune system so that people who have been infected with the virus are less able to fight off other illnesses such as tuberculosis etc. People whose resistance to other illnesses has been severely compromised by the virus, are said to have AIDS.

Transmission

HIV is transmitted from person to person in three main ways, namely:

- through unsafe sex with an infected person;
- through direct contact with infected blood or blood products, i.e. needle-stick injuries, sharing of unsterilised needles or blades, unsafe rendering of first aid to an infected person and unsafe blood transfusion;
- from mother to child, i.e. by fluid transmission in the womb, during childbirth or via breastfeeding;

Point out to the participants that the age group mostly affected by HIV/AIDS is 15-25 years, i.e., from adolescence to early adulthood.

Link this age group to why CHAMP asserts that families need to intervene before children enter the adolescent stage.

Point out that a culture of patriarchy fuels the spread of HIV/AIDS in that it inhibits women's ability to negotiate safe sexual relationships, while men aspire to having multiple partners.

Given patriarchy and gender oppression of women, one infected male is more likely to have sex with multiple women, thus spreading the virus more widely amongst women.

Violence against women increases women's vulnerability to becoming HIV positive, with girls under 18 being most vulnerable to rape.

Rape of girls under 18 is exacerbated by myths which suggest that sleeping with a virgin will cure a man of HIV/AIDS.

These cultures (patriarchy, gender oppression of women, etc.,) are continually reproduced by societal structures such as family, church, and so on.

SESSION SEVEN

Biological progression

- On entering the body, HIV attacks a particular set of cells known as the T-cells (soldiers of the body), which organise the body's overall immune system response to foreign bodies and infection.
- As these cells die, the HI virus increases and the person gets weaker and vulnerable to opportunistic infections.
- Blood tests can be conducted to determine whether a person has HIV.
- It is only after twelve weeks from infection that the blood test can detect whether the person has HIV.
- A person with HIV/AIDS can live up to 10 years.
- Interplay of many factors determine the resilience an infected person will show in the face of this syndrome, not all of which are fully understood. These factors include the person's nutritional habits, strength of his/her immune system, level of exercise and fitness.
- Communicate to the participants that the HI virus can only survive in a certain kind of environment, that is, a warm and moist environment.
- Point out that this means that once it gets into contact with air or sunlight, it dies immediately.
- While awareness of HIV/AIDS is generally high, knowledge and understanding about HIV transmission and the body mechanisms of body fluid exchange is actually very low. This does not mean people are stupid. Rather, because their daily experiences of HIV/AIDS suggests to them that this syndrome is a fatal threat to them and their families, coupled with the total lack of hope of treatment or cure, it is entirely understandable and rational for people to construct their own explanations about what HIV/AIDS is, where it comes from, how it is transmitted and how it can be cured and prevented.
- Point out that we cannot talk about HIV/AIDS and not talk about STIs. Explain that having an STI increases one's chances of HIV infection dramatically as the virus can only enter the body through a lesion (or break) in the skin surface, which happens when one has an STI.

How do you get HIV/AIDS?

HIV is contained in body fluids, especially in blood, semen, and vaginal fluids. HIV can only be transmitted through the **direct exchange** of these body fluids.

Given that the virus is present in very high concentrations in blood, semen, and vaginal fluid, **unprotected sex** is responsible for the vast majority of HIV infections. During sexual intercourse there is a very high chance that the virus may pass through a lesion (or break) in the skin of the genital organs. If a person has a sexually transmitted infection (STI), or his or

her chance of HIV infection when having unprotected sex is dramatically increased. This is because the virus can only enter the body through a lesion or break in the skin. When a person has an STI, there are usually lesions or sores on the sex organs (vagina and penis), which provide a gateway for the virus to enter the body.

HIV can also be transmitted from **mother to child**. In mother-to-child transmission, the virus is transmitted mainly during childbirth, as there is a lot of tearing and direct fluid exchange that may occur. Breastfeeding can also be a risk due to sores on the mother's breasts and cuts in a baby's mouth. HIV is present in very low quantities in breast milk.

HIV can also be transmitted through **direct contact with infected blood** such as in needle-stick injuries and sharing of unspecialised needles or blades. It should be noted that blood transfusion is generally safe in South Africa as all blood products are thoroughly screened by the South African blood transfusion services. It is extremely unlikely that anyone would get infected via a blood transfusion.

HIV is NOT spread through:

- Casual contact, e.g., living or working with someone infected with HIV
- Coughing, sneezing, laughing, talking, kissing
- Sharing toilets, baths, basins with an infected person
- Sharing towels or clothes with an infected person
- Touching, hugging or handshaking
- Sharing food, water, eating utensils
- Sharing tools or machinery
- Mosquitoes or any other insects

How HIV makes us ill using the castle as an example

How the HIV effects our body and makes us ill is illustrated by likening our body to that of a castle as is illustrated in the cartoons. The **castle wall** is like our skin, which protects us from germs and infections. The gates are the body's openings through which germs can enter. Cuts in the skin also allow germs to enter.

Inside our bodies, the immune system helps us to stay healthy by fighting germs that invade our bodies. The immune system is comprised of special cells found in the blood, called white blood cells. Unlike the red blood cells that carry blood, these cells have no colour. These white blood cells are like the **guards on duty** inside the castle. These white blood cells fight the germs that manage to get inside the body. They surround the germs and keep them from spreading.

SESSION SEVEN



There are several different types of white cells, each with a special job. The T-cells (**T-team** in the cartoon) coordinate all the different cells of the immune system, directing them on how and where to fight the infection. There are also white blood cells that help the body to heal after a few days, replacing any cells that were damaged (**clean-up squad** in the cartoon).

The HIV is a very clever germ (**Invader** in the cartoon), which enters the body through a break in the skin and attaches itself to a white blood cell. And takes it over so that the white blood cell becomes an HIV cell. It then reproduces and in this way more and more white blood cells are taken over by the HIV germ. As the HIV germ takes over more and more white blood cells, a person is less able to resist invasion from other germs e.g., TB or flue. In this way a person is more vulnerable to getting sick. A person with AIDS is someone who has very few white blood cells left and who is thus unable to fight off other illnesses.



Family group

Procedure

- Provide a brief summary of what went on in the parent and children groups.
- Ask each family to sit together and brainstorm ways in which caregivers and kids can protect each other and themselves against HIV/AIDS and STIs.

Home assignment

As home assignment, participants are to read the information on HIV/AIDS in the workbook and discuss this as a family.



The AmaQhawe

FAMILY PROJECT

SESSION EIGHT

Dealing with stigma

Review of last session

In the previous session, we learned about HIV/AIDS. We learned about how the virus is transmitted and how it affects the body's immune system. For the home assignment required families to read the information on HIV/AIDS provided in the workbook. Ask families if they have any questions they may still want to ask about the transmission of the virus and how it affects the body.

Introduction

Given the high rate of HIV infection in South Africa and in KwaZulu-Natal particularly, a large number of people in our communities are likely to be HIV positive (one in three in KZN). In order to reduce the spread of the disease even further, it is important that people know whether they are infected or not, so that they can start to take good care of themselves if they are infected as well as take precautions not to spread the disease. Most people don't want to know their status because they are scared that other people will stigmatise and discriminate against them. This session is about understanding why people do this to people with HIV/AIDS. We need this understanding so that we can begin to behave in an accepting and caring way towards people who have HIV/AIDS. This is important in order to slow down the spread of the virus in our communities.

Session Objectives

At the end of the session, the following should have been accomplished:

- Parents and children should be aware of why we stigmatise and discriminate against people with HIV/AIDS.

SESSION EIGHT

- Parents and children should be aware of the impact of stigmatisation on the person concerned.
- Parents and children should be aware of the social consequences of stigma, especially in relation to promoting the spread of HIV/AIDS.

Outline

Explain that the session will consist of separate groups for adults and children, and then a combined parents' and children's group.

Procedure

- Read through **Story Chart 8(a), 8(b), 8(c) and 8(d)** with the whole group. Read the dialogue out loud and dramatise it so that everyone can enjoy the story.
- Ask the participants to separate into parents' and children's groups.

Story summary

Story Chart No 8(a)

Zodwa and S'bu confront their mother about the need to help the Xakekile household. They tell her that they had learned that one can't get infected from helping someone with AIDS. MaQhawe says they will all get sick and calls BabaQhawe who gets angry at the children's suggestion and asks if they want them all to die.

Story Chart No 8(b)

S'bu's friends are taunting Themba at school, calling him an 'AIDS boy' and his mother a 'slut'. They throw a stone at Themba which hits him on the head. Zodwa defends Themba and the gang of boys push her and call her a whore. S'bu goes to protect Zodwa and hits one of the boys. A teacher intervenes and marches S'bu away.

