



Mapping Sexuality: Understanding the knowledge, attitudes and perceptions of adolescent females towards sexuality and sexual and reproductive health in KwaZulu-Natal, South Africa

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DECLARATION

I, **Gina Kirsten Coetzee** (Student number 213570198), declare that:

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Date: 20 June 2017

Supervisor: Dr Eliza Govender

Signature: _____



Date: 20 June 2017

I dedicate this work to

My mother, Rowena Coetzee, for always being on the other side of the phone in the moments when I was ready to give up

To my friend, Margie Rogers, for always reminding me I am going to be okay ... and for pineapples

“When we talk about ‘reproductive rights’ this is what we mean. It’s the difference between people as objects, and people as agents; between regarding people as pawns on the policy chessboard and recognising them as the players, the decision-makers, the drivers of policy; autonomous individuals intimately concerned with the directions of their own lives. Under these conditions women, especially, enjoy better health and live fuller lives.”

– Nafis Sadik, Special Adviser to the UN Secretary General

“The essence of global health equity is the idea that something so precious as health might be viewed as a right.”

– Dr Paul Farmer

“Young people everywhere have the right to the knowledge, tools and services they need to make informed decisions about their bodies and live full, healthy and productive lives.”

– Jill Sheffield, Founder and President of Women Deliver

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To my mum, dad and brother, thank you for your continued support over the last 25 years. Thank you for always encouraging me to be the best version of myself. The way you celebrate my victories and empathise with me through my struggles is the reason I am where I am today. Thank you. I am waiting for my prize for being the first person to get a master's degree in the family, by the way!

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For anyone who reads this dissertation, in whatever life stage you are in, always remember to believe that you can, and you will.

ABSTRACT

Within sub-Saharan Africa, adolescent girls bear a disproportionate burden of sexual and reproductive health (SRH) risks, where the dual risk of HIV infection and adolescent fertility is faced. Specifically in South Africa, it is estimated that nearly 2 000 adolescent girls and young women between the ages of 15 and 24 years are infected by HIV every week. Furthermore, it was estimated that, by 2016, 15,6% of females between the ages of 15 and 19 years old in South Africa had begun childbearing. It is for these reasons that adolescent girls have been identified as a key population.

This study was located at Mayville Secondary School, in the eThekweni district of KwaZulu-Natal (KZN). This area reports high levels of HIV infection, with notably high adolescent fertility rates at this school. This study had three aims: to understand the influences on adolescent female sexuality, to outline the perceptions of SRH self-care among adolescent females, and to understand the perceptions of art-based methodologies in researching sensitive topics. By understanding adolescent sexuality, this study aimed to highlight the influence this had on the self-care capabilities of adolescent females in maintaining their SRH. A culture-centred understanding of Orem's self-care model guided the study. A participatory action research design was adopted, where data collection was threefold: a bodymapping workshop, group discussion and individual interviews.

Key findings highlighted parental relationships and SRH-specific health communication programmes as the most influential in the understanding of sexuality among adolescent females. However, lack of agency in preventing risk, such as rape, and the negative perceptions of health care workers were identified as the main self-care deficits among adolescent females. Furthermore, this study identifies the effectiveness of art-based methodologies in researching and communicating with adolescent females about sexuality. This study highlighted the need for greater understanding of the socio-cultural perceptions of health care workers' understanding of adolescent sexuality, and the provision of SRH services. This study emphasises the need to reduce significant socio-cultural barriers to SRH, in order to ensure adolescent females have the ability to be effective self-care agents in maintaining good SRH.

ACRONYMS AND ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral Therapy
AYFS	Adolescent and Youth Friendly Services
CCA	Culture-Centred Approach
DOE	Department of Education
DOH	Department of Health
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
KZN	KwaZulu-Natal
NAFCI	National Adolescent Friendly Clinic Initiative
NPO	Non-Profit Organisation
PAR	Participatory Action Research
PHC	Primary Health Care
RSA	Republic of South Africa
SABC	South African Broadcasting Corporation
SANAC	South African National Aids Council
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UKZN	University of KwaZulu-Natal
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YFS	Youth Friendly Services

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INTRODUCTION

"We know that when a girl, a future mother, has access to health services and is HIV-free, is given a choice over when she marries and starts having children and has the opportunity to realise her full economic and social potential, she can escape disease and poverty and bring her family, community and country along with her." – Patrick Gaspard, United States of America
ambassador to South Africa

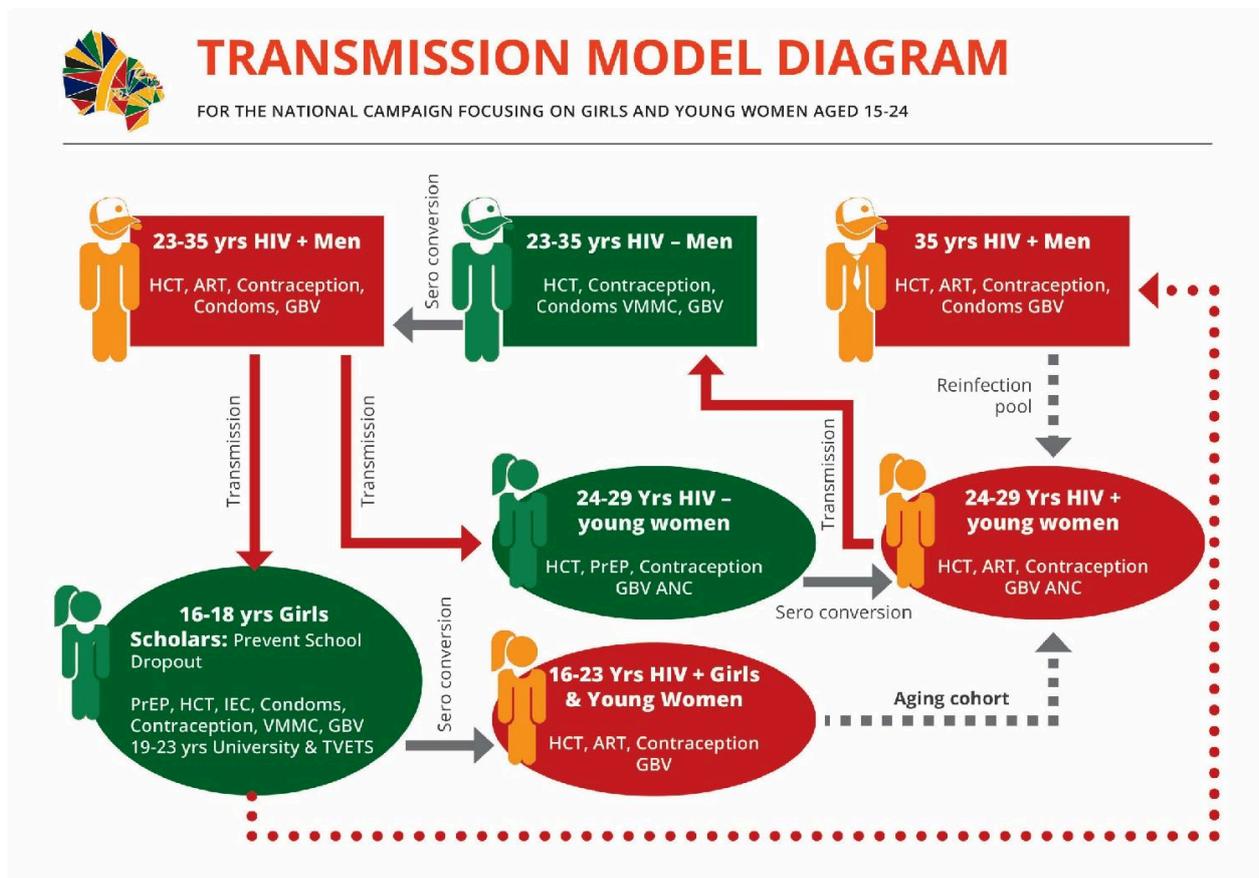
Introduction

In June 2016, deputy president of South Africa and SANAC chairperson, Cyril Ramaphosa, launched the *She Conquers* campaign in South Africa, which focuses on human immunodeficiency virus (HIV) prevention for adolescent girls and young women (AGYW). Ramaphosa stated at the launch in Pietermaritzburg, that despite the notable success of the provision of free treatment for all people living with HIV and AIDS (acquired immunodeficiency syndrome), it was estimated that nearly 2 000 girls and young women between the age of 15 and 24 years are still infected by HIV in South Africa every week (UNAIDS, 2015). The infection rate is increasingly higher than any other country in southern and eastern Africa. These statistics identify AGYW as an alarming key population in South Africa in terms of their sexual and reproductive health (SRH).

The campaign is a three-year programme focused on identifying notably high HIV incidence sub-districts in South Africa, where they aim to increase sexual and reproductive health information and services through adolescent and youth friendly clinics, integrated school programmes, community outreaches and parenting programmes. The objectives of the campaign is to 1) decrease new HIV infections in AGYW, 2) decrease teenage pregnancies, 3) keep girls in school until the completion of high school, 4) decrease sexual and gender-based violence, and 5) increase economic opportunities for young people.

Informed by the findings of recent studies, the campaign is based on the infection pathway in South Africa (de Oliveira *et al*, 2016). By understanding the underlying transmission dynamics of HIV, greater explanation of the sources and consequences of high rates of HIV infection in AGYW in South Africa would be obtained. This campaign utilises a targeted approach to break the transmission cycle of HIV in South Africa. The model identifies that sexual partnering between young women and older men, who may have acquired HIV from women of a similar age as themselves, "is a key feature of the sexual networks driving transmission" (de Oliveira *et al*, 2016: 1). The transmission model identifies that "achieving the goal of an 'AIDS-free generation' depends on reducing the burden of new infections in this key population" (Dellar, Dlamini and Abdool Karim, 2015: 65).

Figure 1.1 Diagram representing the transmission network of HIV between HIV-positive men and adolescent girls and young women



(de Oliveira *et al*, 2016: 7)

This study is situated in light of the increasing infection rate of HIV among AGYW in South Africa, the development of the *She Conquers* campaign, and the global goal of eliminating AIDS as a public health threat by 2030. This study set out to understand the self-care deficits and self-care capabilities of adolescent females towards correct sexual and reproductive health practices. By understanding the self-care capabilities and deficits of adolescent females, greater understanding will be gained on the perceptions and knowledge of adolescents towards healthy sexual practice. By comprehending what adolescents understand about sexual and reproductive health, and why they understand that, this study will make suggestions on how to reduce the self-care deficits apparent in adolescent females.

This chapter will outline the foundation of this study, explaining the landscape of sexual and reproductive health among adolescent females in South Africa. The study location at Mayville Secondary School will be introduced, establishing the rationale and significance of the study. The

theoretical and methodological framework will be briefly outlined, stating the guiding research questions. The chapter will conclude by explaining the structure of the dissertation.

The Face of Sexual and Reproductive Health in South Africa

Over the decades, HIV/AIDS has monopolised much of the South African health sector's focus, as HIV continues to be an uncontrollable global pandemic. Sub-Saharan Africa has the highest infection rate in the world, with South Africa accounting for the highest new infection rate, as well as the country with the highest number of people living with HIV/AIDS (UNAIDS, 2014). An estimated 12.2% of the population, approximately 6,8 million South Africans, are currently believed to be living with HIV/AIDS (UNAIDS, 2014; Statistics South Africa, 2015a).

Among the age group of persons 0-14 years old, the HIV/AIDS prevalence is 2,25%; however, this increases notably to 8,7% among those 15-24 years old, and then even more notably to 25,2% among those 25-49 years old in South Africa (Shisana *et al*, 2014; UNAIDS, 2016; Statistics South Africa, 2015a). There is a striking difference between the prevalence among females and males between the ages of 15 and 24 years old, with 11,6% and 4% infection rates respectively (UNAIDS, 2016). KwaZulu-Natal (KZN) has been identified with the highest prevalence of HIV/AIDS, with an infection rate of 12%. HIV/AIDS has become the central concern for primary sexual and reproductive health in South Africa, particularly among adolescents, outweighing adolescent fertility (Panday *et al*, 2009). However, adolescent fertility remains a large social problem that affects many societies. Adolescent females face dual risk: adolescent fertility and risk of contracting a sexually transmitted infection (STI), particularly the HIV virus.

If there is an increasing population being infected with HIV among those who are 15 to 24 years old, this ultimately means there is an increasing population who are sexually active in South Africa. It was reported that 99 041 female learners (2,5%) fell pregnant in South Africa in 2013. This increased from 81 678 (1,5%) in 2012 (Department of Basic Education, 2014). It was estimated that 5,6% of females between the ages of 14 and 19 years old were pregnant in 2014 in South Africa (Statistics South Africa, 2015b). Further, it was estimated by 2016 that 15,6% of females between the age of 15 and 19 years old had begun childbearing in South Africa (Statistics South Africa, 2016). More specifically, there is a large disparity between the ages of 15 and 19 years old. At the age of 15, only 3,8% of females were reported to have started childbearing, as opposed to 27,8% at the age of 19 years (Statistics South Africa, 2016). The percentage difference between those who are younger than 15 and those who are older than 15 is notable.

The average age of sexual debut in South Africa is 16 years old for females and 15 years old for males. Studies have identified that early sexual debut is linked to increased risk of contracting HIV and falling pregnant (Pettifor *et al*, 2009; Zuma *et al*, 2010; Richter *et al*, 2015). Understanding the sexual decision-making process around the age of sexual debut is essential to understanding the infection pathway among adolescent females in South Africa.

In South Africa, there is a legal right to health services, particularly sexual and reproductive health services. In the constitution of the Republic of South Africa, Act 108 of 1996, Section 27, it states that all South Africans have the right to “access to health care services, including sexual and reproductive health care services” (Department of Health, 2012: 13). It is the government’s legal responsibility to provide these services to everyone. Furthermore, the Children’s Act 38 of 2005 intends to protect the health of children, giving children over the age of 12 the ability to consent for themselves to medical treatment and surgical operations. This further extends to access to contraception, testing for HIV and the provision of condoms freely (Department of Health, 2012). With an ever-increasing population of adolescents who are engaging in sexual activities from an early age, the government has identified the need for sexual and reproductive services to be freely available to adolescents as young as 12 years old.

Statistics place adolescent females at the forefront of the HIV/AIDS epidemic in South Africa. The statistics, coupled with the recent *She Conquers* campaign launched in South Africa, highlights the need to further understand the perceptions of adolescent females towards SRH, in order to curb the increasing infection rate and decrease the teenage pregnancy rate.

Research Aims and Objectives

These statistics and facts identify the looming reality that, despite governmental efforts to increase accessibility to SRH services, barriers still remain among adolescent females towards effective SRH practices. This study aims to understand the knowledge, attitudes and perceptions of adolescent females towards sexuality and SRH in KwaZulu-Natal, South Africa. By understanding *what* adolescents understand and perceive about SRH, and *why* they believe this, this study highlights how this knowledge can be used to effectively reduce the adolescent fertility and HIV rates. SRH campaigns need to understand what girls need and want, in order to establish how they can effectively reach national access to SRH services.

This study has four main objectives:

- ***To identify the self-care deficits and capabilities of adolescent females towards correct, effective and comprehensive SRH practices.*** By understanding the self-care capabilities and deficits of adolescent females, greater understanding will be gained on the perceptions and knowledge of adolescents towards healthy sexual practice. By understanding the self-care deficits of adolescent females, this study will be able to suggest possible ways of fulfilling their self-care deficits.
- ***To expand the body of knowledge on the socio-cultural understanding of sexuality among adolescent females in KZN, South Africa.*** By understanding how this high-risk, critical age group understand sexuality, and all it entails, it is anticipated that insight will be gained in order to make suggestions on how to further engage and educate adolescent females. Furthermore, this study intends to identify the key influences that impact on the definition and perceptions of sexuality, which ultimately impact on the decision-making process towards SRH.
- ***To identify how adolescent females perceive their role in maintaining sexual and reproductive health, as well as their understanding of the role of nurses (health care workers) as supportive-educators in SRH.*** This study aims to fathom where adolescent girls place themselves in terms of risk of falling pregnant or contracting a sexually transmitted infection, as this impacts on their sexual health practices. This study hopes to explain the knowledge and attitudes of adolescent females, in terms of their role and the role of health care workers, in effective sexual and reproductive health self-care.
- ***To explore the potential of art-based methodologies, evaluating their benefits and disadvantages in creating dialogue around sexuality among adolescents.*** The majority of studies conducted on adolescent sexuality and the experiences of sexual and reproductive health services have adopted focus groups and interviews as the main methodologies. This study aims to identify alternative ways to research and communicate about adolescent sexuality.

Key Terms Defined

Adolescent

According to the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the United Children's Fund (UNICEF), adolescence is defined as the growth period between childhood and adulthood, typically defined between the ages of 10 and 19 years old (South African Department of Social Development, 2015). This study is particularly focused on adolescent females between the ages of 14 and 17 years. Further justification on the chosen age range will be explored further, later in this chapter.

Sexuality

The World Health Organization defines sexuality as following:

A central aspect of being human throughout life which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships ... Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (WHO, 2006: 5).

Sexuality, in this study, is defined as an adolescent's sexual and reproductive health, including puberty, emotional maturity, gender roles, and sexual beliefs and values. This study is focused on the interaction of the biological, psychological, social, economic, cultural, legal, historical, religious and spiritual factors in the understanding of sexuality.

Sexual and Reproductive Health

Sexual and reproductive health is defined as "a state of physical, mental and social well-being related to sexuality" (WHO, 2002: 4). Sexual health requires:

"A positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence". Reproductive health refers to "the capability to reproduce, with the freedom to decide if, when and how often to do so" (UN, 1994: Par. 7.2a).

This refers to the rights of men and women to be “informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice ... as well as the right of access to appropriate health care services” (UN, 1994: Par. 7.2a). This study aims to understand the factors that aid or inhibit sexual and reproductive health among adolescents in South Africa.

Knowledge

This study is interested in understanding what knowledge adolescent females have about sexual and reproductive health services, their sexuality, and their level of risk towards pregnancy and contracting an STI, such as HIV. Knowledge is defined as “facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject” (Oxford Dictionary 2016). In this study, knowledge is understood as the facts, information and skills adolescent females have acquired through either experience or education about sexuality and sexual and reproductive health. This study aims to ascertain their theoretical and practical understanding of SRH. Furthermore, how adolescent females gained this knowledge will be explored.

Attitude

Attitude is defined by Krech and Crutchfield (1948: 152) as “an enduring organisation of motivational, emotional, perceptual, and cognitive processes with respect to some aspects of the individual’s world”. Furthermore, it was later defined as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour” (Eagly and Chaiken, 1993: 1). Attitude, in this study, is understood as the tendency to favour or disfavour certain SRH services and practices. This study hopes to increase understanding of the attitudes of adolescent females towards self-care in SRH, their attitudes towards SRH services, and their attitudes towards health care workers in their local clinic. It is their motivational, emotional, perceptual and cognitive processes that influence their expression towards SRH and sexuality.

Perception

Perception is defined as the “conscious recognition and interpretation of sensory stimuli that serve as a basis for understanding, learning and knowing or for motivating a particular action or reaction” (Mosby, 2013: 1361). In this study, perceptions of sexuality and sexual and reproductive health will be explored. This study aims to understand how the perceptions of sexual and reproductive health motivate effective sexual and reproductive health practices. The understanding and knowledge of sexuality will be explored, as this form the basis of perceptions.

Self-care

Orem (1980: 35) defines self-care as “the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being”. This study aims to understand self-care in terms of sexuality and SRH. Furthermore, the self-care deficits and capabilities of adolescent females will be explored. Capabilities are understood as the ability of adolescent females to perform or achieve appropriate sexual and reproductive health, relating specifically to knowledge of contraception. Self-care deficits in this study refer to shortfalls in adolescent females’ knowledge around SRH. These deficits are understood as hindrances to effective understanding of sexual health.

Bodymapping

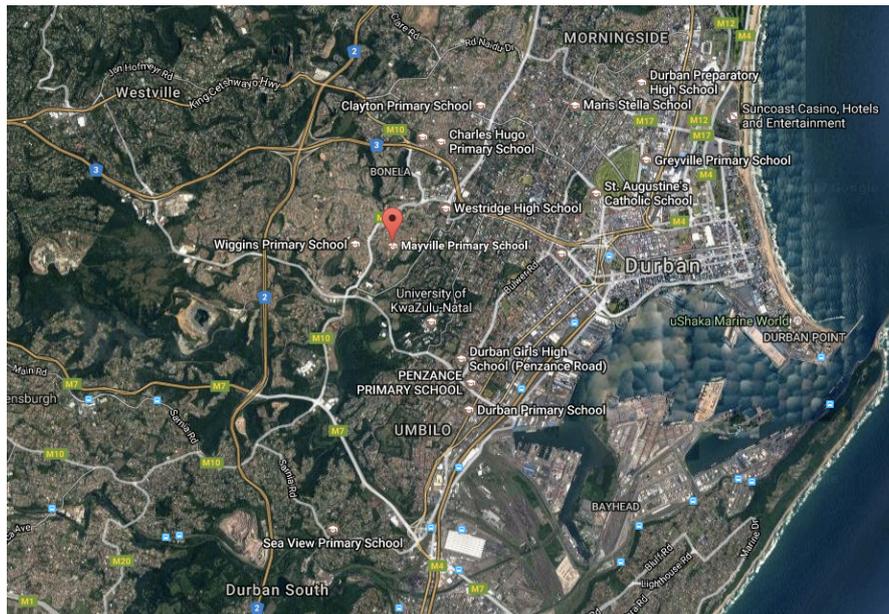
Bodymapping is an art-based, participatory research methodology. It is a life-size, visual representation of one’s body. Multiple creative methods (drawing, painting, visualisation, talking, reflecting, singing and dancing) are used in order to represent a holistic image of the participants, showing their mind, body and community (Solomon, 2008). Through bodymapping, this study hopes to explore the perceptions of adolescent females towards sexuality (mind), the understanding of sexual and reproductive health services (body), and the influences on their decision-making processes (community).

Location and Context of the Study

Mayville Secondary School

This research was based at Mayville Secondary School, Umkhumbane (Mayville), eThekweni District, KwaZulu-Natal, South Africa. It is a government high school with approximately 1 000 students registered. The school is located in a “densely populated area with a high unemployment rate and low socio-economic conditions” (KwaZulu-Natal DOH, 2001). The image below indicates where the school is located within the greater eThekweni area (red pin). The Cato Manor Community Health Centre is located relatively close to the school and services approximately 70 000 people, including students attending Mayville Secondary School (KwaZulu-Natal DOH, 2001). Furthermore, the clinic states that it has user-friendly services specifically allocated to adolescents.

Figure 1.2 Google Earth image showing location of Mayville Secondary School¹



This particular school was chosen because of the reported high teenage pregnancy rate at the school. A survey conducted by the City Health Unit and Hope2Educate in 2009 reported that 36% of female students at the school had fallen pregnant the year before (Ezasegagasini Metro Gazette, 2009). Recent statistics on the pregnancy rate are limited. The study identified that the increased high school dropout rate was linked with the high teenage pregnancy rate. As this study is focused on the sexual and reproductive health practices of adolescent females, this school was chosen because of the history of increasing SRH problems at the school. Based on the high HIV prevalence in KZN, as well as the high adolescent fertility rate specifically in this area, this study identifies the importance of understanding the cultural perceptions of participants in order to reduce these statistics. Furthermore, this study is interested in the experiences of adolescent females at health care clinics, specifically with health care workers and adolescent and youth friendly services. As this school is located near a clinic that offers these services, this school was chosen because it was assumed that participants would have access to the clinic and its services. This location was also chosen because of the accessibility to and familiarity with the specific site.

¹ Source:
<https://www.google.co.za/maps/place/Mayville+Primary+School/@29.8560929,30.9735983,413m/data=!3m1!1e3!4m5!3m4!1s0x1ef7aa08e713a51f:0x5741fa25646a60a5!8m2!3d-29.85553!4d30.97377!6m1!1e1?hl=en>. Accessed 29 April 2017.

Hope2Educate²

This study was conducted with the support of Hope2Educate, a non-profit organisation (NPO) based at the University of KwaZulu-Natal, Howard College Campus. The organisation has partnered with five local schools in the eThekweni district, where a three to four year structured peer education programme has been implemented. Mayville Secondary School is one of the five schools where the programme is based. The programme addresses the behaviours and beliefs that are at the root of the HIV pandemic among young people, such as “substance and alcohol abuse, low self esteem, lack of knowledge about HIV, sexually transmitted infections and risky sexual behaviour, gender inequality and limited access to resources and services”². The programme has a screening process, where influential teenage leaders are chosen to be trained and mentored in order to be positive role models and agents of change in their schools and communities. This programme aims to create educated and informed peer educators who would influence their friends to have “vision and hope for a brighter future and to adopt health-enhancing behaviour that will enable them to reach their full potential and create positive change”.

Rationale and Significance of the Study

Statistics show that there is a critical decision-making process that takes place, generally around the age of 16 years old in South Africa, with regard to sexual and reproductive health. After the age of 15, HIV/AIDS prevalence greatly increases among South African adolescents, as does the adolescent fertility rate. In the broader body of knowledge, research on the perceptions of female adolescents as young as 14 years old towards sexuality is limited. Much of the research is conducted with adolescents older than 18 years old, because of the strict ethical considerations of doing research with minors. However, girls between the ages of 14 and 17 years old are making life-changing decisions about their sexual and reproductive health based on how they perceive sexuality, their level of risk, and sexual and reproductive health practices. By understanding these perceptions, suggestions can potentially be made for future intervention strategies, which will be aimed at ensuring that girls are fully equipped to make informed decisions by the age of sexual debut. By understanding the perceptions of this age group specifically, this study has the potential to inform future health communication campaigns, policy implementation and education, as it identifies the limits and weaknesses that are apparent.

A key research question in this study is to understand what the central influences on adolescent females' perceptions of sexuality are, and how have these influenced their SRH decisions.

² More information on Hope2Educate can be found on the Info4Africa website:
<https://search.info4africa.org.za/?stext=hope2educate&x=0&y=0>. Accessed 29 April 2017

Fundamental to decreasing the teenage pregnancy rate and curbing the HIV infection rate within South Africa is greater understanding of adolescent sexuality. It is the juxtaposition between the poor knowledge of human sexuality among adolescents and the high rate of sexual and reproductive health problems within South Africa that is of concern (Kunene, 1995). As adolescent females are a key population in South Africa in terms of HIV/AIDS risk, it is vital that greater understanding and knowledge of adolescent sexuality is gained. In order to curb the increasing SRH problems in South Africa, culturally specific understanding of sexuality is pertinent; so as to meet the SRH needs of adolescent females.

In South Africa, legally, adolescents have free access to contraceptives from the age of 12 years old without consent (DOH, 2012). This shows that critical decisions are made as early as 12 years old. This identifies that further knowledge on the experiences of adolescents is needed in order to ascertain whether adolescent females, as young as 14 years old, have appropriately mature understanding of the consequences of their sexual and reproductive health decisions.

Much research has been conducted on the experiences of young people regarding adolescent and youth friendly services available in clinics, as well as the experiences of adolescents in regard to health care providers (Dickson-Tetteh, Pettifor and Moleko, 2001; Holt *et al*, 2012; Nkala *et al*, 2015). This study aims to understand the experiences of adolescent females towards SRH services in their community. Research shows that barriers still remain for adolescents in accessing SRH services, due to judgement, breaches in confidentiality and lack of resources. In order to encourage the use of SRH services, it is necessary that adolescent females be autonomous in their self-care. This study has the potential to identify what adolescent females believe they require in order to maintain their sexual and reproductive health. By understanding the self-care abilities of adolescent females, as well as their self-care deficits, this study aims to suggest when and how nursing care is needed in the maintenance of SRH. This study hopes to further the body of knowledge on how adolescent females perceive the role of health care workers and clinics, from a socio-cultural perspective, in influencing their understanding of sexuality and sexual and reproductive health.

The majority of studies conducted on adolescent sexuality and the experiences of sexual and reproductive health services have adopted focus groups and interviews as the main methodology (Harrison *et al*, 2001; Hoosen and Collins, 2004; Khoza, 2004; Govender, 2013). Researching about sexuality and sexual and reproductive health, especially in regard to HIV/AIDS and adolescent fertility, is considered a sensitive topic. This study explores the potential of bodymapping in creating a research

space where participants are able to communicate their opinions and perceptions freely. This study aims to explore the potential of art-based methodology, evaluating its benefits and disadvantages, and how effective it is in creating dialogue around sexuality. The knowledge on the potential of art-based methodologies in researching adolescent SRH in South Africa is limited. This study aims to broaden the body of knowledge on alternative ways of researching and communicating about sexual and reproductive health among adolescents.

Framing the Research

Theoretical Framework

This study will be understood through the theoretical lens of the culture-centred approach (CCA) (Dutta, 2008; Dutta, 2011; Dutta and Basu, 2008; Dutta-Bergman, 2005; Dutta, 2014) and Orem's self-care model (Orem, 1980).

Culture-Centred Approach

CCA advocates "engaging in dialogue with cultural members" (Dutta, 2008: 45). This approach is focused on allowing the subaltern a voice, where the researcher and the researched are brought into a shared critical space, where mutual learning can take place. An emphasis in CCA is to create dialogue within a culture or community, to ensure that information and understanding originate from within the community or culture, rather than being imposed by 'others' (Dutta-Bergman, 2005). Central to CCA is the engagement in dialogue, in order to suggest culturally specific solutions. By engaging in dialogue with adolescent females about sexuality and sexual and reproductive health, allowance is made for a communicative process where a holistic understanding of the issues is gained and culturally specific solutions can be identified. CCA highlights the use of dialogue, which creates agency. This study is focus on agency, in the form of self-care. By allowing for dialogue, greater understanding on the self-care deficits will be identified, thus suggesting culturally specific solutions in order to create agency in sexual and reproductive health self-care.

In identifying dialogue and a shared critical space in research, CCA considers culture as "a dynamic communicative process that leads to a social, economic, and political structure characterized by a system of values that influence attitudes, perceptions, and communication behaviours" (Dutta and Basu, 2008: 561). Culture is influenced by the micro- and macro-environments (Winskell and Enger, 2014; Dutta, 2008). Understanding that culture is dynamic and fluid means that health communication and interventions need to be "culturally specific" to be effective (Airhihenbuwa and Obregon, 2000: 10).

This study aims to elicit culturally specific suggestions for sexual and reproductive health problems by exploring the understandings and experiences of adolescents. This will be understood through identifying the micro- and macro-environmental influences on sexuality and sexual and reproductive health, and conceptualising the fluid and dynamic changes in cultural understandings of health-related problems among adolescent females.

Furthermore, key influences identified by CCA are structure, context and space, and values (Dutta, 2008). This study will explore how these key influences are either aiding or inhibiting the experiences of adolescent females with regard to sexuality and sexual and reproductive health. This study will elicit insight on how structure, context and space, and values have influenced the perceptions, attitudes and knowledge of adolescent females.

Orem's Self-Care Model

This study will further be understood in terms of Orem's self-care model. This model falls under Orem's general theory of nursing, but is used in this study as a way to understand and explain the self-care deficits and capabilities of female adolescent girls towards sexual and reproductive health. Orem's self-care model is composed of three sub-theories: theory of self-care, theory of self-care deficit and theory of nursing systems.

This study is interested in how participants perceive the role of health care workers as teachers and guides. As mentioned in the literature, health care workers have often been seen as barriers to primary health care, rather than as assisting it. This model will enable greater understanding of the perceptions of adolescent females towards health care workers in terms of sexual and reproductive health. The perceptions of adolescents will be explored in terms of the capabilities of health care workers as supportive-educators. The aim of understanding this crucial relationship is to ascertain whether adolescents feel health care workers are meeting their self-care deficits.

These two models/approaches have been chosen in combination, as they both focus on the empowerment of participants. As dialogue is opened between the researcher and the researched, it is hoped that culturally specific, appropriate solutions to problems will be identified, in order to cater for the self-care deficits of adolescents. Culture is central to understanding the self-care deficits and capabilities of participants. Culture also influences how adolescents perceive the role of health care workers in sexual and reproductive health. Gaining understanding on how structure, context, space and

values have influenced their self-care capabilities and deficits is key to this study. Through the use of dialogue, further insight will be gained on the generally problematic adolescent-nurse relationship.

Methodology

A qualitative research approach was adopted in this study. Qualitative research allows the researcher to explore selected issues in “depth, openness, and detail” (Durrheim, 2006: 47). This was deemed the most appropriate methodology, as it allowed for an in-depth and detailed account of adolescent females’ perceptions of sexuality and sexual and reproductive health.

Research Design

A participatory action research design was utilised in this study, as it encourages collaboration between the study participants and the researcher throughout the research steps. The researcher deems this the most appropriate design because, as seen in CCA, this study hopes to involve the participants in the assessment and development of health care services available to them (Dutta, 2008). Participatory action research allows for community-specific solutions to health problems identified by adolescent females. Data collection was conducted through a bodymapping workshop, a debriefing group discussion and individual interviews.

Furthermore, a thematic analysis was conducted on the data collected, where themes were identified in order to answer the research questions.

Sample Population

Eight participants were recruited from Mayville Secondary School, located in the Umkhumbane area in KwaZulu-Natal, and were between the ages of 14 and 17 years old. This study was focused primarily on the female perception of sexuality and SRH; therefore, only females were recruited. This age group was chosen because of the general age of sexual debut in South Africa, which is when adolescent females are making critical and life-changing decisions about their sexual and reproductive health. Recruitment of participants was facilitated through Hope2Educate.

Key Research Questions

In light of the research aims and objectives, the following research questions were identified, as they guided and directed the research process, from the data collection to the data analysis.

1. What are the key influences on adolescents' perceptions of sexuality?
 - How have these influences impacted on adolescents' perceptions of sexuality and sexual and reproductive health?
2. What is the understanding of self-care in respect to SRH among adolescent females?
 - What are their attitudes, beliefs and knowledge regarding their role in maintaining good sexual and reproductive health practices?
 - What are their perceptions of health care facilities, such as Adolescent and Youth Friendly Services, in influencing their decisions regarding sexual and reproductive health practices?
3. What are the perceptions of adolescent females towards an art-based methodology, such as bodymapping, as an effective methodology in researching sensitive topics, such as sexuality?
 - How does bodymapping aid or inhibit effective communication around sexuality and SRH?

Structure of the Dissertation

Chapter One introduces the threatening sexual and reproductive health problems adolescent females face in South Africa. Giving a brief overview of the statistical prevalence of HIV and pregnancy among adolescent girls, it highlights the critical decision-making process that takes place around the age of 16 years old. This chapter introduces the reader to the research aims and objectives, articulating the significance of the study. It contextualises the need for further research on understanding the perceptions, knowledge and attitudes of adolescent females towards sexuality, in order to suggest culturally specific solutions to SRH problems experienced by young girls in South Africa.

Chapter Two explores literature related to the research areas. This chapter presents five prominent themes in the review of literature. Firstly, the chapter explores sexuality in the South African context. The evolution of research on sexuality is explored, identifying relevant studies on sexuality within the context of adolescents and HIV/AIDS. Sexual and reproductive health in South Africa is also established, focusing on the history of SRH in South Africa and the evolution towards adolescent and youth friendly services in order to curb adolescent pregnancy and HIV. The third theme is sexual and reproductive health services in South Africa today. The literature conveys that, despite previous efforts, barriers to health care services still remain. Studies are presented which emphasise the role of health care workers and continuing barriers to SRH services. Fourthly, Orem's self-care model is explored in

the South African context, citing a study conducted in Limpopo. Finally, art-based methodologies as a research method are evaluated. Bodymapping as a tool in HIV/AIDS research and communication is identified.

Chapter Three outlines the theoretical framework which underpins this study. The culture-centred approach (Dutta, 2008) and Orem's self-care model (1980) are closely described in terms of how they relate to this study. CCA focuses on culture, agency and structure within health communication, advocating for culturally specific solutions to health care problems. Orem's self-care model forms part of a general nursing theory. The model unpacks the roles of the adolescents and health care workers in maintaining one's SRH. The model highlights the self-care capabilities and deficits of adolescent females in ensuring their sexual and reproductive health. It delineates when nursing is needed in order to support the self-care demands of adolescents. This chapter explains how these theories are used together in order to answer the research questions.

Chapter Four explains the methodological approach which guided the research design. The chapter explains the critical theory paradigm and the participatory action research design, which were the theoretical foundations for data collection. The process of data collection and data analysis is outlined, with the ethical considerations explained in terms of how they impacted on the research process. As this study was conducted with adolescent females under the age of 18 years old, the ethical considerations were vital in order to ensure the study was beneficial rather than harmful.

Chapter Five presents the data collected and analysed through the thematic analysis. The bodymaps collected were analysed using encoding/decoding, and the data collected through the individual interviews was categorised in order to answer the research questions. Findings are discussed in relation to the literature reviewed, CCA and Orem's self-care model. This chapter aims to state the knowledge, perceptions and attitudes of adolescent females towards sexuality and sexual and reproductive health, as found in this study.

Chapter Six concludes the findings of this study, stating the study's strengths and limitations. This chapter highlights the significance of this study, suggesting recommendations for health communication campaigns in South Africa. Finally, suggestions for further research areas are proposed.

LITERATURE REVIEW

Introduction

The aim of this chapter is to explore the current landscape of research on sexuality and sexual and reproductive health services. The four cornerstones of this study are: sexuality, sexual and reproductive health services, Orem's self-care model and art-based methodologies. Firstly, this chapter will define sexuality within the African context. Historically recounting sexuality, this chapter will review literature on adolescent sexuality in the context of the HIV epidemic in South Africa. The second theme reviewed in this chapter is sexual and reproductive health services in South Africa. Tracking health care services in South Africa, this chapter will uncover the progression of SRH services. This chapter also aims to review the theoretical foundation that underpins this research. Specifically exploring Orem's self-care model in the context of SRH, this chapter will analyse a previous study conducted in South Africa. Lastly, this chapter will explore the previous use of art-based methodologies in health communication research in South Africa.

This literature review aims to give an overview of the research area in order to answer the research questions. The first focal research question is to understand what the key influences on adolescent sexuality are. This chapter has reviewed previous studies on sexuality, specifically adolescent sexuality in South Africa. The aim is to compare the attitudes, knowledge and perceptions of participants with those found in studies previously conducted in South Africa. One's understanding of sexuality directly impacts on one's SRH decisions. This literature review explores SRH in South Africa, establishing the political and historical impact on SRH services. Policy and legislation on SRH in South Africa are outlined in order to compare the level of understanding of SRH services available against the legal access to SRH services.

A second key research question is to explore the self-care understanding of adolescent females in respect to their SRH. Orem's self-care model has been outlined in this chapter. Drawing on a study conducted in Limpopo, where this model was applied in terms of adolescent SRH, this research hopes to compare the results established in the study with the findings of this research (Ramathuba, Khoza and Netshikweta, 2012b). Studies using Orem's self-care model in SRH in South Africa are limited.

Lastly, art-based methodologies, specifically bodymapping, are reviewed. As this study aims to understand the effectiveness of art-based methodologies in communicating and researching sexuality, a previous study where bodymapping was used is highlighted. This research aims to compare the

benefits highlighted in that study with the perceptions and attitudes of participants in this study. As adolescent females are a key population in South Africa, it is vital to establish effective ways to research and communicate about adolescent female SRH.

Sexuality

Defining Sexuality

In order to understand the high prevalence of sexually transmitted infections and adolescent pregnancies in South Africa, there needs to be an understanding of how sexuality and sexual and reproductive health is perceived. The first theme of this literature review will outline adolescent sexuality, specifically in the context of the HIV/AIDS epidemic in South Africa. The first chapter defined sexuality in the context of this study as an adolescent's sexual and reproductive health, including puberty, emotional maturity, gender roles, and sexual beliefs and values. This study aims to understand the interaction between the biological, psychological, social, economic, cultural, legal, historical, religious and spiritual factors in the understanding of sexuality among adolescents. By understanding what has influenced the perceptions of sexuality, it will also be established how this has influenced sexual and reproductive health behaviour.

Within the last two decades, sexuality research has been brought into contention, where before it was largely marginalised as a focus for social enquiry (Parker and Aggleton, 2007). Before the 20th century, sexuality research "concentrated on the phenomenon of sexuality at the level of the individual, while neglecting societal, normative and cultural contexts" (MacPhail and Campbell, 2001: 1614). It was understood that sexuality was directly influenced purely by the biological, where gender roles were assumed. Research did not take into account the social, normative and cultural influences on one's beliefs and values. It was assumed that sexual behaviour was a result of "rational decision-making based on knowledge" (MacPhail and Campbell, 2001: 1614). With the growing prevalence of HIV/AIDS in the early 1980s, coupled with the increased attention placed on gender roles and sexuality, the wider social complexities of sexuality had to be understood in order to communicate effectively about sexual and reproductive health.

It was argued that a more complex and contextualised definition of sexuality, specifically adolescent sexuality, is needed (MacPhail and Campbell, 2001: 1614). In general, sexuality is "how people experience and express themselves as sexual beings ... Sexuality is unique to the individual, is core to who we are, and is dynamic throughout a lifetime" (Goebel, 2017: 208). Sexuality is not a stable

phenomenon; it is constantly changing and evolving, as it is located within a socially shared meaning system (Burr, 2003). Whereas, previously, sexuality was understood to be powered by biological drive, it is now rather understood to be powered by meaning, where meaning itself is profoundly social (Burr, 2003). Sexuality is associated with the created meanings of sexual knowledge, beliefs, values, attitudes and behaviours, beyond sexual orientation, procreation and sexual relations (Tamale, 2011). This, then, assumes that rather than sexuality being a biological issue for human beings, it is rather primarily a moral issue.

Sexuality is deeply rooted in the meanings created by individuals. This means that it therefore cannot be generalised (Moore and Rosenthal, 1993). Specifically in terms of adolescent sexuality, it is the sweeping generalisation about sexuality that has played a “key role in undermining the success of sexual health promotion among youth” (MacPhail and Campbell, 2001: 1615). Within a country like South Africa, there are multiple cultures and races; it is pertinent that one takes into account “the range of behaviours, ideologies and subjective meanings among groups” (Harrison *et al*, 2001: 70). The complexity of adolescent sexuality means that adolescents “conduct their sexual lives through experiences and beliefs that have been generated through their membership of particular societies and communities” (MacPhail and Campbell, 2001: 1614). There is no one blanket definition and understanding of adolescent sexuality, and it is vital that sexual health campaigns take into account sociality and community influence.

African Sexuality

Sexuality can be understood only within the boundaries of the culture through which it is mediated (Vance, 1991; Burr, 2003). The understanding of adolescent sexuality needs to be local, contextualised and specific.

By sexuality we mean not only sexual practices, but also what people know and believe about sex, particularly what they think is natural, proper, and desirable. Sexuality also includes people’s sexual identities in all their cultural and historical variety. This assumes that while sexuality cannot be divorced from the body, it is also socially constructed (Holland *et al*, 1990: 339).

It is therefore relevant to outline African sexuality, as this study was conducted in KwaZulu-Natal, South Africa. As mentioned previously, sexuality is deeply complex; this dissertation gives an overview of African sexuality, but has not reached the depths of it.

There was a need to establish an understanding of African sexuality, specifically in South Africa. “That fact that the language of Western colonialists has dominated sexuality discourses means that the shape and construction of the meanings and definitions of related concepts necessarily reflect realities and experiences outside Africa” (Tamale, 2011: 12). In the historical context of South Africa, much research around sexuality was deeply rooted in European culture, where African sexuality was understood as “exotic, traditional, irrational and immoral practices” (Gausset, 2011: 511). African sexuality has been a subject of great contention as African scholars have scrutinised the traditional understandings of African sexuality. Whereas African sexuality was seen to be something that needed to be controlled, scholars have rejected the Eurocentric ideas of African sexuality.

Culture is central to the understanding of African sexuality. It is understood that African people have two moral systems: firstly, the belief of abstinence among adolescents until marriage, for either cultural or religious reasons, and secondly, the belief that sexuality is natural and for the purpose of pleasure, so therefore should be enjoyed (Peltzer *et al*, 2006; Coovadia *et al*, 2009). The Christian/‘traditional’ African belief of moral chastity, sexual abstinence and marital monogamy is juxtaposed with the idea of ‘romantic love’, where multiple concurrent sexual relationships are acceptable (Peltzer *et al*, 2006; Coovadia *et al*, 2009).

Literature highlights the importance of understanding sexuality within the culture, society and community through which it is mediated. If health communication campaigns are to be effective, there is a need to understand African sexuality further. As the perception of sexuality forms the basis of sexual and reproductive health practices, this study highlights the need to explore the contextual understanding of sexuality among South African adolescent girls. Sexuality is influenced by multiple factors, as mentioned earlier; this study aims to understand these influences in the context of SRH in South Africa. Due to the increasing threat of the HIV prevalence in South Africa, the trajectory of adolescent sexuality has been greatly affected. The impact of HIV within South Africa has influenced the social, normative and cultural understanding of sexuality.

Adolescent Sexuality in the Context of HIV within South Africa

Adolescents bear a disproportionate burden of the HIV infection rate in South Africa. More specifically, adolescent females face the dual risk of contracting HIV and falling pregnant at an early age (Zuma *et al*, 2010). The statistical evidence of the prevalence of HIV among adolescent girls indicates the complexity of adolescent sexuality and adolescents’ sexual and reproductive needs in the context of the HIV epidemic. Sexuality in this chapter has been explained and explored as a multifaceted and

multidimensional entity, which requires definitions to be contextualised, specifically within the African context. Much research into adolescent sexuality has treated sexuality in a stereotypical, one-dimensional way with inadequate attention on young people, whose views and behaviours challenge dominant stereotypes (MacPhail and Campbell, 2001: 1614). Central to the multidimensional understanding of sexuality in this study is the recognition that adolescent sexuality “is influenced by factors at three levels: within the person, within the proximal context (interpersonal relationships and physical and organisational environment) and within the distal context (culture and structural factors)” (Eaton *et al*, 2003: 149).

The vulnerability of dual risk among adolescent females in South Africa creates an environment where understanding their perceptions of sexuality, and the influences these have on their sexual and reproductive health, is imperative. Within adolescents, HIV infection is likely to be recent and HIV-related mortality is likely to be minimal, thus “HIV prevalence in adolescent communities provides a reasonable proxy for incident HIV infections” (Kharsany *et al*, 2014: 956). Specifically, adolescent girls aged 15 to 19 years who have acquired HIV, acquire the virus five to seven years earlier than their male counterparts, with a “three- to- four-fold higher incidence rate” (Kharsany *et al*, 2014: 956). It is for this reason that the AIDS epidemic has been identified as a “gendered epidemic” in South Africa (Hoosen and Collins, 2004: 488). It raises the question of why adolescent girls are so vulnerable to HIV infection. In order to comprehend fully the complexity of sexuality, “a sound understanding of the local epidemic is required as well as the bio-behavioural nexus that renders adolescent girls and young women more vulnerable to HIV infection” (Dellar, Dlamini and Abdool Karim, 2015: 68).

Considering the increased risk of adolescents contracting HIV, as well as the risk of adolescent females falling pregnant, one has to consider the influence of perceived risk on the sexual behaviour of adolescents. “A requirement for translating knowledge into behaviour change is a feeling of personal vulnerability to HIV infection” (MacPhail and Campbell, 2001: 1619). In order for the knowledge of sexuality to cause action, adolescent females have to consider their risk. In the South African National Prevalence, Incidence and Behaviour Survey conducted in 2012, it was reported that 82,2% of participants aged 15 to 24 years old believed they either would not, or probably would not, contract HIV (Shisana *et al*, 2014). An earlier national survey identified that 43% of participants perceived that they were at great risk of an unplanned pregnancy (Kaiser and SABC, 2007). As this study is interested in understanding self-care among adolescent females, understanding perceived risk is vital in engaging in self-care. The level of perceived risk influences adolescent females’ engagement in SRH self-care. It is

within these boundaries of their level of knowledge, their attitudes and perceptions towards sexuality and their SRH that sexual practices are mediated.

The following section will explore the knowledge, attitudes and perceptions of adolescents towards sexuality within the context of maintaining their sexual and reproductive health. Sexual debut and the influence of the family structure are identified as key determinants in the understanding of sexuality, and are explored more in the following section.

Knowledge, Attitudes and Perceptions

This section will present studies that have explored adolescent sexuality within South Africa, and the multiple influences on the understanding of sexuality. These factors have impacted on adolescents' behavioural decisions towards sexuality "through altering their perceptions of the personal and social consequences of falling pregnant and their self-efficacy in relation to sexual behaviour" (Kanku and Mash, 2010: 563). As stated earlier, the understanding of sexuality is multidimensional. These studies highlight the multidimensional influences on the construction of sexuality and the influences on the perception of sexuality. As this research is focused on understanding the key influences on adolescent sexuality, these studies mentioned form a basis of the understanding of adolescent sexuality within the context of South Africa.