Story Chart No 8(c)

Nomsa tells Gugu that Nkosinathi's ex-girlfriend has AIDS. Aunti-Ntombi notices that Gugu is worried about something and asks her about it. Gugu tells her and Aunti-Ntombi suggests that she goes for an HIV test.

Story Chart No 8(d)

Later that evening, when BabaQhawe and MaQhawe hear that S'bu fought at school defending Themba and Zodwa, they reinforce their warning that the children should stay away from Themba and the Xakekile family because they have AIDS. Gugu asks them if they would reject a family member if one of them had AIDS because she is worried after hearing that Nkosinathi's girlfriend is thought to have AIDS. Both BabaQhawe and MaQhawe say they will stand by her.

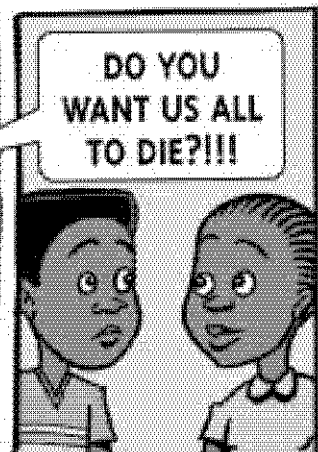
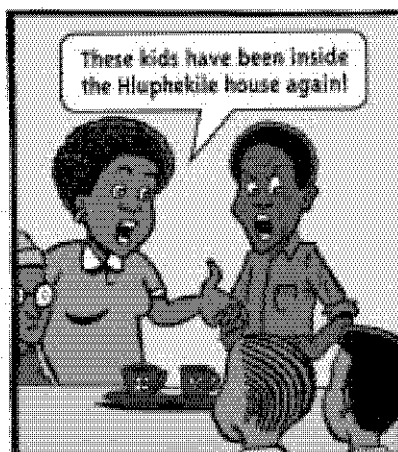
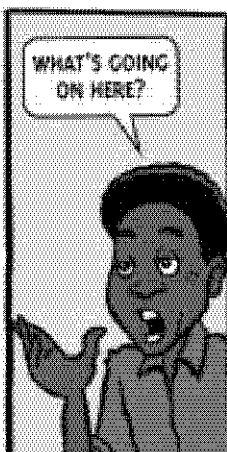
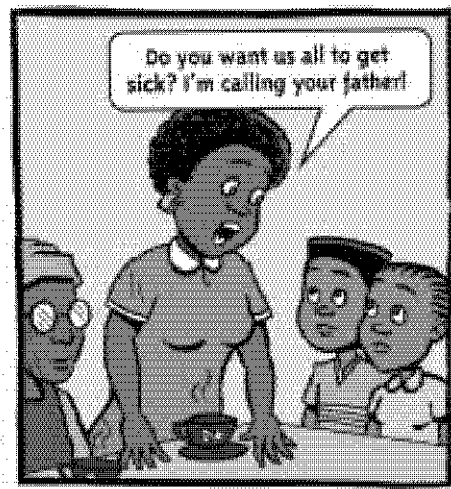
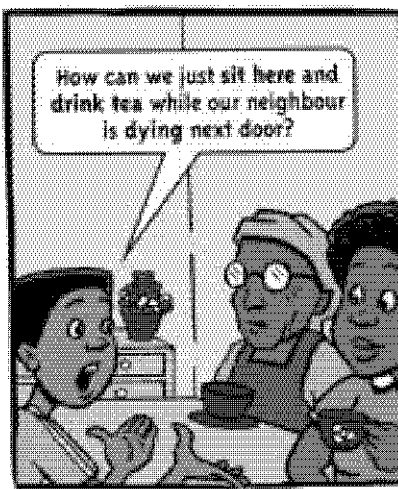
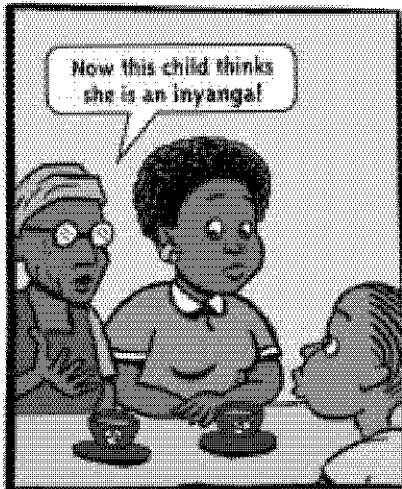
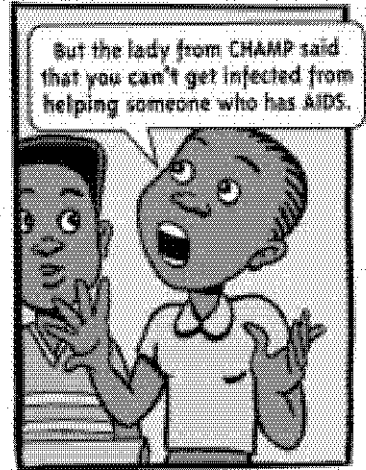
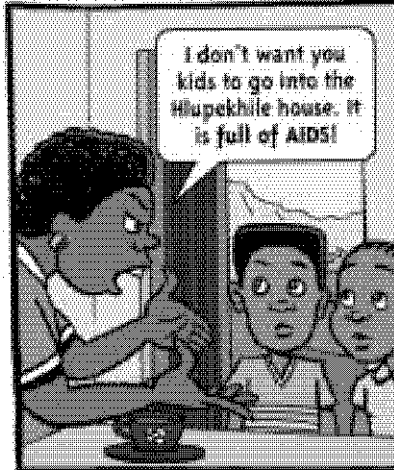
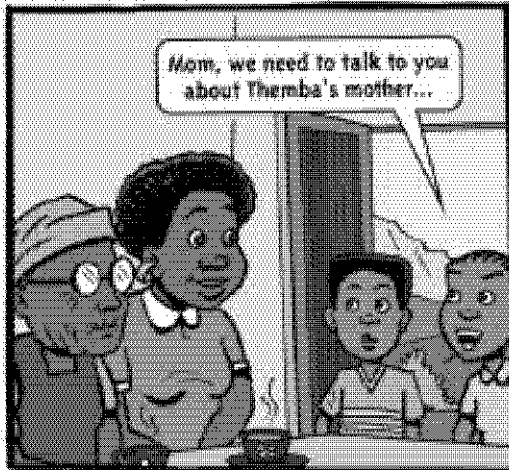
The Session 8