A key study was conducted in rural KZN on understanding the risk of young women contracting HIV/AIDS, focusing on adolescent sexuality and vulnerability (Harrison *et al*, 2001). The study was conducted among 14 and 15 year old girls in the form of group discussions. The findings of this study indicated that adolescents have multiple ways of understanding the term 'sexually active', also identifying the different gendered responses to sexuality. The study confirmed many of the stereotypes around adolescent sexuality, such as young women being at high risk due to "early sexual initiation, older male partners, unprotected sex, pursuing relationships for money and material goods, limited power in sexual negotiation and decision-making, and the presence of coercion" (Harrison *et al*, 2001: 76). The economic constraints of South Africa directly impact on the SRH decisions of many adolescents, where sexual decisions are made in terms of related economic gains. The study identified socialisation as a key determinant in maintaining the 'status quo' towards sexuality, highlighting the normative influence on sexuality. The study highlighted greater need to understand the 'why' around sexuality, ensuring the context around these stereotypes is understood, as is also highlighted in MacPhail and Campbell (2001).

Furthermore, a study was conducted in the North West province in South Africa among females between the ages of 16 and 25 years old, as well as males between the ages of 18 and 23 years old. It investigated the attitudes, understanding and perceptions towards pregnancy, sexuality and contraceptive use in the town of Taung (Kanku and Mash, 2010). Factors found to influence adolescent pregnancy were socioeconomic factors such as poverty, intergenerational relationships and transactional relationships. Substance abuse, particularly alcohol, was identified as a critical influence. Furthermore, peer pressure, sexual coercion, proving one's fertility, and poor sexual negotiation skills were established as alternative factors. It was concluded that the understanding of contraceptives and reproductive health was poor. Majority of adolescents perceived falling pregnant as a negative event because of the multiple consequences. Findings from this study are very similar to those identified in rural KZN nine years earlier (Harrison *et al*, 2001).

These findings were validated in a further study conducted by MacPhail and Campbell (2001: 1624). This study identified "peer norms and pressures; negative and unsupportive adult attitudes to youth sexuality; restricted availability of condoms; and broader social issues related to the social construction of gender and to economic constraints on young people" as influencing adolescents' understanding of sexuality and the maintaining of their sexual and reproductive health. Similarly, consistent condom use, maintaining one sexual partner, delaying or abstaining from sexual activities until getting married, and avoiding early sexual debut were associated with SRH (Khoza, 2004). The social construction of gender and gender norms is central to the shaping of adolescent sexuality. Studies highlight the influence of families and communities in infusing the societal norms and values of the gender differences in sexuality experiences, which greatly impact on the understanding of sexuality (Khoza, 2004; Mkhwanazi, 2010). The proximal context factor of interpersonal relationships is highlighted as a key influence on the construction of sexuality.

More recently, similar factors were identified in various other studies conducted at various locations around South Africa. In the South African National HIV Prevalence, Incidence and Behaviour Survey (Shisana *et al*, 2014), the researchers identified early sexual debut, age-disparate relationships, multiple sexual partners and poor condom use as the main behavioural determinants in the spread of the virus among adolescents. The cause of vulnerability in adolescents is difficult to elucidate; however, research suggests certain prominent structural, social and biological factors that increase risk, specifically in adolescent females (van der Riet and Nicholson, 2014; Dellar, Dlamini and Abdool Karim, 2015; Naicker *et al*, 2015). Specifically, these are "age-disparate relationships, transactional relationships, limited schooling, experience of food security, experience of gender-based violence,

increased genital inflammation” (Dellar, Dlamini and Abdool Karim, 2015: 64). Socio-behavioural factors that are seen to increase the risk of adolescent females contracting HIV include the high levels of inter-generational relationships between young women and older men, coupled with the lowered ability to negotiate condom use due to gender-related power dynamics (Dellar, Dlamini and Abdool Karim, 2015; Naicker *et al*, 2015; Evans *et al*, 2016).

Engagement in age-disparate relationships has also been identified as a central factor in shaping the understanding of sexuality and the increase of HIV risk in young women (Harrison *et al*, 2001; Dellar, Dlamini and Abdool Karim, 2015; Kharsany *et al*, 2015; Evans *et al*, 2016). However, two longitudinal studies conducted in South Africa did not find a relationship between inter-generational relationships and HIV incidence in young women. The first study was conducted from 2003 to 2012 in the uMkhanyakude district in KwaZulu-Natal (Harling *et al*, 2014). The second study was conducted in three urban areas in Durban, KwaZulu-Natal; Johannesburg, Gauteng; and Klerksdorp, North West province from 2009 to 2012 (Balkus *et al*, 2015). An explanation for the contradictory data set is the context-specific nature of the investigations, which may suggest that these results cannot be generalised to other areas.

Peer pressure to have sex, ignorance on basic sexuality and pregnancy, coercion, and refusal to use condoms were highlighted by Osaikhuwuomwan and Osemwenkha (2013) as the greatest contributors to teenage pregnancy. Although they found adolescents to have negative feelings towards early pregnancy, they state that their perceptions and understanding of sexuality and contraception was poor and insufficient. Influences such as the perception of reduced risk have ultimately impacted on how adolescents treat sexuality and sexual practice.

Substantial research is lacking on the understanding of sexuality and the maintenance of good sexual and reproductive health among female adolescents, who are as young as 14 years old (Harrison *et al*, 2001; Kharsany *et al*, 2014; Dellar, Dlamini and Abdool Karim, 2015). The majority of studies are conducted with girls older than 18 years old, with a fair proportion conducted with girls between the ages of 15 and 24 years old (Harrison *et al*, 2001). Research ethics treads carefully in research of adolescents under the age of 18 years old because of the ethical implications. However, research shows that adolescent girls under the age of 18 are a vulnerable population, and there is a need to understand their sexual practices better. As it has been highlighted, the influence of attitude, knowledge and understanding on the sexual decisions of adolescent females greatly impacts on the risk of contracting HIV or falling pregnant. This study highlights the need for increased knowledge of the

understanding of sexuality among young adolescent girls, as they provide the foundation of the understanding of sexuality at the age of sexual debut.

Sexual Debut

Within South Africa, the primary method of HIV transmission is through heterosexual sexual intercourse (Zuma *et al*, 2010). Understanding early sexual debut in South Africa is essential in determining the infection pathway among adolescents. Studies have identified that “early sexual debut is associated with increased likelihood of risky sexual behaviour later in life” (Zuma *et al*, 2010: 48). The earlier one engages in sexual intercourse, the longer the potential exposure to HIV and the higher the risk of falling pregnant. The mean age of sexual debut in South Africa is 16 years old (Manzini, 2001; Simbayi *et al*, 2004; Pettifor *et al*, 2005; Pettifor *et al*, 2009; Zuma *et al*, 2010; Kharsany *et al*, 2014; Shisana *et al*, 2014; Ritcher *et al*, 2015). Between the ages of 15 and 18 years old, there is a dramatic increase in sexual debut among females, peaking at age 16 (Ritcher *et al*, 2015).

In a national representative second-generation HIV prevalence and incidence survey conducted in South Africa, it was highlighted that 39% of participants between the ages of 15 and 24 years old had reported to early sexual debut. In this study, sexual debut was considered early if it occurred before the age of 16 years old (Zuma *et al*, 2010). This finding was higher than that obtained in a previous South African survey of youth (Parker *et al*, 2007). Specifically, those between the ages of 15 and 19 years old were more likely (62,5%) to report early sexual debut, as opposed to those between 20 and 24 years old. The study further identified that those who engaged in early sexual debut were noticeably more likely to have multiple sexual partners.

Furthermore, condom use among those who engaged in early sexual practice remained notably low (Harrison *et al*, 2005; Pettifor *et al*, 2009; Zuma *et al*, 2010). Early sexual debut, coupled with risky sexual behaviour (such as having multiple sexual partners and unprotected sex), is detrimental to the fight to curb the HIV epidemic in South Africa. “This is more critical since in most cases sexual debut is often unprotected, unguided and uninformed” (Zuma *et al*, 2010: 52). Studies documenting age of sexual debut in South Africa clearly illuminate the increased risk of contracting HIV and/or falling pregnant with early sexual debut (Harrison *et al*, 2005; Anderson *et al*, 2007; Pettifor *et al*, 2009; Zuma *et al*, 2010; Ritcher *et al*, 2015).

Understanding the sexual practices of youth is vital in curbing the HIV infection rate in South Africa. Within South Africa, delaying sexual debut is a strategy many national programmes are promoting

(Zuma *et al*, 2010; Ritcher *et al*, 2015; Pettifor *et al*, 2009). By delaying sexual debut, it is assumed that adolescents would become better informed and equipped to ensure their own sexual and reproductive health. Zuma *et al* (2010: 53) highlight from their study that “poor or lack of preparation for sexual activity among young South Africans” was apparent among those who engaged in early first sexual encounters. Their study suggested, “effective behavioural interventions at early stages may be protective against HIV infection throughout the life course” (Zuma *et al*, 2010: 53).

This master’s research was conducted with female adolescents between the ages of 14 and 17 years old. It was understood that, due to the age of sexual debut in South Africa being around the age of 16 years old, these girls would be making vital life decisions about their sexual and reproductive health that would significantly impact on their sexual decisions for the future. Comprehending their understanding of sexuality and sexual and reproductive health around the age of sexual debut would enable the researcher to understand the decision-making process that takes place at the time of sexual debut, in order to establish the self-care needs and abilities of adolescent females. The studies mentioned above have not only highlighted the importance of delaying sexual debut, but have also further identified the importance of ensuring that adolescents are well informed, educated and supported at the time of sexual debut.

The Family Influence

This study acknowledges the influence of family structure on the attitude, knowledge and perceptions of adolescent females towards sexuality and their sexual and reproductive health. As this study was conducted with females at the general age of sexual debut, the influence of the family structure was highlighted because it is generally assumed to be the foundation of sexual education (Mudhovozi, Ramarumo and Sodi, 2012). Previous literature has highlighted that there are many factors that influence the understanding of sexuality; however, this study has further explored the family because of its historical and social influence. Generally, the family structure forms the foundation of one’s decision-making process. The family structure focuses on the proximal context of the influence of interpersonal relationships. This study aimed to establish the influence of family on the sexual health of adolescents, establishing the relationship between family members and adolescents.

Covering the historical evolution of sexuality, this last section will deal with the influence of family on the formation of adolescent sexuality. There has been much research conducted on the relationship between parents and children and their influence on sexuality education. Studies have identified that parents’ attitude towards sexuality and sexual communication, in terms of sexual health, has a

significant influence on the children's attitudes towards sexuality, their sexual debut and sexual practices, and their effective use of contraceptives (Jaccard *et al*, 1998). Senior members in the family are seen as socialising agents for appropriate behaviours to the children (Khoza, 2004). Specifically, we see the role of mothers as "imparting sexual knowledge to their daughters so that they will be able to make informed decisions about when to start sexual activities and to take precautions to protect themselves against HIV/AIDS" (Mudhovozi *et al*, 2012: 120).

However, many adults do not always see adolescent sexuality as a natural phase of development, and therefore view it as something that needs to be controlled (Mudhovozi *et al*, 2012). Therefore, parents tend to withhold information from children in order not to encourage sexual activities (Mkhwanazi, 2010). Parents do this because they believe they are "protecting young people from information that they believe may lead to sexual experimentation" (Mudhovozi *et al*, 2012: 121). However, rather than showing that sexual communication between parents and children encourages sexual activities, research has shown how "young people who openly communicate about sexuality with their parents, especially mothers, are less likely to be sexually active, or if girls, become less likely to fall pregnant before marriage" (Mudhovozi *et al*, 2012: 122). Furthermore, research recognised "the need to give sexuality education to children from as early as the age of ten" (Kunene, 1995: 48).

Relevant to this study, is a study conducted at Vulindlela, KwaZulu-Natal, in 2014 (Kharsany *et al*, 2014). The study was conducted with 3 242 students at five schools in the area, and focused on the transmission of HIV among high school students in rural South Africa. The study highlighted the generally unstable family structures: 22,9% of students did not have a mother still alive, with a further 22,6% having a biological mother still alive but not living with them. Generally, fathers remained absent: only 58,3% of students reported that their biological father was alive, and only 51,7% lived with their fathers (Kharsany *et al*, 2014). It was from this understanding of the broken family structure that the study made sense of the HIV prevalence among students.

The Vulindlela study identified that HIV prevalence was higher in adolescent girls who did not have a living biological mother, and higher among adolescent boys who did not have a living mother or father (Kharsany *et al*, 2014). This underscores the fact that the lack of a living parent in a student's life places them at higher risk of engaging in risky sexual behaviour (Kharsany *et al*, 2014: 956). The study stated, "cohesive family structures are important determinants of risk, as parents could help instil and reinforce messages of protection from risky behaviour" (Kharsany *et al*, 2014: 964). The unstable family structure in many participants' home environment highlighted how many students lack the emotional support of

their parents in negotiating safe sexual practice in order to decrease their risk of contracting HIV or falling pregnant. Kunene (1995: 48) states that the “breakdown in traditional family lifestyle has deprived black teenagers of the sexuality education they used to get from their elders”.

There are multiple factors that influence the understanding of sexuality among adolescents. This study has specifically highlighted sexual debut and the family structure. Because this study was conducted with adolescent females between the ages of 14 and 17 years old, sexual debut was highlighted as a key factor. Participants in the study would be around the general age of sexual debut in South Africa. This means that life-changing decisions about their sexuality and the critical development of their understanding of SRH would be taking place. This study highlights that research states that many adolescents are uninformed, unprotected and unguided. This study aims to understand the level of knowledge adolescents hold towards sexuality and SRH, in order to establish whether adolescent females are appropriately equipped around the age of sexual debut in order to make informed sexual health decisions.

Sexual and Reproductive Health

History of Sexual and Reproductive Health in South Africa

The historical context of South Africa is deeply rooted in racialisation and segregation (Burgard, 2004; Coovadia *et al*, 2009). The apartheid system from 1948 to 1994 classified South Africans into four racial groups: blacks, coloureds, Indians and whites. Rights and privileges in the country were apportioned according to skin tone, with white people having the greatest privilege and black people having the least. The system was based on *separate development*, a notion that all racial groups should develop independently. This impacted not only on the political rights of black South Africans, but on their social, economic and health rights as well. South Africans of colour were divided into separate *homelands*, where they were restricted in every area of their lives, including spatial mobility, employment and education (Kaufman, 1998; Coovadia *et al*, 2009). There were ten homelands in South Africa where black people were designated to live within the white Republic of South Africa (RSA).

In 1974, the family planning programme was implemented by the white minority government. It became the focal point of racial political contestation, where it was believed to be a way to “place a check on the high population growth rate which was burdening limited resources” (Kaufman, 2000: 105). There was a growing fear among whites of the expanding black population (Kaufman, 2000). Reproductive services were provided mainly for the purpose of maternal and child health services, with the aim of

limiting population growth (Kaufman, 1998; Kaufman, 2000; Cooper *et al*, 2004; Anderson *et al*, 2007). The family planning programme became a form of social and political control. By reducing the population of black people in South Africa, it aimed to reduce the political potential of the majority. Despite the ideological battle surrounding the programme, some black women still sought contraceptives, with 44% use among black South Africans in the 1980s.

Within the separate homelands, family planning programmes were poorly funded, if they existed at all. “Male labour migration and residence in a homeland have been defining features of millions of black South African lives, and are hypothesized to play an important role in contraceptive use” (Kaufman, 1998: 422). In South Africa, the impact of reproductive services within homelands under apartheid is seen to have influenced the use of contraceptives in areas that were greatly underserved, compared with white areas. Accessibility to reproductive health services was difficult among the homelands (Kaufman, 1998; Burgard, 2004). The impact of forced male labour migration, due to the separate living areas, caused insecurities around promiscuity among women and the higher demand for children, thus influencing contraceptive use among women (Kaufman, 1998; Burgard, 2004; Coovadia *et al*, 2009; Naicker *et al*, 2015). Kaufman (1998: 421) sums up the impact of apartheid on family planning: “homeland policies, the labour migration system, and the suspicion by blacks of government policies produced a climate of uncertainty in which reproductive decisions were made”.

Opposition and armed struggle against the apartheid government led to the transitional political period in South Africa from 1990 until the first democratic election held in 1994. The African National Party (ANC) won the election and was voted as the ruling party in South Africa, allowing for the first democratic president. It was during this period that the ANC established a health commission that aimed to formulate a health plan that would transform the health system in South Africa, in order to create health care for all (Cooper *et al*, 2004).

In 1994, the Department of Health (DOH) implemented the Primary Health Care (PHC) in South Africa, as a way to redress the past neglect of the health needs of poor black South Africans, specifically black women. The PHC in South Africa introduced free primary-level health services, targeted at women and children. The new approach to health care in South Africa aimed to emphasise human rights, equity, greater access, decentralised services and preventive and promotive health care (Cooper *et al*, 2004). Over the following years, several changes in law and policy were carried out to cater specifically for the sexual and reproductive needs of men and women, ensuring they had access to the appropriate services. Later, a focus was placed on adolescent sexual and reproductive health service, through

which, in 1999, the National Adolescent Friendly Clinic Initiative was launched. These key changes in South African health care will be expanded on further in this chapter (*Contraception and the Law, Adolescent and Youth Friendly Services*).

There have been significant achievements within SRH services in South Africa; however, the newly elected ANC government of 1994 faced enormous challenges that remained from the apartheid government. These challenges are still seen impacting on service delivery within South Africa. The weaknesses in the broader health care system have led to shortcomings in new policies and services being implemented in PHC. The legislative and reproductive health policy advances in South Africa are “among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights” (Cooper *et al*, 2004: 70). However, “failures in leadership and stewardship and weak management have led to inadequate implementation of what are good policies” (Coovadia *et al*, 2009: 817). Implementation has been hampered due to the lack of financial and human resources, thus directly impacting on the effective use of SRH services today. After 23 years of democracy, South Africa is still grappling with the legacy of apartheid and the “challenges of transforming institutions and promoting equity in development” (Coovadia *et al*, 2009: 817).

It is from this understanding that one can establish that “the roots of a dysfunctional system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in policies from periods of the country’s history, from colonial subjugation, apartheid dispossession, to the post-apartheid period” (Coovadia *et al*, 2009: 817). The trajectory of health, specifically SRH, within South Africa is deeply rooted in the historical context that underwrites South Africa. The link between the social structures of the past and the reproductive health issues of today cannot be separated, thus the success of current family planning programmes remains relative (Yukapi, 2015). Decades of policies, legislations and laws have influenced the effectiveness of sexual and reproductive health within South Africa, highlighting it as an unresolved dilemma still today.

Although the destructive apartheid system was abolished in the mid-1990s, “racial inequality and de facto segregation” still remain in South Africa (Anderson *et al*, 2007: 99). The multitude of factors that influence health within South Africa, such as inequalities in socio-economic status, greatly impact on the effectiveness of PHC and service delivery. There is a desperate need to address the disempowerment, discrimination and underdevelopment caused by apartheid, in order to bridge the gap in health care in South Africa. Coovadia *et al* (2009: 817) state, “Programmes that directly address

social determinants of health and development, such as discrimination and stigma, subordination of women, poverty and inequality, violence and traditional practices, are essential for promoting health and reducing disease.” Sexual and reproductive health in South Africa is a profoundly complicated matter that goes beyond the provision of SRH services, requiring also an attempt to meet the social injustices that still remain in South Africa.

Contraception provision within post-apartheid South Africa will be discussed further below, as it forms one aspect of redefining SRH provision in South Africa.

Contraception and the Law

Post-apartheid, democratic South Africa constitutionally covers and protects the people of South Africa. The constitution of the Republic of South Africa, Act 108 of 1996, section 27 states that all South Africans have the right to “access to health care services, including sexual and reproductive health care services” (DOH, 2012a: 13). It is the government’s constitutional responsibility to provide these services to all South Africans. Furthermore, the Children’s Act 38 of 2005 intends to protect the health of children, giving children over the age of 12 the ability to consent for themselves to medical treatment and surgical operations. This further extends to access to contraception, testing for HIV and the provision of condoms freely (DOH, 2012a). The government, however, identifies that medical advice, as well as counselling, is an important prerequisite to ensure the protection of the child’s health. Contraceptives are required to be freely available to adolescents at clinics at minimal to no cost.

Contraceptive options that are required to be available at government hospitals and clinics range from condoms (male and female) to emergency contraception, hormonal methods (injectable, implants and pills) and intra-uterine devices (IUD). Commonly, pills, male condoms and injectables are offered at all public-sector clinics; the IUD is often only offered at urban clinics and referral facilities, and female condoms are available at limited facilities (Holt *et al*, 2012). The table below explains the contraceptive methods that are offered by public health hospitals and clinics in South Africa.

Table 2.1 Table illustrating the various modern contraceptive methods available at public health facilities (South Africa)

Modern Contraceptive Methods	
Method	Description
Male Condom	This is made of latex rubber, and some are coated with a dry lubricant or with spermicide.
Female Condom	The female condom is a soft polyurethane tube with one closed end and one open end. Both ends have a flexible ring or rim. The ring at the closed end is inserted into the vagina over the cervix to hold the tube in place, while the ring at the open end remains outside the opening of the vagina.
Injectables	The injectable contains hormones given to the recipient at regular intervals by a health care provider.
Implant	Hormonal implants are small, thin, flexible plastic rods about the size of a matchstick, inserted under the skin by a health care provider, and can be removed at a later stage.
Oral Contraceptive Pills	The pill comes in a 28-day or 21-day pack. The pills contain hormones that regulate the reproductive system to prevent pregnancy.
Intra-Uterine Device (IUD)	The Cu IUD is a small, thin, T-shaped plastic and copper device that is inserted into the vagina and placed in the womb (uterus). It is also known as 'the loop'.
Post-Exposure Prophylaxis (PEP)	PEP is a 28-day course of antiretroviral drugs which helps prevent HIV from developing in the body.
Emergency Contraceptive Pill	The emergency contraceptive pill (morning-after pill) is used to prevent an unplanned pregnancy after unprotected sex.
Emergency Cu IUD	The Cu IUD can be inserted into the womb up to five days after having unprotected sex to prevent pregnancy.

(Adapted from DOH, 2012b: 36)

As the government has identified that contraceptives should be freely available from the age of 12 years old in South Africa, this study identifies that girls between the ages of 14 and 17 years old are considered old enough, legally, to receive sexual and reproductive health services. Thus, this fundamentally implies that girls between the ages of 14 and 17 years old are mature enough to have a personal opinion on sexuality. As the government has identified girls over the age of 12 old enough to make decisions about their sexual and reproductive health, it is vital that there is greater understanding on how they perceive sexuality and their SRH.

The historical foundation of SRH services in South Africa has directly impacted on the attitude and perceptions of adolescents towards sexuality, which has in turn impacted on how adolescents engage with SRH services.

Despite the effort of the new democratic government to redefine SRH services in South Africa, the effect of the corrupt apartheid system is still apparent in South Africa today. This has directly impacted on the understanding of sexuality among adolescents. The socio-economic impact of apartheid is still apparent today, where many black South Africans still remain in poverty. As has been discussed before, the economic impact on sexuality is important to acknowledge, as adolescents are engaging in transactional relationships for economic security (Harrison *et al*, 2001; MacPhail and Campbell, 2001; Kanku and Mash, 2010; Dellar, Dlamini and Abdool Karim, 2015). Furthermore, ANC inherited major debt from the apartheid government, which directly impacted on the financial resources of the country. The government has specifically aimed to increase access to SRH services by legally allowing all South Africans free access to public health services. However, financial and human resource constraints still remain. The structural constraints to SRH have impacted on the perceptions of sexuality among adolescents, thus further impacting on their SRH practices (MacPhail and Campbell, 2001).

The Nurse-Adolescent Relationship

Despite the government's efforts to change the laws and policies around the accessibility of sexual and reproductive health services in South Africa, barriers to services still remained post-apartheid (Tylee *et al*, 2007; Alli *et al*, 2013; Frohlich *et al*, 2014). Coupled with the complexities of the past and the lack of financial and human resources, SRH problems such as HIV/AIDS and teenage pregnancy rates were increasing in the post-apartheid era. Specifically, laws on access to SRH services for adolescents were designed to increase the use of contraceptives among young South Africans; however, literature identified that, despite their legal right, adolescents found that health care workers created a barrier to effective sexual and reproductive health. Due to the negative perceptions of health care workers

towards adolescent sexuality, SRH services in public clinics were underutilised. Adolescents perceived health care workers as unfriendly and uninterested (Ramathuba *et al*, 2012b). This ultimately impacted negatively on the HIV prevalence and adolescent fertility control among adolescents in South Africa, as SRH services were hindered.

The stigmatising of teenage sexuality by nurses led to the unwillingness to acknowledge adolescents' experiences, which ultimately undermined the effectiveness of contraception (Wood and Jewkes, 2006). Health care workers' cultural beliefs strongly impacted on how they treated adolescents – the belief that women shouldn't have sex before marriage, for example (Holt *et al*, 2012). Furthermore, a lack of specific youth-friendly training and dedicated space for youth services was reported as a barrier to sexual and reproductive health services (Dickson- Tetteh *et al*, 2001; Geary *et al*, 2014). The underlying gap in the health care system's ability to deliver age-appropriate services for adolescents became evident with the increasing rate of SRH problems in South Africa (Mburu *et al*, 2013). These barriers needed to be addressed in order to curb the high HIV (STI) and adolescent fertility rates. Central to this was improving the adolescent-nurse relationship.

Therefore, it was established that addressing the problematic relationship between nurses and adolescents would ultimately impact positively on effective contraceptive use among young South Africans (Holt *et al*, 2012; Geary *et al*, 2014; Geary *et al*, 2015). This brought about the national implementation of Adolescent and Youth Friendly Services (AYFS) through public health care facilities in South Africa. The following section will explore and discuss the implementation and assessment of AYFS within South Africa, as a national response to the problematic adolescent-nurse relationship.

Adolescent and Youth Friendly Services

Sexual and reproductive health services specifically tailored to adolescents are a fairly recent public health initiative (Senderowitz, 1999). Previously, young people were not considered to need reproductive health services because of the way society viewed the norms of adolescent sexuality. Significant social change has taken place that has prompted programme planners and managers to re-evaluate the assumptions of adolescent sexuality and adolescents' SRH needs. It is considered that “adolescent health care is distinct from both paediatric and adult health care because of the physiological and psychosocial transitions that occur during this period” (Jaspan *et al*, 2009: 9). Furthermore, the SRH needs of adolescents were put at the forefront of reproductive health care services as the alarming increase of HIV infection in adolescents became apparent (Senderowitz, 1999). It was for this reason that it was identified that adolescents, as a young and key population,

require “comprehensive, integrated services that respond to their specific developmental needs” (Delany-Moretlwe *et al*, 2015: 29).

It was important to highlight that “a holistic approach to contraceptive provision involves considering the individual’s overall sexual and reproductive health needs” (Apter, Cacciatore and Hermanson, 2004: 81). Adolescent sexual health is built on the foundation of recognizing sexual rights, ensuring sexuality education and counselling, and providing confidential, high quality services (Apter *et al*, 2004). More importantly, given the disproportionate burden of HIV incidence among adolescent girls, SRH services need to be tailored to their specific needs. It is highlighted that “the availability, accessibility, and acceptability of health care services for young women significantly impact their use of prevention methods, which in turn influences their risk for pregnancy and HIV infection” (Holt *et al*, 2012: 284). As a systematic invention, AYFS aimed to create an environment for the effective uptake of contraception.

To be considered adolescent-friendly service, the World Health Organisation (WHO) highlights the following characteristics (WHO, 2012: 1):

1. Equitable: All adolescents, not just certain groups, are able to obtain the health services they need.
2. Accessible: Adolescents are able to obtain the services that are provided.
3. Acceptable: Health services are provided in ways that meet the expectations of adolescent clients.
4. Appropriate: The health services that adolescents need are provided.
5. Effective: The right health services are provided in the right way and make a positive contribution to the health of adolescents.

Internationally, WHO recognised the importance of providing specific services for adolescents in order to reduce the negative experiences that were impairing the use of clinics, and contraceptive use specifically (Mathews *et al*, 2009). In 2002, WHO released a document titled “Adolescent Friendly Health Services: An Agenda for Change” (Ashton *et al*, 2009). This document set out the universal standards, particularly for third world countries, on how clinics and health care providers should tackle the challenge of changing the experiences of adolescents. WHO states that AYFS have to be “accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient” (McIntyre, 2002: 27). This is achieved in multiple practical ways: training for doctors and nurses in dealing with adolescents and youth; ensuring confidentiality and privacy during consultations; availability of appropriate services; involvement of adolescents in the planning and monitoring of services; and

technical competence in dealing with the developmental needs of adolescents (McIntyre, 2002). Countries such as India, Tanzania, the United States of America, Mongolia and Zambia have adopted these guidelines in implementing AYFS locally (Mburu *et al*, 2013; Renju *et al*, 2010; Sovd *et al*, 2006; Secor-Turner, 2014; Nath and Garg, 2008; Chandra-Mouli *et al*, 2013).

In South Africa, despite the legal right to health services, and particularly sexual and reproductive health services, the uptake of contraceptives remained low in early post-apartheid South Africa. Unsafe sexual practices such as unprotected sexual behaviour were still apparent (Khoza, 2004; Wood and Jewkes, 2006; Thomas, 2009; Macleod and Tracey, 2010; Seutlwadi, Peltzer and Mchunu, 2012). There was a need to understand what the barriers to contraceptive use. Many factors were identified; of the most important was accessibility. Adolescents identified health care workers' negative attitudes, lack of confidentiality, long queues, lack of privacy, and shame and guilt as some of the barriers to accessing SRH services (Dickson-Tetteh, Pettifor and Moleko, 2001; Holt *et al*, 2012; Nkala *et al*, 2015). These factors highlighted the need for youth friendly services in South Africa.

Locally, AYFS were implemented in South Africa under the National Adolescent Friendly Clinic Initiative (NAFCI) (Erulkar, Beksinska and Cebekhulu, 2001; Ashton and Dickson, 2003; Ashton, Dickson and Pleaner, 2009). This initiative falls under the national sexual health campaign, loveLife (Dickson-Tetteh *et al*, 2001; Ashton and Dickson, 2003; Ashton *et al*, 2009). The aim of loveLife/NAFCI was to encourage positive behaviour change among South Africans, specifically the youth, in order to reduce teenage pregnancy, sexually transmitted infections and HIV/AIDS.

The key objectives of the programme are to make health services more accessible and acceptable to adolescents, establish national standards and criteria for adolescent health care in clinics throughout the country, and build the capacity of health care workers to provide quality services (Dickson-Tetteh *et al*, 2001: 160).

In order to establish what young South Africans consider 'adolescent friendly services', focus groups were conducted with adolescents. Four guiding principles were established: focus on clients; focus on systems and processes; focus on measurement; and focus on teamwork (Ashton and Dickson, 2003: 98). The aim is to provide services that meet the specific needs and expectations of adolescents by ensuring the system and environment are friendly and appropriate. AYFS highlight the need for teamwork in order to meet the needs of adolescents, drawing on all clinic staff in the improvement of services.

By 2001, the programme had expanded to all nine provinces, with services available at 305 health facilities. The programme was then further scaled up to a national policy, adopted by the South African Department of Health, and renamed in 2006 to Youth Friendly Services (YFS). Services vary from ARV treatment, care and support, to education and counselling on sexuality, safer sex, and reproductive health; STI education, diagnosis and management; contraceptive education and provision; pregnancy testing, with antenatal and postnatal care; and pre- and post-termination of pregnancy counselling (Geary *et al*, 2014).

As mentioned above, loveLife had formed part of the foundation of AYFS services in South Africa. The historical context of loveLife, South Africa's largest national HIV-prevention initiative for adolescents, will be explained below (Koon *et al*, 2014).

The campaign was launched in 1999 as a partnership between multiple stakeholders in South Africa. It brought together leading South African public health organisations and community organisations, the South Africa government, major South African media groups, and private foundations (Lesko, 2007). The campaign is a print and media education initiative, involving peer education (groundBREAKERS), outreach and mobilisation (Schiver *et al*, 2014). The different mediums used are "billboards, television and radio programmes, Sunday newspaper inserts, telephone helplines, sports days and community-wide events" (Lesko, 2007: 520). The strategic objectives of the campaign are to reduce HIV infections and teenage pregnancies, while keeping young girls in school and improving the employment opportunities of young people in South Africa.

The campaign aims to be relevant to young people in South Africa. By "combining marketing techniques with public health education, loveLife explicitly and deliberately fuses messaging about safe sex with iconography of popular youth culture so that 'safety' becomes 'cool'" (Lesko, 2007: 520). However, the success of loveLife has been criticised because of the methods used. Despite evidence that "several programmes have been demonstrated to be effective in improving knowledge and attitudes concerning HIV and the uptake of HIV testing" (Dellar, Dlamini and Abdool Karim, 2015: 67), the campaign has been ridiculed for creating obscurity around SRH, rather than addressing problems directly. In 2006, the South African government reduced the funding of loveLife because of little evidence to show that the campaign was, in fact, influencing the behaviour of young people (Lesko, 2007).

Funding through loveLife for AYFS in South Africa ceased in 2006. The DOH agreed to manage a simplified version of NAFCI (Koon *et al*, 2014). It was scaled up to a national policy in 2006 and renamed Youth Friendly Services (YFS), as mentioned. However, this scaling up has produced difficulties as the system is decentralised, and the burden of inequalities in health care is still apparent, affecting the perceptions of quality and the trust in the health care system (Schiver *et al*, 2014). In the 2010/2011 report, the Department of Health figures indicated that 47% of public funded primary health care facilities in South Africa were implementing YFS (DOH, 2011). However, the DOH aimed to have 70% implementing this programme by 2012/2013 (DOH, 2010). Recent statistics on the implementation of YFS in South Africa are limited.

SRH Services in South Africa Today

Despite the efforts of government, in terms of the legal access to SRH services, and the implementation of adolescent and youth friendly services in order to curb the negative experiences of adolescents, barriers to services are still apparent in South Africa. Even with the efforts of the government and non-profit organisations to change the stigmatisms that surround clinic access and contraceptive use, studies still highlight the generally poor implementation of youth friendly services in South Africa.

Barriers to Services

Research shows that there was improved access to HIV testing following the implementation of AYFS; however, experiences of negative attitudes of health workers and breaches in confidentiality persisted (Mathews *et al*, 2009; MiET Africa, 2011; Holt *et al*, 2012; Geary *et al*, 2014; Geary *et al*, 2015). A study conducted in rural South Africa highlighted that despite efforts to improve the experiences of adolescents, nurses reported a lack of youth friendly training among staff, as well as a lack of dedicated space for young people, as the greatest barriers to provision of services. Of the eight participating clinics, four did not appear to uphold the constitutional rights of youth aged 12 years and older to access health care independently. Breaches in confidentiality were reported as the most apparent hindrance (Geary *et al*, 2014). The goal of implementing YFS in 70% of public health clinics was not realised in this community. Health care workers suggested that the greatest need in clinics, in order to ensure services were youth friendly, was that “training and on-going support should be provided” (pg. 259).

A specific study conducted in Soweto identified that, despite the implementation of YFS, knowledge of the services available was very low, with no comprehensive knowledge of the programme's purpose or activities. The study established that, generally, young people were dissatisfied with the services available, with a lack of resources, long waiting times and the poor quality of care due to the lack of choice and inequity, being the greatest barriers to health care services (Schiver *et al*, 2014). Studies have highlighted that socio-psychological issues are a great hindrance to the use of SRH services, where "coverage of services is low, largely because of stigma and discrimination experienced at both the health system and policy levels" (Delany-Moretlwe *et al*, 2015: 29). Additional barriers are attributed to cost, inconvenient hours as well as legal and policy constraints (MiET Africa, 2011).

Health care workers have been reported to restrict certain services to only those over the age of 18 years, despite adolescents' constitutional rights (Holt *et al*, 2012). Some health care workers still hold the belief that young women should not be sexually active before marriage, thus hinder their provision of full SRH services (MiET Africa, 2011; Holt *et al*, 2012; Geary *et al*, 2015). Discrimination and stigmatisation were specifically identified in a study, where participants stated that health care workers "would be rude to them, tell their parents or deliberately misinform them" (Mkhwanazi, 2010: 356). Despite the constitutional right of adolescent females to SRH services, "when teenagers tried to access contraceptives in clinics, they were ridiculed and taunted by nurses, who labelled them 'loose women' (Mkhwanazi, 2010: 356).

Studies have identified the potential of health care workers in reducing individual risk factors among adolescents, as a young key population, namely, "ensuring they receive the maximum social support they are eligible for, providing reliable and non-judgemental counselling on sexual and reproductive health and relationships, delivering contraceptives and screening and treating STIs in the context of accessible, youth-friendly services" (Dellar, Waxman and Abdool Karim, 2015: 952). It is imperative for services to be available, accessible and acceptable in order to increase the uptake of SRH services and, ultimately, the effective use of contraception. Health care workers bridge the gap between the services available and the adolescent females who utilise the clinics. It is vital that the relationship between nurses and adolescents is benevolent.

However, some clinics have been praised for their successes in the community (Ashton and Dickson, 2003). A study conducted in 2007 established that, in 11 public health clinics where adolescent friendly standards were implemented, a significantly better performance in the provision of services was achieved (Dickson, Ashton and Smith, 2007). Questions of the effectiveness of AYFS still remain, with

multiple studies stating that there is limited evidence that youth friendly services may improve reproductive outcomes of young people (Erulkar *et al*, 2001; Mathews *et al*, 2009; Brittain *et al*, 2015; Geary *et al*, 2015). There is, however, a definite need for further integration of HIV prevention efforts into broader sexual and reproductive health services in public health facilities in South Africa. By integrating health systems to address barriers to health care, these interventions are potentially critical, “as there is a significant demand for more comprehensive SRH services that recognise the inter-relationships between HIV and broader SRH and thus the importance of integrated service delivery” (Dellar, Dlamini and Abdool Karim, 2015: 67).

Studies have identified that further technical training in adolescent health care is needed for health care workers in order to ensure that YFS are appropriate, beneficial and sustainable (Wood and Jewkes, 2006; Thomas, 2009; Jaspan *et al*, 2010; MiET, 2011; Holt *et al*, 2012; Mburu *et al*, 2013; Godia *et al*, 2013; Schiver *et al*, 2014; Geary *et al*, 2014; Schiver *et al*, 2014; Tanner *et al*, 2014; Geary *et al*, 2015). Further training on how to provide sensitive and equitable treatment for all is vital in order to ensure services are adolescent friendly: “there is a need to address the cultural, religious and traditional value systems that prevent health service providers from providing good quality and comprehensive SRH services to young people” (Godia *et al*, 2013: 476). Furthermore, health care workers believe that, in order for youth friendly services to be effective in South Africa, staff shortages and lack of equipment and supplies need to be addressed (Maharaj and Cleland, 2005; Holt *et al*, 2012; Mataboge, Beukes and Nolte, 2015). Health care workers highlight that time constraints posed by the heavy patient loads in public health clinics presented a great barrier to offering the full services available to adolescents (Maharaj and Cleland, 2005).

Further studies on clinic organisation and clinic culture are suggested (Tanner *et al*, 2014). By improving the clinics’ physical and social environment, it is assumed that significant barriers to adolescent SRH care can be reduced. The physical environment should be an adolescent friendly space, and the social environment the specific training of health care workers in order to meet the specialised needs of youth (Tanner *et al*, 2014). However, “the program goes beyond training staff to be friendlier or improving their clinical skills. Collaboration, empowerment and ownership have been significant by products of this program” (Ashton and Dickson, 2003: 100). It was where clinics “developed a bond between the youth, clinic staff and community” that the greatest impact locally was identified (Ashton and Dickson, 2003: 101). AYFS need to go beyond friendly health care workers and the adolescent friendly clinic facilities; all facets of the community need to be engaged with, in order to create a holistic approach to adolescent sexuality and SRH.

A key research question in this study is to understand the level of self-care in respect to SRH among adolescent females, and the impact of health care workers and facilities in influencing their decisions. The studies above have shown that health care workers and facilities greatly impact the experiences of SRH services for adolescents. Many studies have identified that health care workers/nurses pose a barrier to SRH services, rather than positively impacting the effective use of SRH services. This study aims to apply Orem's self-care model, in order to establish how adolescent females evaluate their self-care abilities and their experiences of health care workers in meeting their self-care deficits. Furthermore, this study aims to identify the experiences of adolescent females with regard to AYFS in their community. The study hopes to identify how AYFS have influenced the attitude, knowledge and perceptions of adolescent females towards sexuality and, ultimately, their experiences of SRH services.

Knowledge of Contraception

There are four essential elements in the effective use of contraception: "a desire to use protection, a good contraceptive method, ability to obtain the contraceptive method and the ability to use" (Apter *et al*, 2004: 88). In order for effective contraception, each of these elements needs to be met. Three of these elements have been discussed in the previous sections, where this dissertation has identified the perception of risk among adolescents towards HIV and falling pregnant. Effective contraceptive methods need to be available, as this dissertation has identified the legal rights of adolescents to SRH services. The barriers to SRH services, thus hindering the ability for adolescents to obtain contraceptives, have been discussed. This last section will highlight the ability of adolescents to use contraceptives, expanding on the knowledge of different contraceptive methods.

Studies have identified that a lack in correct sexual and reproductive health education remains in South Africa among adolescents (Wood and Jewkes, 2006; Kanku and Mash, 2010; Holt *et al*, 2012; Ramathuba, Khoza and Netshikweta, 2012a; Geary *et al*, 2015). Despite the efforts of AYFS and extensive health communication campaigns, comprehensive knowledge of the multiple contraceptive methods available is limited (Holt *et al*, 2012). "Despite on-going campaigns and intervention programmes promoting safe sex, contraceptive use remains a controversial area among South African youth" (Seutlwadi, Peltzer and Mchunu, 2012: 43). There is a need for greater information on human sexuality, conception and contraception at as early a stage as primary school, in order to eliminate misconception about contraceptives (Ramathuba *et al*, 2012b).

The most common contraceptive used is the male condom (Kanku and Mash, 2010; Seutlwadi *et al*, 2012; Ramathuba *et al*, 2012a). Among women, the ease of getting condoms and delayed sexual debut

were associated with higher contraceptive use. Among men, increased knowledge of contraceptives, open conversations with their partners, and loveLife and multimedia programme exposure were associated with increased contraceptive use (Seutlwadi *et al*, 2012). There is a definite lack of knowledge of the emergency contraceptives, IUD and female condoms (Ramathuba *et al*, 2012b). Although there are multiple contraceptive methods, adolescents are limited in their knowledge of the options available to them.

In the recently published demographic and health survey in South Africa, contraception knowledge was assessed among adolescent females between the age of 15 and 19 years old. 60% of participants stated that they used a form contraceptive method (modern or traditional). The most common method used is the male condom (23,8%), with the two-month hormone injection being the second choice (16,1%). Notably 0% of participants identified the use of an IUD, as well as 0% stating the use of an emergency contraceptive. It was further highlighted that 40% participants were using no contraceptive method of any form (Statistics South Africa, 2016).

As this literature review has highlighted, despite the perception of risk towards SRH problems and the legal availability of contraceptives to adolescents in South Africa, the lack of knowledge and the barriers to services remain a hindrance to effective contraceptive use. It is vital to expand the body of knowledge on adolescent sexuality and their perceptions of SRH, in order to communicate effectively about adolescent SRH. Furthermore, in order for sexual and reproductive health services to be effective, the barriers to services need to be addressed through greater understanding of adolescent experiences of health care facilities. The problematic adolescent-nurse relationship needs to be further analysed and resolved. This study aims to use Orem's self-care model (1980) as a way of establishing the self-care abilities and deficits among adolescent females, as well as establishing the role of nurses in meeting the SRH needs of adolescent females.

Orem's Self-Care Model

As a general nursing theory, Orem's self-care model will be explained and explored in greater detail under the Theoretical Framework chapter. This section aims to review Orem's self-care model in the context of SRH, as applied in a South African context. As this chapter has highlighted, knowledge of contraception and contraceptive use is a vital indicator of sexual health. Sexuality encompasses more than sex; it is the understanding of STIs, conception, contraceptives and social factors that influences behaviour. In order to curb the increasing adolescent fertility and adolescent HIV infection rates, it is pertinent that adolescents are equipped with comprehensive, adequate and accurate information in order to achieve self-care and take responsibility for their own SRH (Ramathuba *et al*, 2012b). This section of the literature review will outline a study conducted in Limpopo, South Africa, where Orem's self-care model was applied in order to empower secondary school girls with contraceptive knowledge and use.

Thulamela Municipality, Limpopo, South Africa

The Thulamela Municipality is located in the eastern part of Limpopo, which borders on the Kruger National Park. With a population of approximately 600 000 people, the area is largely impoverished, recording a 43,8% unemployment rate. Specifically, 58,3% of youth in the area remain unemployed. The study was problematized based on studies identifying that contraceptive knowledge and contraceptive uptake in the Limpopo province remained poor (Ramathuba *et al*, 2012b). Orem's self-care model was used as the framework to understand how the lack of contraceptive knowledge and effective counselling leads to misinformation and poor use of contraceptives, and, furthermore, to explain how Orem's theory of self-care can be applied in order to empower secondary school girls to make informed, knowledgeable decisions on the use of contraceptives and caring for their sexual health.

The study was conducted with 273 secondary school girls in grades 10 to 12, between the ages of 13 and 19 years old. A quantitative research methodology was used, in the form of open- and close-ended questionnaires, distributed at six secondary schools. The questionnaires aimed to gain information on their level of sexuality education and contraceptive knowledge, attitudes of health care workers, and their use of SRH services. Findings from the study indicated the self-care capabilities and deficits of adolescent girls.

Due to their age, their educational level and life experiences in their context, it is assumed that adolescent females have the ability to maintain their sexual and reproductive health for themselves. From these developmental characteristics, it is presumed that adolescents' self-care abilities evolve with their progression from one life stage to another. This specific study identified that participants had the ability of self-care, with some highlighting abstinence, as they were not ready to have sex. Furthermore, 51% indicated using some form of contraceptive, specifically, 29% identifying the use of condoms, 9% injection and 3% pills (Ramathuba *et al*, 2012b). Participants showed self-care agency through their ability to visit local reproductive health services to consult for contraceptives. Furthermore, they identified their ability to refrain from unprotected sex and negotiate safe sexual practice.

Although self-care agency was identified in participants, the fulfilment of the therapeutic self-care demands was lacking. This refers to the "totality of self care actions to be performed for some duration in order to meet self care requisite" (Ramathuba *et al*, 2012: 219). In this study, it was highlighted that contraceptive use was inconsistent and irregular. The self-care requisites of adolescent females are specialised for the developmental stage, where specific care and education are necessary in order to ensure the maintenance of health and well-being. As this study discovered, although participants had self-care abilities, self-care deficits were still apparent. Orem's theory of self-care deficits delineates when nursing is needed. Deficits were found in appropriate and adequate sexual and reproductive health information. Majority of information was gained from school, parents and peers. The study found that "the care capabilities of secondary school girls are less than the required for meeting the self care demand" (pg. 220). 84% of participants identified that, despite the information they were given on sexuality, they had not changed their behaviour. Researchers attributed the deficit of knowledge to the lack of concrete sexual education, as well as the lack of open communication between adolescents and their parents, teachers and church leaders. Culture was underlined as a barrier to communication (Ramathuba *et al*, 2012b).

Central to Orem's theory of self-care is the role of nurses in meeting the self-care deficits of adolescents. "A nursing system is designed by the nurse based on self care needs and abilities" (Ramathuba *et al*, 2012b: 221). The supportive-educative nursing system is created to provide physical and psychological support for adolescents. However, the study found nurses hampering the process of meeting their self-care demands. Judgement, scolding and ridicule were identified as factors associated with the under-utilisation of clinics and nurses. A key judgement of nurses was that participants were too young to engage in sexual intercourse (Ramathuba *et al*, 2012b). Ramathuba, Khoza and

Netshikweta (2012b) underline that it is vital that nurses respect adolescents and provide the necessary services they need.

This study that applied Orem's self-care model recommended that proper and adequate information was further needed in order to empower girls in self-care. More information on human sexuality, conception and contraceptives was identified as a need. The nurses needed to provide confidential counselling and quality contraceptive information and services, with further information on the benefits of contraceptives.

The question remains: how is the Limpopo study relevant to this research? Orem's self-care model forms part of the theoretical framework through which data was analysed. This study aimed to understand adolescents' knowledge of sexuality, attitude towards self-care and SRH, and perception of health care workers. The findings of the research conducted in Limpopo created a foundation for this study. As it intended to empower secondary school girls through the application of Orem's self-care model, this study aims to apply this model in the context of a local school in KZN. The study in Limpopo adopted a quantitative methodology, yielding quantitative data on the level of knowledge of contraception and sexual health. This study adopted a qualitative methodology, aiming to yield rich and thorough data explaining the attitudes and perceptions of adolescents towards sexuality and SRH.

Art-Based Methodologies

A study conducted by Khoza (2004) on adolescents' knowledge, beliefs and experiences regarding sexual practice in South Africa stated that a limitation of sexuality research is the discomfort of participants in talking about their sexual experiences in groups. Much of the research conducted in South Africa on adolescent sexuality adopted conventional methods of data collection, such as interviews, focus group discussions and questionnaires (Harrison *et al*, 2001; Hoosen and Collins, 2004; Khoza, 2004; Govender, 2013). However, often these methods are very structured and are conducted in a formal setting, which creates a barrier to effective dialogue and discussion with adolescents, particularly around SRH. Art-based methodologies have grown in popularity over the years as an alternative way to engage with adolescents, in order to "offer a new form of qualitative inquiry to address challenges of traditional techniques of research which are not positioned to adequately handle many questions that need to be asked" (Govender, 2013: 54).