CHAMP

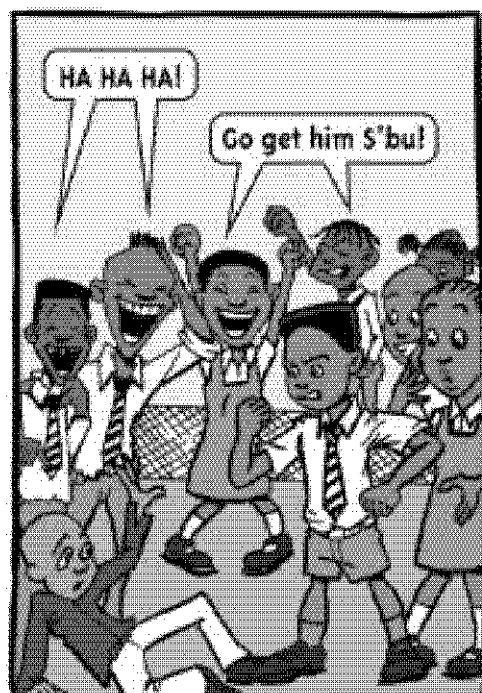
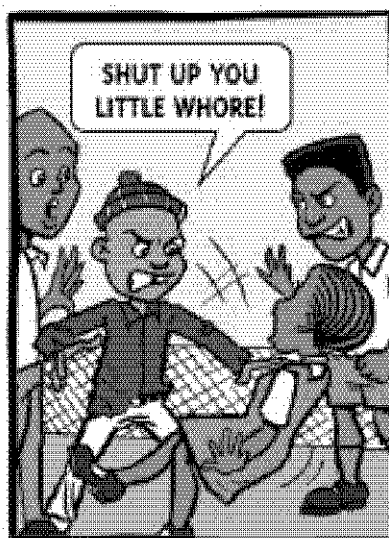
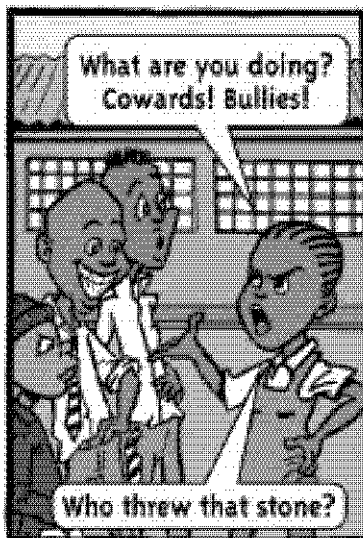
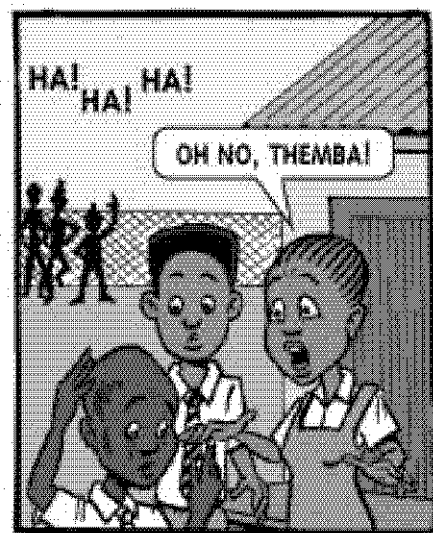
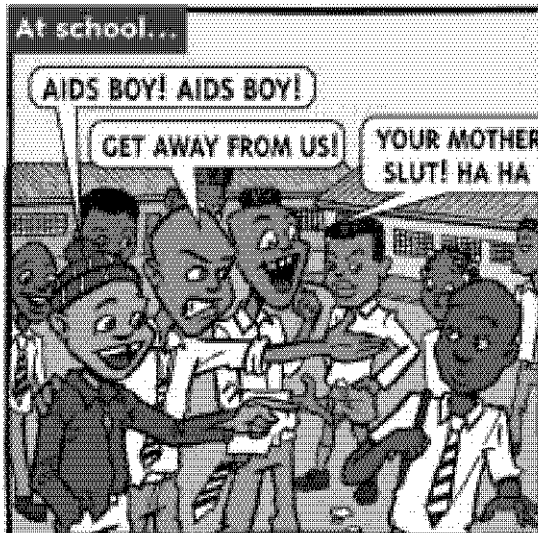
AmaOhawe

DEALING WITH STIGMA

FAMILY PROJECT



SESSION EIGHT

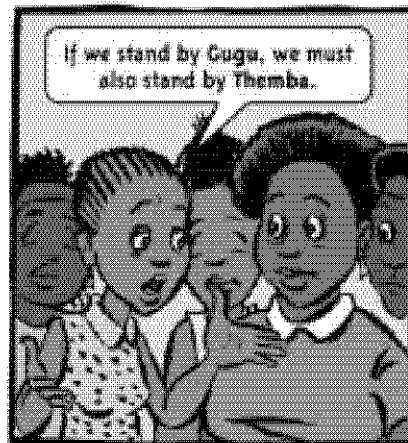
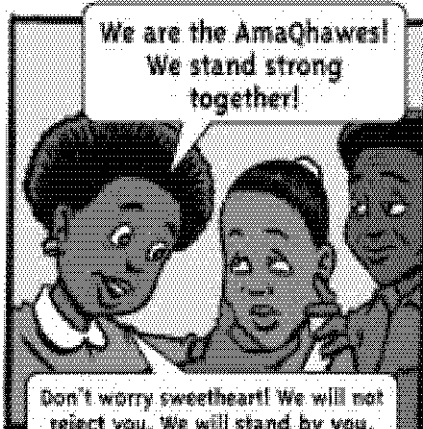
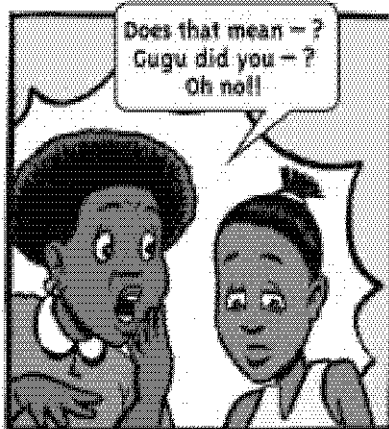
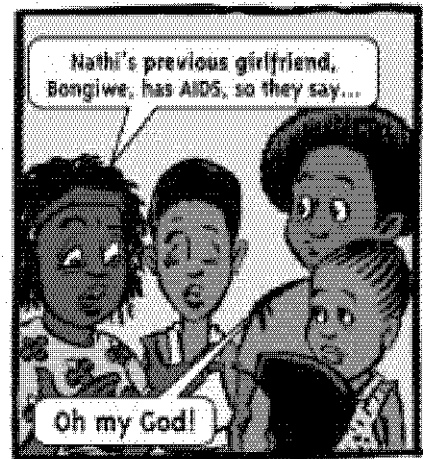
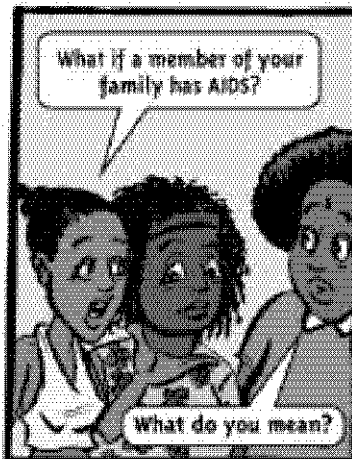
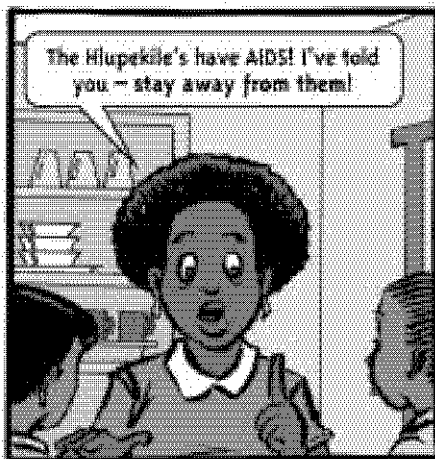
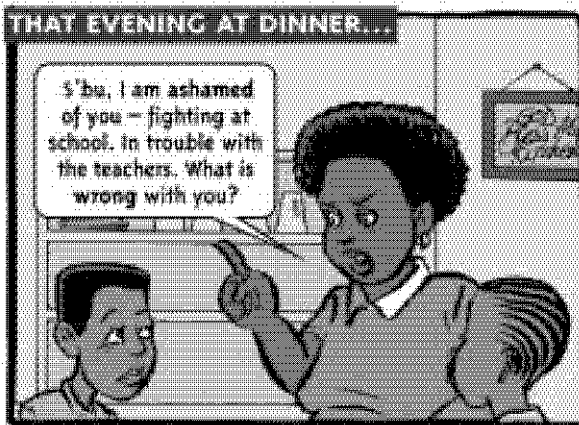


SESSION EIGHT



SESSION EIGHT

THAT EVENING AT DINNER...



Parents' group

Procedure

- Divide the participants into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Parents' and Children's Discussion Questions** based on **Story Charts 8a and 8b**.
- Return to plenary and discuss how all the responses of ma Maqhawe and baba Maqhawe as well as S'bu's friends, are examples of discrimination and stigma and how these responses are a product of our own fears relating to contagion, and which makes the person who is HIV positive feel unsupported and bad about themselves (see facilitator's notes).
- Play the 'Discrimination Game'. Give every fourth participant a yellow bead and all the others a red bead. Ask all the participants to display their beads. Ask all the participants with a red bead to talk to one another but not to talk to someone with a yellow bead. After five minutes, ask the participants with yellow beads to share how the exercise made them feel. Relate the feedback of the participants with the yellow beads to how it feels to be discriminated against.
- Brainstorm in plenary the impact of stigmatisation of HIV positive people on the spread of HIV/AIDS.

Parents' and children's discussion questions

1. What do you think makes ma Maqhawe and baba Maqhawe say that if they help the Xakekile family they will all get sick and die?
2. Is this justifiable or not from what you know about HIV/AIDS? give reasons.
3. What do you think makes S'bu's friends tell Themba to get away from them, calling him an 'AIDS boy' and throwing stones at him?
4. Do you think this is fair?
5. How do you think this makes Themba feel?
6. What do you think makes S'bu's friends call Themba's mother a 'slut'?
7. Do you think this is justifiable or not? Give reasons for your answer.
8. Are there certain types of people who get HIV/AIDS?
9. How true is this?

Children's group

Procedure

- Divide the participants into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Parents' and Children's Discussion Questions** based on **Story Charts 8(a) and 8(b)**.
- Return to plenary and discuss how all the responses of ma Maqhawe and baba Maqhawe as well as S'bu's friends, are examples of discrimination and stigma and how these responses are a product of our own anxieties relating to contagion and which makes the person who is HIV positive feel unsupported and bad about themselves (see facilitator's notes).
- Play the 'Discrimination Game'. Give every fourth participant a yellow bead and all the others a red bead. Ask all the participants to display their beads. Ask all the participants with a red bead to talk to one another but not to talk to someone with a yellow bead. After five minutes, ask the participants with yellow beads to share how the exercise made them feel. Relate the feedback of the participants with the yellow beads to how it feels to be discriminated against.
- Brainstorm in plenary the impact of stigmatisation of HIV positive people on the spread of HIV/AIDS.

Family group

Procedure

- Provide a brief summary of what went on in the parents' and children's groups.
- Ask the family groups to answer the **Family Discussion Questions** based on **Story Chart 8(c) and 8(d)**:

Family Discussion Questions

1. How do these positive and caring responses make Gugu feel?
2. How will accepting people who are HIV positive help combat the spread of the virus?

Notes for facilitators

Why do we stigmatise others?

- Because there is no cure for HIV/AIDS people are very scared of it. In addition, because it

SESSION EIGHT



is associated with sexuality and having multiple partners, people are also afraid that if they have HIV/AIDS other people will think that they have been promiscuous.

- In order to get rid of our own fear that we might be vulnerable to getting HIV/AIDS we may not want to think about it at all. We may also like to pretend that the disease doesn't exist or that it is a plot to kill people by the old apartheid government. These are the different ways people use to deal with their fear.
- Another common way that people deal with their fear is to blame the person who is HIV positive for their status by saying that they were promiscuous. This is called stigmatisation. This makes the person feel safe especially if they have been monogamous or abstained from sex. The truth is that while you may have been monogamous, your partner may not have been.
- People may also identify other groups as being more vulnerable to infection, thereby making themselves feel less vulnerable. For example, people with more money may say it only happens to poor people. White people may say it only happens to Black people. This is called stereotyping.
- The truth is that HIV/AIDS does not discriminate. If you have unsafe sex with a person whose HIV status you don't know then you are vulnerable to being infected. Priests, politicians, teachers, business people, pop stars, sports heroes can all get AIDS.
- The danger of stigmatising and stereotyping of people makes people scared to know their status in case they are positive. The result is that many people who are HIV positive do not know their status and may continue to have unsafe sex and infect more people.
- A person who is stigmatised for being HIV positive is likely to feel rejected, lonely, unsupported, guilty and depressed, which is likely to make them become sicker.



Home assignment

As home assignment ask families to play the **Discrimination Game**. Explain to the families that the purpose of this game is to allow people an opportunity to experience how the people we discriminate against feel and how it could be if we would stop stigmatising and discriminating against people others (**The-Non-Discrimination Game**).

To play the game families need the following material:

1. Two coins, these will serve the purpose of a dice. Heads equals one and tails equals two.
2. A box of matches, have a match for each player. There can only be six players at a time.
3. A packet of sweets.
4. Counters, one for each player, these can be anything stones or buttons.

SESSION EIGHT

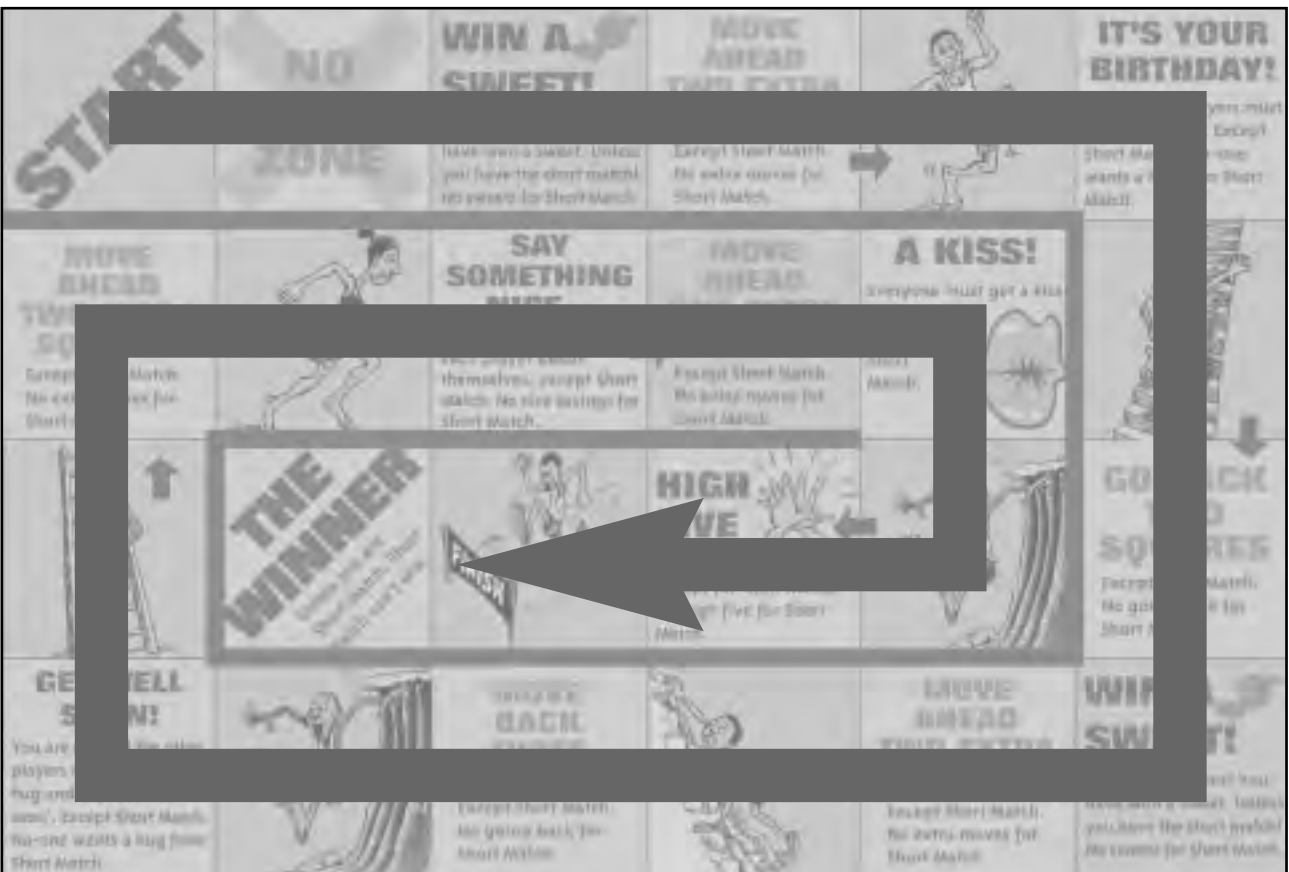
How to play the game:

Place a match for players into a matchbox and let them stick halfway out the box. Break one match in half so it is a short match. Get players to choose their match. The player who picks the broken match gets to be called 'short match'.

Place your counters on the starting block. Toss the two coins to see how many squares you can move. A player can only move 2, 3 or 4 squares at a time (unless the board instructs you otherwise).

Follow instructions on the board and move in the direction of the arrows. The first player to reach 'The Winner' block wins! The winner takes the rest of the sweets!

At any stage of the game, someone can suggest that a vote be taken to stop the **Discrimination Game** and instead play the **Non-Discrimination Game** where there is no 'short match' and see which you prefer!



This is how the players move their counters around the game.

The AmaQhawe

FAMILY PROJECT

SESSION NINE

Surviving loss and bereavement

Review of the last session

In the previous session, we explored the problem of stigma, especially in relation to understanding why we stigmatise and discriminate against people with HIV/AIDS as well as the effect this has on spreading the virus. As a home assignment you were asked to play the discrimination game in the workbook. Ask families for feedback on these tasks.

Introduction

Given current statistics, which suggest that one in three people in KwaZulu-Natal are HIV positive, all of us are affected by the problem and will probably know someone who is HIV positive. While we have mainly focused our attention on reducing risky behaviour, it is also true that we may have experienced the loss of someone in our family, a relative, friend or someone whom we know in the community we live in. This can make us feel very sad and unhappy, angry, confused and afraid of what might happen to us. This session tries to look at some of the things that happens to us when we experience the loss of someone close to us or someone that we may know, whether through AIDS or through some other means.

Session objectives

At the end of the session, the following should have been accomplished:

- Parents and children should be aware of loss reactions and responses.
- Parents and children should be aware of how people cope with loss.
- Parents should be aware of how children tend to deal with loss.