The definition of art-based methodologies is a “systematic use of the artistic process, the actual making of artistic expressions in all of the different forms of the arts, as a primary way of understanding and examining experience by both researchers and the people that they involve in their studies” (Knowles and Cole, 2008: 29). It is understood as an emerging tradition of participatory critical action research, emphasising participation and collaboration during the entire research process (Lincoln, 1995). As a methodology, it mobilises adolescents towards their own empowerment, through promoting participation and self-development (Govender, 2013). It creates a flexible environment, with the freedom to communicate as participants negotiate their level of participation. When participants are able to negotiate their level of participation, they can also negotiate *self/other* power relations. The researcher and the researched are drawn into a shared research space, where participants are able to see themselves in relation to others. Adolescents are then seen as knowledge producers, as spaces for dialogue are created.

This dissertation aims to explore the potential of participatory research approaches in addressing the complexities of researching sexuality and SRH among young people. An art-based research methodology was adopted in the study through the use of mapping. Participatory action research and the methodology are explained further in the Methodology chapter. As part of an art-based methodology, bodymapping will be explained in this literature review, expanding on research conducted on its effectiveness in aiding communication within HIV/AIDS research.

Mapping as a participatory method has various forms, for example, participatory mapping, social mapping, intervention mapping, concept mapping and bodymapping (Govender, 2013). For the purpose of this study, participatory mapping will be explained as it forms the basis of the application of bodymapping. Mapping is a form of visual methodology. It “refers to maps made or drawn by members of a community on paper or on the ground. It is a process by which information is represented in a spatial form” (Narayanasamy, 2009: 41). As a method, participatory mapping fits within the broader framework of participatory methodologies, as it engages with community members for data collection and information generation, where participants have control over the data construction process.

Bodymapping is a form of participatory mapping. Originally used in the context of HIV/AIDS in South Africa, bodymapping has evolved and been adapted to be used in multiple contexts. It is a way of “telling stories and making art about yourself”, with the hope that this will provide solutions to problems faced by the participants (Solomon, 2008: 2). Bodymapping is life-size visual representation of one’s body. Multiple creative methods (drawing, painting, visualization, talking, reflecting, singing, dancing)

can be used in order to represent a holistic image of the participants, showing their mind, body and community (Solomon, 2008). In bodymapping, “the use of drawing, visuals and creative materials such as paints, pastels, food colouring and bold markers allow the participants to document their lived experiences through visual representations” (Govender, 2013: 59). Through these representations, a range of problems, impressions, perceptions, thoughts and experiences are represented on the traced outline of the participant’s body.

Bodymapping and HIV/AIDS

With the increasing teenage pregnancy and HIV infection rates among adolescent girls in South Africa, there is a need to create dialogue with adolescent girls in order to understand and fulfil their SRH requirements. Previous studies conducted in South Africa on adolescent sexuality have established that it is not always easy and comfortable for participants to discuss their sexual experiences in groups or in interviews (Khoza, 2004). These studies have established that “because the topic of sexualities is often wrapped in silences, taboos, and privacies, researchers need to hone distinctive techniques and methods that unearth invisible, silenced and repressed knowledge” (Tamale, 2011: 12). As discussed earlier, bodymapping as a participatory art research methodology creates a flexible environment in which communication has the possibility of being free and comfortable.

This dissertation aimed to assess the perceptions of adolescent females towards art-based methodologies, specifically bodymapping, as an effective tool in researching and communicating about sensitive topics such as sexuality and SRH. The study intends to establish whether bodymapping was perceived as either aiding or inhibiting effective communication among adolescent girls, in terms of their sexual and reproductive health.

Previously, bodymapping was used in the context of HIV/AIDS research within South Africa. A study conducted in KwaZulu-Natal aimed to explore the experiences of young people in the participation of HIV and AIDS communication, using bodymapping (Govender, 2013). The findings from the study highlighted multiple benefits of bodymapping in engaging with adolescents in HIV/AIDS communication. It was established that bodymapping increased the confidence of participants to engage and participate in the research. Students were required to be active participants, where increased confidence encouraged increased self-initiative. A higher level of confidence meant dialogue was encouraged through bodymapping. The bodymapping workshops created a space to engage in discussion and build social relationships, where students were able to identify similar challenges between participants. The

bodymapping workshop created a relaxing environment in which to connect with others, where they discovered that problems faced were collective commonalities.

The study highlighted that bodymapping encouraged introspection and self-reflection. Students stated that the process required them to ask questions of themselves and understand more about what they understood and perceived. The workshops encouraged problem identification and problem solving, as students discussed issues that are usually hidden and not confronted. Participatory action research methodologies not only aim to create spaces for participation, but also to create spaces for action, where participants identify relevant problems in their communities as well as relevant solutions for their communities. Bodymapping effectively created a space for participation and action. Lastly, this study highlighted the potential of art as an alternative form of expression. The use of colour and symbols allowed participants to create their own interpretations, as they explored their own ideas in a safe, flexible, comfortable space.

However, although many positive attributes were identified in bodymapping, some participants found the process frustrating and tense. The challenges of the workshop show that not all participants were comfortable with drawing as an art methodology. They were unsure of how to express their emotions by drawing on their bodymaps. Some participants stated that they did not like being unaware of the outcome of the whole bodymapping process. They felt they had discussed several issues, but did not know how to resolve them moving forward from the bodymapping workshop. The study concluded that there are many benefits to bodymapping as a participatory research methodology. However, a “variety of methodologies must be used to encourage maximum participation” (Govender, 2013: 165).

Govender (2013) has highlighted the potential of bodymapping as an effective tool in communicating and researching around HIV/AIDS in the South African context. Due to the sensitivity of sexuality and the experiences of SRH services, it is vital for alternative ways of communicating and researching with young people to be identified. This study aims to assess the effectiveness of art-based methodologies in researching with adolescent females, as they are given the space to communicate about their SRH experiences. This study sets out to evaluate art-based methodologies as an alternative methodology to research this key population in the context of the growing SRH problems faced in South Africa.

Conclusion

This chapter has discussed literature relevant to adolescent sexuality, adolescents' experiences of SRH services, and the influence these have on SRH practices for adolescent females. The chapter argued the multidimensional understanding of adolescent sexuality and the need to broaden the understanding of adolescent sexuality, as it forms the basis of the sexual health decision-making process. The chapter highlighted multiple factors, specifically sexual debut and the family structure, that influence the construction of sexuality among adolescents. Further exploring how these factors impact on their interaction with SRH services. Furthermore, this chapter identified the problematic nurse-adolescent relationship, where health care workers posed as a barrier to SRH services. This highlighted the need for greater understanding of the self-care capabilities and deficits of adolescent females, in order to delineate when nursing is needed in SRH provision. Lastly, art-based methodologies have been explored, specifically highlighting the benefits of bodymapping in SRH communication. This literature review has highlighted the need for further understanding of the effectiveness of art-based methodologies, in not only researching, but also communicating with adolescents about sexuality and their sexual and reproductive health.

The following chapter will explain the theoretical framework that informed this study.

THEORETICAL FRAMEWORK

Introduction

As outlined in this study, sexuality has been defined in terms of its interaction with the “biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual” aspects of life (WHO, 2002: 5). It is recognised that in order for one to understand sexuality, one has to understand the multiple influential factors that impact on it. Furthermore, this study has identified that sexual and reproductive health is a “state of mental and social well-being related to sexuality” (WHO, 2002). This explanation allows space for multiple explanations in which to understand what sexual and reproductive health may mean to various people, in different contexts and cultures. This study aims to map sexuality among adolescent females in KZN, primarily to understand the locally specific, culturally contextual knowledge of sexuality and how this impacts on their SRH decisions. Essentially, as sexuality and sexual and reproductive health are explored, this study intends to identify the factors that impact on the understanding of sexuality among adolescent females, as well as explore what sexual and reproductive health means to an adolescent female in KwaZulu-Natal.

From this standpoint, the culture-centred approach (Dutta, 2008) and Orem’s self-care model (Orem, 1980) were chosen as the theoretical lens through which this study would be understood. This chapter will delve into the origins, characteristics, functions and applications of CCA, highlighting the importance of *culture*, *agency* and *structure* as influential factors in understanding SRH among adolescent females. Furthermore, this study is interested in understanding what SRH means to adolescent females. It is focused on the perceived role of adolescent females and nurses in maintaining sexual and reproductive health. Therefore, Orem’s self-care model was chosen in order to assess the perceived roles of adolescents in SRH self-care. This model highlights the need for nursing, outlining the need for nurses to be supportive educators. As this model is applied, this study aims to assess the self-care capabilities and deficits of adolescent females, and how health care workers in South Africa aid or inhibit the experiences of adolescent females. This nursing theory will be broken down into three interacting theories (theory of self-care, theory of self-care deficits and theory of nursing systems) that work in conjunction, in order to form a framework for self-care. These theoretical frameworks were used as a guiding structure within the data collection and the data analysis process.

This study aims to combine a public health theory (Orem’s nursing theory) with a cultural studies theory (CCA), in order to understand the socio-cultural influences on the sexual health practices of adolescent females, and the impact these have on health care facilities. Orem’s self-care model places emphasis

on the individual, where as CCA highlights culture and structure, which ultimately influence the individual. These two theories will be used together in order to establish the culture-centred understanding of self-care. Self-care will be understood not only by the self-care capabilities of adolescent females, but also by the influence of culture and structure on the capabilities of adolescent females.

Culture-Centred Approach

This study intends to explore the socio-cultural understanding of sexuality among adolescent females. This part of the chapter will explore the historical overview of the understanding of culture in health communication, focusing on the shift from a dominant approach to a culture-centred approach in health communication. CCA is built upon three cornerstones: *culture*, *structure* and *agency*. This will be explained in regard to this research, in how they influence and impact on the understanding of sexuality and sexual and reproductive health among female adolescents in South Africa. This understanding, in turn, impacts on the self-care capabilities and deficits of adolescent females in maintaining their SRH. There are diverse ways in which meanings of health and illness are formed in diverse societies and cultures; this study aims to understand what sexual and reproductive health means to adolescent females in the Mayville, KZN, context. With the increasing SRH problems in KZN, it is pertinent to understand the meaning of health and illness within this culturally specific context and how this impacts on the self-care abilities of adolescent females.

The Transition from a Dominant Approach

Over the years, increasing attention has been placed on studying health communication within the cultural context in which it is placed, in order to create the climate for multicultural health communication structures (Airhihenbuwa, 1995; Basu and Dutta, 2007; Dutta, 2007; Dutta, 2008; Dutta and Basu, 2011). In order for one to understand the foundations of CCA, one needs to understand the transition from a dominant approach in health communication towards a participatory approach. Under the dominant approach, communication was viewed as a linear, top-down communication process, where beliefs, information and knowledge were transmitted from the core sectors to the subaltern spaces (Dutta and Basu, 2007; Dutta and Basu, 2008). In health communication, this meant that the biomedical model was favoured in problematising health, and ultimately offering solutions to health problems. The dominant approach viewed communication as a one-way transmission where experts communicated with a passive audience. However, this did not take into account the culture or context surrounding health communication. "The absence of cultural considerations is accompanied by the

absence of the voices of cultural communities that have typically been treated as the subjects of health communication interventions, drawing upon a top-down Westcentric biomedical narrative” (Dutta and Basu, 2011: 329). Criticisms towards the dominant approach to health communication highlighted the erasing of marginalised voices from the discursive sphere.

Through critical analysis of the dominant approach to health communication, four key criticisms were identified: individualism, cognitive bias, decontextualisation and bias towards the expert position (Dutta-Bergman, 2005; Dutta, 2008). Firstly, the dominant approach was focused at the individual level (Dutta, 2008). Campaigns were aimed at behaviour change at the individual level, where the decision-making process was accounted to an individual’s attitudes, beliefs and cognition. Eurocentric individualism does not consider the collective cultural context that guides and informs the decision-making process (Dutta-Bergman, 2005). Within HIV/AIDS and SRH campaigns, the dominant approach would aim to change an individual’s sexual behaviour by encouraging safe sexual practices, but it would not take into account the “socio-economic status, access to resources, shifting cultural norms, community-wide decision networks, issues of gender inequality and relationship negotiation” which greatly impact on the decision-making process of all individuals (Dutta, 2008: 50).

Furthermore, the dominant approach conceptualised rational thought at the centre of the decision-making process in health. Basing campaigns on rational thought eliminated the idea that some decisions are made on the spur of the moment, where rational thought doesn’t take place. As mentioned earlier, the dominant approach aimed to influence the audience to change their behaviour by arguing the rational thought behind certain decisions. This again annihilated the cultural and contextual influences that impact on rational thought processes (Dutta-Bergman, 2005; Dutta, 2008). Related to this was the decontextualisation imposed by the dominant approach. “Health as conceptualised in the dominant approach is typically removed from the context that surrounds it” (Dutta, 2008: 53). The dominant approach did not take into account the constraints that may negatively affect the decision-making process of an individual. It was argued that communication needs to be bottom-up in order to understand the structural context that surrounds individuals, which ultimately impacts on their ability to make effective SRH decisions.

The dominant approach aimed to maintain control and status quo within health communication. This was achieved through bias towards the expert position. Rather than engaging with marginalised groups, health communication research remained within the ivory towers (Dutta, 2008). Void from health communication campaign design was the involvement of community members in identifying and

defining health problems and possible solutions (Dutta and Basu, 2007). This revoked agency from community members, where 'experts' were assumed to have the knowledge and ability to examine the beliefs, values and practices of those they researched (Dutta, 2008). For example, campaigns were often designed in the First World, in order for them to be implemented in the Third World, thus being intrinsically removed from context, culture and community. This further perpetuated the top-down Eurocentric biomedical narrative within health communication (Dutta and Basu, 2011).

When the dominant approach to health communication failed to ensure effective behaviour change, re-evaluation of the approach was fore-fronted. The concept of social change, rather than behaviour change, was highlighted. In order for social change to occur, the cultural context had to be acknowledged, where culture was placed at the centre of all health communication.

The Need for a Culture-Centred Approach

CCA was built upon the criticism highlighted by Airhienuwa (1995) and Dutta-Bergman (2004) towards the dominant approach in health communication (Dutta, 2008). The CCA was born out of the rejection of knowledge alone being enough for behaviour change (Airhienuwa and Obregon, 2000). Whereas the dominant approach seeks to instruct and intervene, the CCA seeks to bring about social change. It was argued that, in order for a health campaign to be successful, campaign planners needed a greater understanding of their 'target audience', taking into account the influence of culture on the decision-making process.

Theoretically, CCA is rooted in critical theory, cultural studies, postcolonial theory and subaltern studies (Dutta, 2008). Within CCA, which draws from critical theory, health communication scholarship "is engaged with questions of power, ideology, hegemony and control in the discourses and practices of healthcare" (Dutta, 2008: 10). Whereas the dominant theory previously used communication as a one-way, linear model, CCA examines how knowledge is used in order to maintain power and control, thus perpetuating the status quo. Furthermore, critical theory is interested in understanding the role of social structures in restricting the experiences of the underprivileged class, through the use of ideology and hegemony. It aims to disrupt power by engaging with marginalised groups who have previously been left out of the discursive space. Where critical theory raises questions around ideology and hegemony, cultural studies is interested in how knowledge is socially constructed by the elite. Cultural studies emphasises the "social constructions of discourse and the culturally situated nature of health narratives" (Dutta, 2008: 10). Whereas, before, the dominant approach voided cultural sensitivity, CCA

acknowledges the influence of culture in the social construction of everyday experiences and power relations.

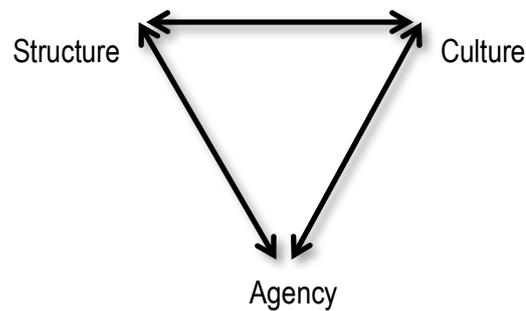
CCA furthermore draws on postcolonial theory (Dutta, 2008; Dutta and Basu, 2008; Dutta, 2011). Postcolonial theory is “fundamentally transformative in seeking to alter those knowledge structures that erase the stories of violence inherent in global neo-colonial configurations and create spaces for listening to the voices of subaltern sectors of the globe” (Dutta, 2011: 5). Furthermore, subaltern theory is guided by “the desire to rewrite the narratives that constitute the discursive spaces of history by listening to locally situated voices that have been systemically erased” (Dutta, 2011: 7). Together, these theories work towards redefining the research space in order to create dialogue within marginalised groups. Where previously the dominant approach silenced subaltern groups, CCA acknowledges the need to engage with these groups in order to create effective health communication campaigns. The aim is to create alternative discursive spaces that challenge hegemony of the knowledge elite. Where the traditional approach focused on an expert understanding of health problems, CCA advocates “engaging in dialogue with cultural members” (Dutta, 2008: 45).

It is from this theoretical understanding of CCA that the three cornerstones of the approach are identified: *culture*, *agency* and *structure*.

The Three Cornerstones

CCA to health communication is essentially focused on understanding health meanings and experiences among marginalised communities. CCA is built upon the foundation of culture, agency and structure, and it is the interaction of these three key concepts by which it “creates openings for listening to the voices of marginalised communities, constructing discursive spaces which interrogate the erasures in marginalised settings and offer opportunities for co-constructing the voices of those who have traditionally been silenced by engaging them in dialogue” (Dutta, 2008: 5).

Figure 3.1 The culture-centred approach to health communication



(Dutta, 2008: 5)

Culture

The first cornerstone of CCA is culture, understood as a complex network of meanings which is in a constant state of flux (Dutta, 2011; Dutta, 2014). Dutta and Basu (2008: 561) conceptualise culture as “a dynamic communicative process that leads to social, economic, and political structure characterised by a system of values that influences attitudes, perception, and communication behaviours”. The dynamic communicative nature of culture is fundamental to this study, as it places culture as the central communicative tool through which health is understood and communicated (Airhihenbuwa and Obregon, 2000). Culture, which distinguishes one group from another, provides the communicative scaffolding through which health is given meaning, where health and illness are embedded within cultural beliefs, values and practices (Dutta-Bergman, 2004; Dutta, 2008; Dutta and Basu, 2011).

This study is focused on grasping socio-cultural understanding, where the social and cultural factors are identified in influencing the perceptions, beliefs and values of sexuality and SRH. Where the dominant approach stated that culture was unchanging and static, CCA acknowledges the dynamic and fluid state of culture. This ultimately means that the meaning of health is localised and contextual. What one culture may believe the meaning of health and illness to be, does not necessarily mean another culture believes the same. In order for SRH campaigns to be effective in South Africa, cultural sensitivity is crucial. This study hopes to place culture at its forefront, in order to find culturally specific solutions to localised health problems.

The central question of this study is to understand in what way culture has influenced the attitudes, perceptions and communicative behaviours of adolescent females towards sexual and reproductive health. “Culture emerges as the strongest determinant of the context of life that shapes knowledge creation, sharing of meanings, and behaviour changes” (Dutta and Basu, 2008: 561). As sexuality

places culture central to the formation of one's sexuality, culture essentially has to be the lens through which sexuality is understood. How culture has shaped the knowledge creation of SRH, how it has shaped the meaning of sexual and reproductive health, and how it has influenced behavioural changes towards sexual and reproductive health are questions this study hopes to answer as it puts culture at the centre.

Highlighted in CCA are values. Dutta states that "the culture centred approach suggests that values are central to the ways in which we conceptualise the problems we consider to be important and the corresponding solutions we develop to those problems" (Dutta, 2008: 64). Values influence how problems are defined and how solutions are developed. These values could be family, cultural, religious or spiritual values. This study is interested in understanding the various values that have influenced the perceptions of adolescent females towards sexual and reproductive health, in order to understand how they conceptualise sexual and reproductive health problems. Furthermore, by understanding the value systems of adolescent females, this study hopes to understand what they consider important in regard to SRH, and how this influences the solutions they seek to solve these problems. Ultimately, these values will influence the self-care capabilities of adolescent females, as they decide what is of importance.

Cultural values are deeply important to how health problems are identified and how solutions are sought out. For example, generally in Western culture, it is considered unacceptable to have multiple sexual partners at the same time. However, in other cultures, polyamory is a socially acceptable behaviour. Should a health campaign be successful in a certain context, it has to be culturally sensitive to the values of that particular culture; for example, instead of advocating for faithfulness to one partner, rather advocating for safe sexual practices. "One of the key elements of CCA is in depicting the value-based nature of knowledge production, documenting the broader cultural logics that are reified through the production and circulation of knowledge" (Dutta, 2014: 72).

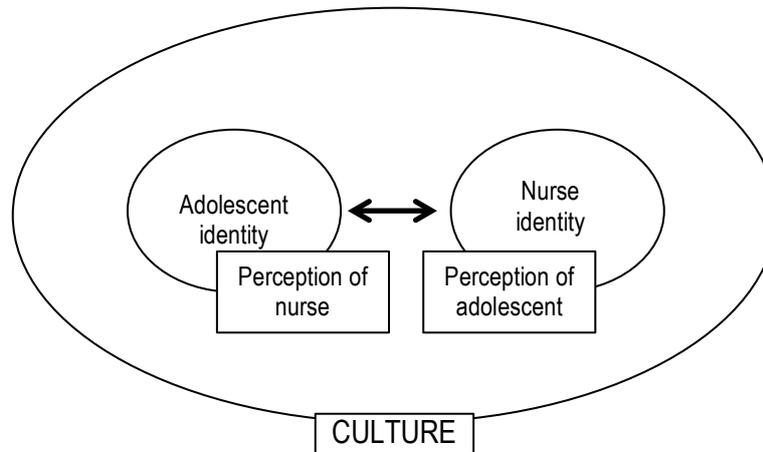
Within CCA, culture, identity and health are intertwined. Identity within CCA is defined as "the way in which we see ourselves, and is intrinsically connected to our understandings of health and illness, our relationships with others in healthcare settings, and the actions we engage in the context of health and illness" (Dutta, 2008: 90). Whereas in the dominant approach individualism was favoured, CCA acknowledges the collective identity of community members. Health decisions are made within the realm of the collective identity of the community. For example, barriers to SRH services may be located within the collective context, rather than within the individual context (Dutta-Bergman, 2005: 106). This

study aims to understand the self-care capabilities of adolescent females. It is vital to acknowledge that the self-care capabilities will be influenced by the collective identity of their community. Barriers to SRH services may be because of their collective socio-cultural identity, rather than personal self-care deficits. This study aims to understand all the influences on the self-care capabilities of adolescent females.

Specifically essential to this study is the concept of identities and relationships. This study aims to understand the nurse-adolescent relationship in regard to SRH services. Along with Orem's self-care model, CCA will be used in order to understand the perceptions of adolescents towards nurses in terms of health care. In CCA, it is understood that identities "are culturally situated, as the culture provides the contextual space within which individuals develop a sense of self, come to value certain aspects of the self, and come to enact this self-concept through their day-to-day actions" (Dutta, 2008: 90). How an adolescent female perceives herself will ultimately influence the way in which she perceives health care, and is integral to how the relationship towards health care is negotiated, expectations are communicated and health care solutions are managed (Dutta, 2008). Within this study, it is imperative to acknowledge the "cultural context, values and meaning systems which shape the way in which identities are developed", as this will influence the negotiated relationship between the nurse and the adolescent (Dutta, 2008: 97).

As adolescent females negotiate and renegotiate their identities in relation to the perception of the nurse, it shows the ability of adolescent females to play an active role in participating with their SRH, as well as participating in the decision-making process. The nurse's identity will influence how she perceives the adolescent female, which will ultimately influence the way in which she interacts with the adolescent female. This study is interested in understanding the perceived role of adolescents in negotiating health decisions, as well as the perception of nurses in terms of their role in SRH.

Figure 3.2 The role of identities in nurse-adolescent relationship negotiation



(Adapted from Dutta, 2008: 97)

Structure

Structure deals with the aspects of “social organisation that constrain and enable the capacity of cultural participants to seek out health choices and engage with health-related behaviour” (Dutta, 2008: 6). It is related to both material and communicative resources, as well as to how health care services are organised (Dutta and Basu, 2011; Dutta, 2011; Dutta, 2014). Examples of structures may be medical services, transportation services, food and shelter. In many marginalised communities, structure is constraining, as resources are limited. Lack of appropriate structure within these communities limits cultural members in seeking out health choices and engaging in appropriate health-related behaviour. However, structure can be both constraining and enabling. On the one hand, it is constraining, as marginalised cultural members are limited by the health care resources available or unavailable to them. On the other hand, it is enabling, as it creates opportunity for cultural members to challenge the way health care systems are constructed (Dutta, 2008; Dutta and Basu, 2011; Dutta, 2011; Dutta, 2014).