- Parents and children should know about some ways of coping with loss.
- Parents and children should be aware of supporting others who may experience loss.
- Normalise reactions to loss as common experience.

Outline

Explain that the session will consist of separate groups for adults and children and then a combined parent's and children's group.

Procedure

- Read through **Story Chart 9(a) and 9(b)** with the whole group. Read the dialogue out loud and dramatise it so that everyone can enjoy the story.
- Ask the participants to separate into parent's and children's groups.

Story summary

Story Chart 9a

Themba's mother dies during the night. Themba is in a state of shock and does not know who to turn to. He goes to the Amaqhawe's house in the early hours of the morning together with the baby. The Amaqhawe family is very supportive. Themba can't believe what has happened to him and is very angry towards his mother for leaving him. He doesn't know what he is going to do.

Story Chart 9b

Themba arrives back at school and the children at first do not know how to relate to him. Zodwa's friends and S'bu go up to him and give him a hug say that they are there for him. Eventually all the 'naughty' boys also go up to Themba and apologise for being nasty to him before. Themba's friends make him feel so much better.

Story Chart 9c

The Amaqhawe's take charge of the funeral. Later Maqhawe and Zodwa help Themba to clean up the Xakekile house. Zodwa says to Themba that he should keep a few of his mother's personal things in a box to remember her by.

The Session 9

CHAMP

AmaQhawe

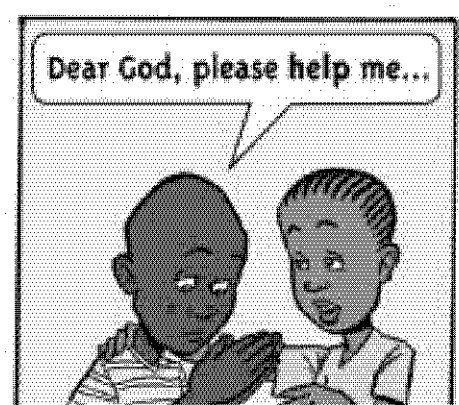
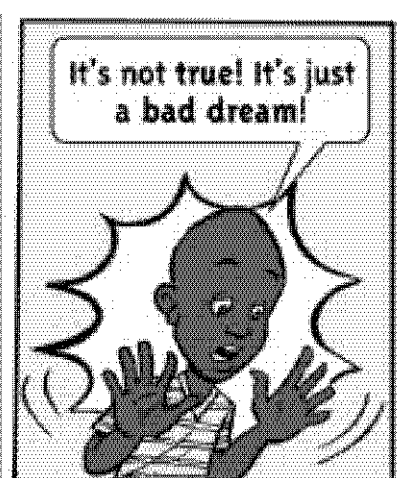
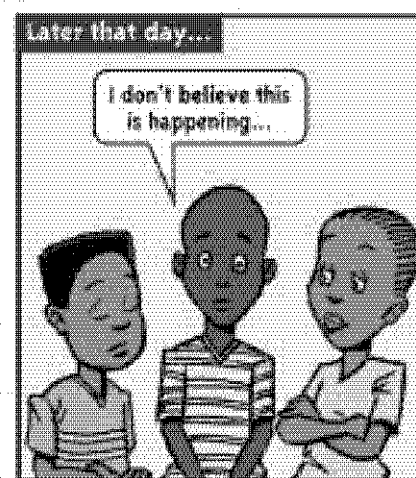
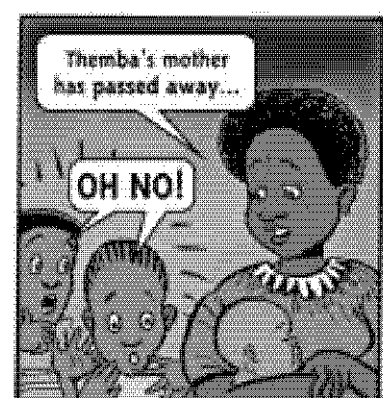
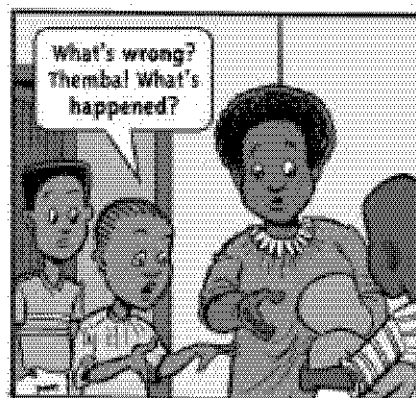
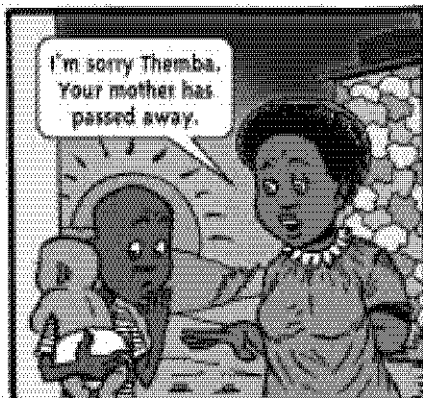
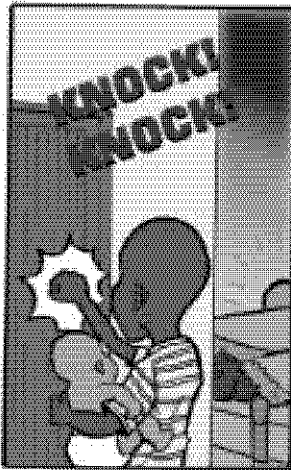
FAMILY PROJECT

BEREAVEMENT

Inside the Hlupekile house...

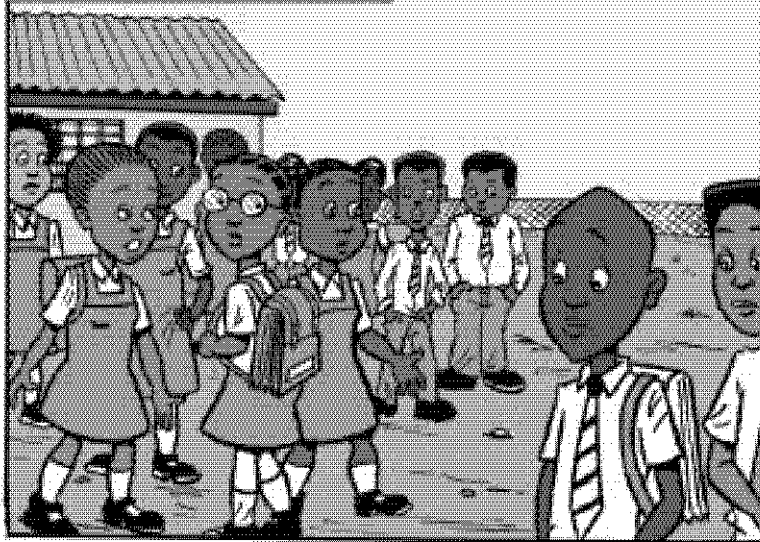


SESSION NINE

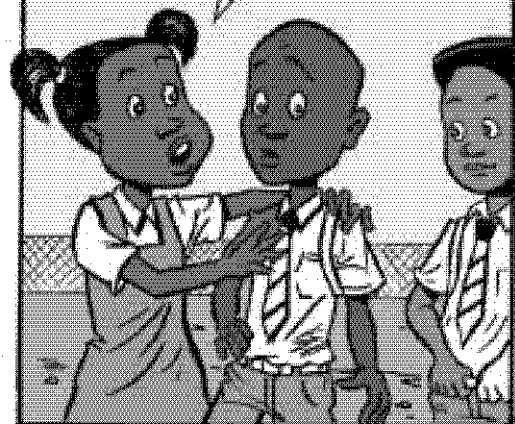


SESSION NINE

The next day, at school...



Oh! Themba! I am so sorry to hear about your mother!

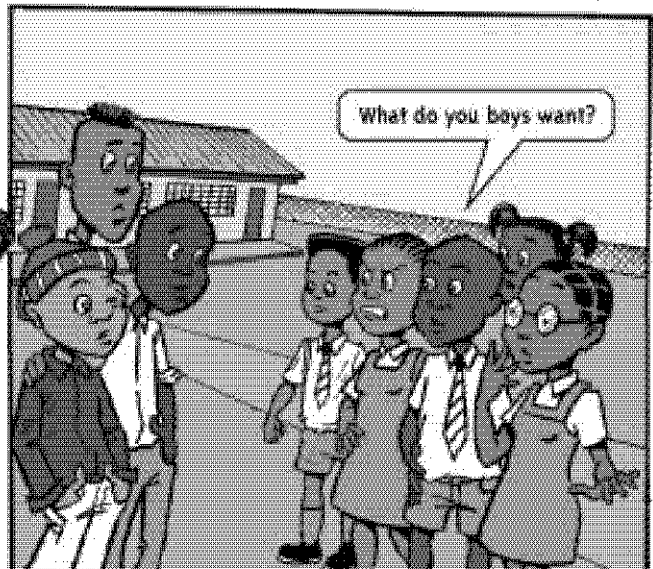


I'm sorry too!