Structure at the macro level refers to the resources at the national and international level. This includes policy and national and global corporations that work together with structure at the micro level (Dutta, 2011). CCA places emphasis on understanding how the macro, meso and micro levels of structure limit the possibilities of community members. Concerning the macro level, this study aims to understand whether and how the socio-cultural trends, such as national health care policy, limit the possibility of adolescent females gaining access to effective SRH. The meso level of structure refers to the surrounding environmental influences, such as one’s community, family, school and religious

organisations (Dutta, 2011). This study aims to understand the surrounding structural influences on the perceptions, beliefs and health practices of adolescent females towards SRH – how their family, their school, their religious groups and their community have influenced their understanding of sexuality, and how they have either aided or inhibited their life experiences of effective SRH practices.

At the micro level, contexts are intertwined within the structures which are embedded within a community. Context is understood as the local interface through which cultural members make choices and structure is outworked (Dutta, 2008). “Local contexts surrounding health meanings, health values, health beliefs, and health practices exist in a continuous flux with the broader structures surrounding them” (Dutta, 2008: 63). At the micro level, structure refers to the socio-economic positioning of a cultural community. Contexts are the immediate surroundings that influence the decision-making process of cultural members, such that, for example, “knowledge of HIV/AIDS and the perceptions of risk are embedded within contextual factors, such as poverty, literacy, education, class, race, and gender (Basu and Dutta, 2007: 188). In order for this study to make culturally specific health suggestions, it is crucial to highlight the contextual influences that impact on the SRH meanings, values, beliefs and practices. This study intends to outline how contextual factors at the micro level, in flux with the macro level structures, have impacted on adolescent females’ understanding of sexual and reproductive health.

In order for a health campaign to bring about the intended social change, the basic capabilities within a community, such as poverty and lack of basic resources, need to be taken into account. As will be further explained under Orem’s theory of self-care, in this study it is essential to account for the structural constraints that limit the abilities of adolescent females in effective SRH care. “Health decisions might be located in the capability of community members to gain access to some of the primary resources of life, such as food, clothing, and shelter. In the face of the absence of these basic resources, engaging in higher order health behaviour such as ... having safe sex might seem irrelevant” (Dutta-Bergman, 2005: 109). Before the developmental requisites of adolescent females can be met, the universal requisites have to be addressed. As the Umkhumbane (Mayville) area is described as a “densely populated area with a high unemployment rate and low socio-economic conditions” (KwaZulu-Natal DOH, 2001), it is crucial to acknowledge and highlight the structural constraints that influence adolescent females’ experiences towards effective sexual and reproductive health services. This will be explored further under the Data Presentation chapter.

CCA also places into question the idea of space and power. Within society, the dominant and marginalised communities exist in centre-periphery relationships (Dutta, 2008). This means that those who are closer to the centre have the greatest access to power, and thus have the ability to influence policy implementation. Those who are on the periphery are considered the target audience of health campaigns. CCA places into question the positioning of cultural members in relation to those in power. CCA aims to “foreground the spatial distribution of power in the way we communicate about health” (Dutta, 2008: 64). As will be discussed further under “Agency”, CCA intends to redistribute power among those marginalised groups. Instead of advocating for a top-down, linear approach to health communication, CCA suggests a bottom-up, discursive space, where cultural members have agency and power.

Agency

Agency is placed at its interaction with culture and structure (Dutta, 2011). Agency is defined as “the capacity of cultural members to enact their choices and to participate actively in negotiating the structures within which they find themselves” (Dutta, 2008: 7). Agency refers to both the ability of cultural members to directly challenge the structures that constrain their everyday life experiences, as well as the ability to negotiate a healthy lifestyle within these structures (Dutta, 2008; Dutta, 2014). CCA allows for the exploration of the capabilities of adolescent females to enact their agency within the local structures that either aid or inhibit their SRH experiences. Agency is foregrounded in CCA through the way cultural members actively construct health meanings, developing an understanding of key problems faced by the community (Dutta and Basu, 2007; Dutta-Bergman, 2005). This means that health meanings are socially constructed by the cultural members. “Agency taps into the ability of individuals and of their communities to be active participants in determining health agendas and in formulating solutions to a variety of health problems, as these are perceived by the community” (Dutta, 2008: 7). This means that, through engagement, the emphasis is shifted to the community members as the producers of knowledge, thus re-evaluating the researcher-researched relationship.

CCA highlights *voice* and *dialogue*. Agency is foregrounded through dialogue with cultural members, in order to give them a voice within discursive spaces. “Through dialogue, the culture centred approach foregrounds these sense-making narratives and seeks to achieve social change by the introduction of these marginalised voices into the discursive space” (Dutta and Basu, 2008: 562). Dialogue is essential as a conduit for highlighting the context surrounding health beliefs, values and practices. Creating culturally specific health communication campaigns entails creating a dialogic, participatory framework that allows marginalised groups the affirmation of their worldview, the use of their cultural beliefs and

knowledge, and the opportunity to build on their own strengths, abilities and needs (Basu and Dutta, 2007).

Through the use of art-based participatory action research, this study aims to create a dialogic environment where the voices of adolescent females can be heard, where they have the agency to identify and define SRH-related issues and concerns that they face on a daily basis. “The participatory, dialogic approach empowers marginalised communities to talk about their existential realities, trial and error experiences, perceptions, needs and capabilities” (Basu and Dutta, 2007: 188).

CCA aims to address the spatial distribution of those who have power and those who do not. It aims to engage with marginalised communities, in order to create a bottom-up approach to communication, where marginalised communities are given a voice. Historically in South Africa, African people were left out of the discursive space through the apartheid regime, silenced through poverty, poor education and unemployment (Tomaselli, 2011). The crippling effect of apartheid still lingers in South Africa, through the unequal life experiences of South Africans. Dutta and Basu (2011: 329) state the following:

Noting the absence of cultural voices as a starting point and drawing from the postcolonial and subaltern studies project, the culture centred approach utilises the tools of dialogue, narrative co-construction, solidarity building, and participatory communication in order to engage with voices of cultural communities, to listen to these voices, and to seek out spaces of change based on conversations with marginalised voices.

As stated in the Introduction chapter of this dissertation, research with girls as young as 14 years old on their SRH experiences is fairly limited. In the first instance, this study hopes to engage with adolescent females who have generally been left out of the research space. Secondly, the Mayville area, on the peripheries of Durban, would be considered a marginalised group, as it is a peri-urban, low socio-economic community. This study aims to engage with adolescent females, in order to bring these community members into a shared space, “based on dialogue between the researcher and the community members, with the goals of listening to the voices of cultural members in suggesting culture-based health solutions” (Dutta and Basu, 2008: 560).

In order for agency to be ensured within CCA, a re-evaluation of the individualist bias of dominant approach is required, where behaviour change is the central goal. In order for social change to be the central goal, the researcher’s position has to be rethought. In CCA, the researcher moves from an

objective position to that of a participant engaged in the process of dialogue (Dutta and Basu, 2008; Dutta and Basu, 2011). “The culture-centred approach suggests a transformation in the role of the researcher – from an interventionist who executes campaigns to a listener who engages in dialogue with the members of the community” (Dutta and Basu, 2008: 562). This requires the researcher to rethink the researcher-researched relationship, where he views himself as the expert, gathering data from participants. Rather, the researcher enters into a mutual relationship with the participants, where mutual learning takes place. This requires the researcher to use the critical tool of self-reflexivity, where he/ she is constantly questioning himself/ herself in relation to the participants and the research process (Dutta and Basu, 2007).

This perspective takes us outside the realm of wanting to change people and to teach them how to better live their lives through one-way transmission-based models to a framework built on the goal of developing an understanding of people and their culture based on dialogue and mutual understanding; the emphasis is on listening to the voices of people that have otherwise been erased from mainstream discursive spaces (Dutta and Basu, 2008: 562).

Through the use of an art-based community participatory approach, this study intends to create a shared critical space, where the researcher and the researched enter into a mutual learning relationship (Dutta and Basu, 2011). As the researcher listens to the health-related beliefs, values, practices and issues, the researched are able to better understand themselves – their sexuality, beliefs, values and perceptions. Through the use of bodymapping, this study hopes to give the participants an educative tool to better understand themselves and their community. Ultimately, the researcher becomes a facilitator, where the concepts and explanations are those of the “cultural members in dialogue with the researcher” (Dutta-Bergman, 2005: 117).

Applying the Culture-Centred Approach

CCA is the interaction of culture, structure and agency, where communication is situated at the intersections (Dutta, 2014). Structures within cultural communities are outworked through the local contexts in which they are situated. This means that “structural features gain meaning through the contexts of the local culture, thus creating a site for the articulation and sharing of meaning” (Dutta, 2008: 7). Within this study, the structural features of health care facilities are given meaning through the real-life experiences of adolescent females. This study aims to understand the real-life experiences of adolescent females concerning health care facilities and health care workers, evaluating whether they aid or inhibit their self-care capabilities. At the same time, culture offers the foundation for structure,

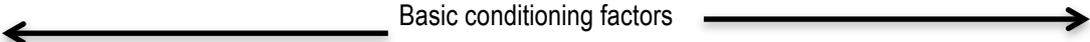
such that structures are reified and challenged through the circulation of cultural meaning systems (Dutta and Basu, 2011). “It is through the articulation of new meanings that cultures create points of social change” (pg. 330). It will be through the articulation of new meanings of what adolescent females perceive about sexuality and SRH that points of social change will be created.

At the crux of structure and culture is agency. This is enacted where community members struggle with the structural constraints that face them (Dutta, 2008; Dutta and Basu, 2011; Dutta, 2014). “Agency offers an opportunity to situate the lives of marginalised individuals, groups, and communities in the realm of their active engagement in living with and challenging the structures that constrain their lives” (Dutta and Basu, 2011: 331). Through the use of dialogue, this study hopes to give agency to adolescent females, as they have the ability to be actively involved in the identification of health-related problems in their community, and thus also have the opportunity to challenge the structures within their community. This ultimately creates a space where communicating for social change has an opportunity to be carried out. “From the standpoint of praxis, the culture centred approach stresses the need to develop respect for the capabilities of members of marginalised communities to define their health needs and to seek out solutions that fulfil their needs” (Dutta and Basu, 2011: 331). The crux of CCA in this study is understanding that adolescent females have the ability to identify their SRH needs and the ability to provide health-related solutions to problems they face. This study aims to create a discursive space where this problem-solving process is facilitated.

Orem's Self-Care Model

A central aim of this research is to further understand and comprehend the self-care capabilities and deficits of adolescent females in regard to sexual and reproductive health practices. Orem's self-care model has been chosen in order to conceptualise the deficits and capabilities of participants at Mayville Secondary School. Furthermore, this model will be used in order to gain greater insight into the perceptions of adolescent females towards the role of their relationship with nurses in either aiding or inhibiting their experiences of sexual and reproductive services available to them in their community. As a theoretical framework, this part of the chapter will be divided into three sections: the theory of self-care, the theory of self-care deficits and the theory of nursing systems. These theories are three interrelated theories that form Orem's general nursing theory. Conceptually, these will be summed up into a model of self-care, which will be used to represent the relationship between the abilities of adolescent females and the capabilities of nurses in regard to SRH services.

Table 3.1 Relationship of the three theories in Orem's general theory of nursing

Theory of Self-Care	Theory of Self-Care Deficits	Theory of Nursing Systems
Self-care	When the therapeutic self-care demand exceeds self-care agency, a self-care deficit exists and nursing is needed.	Nursing agency
Self-care agency		Nursing system
Self-care requisites <ul style="list-style-type: none"> • Universal • Developmental • Health deviation 		<ul style="list-style-type: none"> • Wholly compensatory • Partly compensatory • Supportive-educative
Therapeutic self-care demand		
		

(Adapted from Foster and Bennett, 2002: 127)

Orem's general theory of nursing was first established in 1959 after Orem raised the question, "What conditions exists in a person when judgements are made that a nurse(s) should be brought into the situation (i.e. that persons should be under nursing care)?" (Orem, 2001: 20). This question highlighted the concept that nurses are understood as 'another self', thus meaning, when individuals are capable they will care for themselves; however, when this is not possible, nurses becomes the 'another self' and assist with self-care.

Her general theory of nursing can be understood as follows: “The condition that validates the existence of a requirement of nursing in an adult is the health-associated absence of the ability to maintain continuously that amount and quality of self-care that is therapeutic in sustaining life and health, in recovering from disease or injury or in coping with the effects” (Foster and Bennett, 2002: 126). What is important to highlight here is how she further states that the general theory for nursing in regard to children is that “the condition is the inability of the parent (or guardian) associated with the child’s health state to maintain continuously for the child the amount and quality of care that is therapeutic” (Foster and Bennett, 2002: 126). Although, in South Africa, anyone under the age of 18 is considered a minor and is considered the responsibility of a parent or guardian, this study identifies participants as ‘adults’ with the ability to administrate self-care for themselves. Due to the constitutional law that states that SRH services are available to minors from the age of 12 years old without parental consent, this study acknowledges this as the understanding that participants between the ages of 14 and 17 years old are considered to have the ability to administrate self-care effectively.

Definition of Health

In order to understand Orem’s general theory of nursing, a definition of health needs to be established, as this is the ultimate goal of self-care. The World Health Organization states that the definition of health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2005: 1). Furthermore, Orem defines health as a “state of personal integrity in terms of function and structure” (Pearson, Vaughan and FitzGerald, 2005: 108). This relates to a healthy state of physical, social and psychological well-being, being maintained through self-care. The ability to accomplish self-care is the definition of health. It is when this state changes and the health needs of an individual change that health is compromised. “The person and the environment are seen as systems that are in constant communication” (Pearson *et al*, 2005: 109). Well-being and self-care involve constant communication with the environment which surrounds an individual. Environmental factors may have positive or negative effects on an individual. Health cannot be seen in isolation to the “physical, chemical, biologic and social features” that surround it (Pearson *et al*, 2005: 109).

Theory of Self-Care

In order to understand the theory of self-care, one needs to understand the concepts which constitute the theory. These are self-care, self-care agency, basic conditioning factors, self-care requisites and therapeutic self-care demands.

Self-Care

Self-care is defined as “the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and wellbeing” (Orem, 1980: 35). Another definition is given as “a process whereby a lay person functions on his/her own behalf in health promotion and prevention and in disease detection and treatment” (Pearson *et al*, 2005: 104). Both of these definitions will be adopted in this study in understanding the self-care capabilities of adolescent females with regard to SRH. These definitions allow the study to identify the practices and activities adolescent females recognise as having the ability to achieve health promotion and prevention, specifically in regard to STIs, HIV/AIDS prevention and pregnancy.

Central to the understanding of self-care are two core concepts, as follows: “self-care is behaviour that evolves through combination of social and cognitive experience and is learned through one’s interpersonal relationships, communication and culture,” and secondly, “self-care contributes to the self-esteem and self-image of a person and is directly affected by self-concept” (Pearson *et al*, 2005: 106). Pertinent to this study is understanding the influence of interpersonal relationships, communication and culture in the understanding of self-care in regard to SRH. These three influences will greatly impact on how individuals perceive self-care, and thus their self-concept. Sexuality is a central aspect of one’s life’s identity, forming a strong foundation of an individual’s self-concept. This study identifies that one’s self-care ability in regard to self-care will directly impact on one’s self-concept, self-esteem and self-image. This study hopes to highlight the perception of self-care in regard to sexuality as an influence impacting on adolescent females’ self-concept.

Orem further states that “self-care has purpose. It is an action that has pattern and sequence and when it is effectively performed contributes in specific ways to human structural integrity, human functioning, and human development” (Orem, 1980: 37). For example, in regard to SRH, the continuous action of going to a clinic every month in order to collect contraceptives, as well as effectively taking the pill every day, would be examples of self-care. This study aims to understand the ability of adolescent females to carry out actions effectively so as to form a pattern and sequence, in order to ensure health promotion and prevention. Self-care maintains that individuals should be given the opportunity to grow within their own potential to take initiative and responsibility in order to maintain health.

Self-Care Agency

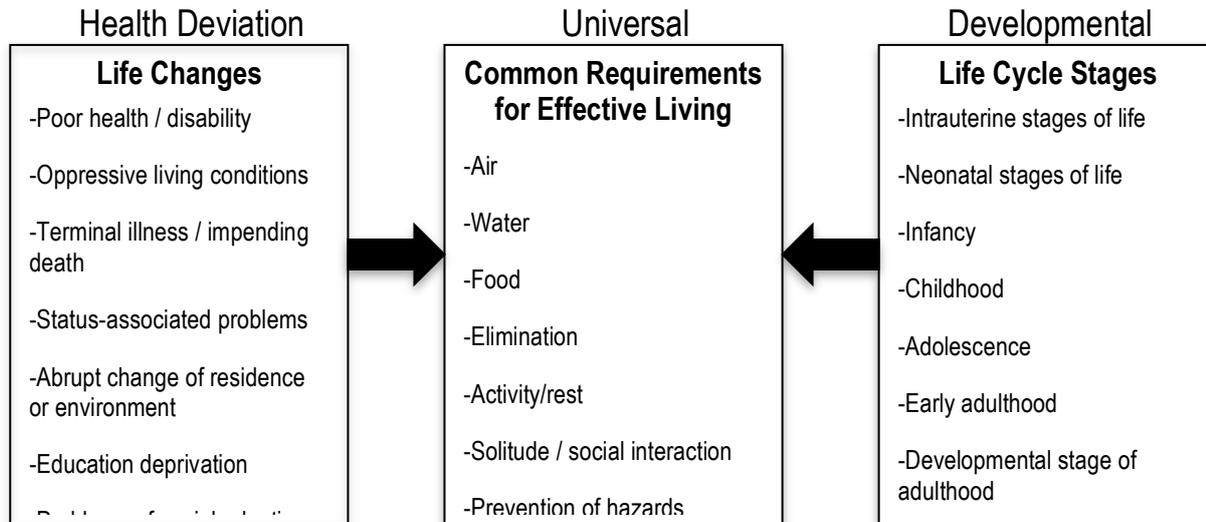
Ultimately, should an individual have the ability to maintain self-care, one is referred to as a self-care agent, thus having *self-care agency*. This can be understood as a “human’s acquired ability or power to engage in self-care” (Foster and Bennett, 2002: 127). This ability to engage in self-care is dependent on multiple factors, such as one’s “developmental state, socio-cultural orientation, health and available resources” (Ramathuba *et al*, 2012b: 219). The ability for individuals to have self-care agency is dependent on not only internal factors, but also external factors, for example, the influence of culture or life experiences or one’s state of health. Foster and Bennett (2002: 127) identify these as *basic conditioning factors*, further stating factors such as “age, gender, family system factors, patterns of living, environmental factors, and resource adequacy and availability”. Understanding these basic conditioning factors is central to this study. This study focuses on adolescent females’ perceptions of themselves as self-care agents in SRH, by understanding the conditioning factors that influence their ability to perform self-care. This understanding will be further informed by CCA, as it highlights culture as central to perceptions; also, the influence of structure and context (for example, environmental factors and health care adequacy and availability) will be explored in order to understand how these either aid or inhibit adolescents as self-care agents.

Orem highlights that if an individual does not acknowledge one’s ability as a self-care agent, having not thought of one’s role in effective self-care, one will need to be assisted by a nurse in understanding oneself as a self-care agent (Orem, 1980). One needs firstly to identify one’s need for self-care, one’s ability as a self-care agent and one’s ability to maintain self-care, in order for effective health promotion and prevention to be achieved. This research intends to conceptualise whether adolescent females acknowledge themselves as self-care agents, by understanding the attitudes and perceptions of adolescent females towards their role in maintaining effective self-care.

Self-Care Requisites

Becoming a self-care agent identifies that one recognises one’s right to meet their self-care needs (Pearson *et al*, 2005). Orem categorises these self-care needs into three categories: *universal*, *developmental* and *health deviation*. These are understood as *self-care requisites*. Self-care requisites are “expressions of the kinds of purposive self-care that individuals require” (Orem, 1980: 41). Orem further defines self-care requisites as “the reasons for which self-care is undertaken; they express the intended or desired results” (Orem, 2001: 522). Should someone acknowledge oneself as a self-care agent, one would also will acknowledged the need to fulfil these self-care requisites.

Table 3.2 Influences on self-care in relation to the requirements for effective living



(Adapted from Pearson *et al*, 2005: 107)

Universal self-care requisites are associated with life processes (Foster and Bennett, 2002). These self-care needs are necessary for the maintenance of life and well-being. Universal self-care requisites can be understood as “the activities for daily living” (Bennett and Foster, 2002: 128). Crucial to the understanding of self-care requisites is that they are interrelated factors that ultimately impact on each other. Universal self-care requisites lie at the centre of self-care needs, with health deviation and developmental self-care needs related to them. Health deviation self-care requisites are understood as “genetic and constitutional defects and human and structural and functional deviations” (Orem, 2001: 48). These occur when health or illness demand a change in the self-care behaviour of an individual. Either the individual is able to adapt to the change and continue self-care, or a self-care deficit results. (This will be further explained later.)

Finally, and most crucial to this study, are developmental self-care requisites. Developmental self-care requisites “are associated with human growth and developmental processes and with conditions and events occurring during various stages of the life cycle ... and events that can adversely affect development” (Orem: 2001: 48). Developmental self-care requisites are of central concern to this study, as they are focused on the developmental changes that occur during the different life cycles. This study is particularly interested in the developmental stage between childhood and adulthood, considered the adolescence stage. It is during this stage that an adolescent would identify one’s self-care deficits, the lack of knowledge and understanding in being an effective self-care agent. In regard to sexual and

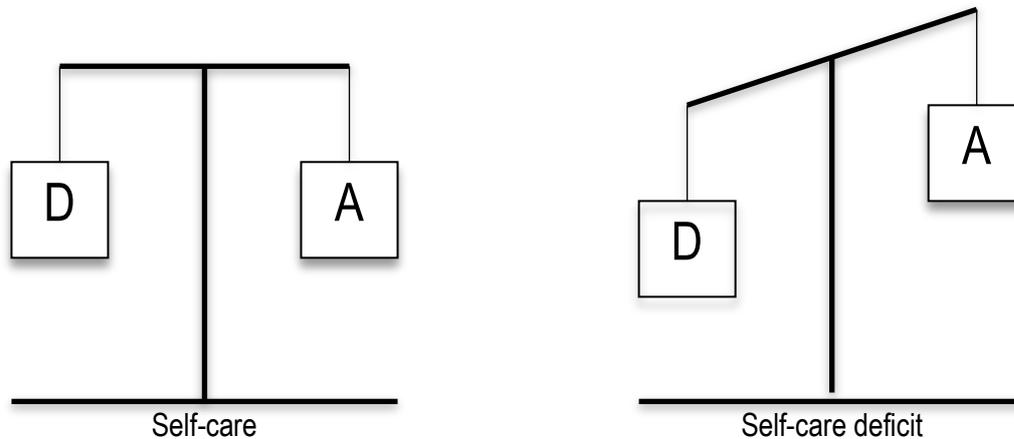
reproductive health, it is understood that during the developmental process between childhood and adulthood, when individuals are considered adolescents, the self-care needs of females will change. As individuals mature both sexually and psychologically, their sexual and reproductive needs will, in turn, need maturation.

Although this study is focused on the developmental self-care requisites of adolescent females in regard to SRH, one cannot disregard the influential impact that both universal and health deviation self-care requisites will have on the self-care agency of individuals. Effective sexual and reproductive health requires all self-care requisites to be met and fulfilled in order to achieve holistic well-being. Orem states, “[f]rom the perspective of preventive health care, effectively meeting universal and developmental self-care requisites in well individuals is ideally in the nature of primary prevention of disease and ill health” (Orem, 1980: 41). It is crucial to acknowledge that, although this study aims to understand the developmental capabilities and deficits of adolescent females with regard to SRH, one cannot ignore the impact that universal – or health deviation – self-care deficits will have on their effectiveness as self-care agents. It is also important to acknowledge that requisites for self-care “have their origins in human beings and their environments ... Ways of meeting self-care needs are cultural elements and vary with individuals and larger social groups” (Orem, 1980: 29). As with CCA, culture is placed at the understanding of how individuals identify their self-care requirements, as these are influenced by their larger socio-cultural environment.

Therapeutic Self-Care Demand

Ultimately, the balance of self-care demand and self-care ability is understood as *therapeutic self-care demand*. Therapeutic self-care demand is the “totality of care measures necessary at specific times or over a duration of time for meeting an individual’s self-care requisites, by using appropriate methods and related sets of operations and actions” (Orem, 2001: 523). These actions are deliberate actions performed in order to benefit oneself in regard to self-care. If the demand for self-care outweighs the ability for self-care, it is understood that there is a self-care deficit. Self-care deficit will be further explored under Orem’s second interrelated theory: theory of self-care deficit.

Figure 3.4 Representation of demand versus ability in self-care



D = Demand

A = Ability to meet demand

(Adapted from Pearson *et al*, 2005: 108)

Theory of Self-Care Deficit

The theory of self-care deficit is at the core and centre of Orem's general theory of nursing, as it defines and delineates when nursing is needed (Orem, 1980; Foster and Bennett, 2002; Ramathuba *et al*, 2012b). According to her theory, nursing is needed when an individual is unable or limited in their ability to ensure effective and continuous self-care. Orem further defines this as follows: "Nursing may be provided if the care abilities are less than those required for meeting a known self-care demand ... [or] self-care abilities exceed or are equal to those required to meeting the self-care demand, but a future deficit relationship can be foreseen because of the predictable decreases in abilities, qualitative or quantitative increases in the care demand, or both" (Orem, 2001: 147). Orem identifies that nursing is also needed when individuals are required to incorporate newly prescribed measures into their self-care system which require specialised knowledge and skills that need to be obtained through professional training and expertise (Foster and Bennett, 2002).

As depicted in Figure 3.1, a self-care deficit occurs when one's self-care demand outweighs one's ability to meet the demand. Orem delineates that this is when nursing is needed. In the theory of self-care deficits, Orem identifies six methods that nurses can use in order to help balance an individual's self-care demands and abilities. She further defines and explains the role of nurses and the role of the patient/client in ensuring the effectiveness of the helping methods (Orem, 1980: 95):

Table 3.3 Nurse and patient roles in nursing situations as specified by methods of helping

Method of Helping	Nurse's Role	Patient's Role
<i>Doing or acting for another</i>	Acts in place of and for the patient	- Recipient of care to meet the therapeutic self-care demand and to compensate for self-care limitations - Recipient of services relevant to environmental control and resources
<i>Guiding and directing another</i>	Provider of factual or technological information relevant to the regulation of self-care agency or the meeting of self-care requisites	Receiver, processor and user of information as self-care agent or as regulator of self-care agency
<i>Providing physical support</i>	A partner co-operating in performing self-care actions to regulate the exercise or value of self-care agency by the patient	Performer of actions to meet self-care requisites, or regulator of the exercise or value of self-care agency in co-operation with a nurse
<i>Providing psychological support</i>	An 'understanding presence', a listener, a person who can institute the use of other methods of helping if necessary	A person confronting, resolving and solving difficult problems or living through difficult situations
<i>Providing an environment that supports development</i>	Supplier and regulator of essential environmental conditions and a significant other in the patient's environment	A person who is confronted with living and caring for himself or herself in a way and in an environment that support and promote personal development
<i>Teaching</i>	Teaching of: - Knowledge describing and explaining self-care requisites and the therapeutic self-care demand - Methods and courses of action to meet self-care requisites - Methods of calculating the therapeutic self-care demand - Methods of overcoming or compensating for self-care action limitations - Methods of managing self-care	Learner engaged in the development of knowledge and skill requisites for continuous and effective self-care

(Orem, 1980: 96)

This study highlights these practical expectations and actions that Orem identifies within sexual and reproductive health. Specifically highlighted with AYFS in South Africa, it is described that all SRH facilities should create an environment that is supportive of all adolescents' needs, where teaching and education are provided in regard to the health needs of adolescents. These facilities also highlight the role of nurses as guiders and directors in helping support the needs of adolescents, specifically in regard to their SRH needs. This study aims to understand how adolescents perceive nurses in their community in regard to these six actions highlighted by Orem. As these six methods are used, so the self-care deficits of adolescents are reduced. This study intends to highlight whether nurses are fulfilling these methods as means of meeting the self-care demands of adolescents.

The central aim of nursing is to annihilate the self-care deficit in individuals. This can be achieved in three ways. The nurse may reduce the self-care demand to a level where an individual is able to meet the demand with their current self-care abilities. Alternatively, the nurse will use various methods to increase the self-care ability of an individual, so as to meet one's own self-care demands, thus eliminating any self-care deficits. If the reduction of self-care demands or the increasing of self-care abilities cannot be achieved, the nurse will then have to meet the individual's self-care needs directly (Pearson *et al*, 2005).

Nursing Practices

In order to achieve the six methods identified earlier as the role of a nurse, Orem defines five work operations, or nursing practices, that are to be used in nursing, as follows (Orem, 1980; Orem, 2001; Foster and Bennett, 2002; Pearson *et al*, 2005; Ramathuba *et al*, 2012b):

1. Entering into and maintaining nurse-patient relationships with individuals, families or groups
2. Determining whether and how patients can be helped through nursing
3. Responding to patients' requests, desires and needs for nurse contact and assistance
4. Prescribing, providing and regulating direct help to patients in the form of nursing
5. Co-ordinating and integrating nursing with the patient's daily living, other health care needed or being received, and social and educational services needed or being received

In this study, these are specifically used in order to assist adolescent females with the appropriate information, counselling and care in sexual and reproductive health. In relation to this study, these are defined by and adapted from a previous study conducted on SRH in South Africa, as follows (Ramathuba *et al*, 2012b: 221):

1. Entering into and maintaining nurse-client relationships
2. Determining how the clients can be helped through reproductive health services
3. Responding to their requests, desires and needs for nurse contact and assistance
4. Prescribing, providing and regulating direct help in the form of reproductive health service; and co-ordinating and integrating reproductive health with their daily living, other health care needs, and social and educational services

As identified through the literature, a barrier to contraceptive use in South Africa has been identified as the problematic nurse-adolescent relationship. These work operations, identified above, depict the ideals of an effective nurse-adolescent relationship, where adolescents are given the opportunity to voice their desires, requests and needs in regard to SRH freely, devoid of all judgement, personal opinion and negative consequences. It places SRH self-care needs at the centre of nursing practice, where a nurse aims either to reduce the self-care demand of adolescents, or to increase the self-care abilities of adolescents in order to effectively meet their SRH self-care needs.

This section has described and defined *what* self-care is, as well as defined *why* there is a need for nursing in reducing self-care deficits. The third theory in Orem's general theory of nursing "outlines *how* the patient's self-care needs will be met by the nurse, the patient, or both" (Foster and Bennett, 2002: 130).

Theory of Nursing Systems

As stated above, the theory of nursing systems is designed by a nurse, outlining how a nurse and the patient plan to meet the self-care deficits of an individual. This system is designed based on the self-care needs and abilities of the individual (Ramathuba *et al*, 2012b). If there is a self-care deficit, being a "deficit between what the individual can do (self-care agency) and what needs to be done to maintain optimum functioning (therapeutic self-care demand)", then a nursing system needs to be used in order to establish the actions of the nurse and the individual (Foster and Bennett, 2002: 131). When self-care agency cannot be achieved by the patient, nursing agency is introduced. This is self-care carried out by a nurse for the benefit and well-being of the patient, instead of the patient carrying out self-care for

himself (Foster and Bennett, 2002). "Nursing agency is a complex property or attribute of people educated and trained as nurses that enables them to act, to know, and to help others meet their therapeutic self-care demands by exercising or developing their own self-care agency" (Foster and Bennett, 2002: 131). When an individual assesses that there is a self-care deficit in his ability to care for himself, a nursing system is sought out.

Orem defines and outlines three nursing systems that can be utilised in order to meet the self-care requisites of an individual. These are classified as the *wholly compensatory system*, the *partly compensatory system*, and the *supportive-educative system* (Orem, 1980; Orem, 2001; Foster and Bennett, 2002; Pearson *et al*, 2005). "Nursing systems are formed when nurses use their abilities to prescribe, design, and provide nursing for legitimate patients by performing discrete actions and systems of actions" (Orem, 1980: 29). Concerning this system, Orem identifies four key aims of the nursing system in meeting the self-care needs of an individual, as follows:

1. The nursing system aims to make clear the "scope of the nursing responsibility in health care situations".
2. The nursing system aims to make clear the "general and specific roles of nurses, patients, and others".
3. The nursing system aims to make clear the "reasons for the nurses' relationship with patients".
4. The nursing system aims to make clear the "kinds of actions to be performed and the performance patterns and nurses' and patients' actions in regulating patients' self-care agency and in meeting their therapeutic self-care demand" (Orem, 2001: 348).

The three nursing systems will be briefly explained further here; however, the supportive-educative system will be focused on, as this is the nursing system most pertinent to this study. The reason this system was chosen was because it was assumed adolescent females have the potential to meet their self-care deficits, with the teaching and support of health care workers. A brief explanation of the two other systems will follow.

The wholly compensatory nursing system is used when an individual is totally reliant on the care of a nurse in order to meet his self-care requisites (Orem, 1980; Foster and Bennett, 2002; Pearson *et al*, 2005). An example of an individual who needs a wholly compensatory nursing system is an individual who is in a coma and physically cannot meet his own self-care needs. A partly compensatory nursing system is defined as a system with a situation where "both nurse and patient perform care measures or

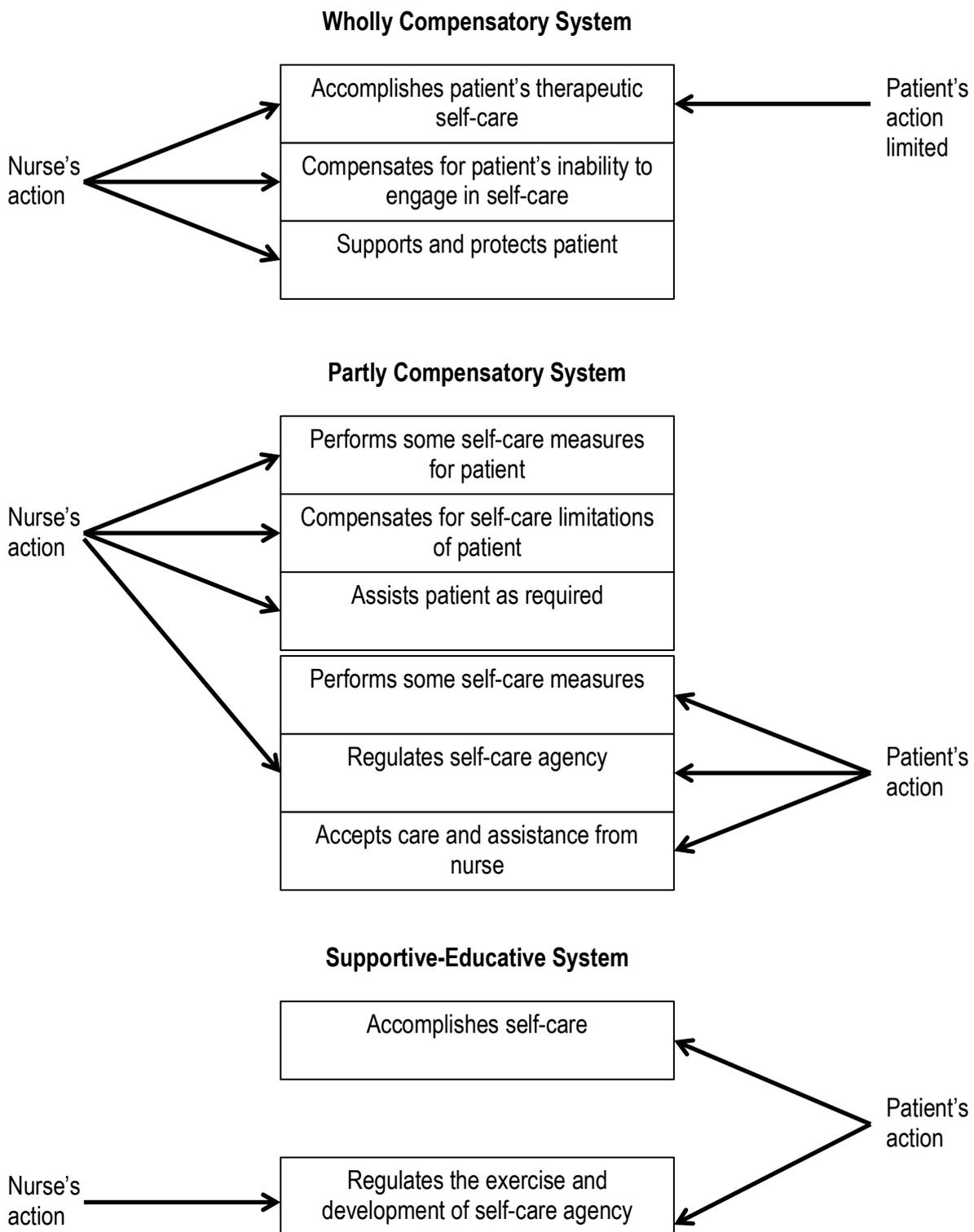
other actions involving manipulative tasks or ambulation ... [Either] the patient or the nurse may have the major role in the performance of care measures” (Orem, 2001: 354). In this situation, the patient is able to attend to certain needs for himself; however, he needs the assistance of a nurse for other needs. An example of this situation would be a patient who has just had surgery. He would be able to care for himself by brushing his teeth, cleaning his face, etc. However, he would need the assistance of a nurse in order to change his bandages and ensure the cleanliness of his wound (Foster and Bennett, 2002; Pearson *et al*, 2005).

Figure 3.5 below illustrates the three primary nursing systems identified by Orem.

Supportive-Educative System

In the supportive-educative nursing system, it is understood that an individual is potentially capable of meeting his own self-care needs, and the nurse’s actions relate to teaching and supporting the individual in order to ensure he can do this effectively (Pearson *et al*, 2005). The supportive-educative system is the only nursing system where “the patient’s requirements for assistance relate to decision making, behaviour control, and acquiring knowledge and skills” (Orem, 1980: 101). Furthermore, Orem identifies that the most valid helping technique in this nursing system is a combination of “support, guidance, provision of a developmental environment, and teaching” (Orem, 1980: 101). Within this nursing system, it is the role of the nurse to encourage a patient to become a self-care agent. Through the use of teaching, guiding and supporting, the nurse reduces the self-care deficits of an individual, in order for him to fulfil his self-care requisites. The primary role of the nurse is that of a “teacher or consultant” (Foster and Bennett, 2002: 132).

Figure 3.5 Basic nursing systems



(Orem, 1980: 98)

The supportive-educative system is the most appropriate nursing system for this study because a female adolescent is required to take charge of her own self-care, but requires the educative support of a nurse. Through this educative-supportive role, the nurse is responsible for meeting the adolescent's therapeutic self-care demands. This is achieved when the nurse exposes the adolescent to the "total self care actions to be performed for some duration in order to meet self care requisites" (Ramathuba *et al*, 2012b: 219). Should an adolescent seek information in regard to her sexual and reproductive health, a nurse is understood to be a teacher or consultant, exposing the adolescent to all the necessary information for her to make an educated decision. In regard to SRH, the role of nurses as supportive educators establishes their ability as nursing agents to provide support, enhance the decision-making process for adolescents, encourage behaviour control and its effective application, as well as teach and guide adolescents in effective self-care. Through this process, nurses are ultimately encouraging adolescents to become effective self-care agents, who understand not only what effective self-care means in terms of SRH, but also how to continuously outwork their SRH as their own self-care agents.

Criticisms of Orem's Self-Care Model

It is important to acknowledge the oppositional opinions towards self-care. A political opinion of the pushing for individual responsibility for self-care is seen as an attempt to reduce the need for state provision. However, at the basis of Orem's general theory of nursing, pushing for individual responsibility for self-care requires just as much state provision as the traditional health-care system. These resources are used in different ways (Pearson *et al*, 2005). Particularly in this study, ensuring that nurses are well equipped and able to assist adolescent females in terms of SRH self-care will require intensive state provision. However, the result of this will be the development of effective adolescent self-care agents. Therefore, state provision can be used effectively and concentrated on areas where nursing agency is needed. A caution identified by scholars is that "handing back enough knowledge to allow informed decision-making by the patient threatens the health care professionals themselves ... resistance by some health professionals to increased employment of self-care modes is to be expected" (Pearson *et al*, 2005: 105). It has to be acknowledged that resistance to pushing for individual patient responsibility may intimidate health care professionals as their responsibilities shift and change.

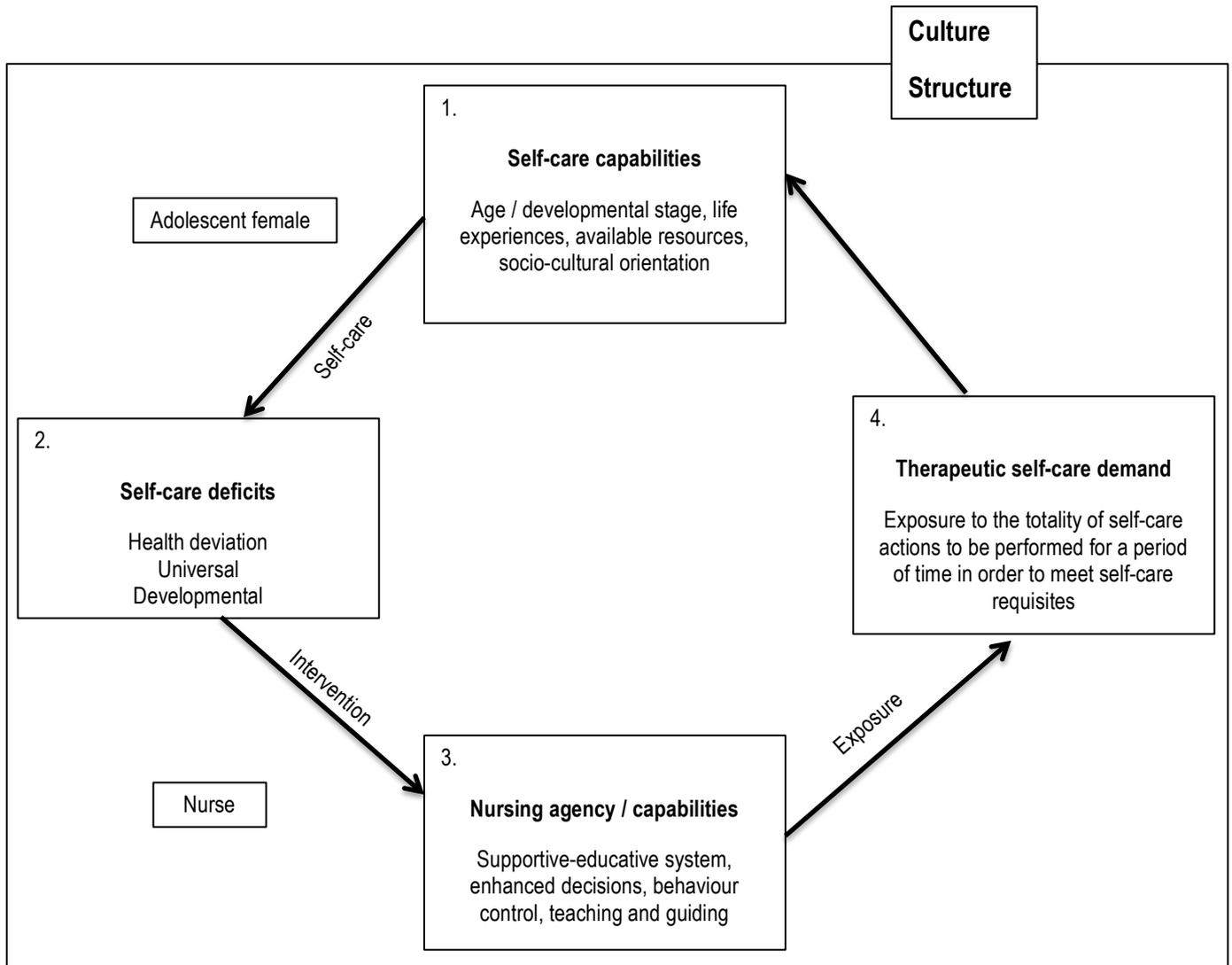
Another criticism of the theory of self-care is the fact that there is too much concentration on the responsibility of self-care and not enough emphasis upon the social structures that contribute to health (Pearson *et al*, 2005). This is an important criticism, as previous literature has identified that one of the barriers to contraceptive use is the impact of social structures. This study acknowledges the impact this

has on the implementation of effective self-care, and therefore not only focuses on the nurse-client relationship, but also acknowledges the impact of inadequate resources on this relationship.

The most important criticism of Orem's general nursing theory is the lack of emphasis on the social structures which contribute to health. Orem's self-care model does not take into account the structural and cultural influences which impact on the self-care capabilities of patients. As highlighted earlier in this chapter, CCA places culture at the centre of health meaning systems. It further acknowledges the influence of the micro, meso and macro environments on the capabilities of communities in negotiating health care systems. It is for this reason that this study advocates a culture-centred self-care model in understanding the self-care abilities of adolescent females. This study highlights the need to understand the self-care capabilities and deficits of adolescents, as these directly impact on the effectiveness of their SRH self-care. However, it analyses these within the context of culture and structure, as these impact on the adolescent females' sexual health decisions.

Applying a Culture-Centred Self-Care Model

Figure 3.6 Culture-centred self-care model



(Adapted from Ramathuba *et al*, 2012b: 224)

In applying this model, this study highlights the self-care capabilities of female adolescents as their knowledge and understanding of sexuality and sexual and reproductive health, and how these have influenced their self-care abilities. In order to understand the self-care capabilities and deficits, this study needs to establish the basic conditioning factors that prevent adolescent females from being effective self-care agents. The basic conditioning factors identified in this study are those of “age, developmental stage, socio-cultural factors, health care system factors, family system factors, patterns

of living, environmental factors and resource adequacy and availability” (Foster and Bennett, 2002: 127). Furthermore, developmental self-care deficits are identified, as they impact on the decisions of adolescent females. However, these deficits are seen within the larger cultural and structural context. This study will assess the impact of culture and structure in terms of the influence they have on the self-care agency of adolescent females.

This model will be used to understand the perceived roles of nurses and adolescents in regard to self-care. As discussed earlier, Orem’s theory of nursing outlines the expected role of nurses, specifically within a supportive-educative system. This study aims to establish whether adolescent females do actually perceive nurses as supportive educators who assist in decision-making, behaviour control and the transfer of knowledge and skills. This study will assess the nursing capabilities/agency, as perceived by adolescent females, in exposing adolescents to all self-care methods, such as their right to contraceptives, their right to safe sex, and the effective use of contraceptives. This relationship is deeply rooted in the cultural identities of the adolescent females and the nurses. This model will assess the perception of health care workers and facilities within the cultural context which surrounds them.

This model will also be applied in order to establish the perceived role adolescent females identify for themselves in ensuring their own effective SRH. It is vital to ensure that adolescent females have the ability to be effective self-care agents in terms of SRH. This will be analysed in terms of the nursing practices that Orem identifies. What do adolescent females understand in terms of their responsibility in regard to self-care? Ultimately, this study will evaluate the therapeutic self-care demands of adolescents. Do they have total exposure to all the self-care actions that are necessary for a period of time in order to ensure prevention of disease and prevention of pregnancy? This study, however, places the self-care abilities of adolescent females within their socio-cultural context.

Orem’s general theory of nursing is deeply beneficial to this study, as it specifies when nursing is needed, and it also identifies the importance of ensuring that adolescents have the ability to be effective self-care agents in health promotion and health maintenance. In South Africa, where there is an alarming rate of adolescent pregnancies and an increased risk of contracting HIV, it is pertinent that we are creating an environment where adolescents have self-care agency before/around the age of sexual debut.

Conclusion

This chapter has highlighted the need for a culturally specific understanding of self-care. As the foundations of CCA and Orem's theory of self-care have been explored, this chapter has highlighted how these theories will be applied to this study, in order to answer the research questions. As a guiding theoretical framework, these theories will enable a better grasp of adolescent females' understanding of sexuality and sexual and reproductive health.

The following chapter explains the methodological approach adopted in this study.

METHODOLOGY

Introduction

The previous chapter outlined the theoretical approach to this study, focusing on the culture-centred approach (Dutta, 2008) and Orem's self-care model (Orem, 1980). These theories were used as a guiding framework in data collection and data analysis. The theoretical framework forms a foundation to describe and theoretically locate the study in order to better explain and understand the perceptions of adolescent females towards SRH self-care.

This chapter focuses on the research methodology. The methodology consists of not only the understanding of the research methods, but also the logic behind the choice of methods. This chapter systematically explores the methodology, positioning the research paradigmatically, exploring the sampling criteria for the study, explaining the data collection process and, lastly, outlining the data analysis techniques. The chapter will touch on the ethical considerations of conducting research, thus impacting on the research trustworthiness.

Positioning the Research

Qualitative Research

This study adopted a qualitative approach to data collection and analysis, as it is focused on understanding the "meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions" of adolescent females towards sexuality and sexual and reproductive health (Berg, 2001: 2). Whereas quantitative research is focused on the amount, counts and measures of things, qualitative research is focused on the essence and ambience of phenomena.