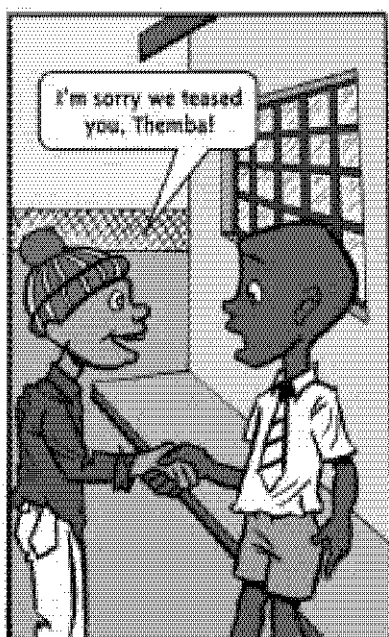
Themba, we are all here for you!



What do you boys want?

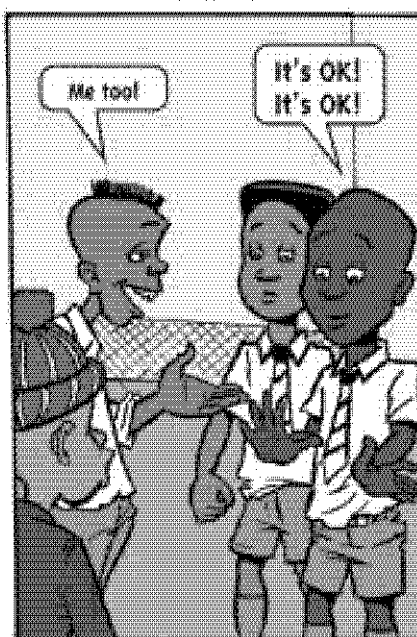


I'm sorry we teased you, Themba!

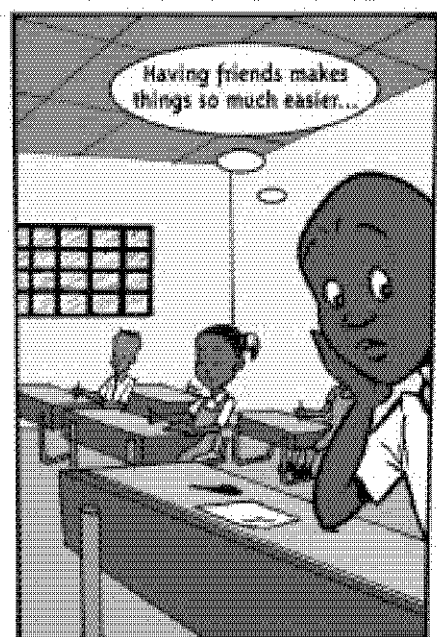


Me too!

It's OK! It's OK!



Having friends makes things so much easier...



SESSION NINE

THE FUNERAL



Later MaQhawe and Zodwa help Themba to sort through his mother's possessions...



Parent's group

Procedure

- Divide the participants into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Parents' Discussion Questions** based on **Story Chart 9(a), 9(b) and 9(c)**.
- Return to plenary and discuss responses. Make sure that grief responses are normalised and stress the importance of support in coping with grief.

Parents discussion questions

1. How do you think Themba feels about his mother's death? (elicit many, including the normal responses of shock, denial, anger, anxiety, depression).
2. If Themba could not go next door to the Maqhawe house, how do you think Themba would have coped with the loss of his mother?
3. How did the Maqhawe family help Themba to cope with the loss of his mother?
4. How did his friends at school help him to cope?
5. How does keeping a memory box help one to cope with the loss of a loved one?
6. What would you do to help Themba?

Children's group

Procedure

- Break children's group into 'buzz' groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Children's Discussion Questions** based on **Story Charts 9(a), 9(b) and 9(c)**.
- Return to plenary and discuss responses. Make sure that grief responses are normalised and stress the importance of support in coping with grief.

SESSION NINE

Children's discussion questions

1. How do you feel about ma Xakekile's death?
2. How do you think Themba feels about his mother's death (elicit many, including the normal responses of shock, denial, anger, anxiety, depression). etc)
3. If Themba could not go next door to the Maqhawe house, how do you think Themba would have coped with the loss of his mother?
4. How did the Maqhawe family help Themba to cope with the loss of his mother?
5. How did his friends at school help him to cope?
6. How does keeping a memory box help one to cope with the loss of a loved one?
7. What could you do to help Themba if you were his friend?



SESSION NINE

Notes to the facilitator

Note that caregivers may have many and varied reactions (some of which are listed below). Try and prompt for these if not forthcoming.

Level of closeness of survivor to deceased tends to increase the intensity of grief experienced.

Remember that bereavement following a death from AIDS often occurs in the context of stigma.

If the AIDS status of the deceased was unknown to the family, there may be significant distress because of the implication of a lack of trust of the family. Stigma complicates the ability to grieve openly and freely.

Typically, the bereaved instinctively try to regain proximity to the lost person. Crying and searching for the lost person is common.

Despair, anger/hostility, guilt, social isolation, loss of control, rumination, depersonalisation, somatisation, and death anxiety are some of the characteristics associated with loss and bereavement.

Sleep disturbance, loss of appetite and vigour, physical symptoms, despair, and over-dependency on others is also often present.

Anger is often directed at many sources. It may include government, the medical fraternity, family and caregivers for maintaining secrecy, and because family members often are not allowed to express themselves about the death. They may also be angry towards the deceased because of the life they may have led.

Survivor guilt may be present, i.e., the sense that it would have been better if a surviving family member (usually caregiver) had died because they now have nothing to live for.

While enabling communication between an ill member and his/ her family prior to death is very advantageous, it is also very difficult.

Be sensitive to family members who are currently confronted with some of the same issues and are seeking help. The best option is to refer.

Remember the earlier session on anxiety containment.

Be very aware of stronger reactions than you would expect from such a story from any of the kids, e.g., if someone becomes tearful, or someone refuses to speak or participate (withdrawal).

SESSION NINE

If you encounter such a person, take the time to be supportive and try and talk to the person at some stage of the session and refer if necessary.

Try and ensure that the session ends positively and that groups do not leave with anxious, angry, or unhappy moods.

Be aware of caregivers and children wishing to talk to someone – refer or provide support, but take the time to listen.

Caregivers become aware of need to express fears and anxieties to children and vice versa.

Family group

Procedure

- Provide a brief summary of what went on in the parent's and children's groups.
- Break participants into family groups.
- Ask parents and children to compare their responses to the story charts.

Home assignment

For the home assignment, read over the information on how to cope with grief and ways of remembering.

The AmaQhawe

FAMILY PROJECT

SESSION TEN

Support networks

Review of the last session

In the last session, we learned about loss and bereavement. We learned about the common responses to losing someone close to us as well as about some ways to cope with loss. Ask families how they found the session and if they have any questions about loss and bereavement.

Introduction

In the last session support was identified as being very important to help people cope when they have lost someone. Support is also very important in helping raise our children. Support people refers to people or groups who help in any way to make parenting easier – family, friends, church members, school people, anyone who helps you out. For example, it could be someone who watches the kids when you run an errand or groups who listens to your concerns and might be able to give you and your family advice. We know that families that are strong are the ones that rely on each other and have many branches. Sometimes they are not even related to each other.

While in the past we may have relied on each other to help raise our children and to keep them safe, findings from the interviews we held indicated that this is not so common anymore. If we know people who can help us look after our children and make sure that they stay safe, then we will feel happier. Also, we will be able to help others when they need help to keep their children safe. This session is thus about developing such support networks.

Session objectives

At the end of the session, the following should have been accomplished:

- Parents and children should understand the role of support networks.
- Parents and children should have identified people who currently fulfil the role of providing support.

- Parents and children should have identified other potential support networks.
- Parents should be aware that increased support can also help them to keep track of their kids better.
- Parents and children should recognise the CHAMP group as a support network.

Outline

Explain that the session will consist of separate groups for adults and children, and then a combined parents' and children's group.

Procedure

- Read through **Story Chart 10 (a) and 10 (b)** with the whole group. Read the dialogue out loud and dramatise it so that everyone can enjoy the story.
- Ask the participants to separate into parents' and children's groups.

Story summary

Story Chart 10(a)

Ma Maqhawe and Gogo are discussing what to do about Themba and the baby. Gogo says that they should try to contact the relatives. She thinks that ma Xakekile had a sister who lives in Gauteng. S'bu suggests that Themba and the baby will be safe with them. Baba Maqhawe says that they can't stay with them because there are too many people in the house already. S'bu suggests that they take down the fence so that it will be easier for them to live together. They take down the fence and Gogo comments that in the olden days they did not have fences between houses.

Story Chart 10(b): That evening

In the evening, while Themba is going to his house, the Maqhawe's feel that the situation is not right. S'bu suggests that he goes and stays with Themba in his house and ma Maqhawe says that the baby should rather stay with her.

Story Chart 10(c): A few weeks later

The Maqhawe's are sitting around the table and discussing the fact that there has been no news from Themba's relatives. S'bu suggests that it doesn't matter because they are one family now. Baba Maqhawe says that while that is so, there are more people in the house to feed. Aunti-Ntombi says that she has heard that one can apply for a foster care grant if one is looking after an orphaned child/ren. Themba also says that he has found a job after school which can help pay for food for himself and his sister. They all reinforce how important it is to support one another.

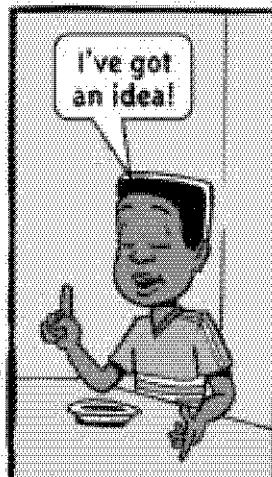
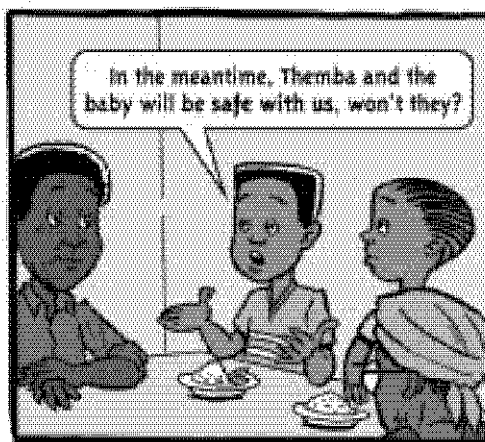
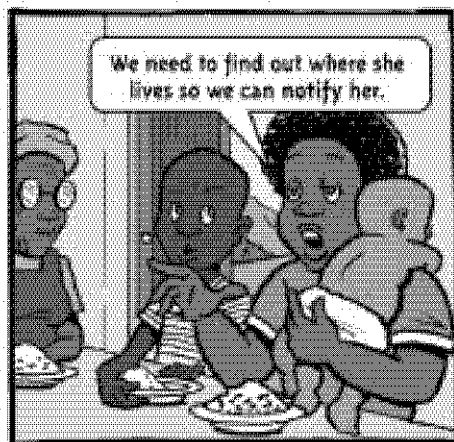
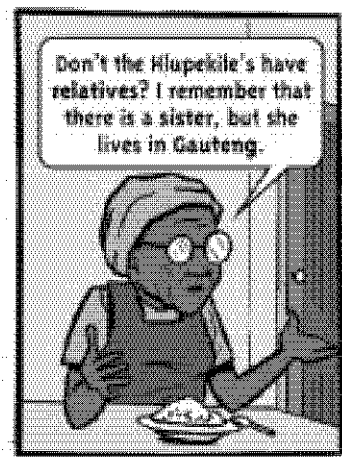
The Session **10**

CHAMP

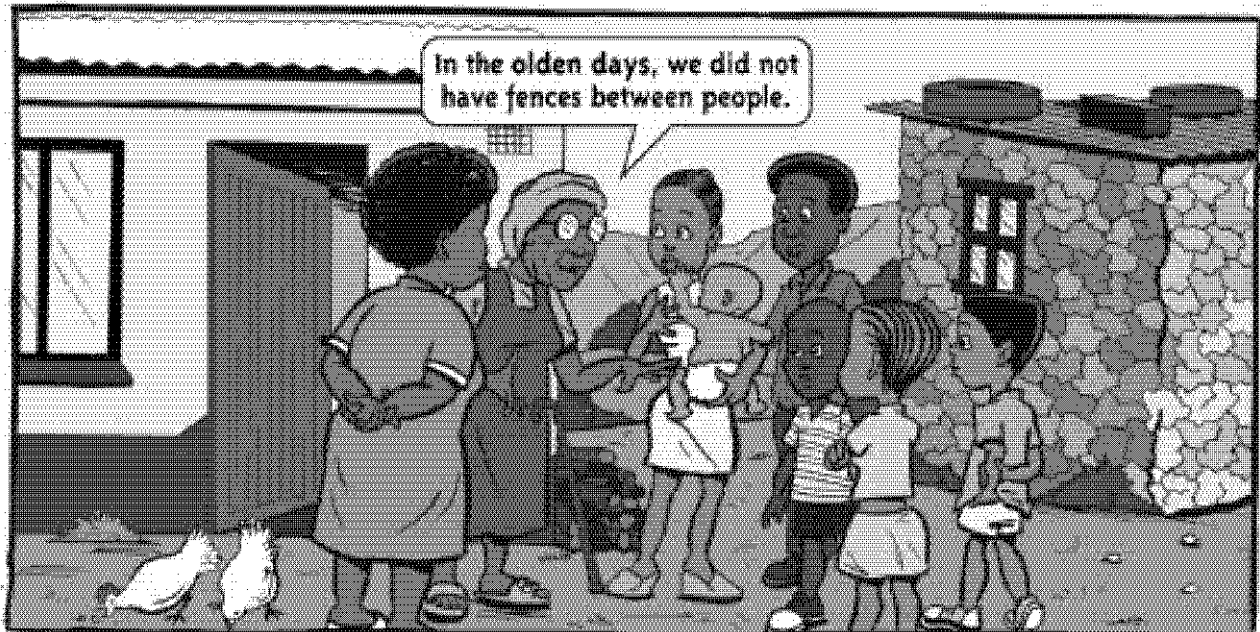
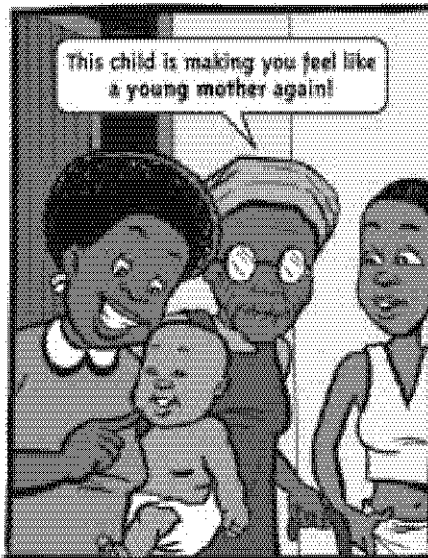
AmaQhawe

FAMILY PROJECT

MAKING PLANS

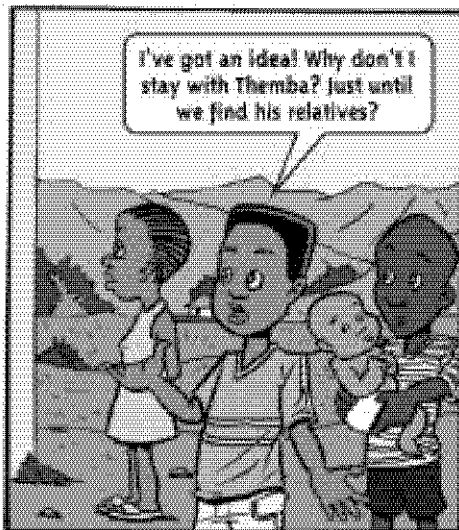
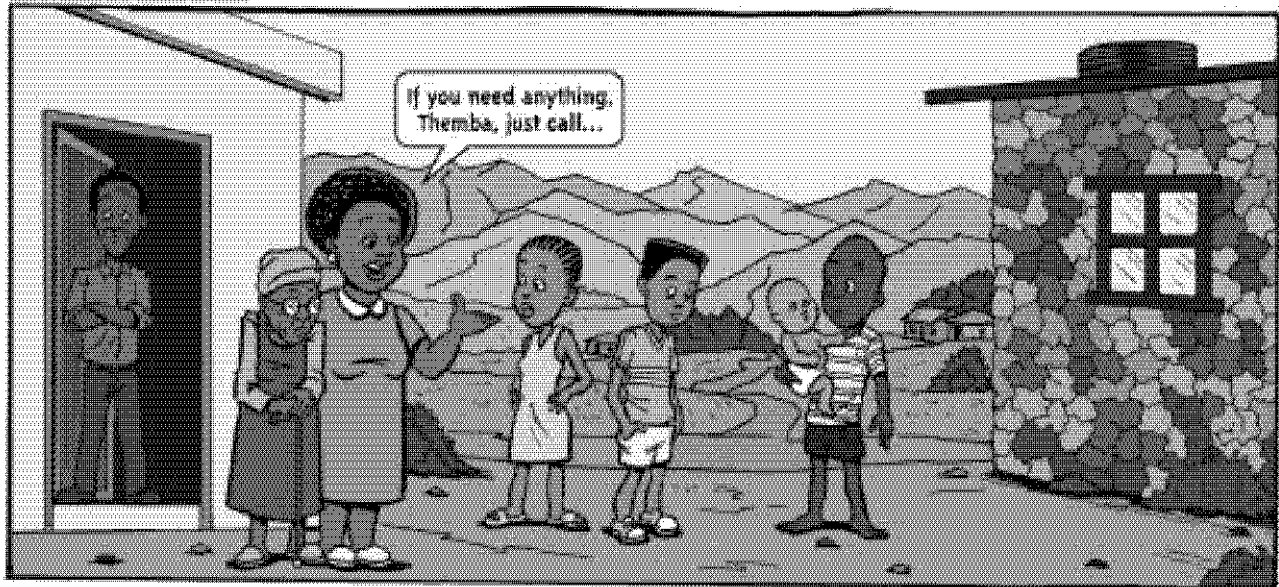


SESSION TEN



SESSION TEN

That evening...



SESSION TEN

A few weeks later...



Parents' group

Procedure

- In plenary, discuss with parents what they understand by the term support.
- During discussion explain the three kinds of support: emotional, instrumental/practical, informational and appraisal support.
- Break participants up into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Parents' and Children's Discussion Questions**.
- Return to plenary and facilitate discussion on ways that CHAMP could serve to support participants more and even facilitate more support within the community.
- Tell parents/caregivers that they are going to play a game.
- Ask them to sit in a circle.

Bead Game

- Pass the bead bag around and ask participants to take one bead for every person they can think of who supports them currently and to hold the beads in their hands.
- Go around and ask parents to talk about each of their beads – their support people/groups.
- Ask them to indicate:
 - who they are
 - how they help the parent
 - how often they help
 - if they help keep track of his/her children
 - in what other ways they help.

Parents' and Children's Discussion Questions

1. How have the Maqhawe family provided support to Themba and the baby?
2. Why is it important for neighbours to support one another?
3. What kinds of support do we, as neighbours need?
4. How can we improve our support networks in the community?
5. Are there ways in which members of the CHAMP group could support each other to develop these support networks?

Children's group

Procedure

- In plenary, discuss with children what they understand by the term support.

SESSION TEN

- During discussion explain the three kinds of support: emotional, instrumental/practical, informational and appraisal support.
- Break participants up into buzz groups of 5-6 participants.
- Ask each group to elect someone to take notes and report back.
- Provide each group with a list of **Parents' and Children's Discussion Questions**.
- Return to plenary and facilitate discussion on ways that CHAMP could serve to support participants more and even facilitate more support within the community.
- Ask the kids to return to their buzz groups in preparation to play the **Support Web** game.
- Play the **Support Web** game (you need yarn or string for this purpose):
 - Group children in a circle.
 - Ask the children to throw the ball of yarn around the circle.
 - Tell them that they must mention the name of someone who helps them before they throw the ball.
 - Tell them they must hold on to the string before they throw the ball.
 - Tell them everyone must throw once before people get a second chance.
 - Show the children how to play the game by throwing the ball first.
- In their groups, ask the children to indicate:
 - how many different people they mentioned.
 - how the different people they mentioned help them.

Family group

Procedure

- Provide a brief summary of what went on in the parents' and children's groups.
- Break participants into family groups.
- Ask parents and children to compare people they identified as those who can support them.
- Bring family groups back into plenary.
- Discuss how support is important in preventing HIV.



Notes for the facilitator

- Make the point that to be a parent is a tough job. We all need support and help to raise our children and keep them safe and healthy. This is especially important as kids get older and spend more time on their own.
- Emphasise why getting support is important to preventing HIV as we need to work collectively in order to ensure that children are safe and exposed to minimum risk. In the past, things were different. Parents could rely on other families to help keep track of their children and anyone could discipline a child if he or she misbehaved. The interviews revealed that there was not much trust between community members anymore.
- Given the risk to children posed by HIV/AIDS, facilitators should emphasise the importance of rebuilding support networks. People that provide support, help keep track of children and help parents deal with the stress. They are also available to help children when they need extra help or advice. Getting support like this helps parents keep children out of dangerous situations.
- The interviews also revealed that generally, fathers makes the rules and say what should be done and the mother takes responsibility for ensuring that this happens. Both boys and girls are supposed to listen to their mother but they often don't listen to mother and they do as they want. The father then blames the mothers for this.
- Facilitators should stress that we should think of different ways of helping our children learn about what is right and wrong. Both mothers and fathers should be involved in this process. It is important that fathers also take part in telling children about the rules that they must follow and not only mothers.
- Communicate to participants that there are different kinds of support:
 - Emotional support is where one feels that he(s) is being listened to and in turn feel less alone in whatever he(s) is going through.
 - Instrumental support is where one is given help in practical ways, for example, giving or borrowing money, giving food, clothes act.
 - Informational support is where assistance is provided by being given information regarding something that one needs to know. For example information on where to go to apply for a grant, to get the best doctor, act.
 - Appraisal support is when one is given feedback on how well something is working. For example, the way they do things (good and bad things about this) and whether they use that information to improve themselves.

For the bead game

- Have sufficient beads for distribution to parents.
- For the bead game, some parents will take only one or two, while others will take a

whole lot. Encourage those who have trouble taking any to think hard about who has been supportive to them, thinking of the different kinds of support discussed earlier. If a parent has none to take, sensitively note it, but point out that by the end of the session, we hope that she or he will have thought of at least one person.

- There will be varying levels of support among parents and children. The activity will provide validation for parents and children with large networks. However, it will also highlight lack of resources for some parents and children. Facilitators need to be prepared for expressions of the loneliness and sadness that parents and children may experience. In addition, other group members should be encouraged to offer ideas and support.
- For the support web game, some children may only be able to mention a few names, while others will be able to mention a whole lot more. Encourage those who have trouble mentioning names to think hard about who has helped them in different ways using the different kinds of support mentioned as a guide.
- Show the children how the people's names they mentioned are like the web they made. They hold us up when we need help.
- Every family needs support. Families with more support do better, so CHAMP wants to help families find support. CHAMP feels that if families and children have more support, families can feel more confident and supported in the decisions they make.
- Families must also act as one with both parents supporting each other in their decisions and taking responsibility for guiding their children.
- Important decisions related to HIV include whether or not to do drugs as well as decisions related to sex.

Caring and sharing

- The Department of Welfare offers a 'foster care grant' to families that may wish to look after and care for a child who has been orphaned as if they were their own child.
- This grant gives the foster parent an amount of R460 per month to assist them to feed, provide clothes and educate the child until it is 18 years old.
- It is best for an orphaned child to be taken in on this basis by a member of the child's family (e.g., aunt or grandmother).
- If no close relatives of the child exist, anyone can become a foster parent to a child. In some areas, there may even be foster homes for children where one caregiver may look after a number of children.
- Social workers in your area are responsible for assisting children who have been orphaned. They will help find foster care for a child. If you wish to become a foster parent, they will also help you to get a foster care grant.

Home assignment

The following homework is to help you build supportive social networks in your area. Remember the more you and your family are involved with self-help groups, church groups, women's groups, non-governmental organisations and so on, the easier it will be to help you protect your family against the bad influences in your community.

1. Each family should think about the various organisations that they know about in their own community.
2. The family must then write down the name of all the groups and organisations they are aware of in their community.
3. After all the groups and organisations have been written down, the family must then find out more about each group or organisation. They must find out who can go to the group or organisation, the sort of issues they deal with, who is the person one can contact for help and their address and phone number.

Organisation name	Contact person	Contact ph/address	Issues they deal with

4. The list that must be brought to the next session for discussion with other families, the steering committee, and the facilitators.
5. At the next session, there will be discussion on how these organisations can be strengthened and can work together to help reduce the bad influences in the community.