There are four distinctive purposes of a qualitative approach to research: meaning, understanding, actions and development of casual explanations (Maxwell, 1998: 75). Firstly, qualitative research seeks to understand the meaning, for participants, of events, situations and actions. Qualitative research "is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter" (Denzin and Lincoln, 1994: 2). Ultimately, qualitative researchers aim to understand things within their natural setting, in order to interpret phenomena in terms of the meaning created by people. Through the multi-method approach to data collection, the researcher is able to gain an in-depth understanding of the phenomena. This study aimed to understand the meaning created by adolescent females regarding their sexuality and sexual and reproductive health, in order to understand their lives and their experiences.

Secondly, a qualitative approach is adopted when a researcher aims to understand a particular context, and the influence this context has on people's actions. This is the crux of this study, as it intended to understand the influences on adolescent females' decision-making processes in maintaining good sexual and reproductive health practices. It aimed to produce rich, descriptive data of participants' understanding, in order to contribute towards the broader knowledge of adolescent sexuality within South Africa.

A qualitative approach allows understanding for the processes that lead up to actions. It allows the researcher to explore issues, such as sexuality, access to health care facilities, and the experiences of health care workers, in "depth, openness, and detail" (Durrheim, 2006: 47). In this study, the researcher was able to examine the daily actions of adolescent females as they negotiate the social, economic and structural constraints of their community. It enabled the researcher to see the "world in action" (Denzin and Lincoln, 2008: 16).

Lastly, qualitative research allows for the development of casual explanations. Although this is typically assumed as a purpose of quantitative research, qualitative research also has the ability to understand the cause and effect relationship of phenomena. Within this study, by understanding the knowledge, attitudes and perceptions of adolescent females towards sexuality and sexual and reproductive health, the researcher would be able to better understand the *why* of the sexual behaviour of adolescent females, by putting behaviour into context.

Critical Theory Research Paradigm

Within social science research, there is an assumption that there are many ways to make sense of things; as opposed to an ultimate truth, there is an understanding of multiple truths in reality. "The nature of knowledge is concerned with whether there is one single route to truth or that diverse methods are needed to grasp the meaning of social experiences" (Boeije, 2010: 6). In research, theory seeks to explain, whereas a paradigm seeks to "provide logical frameworks within which theories are created" (Babbie, 2011: 32). Paradigms provide ways of looking – a frame or model in order to organise one's observations and reasoning (Terre Blanche and Durrheim, 2006). This study falls under the critical theory paradigm.

Critical theory, as an interpretive paradigm, can loosely be understood as an umbrella term for several alternative paradigms, such as feminism, participation inquiry and neo-Marxism (Guba and Lincoln, 1994). There are three sub-strands of critical theory, however; from an epistemological perspective, the

overall difference of a critical theory paradigm, as opposed to another paradigm, is the “value-determined nature of inquiry” (Guba and Lincoln, 1994: 109). This means that a study that has a critical theory approach seeks not only to understand the world, but also to have real-life benefit. It aims to “critique and transform social, political, cultural, economic, ethnic, and gender structures that constrain and exploit humankind, by engagement in confrontation” (Guba and Lincoln, 1994: 113). As a paradigm, it aims to bring restoration and liberation over time.

The ontological position of critical theory is that of *historical realism* (Guba and Lincoln, 1994). Reality is assumed to be apprehendable, where the social, political, cultural, economic, ethnic and gender factors have influenced reality over time. As a paradigmatic foundation for this study, the influence of these factors is seen as central to understanding the perceptions of adolescent females towards sexuality and sexual and reproductive health. Critical theory assumes that knowledge is *transactional and subjective*. As a paradigm, it places the relationship between the researcher and the researched into question. This relationship is seen as interactively linked. The researcher inevitably influences the researched, as their values are brought into the research process. This study aims to create an environment where knowledge is co-constructed between the researcher and the participants (Gottlieb, 1995; Dyll and Tomaselli, 2016). The methodological approach of critical theory is *dialogic and dialectical*. Because knowledge creation is seen as transactional, dialogue is essential, creating a space for reflexivity (Dutta-Bergman, 2004; Dutta, 2008). Critical theory aims to critique and transform society, thus dialogue creates a space for reflection and action. The methodology of this study aims to create a space for dialogue, where reflection and action can take place in order to bring social change.

Participatory Action Research Design

A research paradigm informs the research design of a study. As mentioned above, the critical theory paradigm is broadly interested in the value-determined nature of the inquiry; the real-world impact of the study is at the forefront of research. This is why participatory action research (PAR) was selected as the most fitting research design for this study.

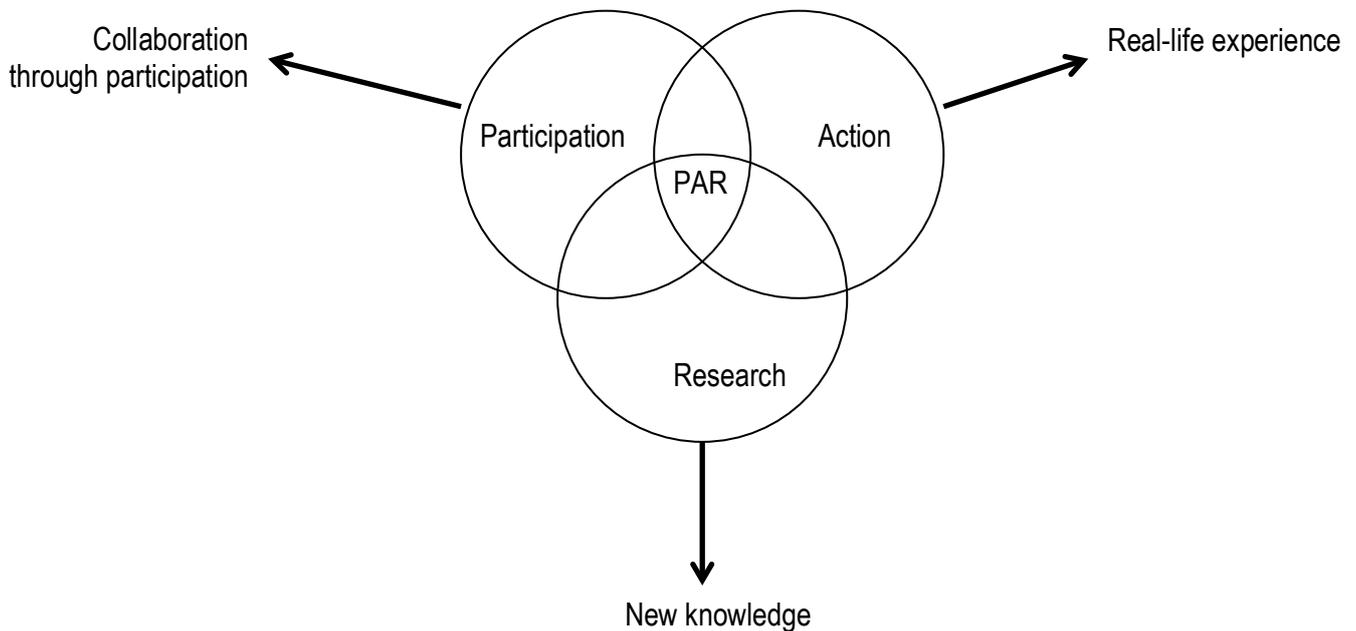
Firstly, PAR places into question power relations – the powerful and the powerless. “Participatory research implies the role of knowledge as a significant instrument of power and control” (Reason, 1994: 328). As opposed to a traditional approach, where researchers are placed in an elitist position and research subjects are considered ‘objects’, PAR re-evaluates questions of power relationships and status (Babbie, 2011; Bless, Higson-Smith and Kagee, 2006). PAR places into question the role of the researcher. In PAR, “the researcher’s function is to serve as a resource to those being studied –

typically, disadvantaged groups – as an opportunity for them to act effectively in their own interest” (Babbie, 2011: 333).

When participants are actively involved, they are able to identify problems that are relevant to them, define how these problems should be solved and have control in designing the research that will help them solve problems that are a reality to them. This study advocates for the self-care efficacy of adolescent females, where they have the ability to take control of their sexual and reproductive health. “Participatory action research provides a way for individuals to take part in the process of generating knowledge and advocating positive social change in order to promote more effective health care practices” (Brydon-Miller, 2003: 187). PAR allows participants to identify sexual and reproductive issues relevant to them, as well as define relevant solutions for themselves. Paulo Freire (1972) termed this process as *conscientization*, a process of “self-awareness through collective self-inquiry and reflection” (Fals-Borda and Rahman, 1991: 16).

Secondly, a participatory approach to research is not only interested in the production of knowledge, but is also a tool “for the education and development of consciousness as well as mobilisation for action” (Babbie, 2011: 333). PAR honours and values the knowledge and experiences of people (Reason, 1994). It takes into account three dimensions of research: new knowledge, real-life experience and collaboration through participation. As researchers collaborate with the participants about real-life social phenomena, new knowledge is created that is beneficial for both the researcher (knowledge) and the researched (social change). The knowledge gained for the researcher is both an understanding of the problems faced by the participants, as well as an understanding of possible social interventions to address these (Dyll-Myklebust, 2011).

Figure 4.1 Participatory action research



(Chevalier and Buckles, 2013: 10)

The third important starting point for PAR is the authentic commitment of the researcher, rooted in the cultural traditions of the everyday person (Reason, 1994). It is only through dialogue that the researcher and the participants re-establish power, as to place both parties at the same level of co-constructors. It is through dialogue that the wisdom of the participants is honoured and respected as expert knowledge. The researcher shows a genuine commitment to authenticity by acknowledging that, although he may take the role of the expert researcher, “the popular knowledge of the people [has] a more profound understanding of the situation” (Reason, 1994: 328).

This study adopts an art-based participatory action research design. Art-based inquiries are seen as an “emerging tradition of participatory critical action research” (Govender, 2013: 54). As this study was interested in broadening the knowledge of adolescent females’ experiences of their sexual and reproductive health, it was essential that the participants were given control of what they wanted to communicate. Visual methodologies in this study gave the control to the participants, as they had the freedom to choose their level of participation and engagement in the research. As a form of PAR, art-based inquiries relinquish power back to the participants as they engage in the self-reflexive process “using various mediums to communicate and reflect” (Govender, 2013: 55). The use of the visual allows

the researcher to “mobilise young people towards their own empowerment”, therefore promoting involvement and self-improvement (Govender, 2013: 55).

As with traditional techniques of inquiry, they run the risk of creating barriers to communication rather than creating a space for knowledge generation. The use of interviews, questionnaires or focus groups alone does not always accommodate the collaboration of the researcher and the participants in working together towards understanding social phenomena (Finley, 2008). Visual methods in this study “allowed for the researcher to negotiate self/other power relations, by providing young people with a method to explore themselves in relation to others (Govender, 2013: 55).

Bodymapping was used as art-based methodology in this study. This will be explained in greater detail under “Data Collection” in this chapter.

Sampling

Sampling Method and Recruitment Strategy

Sampling refers to the method of selecting certain participants from a larger group of a potential population (Matthews and Ross, 2010). The selected participants, the sample, should have shared properties that represent the whole – the population (Bless, Higson-Smith and Kagee, 2006). A sampling strategy is used in order to aid the sampling process, namely probability and non-probability sampling. This study utilised a non-probability sampling strategy, specifically a purposive sampling technique. Sampling was purposive, which means that participants were chosen based on their representation of certain characteristics (Boeije, 2010). In this study, the participation criteria were that they attend Mayville Secondary School, they were female and they were between the ages of 14 and 17 years old (grade 8 to grade 11). Participants were chosen based on these sampling criteria, as they best aligned with the ability to answer the research questions (Teddlie and Yu, 2007).

All potential participants were given an information and informed consent form in English and isiZulu (Appendices 2A, 2B, 2C and 2D). However, because this study researched minors, guardian consent had to be given in order for them to participate. Participants were therefore selected based on their response rate and their willingness to participate in the study. Participants were given free choice to participate. Those who agreed to participate, and also had consent from their guardians, were recruited. As sampling is based on accessibility and willingness, sampling was based on those who had consent (accessibility) and were willing to participate (Babbie, 2011).

Participants were recruited from Mayville Secondary School, located in the Umkhumbane area in KwaZulu-Natal, and were all between the ages of 14 and 17 years old. This age group was chosen because of the general age of sexual debut in South Africa, which is when adolescent females are making critical and life-changing decisions about their sexual and reproductive health. This study is interested in the cultural influences on the perception of sexuality, derived from the socio-economic circumstances in Mayville. Based on the high HIV prevalence in KZN, as well as the high adolescent fertility rate in this area specifically, this study is interested in the importance of understanding the cultural perceptions of participants, in order to reduce these statistics.

Recruitment of participants was facilitated through Hope2Educate. Hope2Educate works in partnership with five schools in a three to four year structured peer education programme, focused on beliefs and behaviours at the root of the HIV pandemic among young people. Recruitment of participants needed to be fair and impartial. This research project was presented to all potential participants, ensuring that all participants had the opportunity to decide about their involvement in the study. The information was presented frankly, explaining the procedures, benefits and requirements of the research. This ensured that all participants were well informed. Recruitment took place during a Hope2Educate session at the school, where a recruitment information letter was given to all students.

The study was presented to 12 potential participants; however, only ten adolescent females returned the signed informed consent form and agreed to participate for herself. This ensured the researcher did not have to exclude any potential participants from the study, and all ten adolescent females were recruited. On the day of the bodymapping workshop, eight girls arrived to participate. The individual interviews took place at a later stage, where seven of the eight girls took part. (This will be explained in more detail under “Data Collection”.)

Data Collection

Bodymapping Workshop

Data collection in this study was a three-fold process, where data collection took place at multiple levels: bodymapping workshop, group debriefing discussion and individual interviews. The first phase of data collection was the bodymapping workshop conducted at Mayville Secondary School. Bodymapping was explored in the Literature Review Chapter, where it was explained as a form of art-based methodology. It was also analysed within the context of HIV/AIDS in South Africa. In this section, bodymapping as a data collection tool will be outlined.

As this study is interested in exploring the perceptions and understanding of sexuality and sexual and reproductive health, it was vital that the methodology allowed for a free and open research environment. Sensitive topics are often challenging to discuss in research, especially with vulnerable populations, such as adolescents. It is for this reason that participatory mapping was chosen as the most appropriate methodology, where “mapping begins from the openness and inclusiveness of the mapmaking process” (Amsden and Van Wynsberghe, 2005: 361). All forms of writing and drawing are encouraged on their bodymaps. This process puts the control in the participants’ hands as they choose freely to express themselves as they wish. This flexibility allows the participants to determine content and form of the final map. As a result of this, “the final products, maps, offer a rich and layered description of the mapmakers’ perspective of the local environment: maps represent the relationships between spatial/physical elements, cultural values and abstract ideas” (Amsden and Van Wynsberghe, 2005: 361).

As a data collection method, participatory mapping ensures not only that participants have control over the research process, but also that there is the “versatility and power of participatory mapping, which can be facilitated with the fun, fulfilment and pride which people derive from it” (Chambers, 2006: 2). Participatory mapping is a fun method that extends beyond extracting knowledge to “facilitating a process of knowledge sharing and collaborative action” (Govender, 2013: 59). It is a tool for capturing the emotional and personal experiences of the participants in an abstract way that can be used as a tool to share the sexual and reproductive stories of adolescent females.

Bodymapping, as part of an art-based research methodology, was identified as the most appropriate method in this study because of the sensitive nature of the topic. It creates an environment which is comfortable for young people to communicate, which may be hindered through verbal discussion (Govender, 2013). As a methodology, it was anticipated that, through using art-based research, it would yield fruitful insight into the perspectives of adolescent females as they are empowered to understand themselves and those around them. It was intended that the bodymapping workshop would empower the participants, so they could share their own experiences of sexuality and sexual and reproductive health, identifying themselves as part of the greater community.

In this study, a singular bodymapping workshop was conducted with eight adolescent females between the ages of 14 and 16 years old at Mayville Secondary School. Before the bodymapping workshop, an icebreaker was played with the participants. The game related to sexual and reproductive health, thus aiding the conversation and building rapport between the researcher and the researched.

Figure 4.2 Icebreaker played with the participants before the bodymapping workshop.



(Photograph by author, taken 21 November 2016)

Following the icebreaker, the participants were each given a body-sized piece of white paper and were allocated an area in the classroom. They were equipped with all the necessary tools in order to complete the task. Participants chose a partner and outlined each other on the paper, writing their date of birth and place of birth, and drawing their community. The bodymapping workshop lasted approximately two hours, during which the participants were navigated through the various steps of the bodymapping process. The workshop was conducted in English and isiZulu, with the help of a facilitator from Hope2Educate in order to ensure instructions were understood by all participants. As the Hope2Educate facilitator already had a good relationship with the participants, it helped ensure the environment was comfortable and the participants felt free to ask any questions they had.

Participants were asked various prepared questions related to their understanding of sexuality, their knowledge of sexual and reproductive services and their perceptions of the health care workers in their communities (Appendix 1A). As Solomon (2008) states, bodymapping allows for the visualisation of the mind, body and community. In this study, bodymapping allowed the researcher to understand the perceptions of sexuality (mind), the understanding of sexual and reproductive health services (body) and the influences on the decision-making processes (community) among adolescent females. These bodymaps were used as a catalyst for further discussion in order to answer the research questions.

The bodymapping workshop was conducted in a group setting with all participants together. However, the bodymap was an individual task, ensuring participants had the freedom to represent themselves as they wished.

Figure 4.3 Bodymapping workshop conducted at Mayville Secondary School



(Photograph by author, taken 21 November 2016)

Debriefing Discussion

Upon completion of the bodymapping workshop, a group debriefing discussion was conducted directly afterwards with all the participants. This discussion allowed for a debriefing on the experiences of the bodymapping workshop. This allowed for reflection of the collaborative experiences of the participants, where they discussed their understanding of the workshop. The group debriefing session was important, as it reassured participants that their personal experiences are part of a collective commonality in regard to the diverse issues they face. This debriefing workshop was focused on the collective perspective of the participants, rather than the personal.

The debriefing discussion emphasised dialogue, agency and voice as identified by CCA. As the participants played an active role in the research process, through dialogue they were able to evaluate their experiences of the bodymapping workshop, thus giving them a 'voice' and creating agency. This study aimed to access the experiences of art-based methodologies as an effective research tool to communicate about sexual and reproductive health. The debriefing discussion not only emphasised the

collective experiences of the participants, but also provided a platform for the participants to be actively involved in the research process.

It was emphasised before the group discussion that no personal information had to be shared if they were not comfortable with it. Furthermore, it was emphasised that all information shared in the discussion should be kept confidential between the participants and the researcher. In order to facilitate discussion, a prepared question guide steered the debriefing discussion (Appendix 1B). The discussion was recorded for further review and reference.

Figure 4.4 Debriefing discussion conducted after the bodymapping workshop



(Photograph by author, taken 21 November 2016)

Individual Interviews

This study used interviews as the primary data collection methodology. Although analysis of the bodymaps and debriefing discussion was conducted, the individual interpretations of the participants were considered the prominent data. There are three categories of interview methodologies: structured, group and unstructured. This study undertook a subtheme of semi-structured interviews. Semi-structured interviews “involve the implementation of a number of predetermined questions” (Berg, 2001: 70). In the case of semi-structured interviews, the interviewer will have predetermined questions, which will be systematically asked to the interviewee. However, the interviewee will have the freedom to digress, where the interviewer can “probe far beyond the answers to their prepared and standardised questions” (Berg, 2001: 70). The use of a question guide ensures consistency between participants;

however, giving the opportunity for participants to respond freely allows them the opportunity to voice their opinions and perceptions openly.

Interviews are considered a more 'natural' way to collect data, as opposed to filling out a questionnaire (Kelly, 2006). This ensures the active verbal engagement of participants with the researcher. The semi-informal interaction creates a space for the researcher to understand further how participants think and what they feel about sexuality and sexual and reproductive health in their community. The interviews give the participants the opportunity to express verbally what they have represented visually in their bodymaps, in order to provide an in-depth understanding of adolescent females' feelings and experiences of their sexuality (Matthews and Ross, 2010).

The purpose of the interviews was for the participants to explain their bodymaps for themselves – what they had written and drawn during the bodymapping workshop. It was for this reason that the interviews were semi-structured and open-ended, allowing participants to discuss beyond the confines of the questions. It was essential for the questions in the interview guide (Appendix 1C) to “reflect an awareness that individuals understand the world in varying ways” (Berg, 2001: 70). Therefore, it was ensured that questions were simple, age-related and straightforward as to pertain to adolescent females.

In PAR, as mentioned, knowledge is co-constructed between the researcher and the participants. Interviews in this study were approached with the idea that “meanings created in the interview are treated as co-constructed between the interviewer and the interviewee” (Kelly, 2006: 297). Meanings are “not only constructed by the two people involved in the interview, but are products of a larger social system for which these individuals act as relays” (Kelly, 2006: 297). The influence of the researcher also has to be acknowledged, as the interviewer and the interviewee co-construct data in the interviews. It was hoped that during the bodymapping workshop, rapport would be built between the researcher and the participants in order for the individual interviews to be free and open conversations between the interviewer and the interviewees, in order to create a mutual learning environment.

These interviews were digitally recorded and later transcribed in order to conduct a thematic analysis. Generally, the interviews lasted between ten and 15 minutes. Originally, eight girls participated in the bodymapping workshop. The individual interviews were conducted three weeks later at Mayville Secondary School. At this session, five of the participants arrived and were interviewed. Logistically, organising a second session to interview the remaining participants proved problematic. As it was the

end of the school year, the second session was conducted in the first term of 2017. At this session, two of the three participants arrived. One participant, therefore, did not conduct an interview.

Participants were given the opportunity to communicate in English or isiZulu (through the use of a translator). All participants chose to respond in English.

As this study set out to evaluate art-based methodologies as effective tools for communication, specifically for sexual and reproductive health, further analysis of the methodology (bodymapping, debriefing discussions and interviews) will be explained in the “Discussion” chapter.

Data Analysis

As it has been stated, a qualitative approach to research allows for the collection of rich, descriptive data. Qualitative data is “mainly about interpreting and getting a good understanding of the words, stories, accounts and explanations of our research respondents” (Matthews and Ross, 2010: 373). It is for this reason a thematic data analysis was chosen as the most appropriate method of data analysis for this study. Thematic analysis is a “process of segmentation, categorisation and relinking of aspects of the data prior to final interpretation” (Grbich, 2007: 16). Braun and Clarke (2006) propose a six-step process of thematic analysis to be followed in order to analyse data. Through this process, the researcher is able to classify data into “patterns and subthemes to form collective experiences, comments and stories” of adolescent females (Govender, 2013: 67). This study is interested in understanding the collective experiences of adolescent females towards sexual and reproductive health services. Thus, through categorising data into common themes and patterns, the researcher gains a better understanding of the general experiences of adolescent females. Data collected through the individual interviews was analysed through thematic analysis.

Table 4.1 Phases of thematic analysis

Phase	Description of process
1. Familiarising yourself with your data	Transcribing data (if necessary); reading and re-reading the data; noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set; collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes; gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2); generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names of each theme.
6. Producing the report	The final opportunity for analysis: selection of vivid, compelling extract examples; final analysis of selected extracts; relating back to the analysis of the research question and literature; producing a scholarly report of analysis.

(Govender, 2013: 69; adapted from Braun and Clarke, 2006: 87)

The bodymaps created formed part of the collected data to be analysed. As stated in Hall's encoding/decoding model the bodymaps created were considered a collection of signs and symbols representing the understanding and perceptions of the participants towards SRH (1980). Hall identifies that a message is encoded by a producer and decoded by an audience/receiver. In this study, the adolescent girls were producers and the researcher was considered the receiver. The researcher decoded the meaning encoded by the participants, as interpretation took place. However, Hall states that "there is no necessary connection between the encoded meaning intended by the producer and the decoded meaning ultimately arrived at by the receiver" (Hall, 2010). The encoded message may not always be decoded as the producer may have intended.

In this study, participants had the opportunity to explain and discuss their bodymaps with the researcher during their individual interviews. The researcher was able to ask questions, and the participants were able to explain their bodymaps further. The intended message of the participants may not, however, be the decoded message the researcher obtains when analysing. Hall (1980) identifies that misunderstandings occur because the receiver decodes the message through his own personal experiences, marred by his socio-cultural background. It is vital to identify the subjectivities of the researcher in the analysis of the data. The personal experiences of the researcher were the frame of reference through which data was analysed. Although the participants were able to explain the meaning of their bodymaps, the researcher had to acknowledge the subjective influence in the further analysis of the visuals.

Eight participants took part in the bodymapping workshop. However, only seven of the eight participants took part in the individual interviews. The bodymap of the one participant who did not take part was still decoded by the researcher; however, the analysis was reliant on the subjectivities of the researcher, as the participant was unable to explain her bodymap for herself.

Analysis was further informed through the theoretical framework of CCA and Orem's self-care model. As discussed in Chapter 3, CCA is built on the foundation of structure, culture and agency. Data collected in this study was further analysed through CCA, highlighting the influence of culture on the sexual behaviours of adolescent females. One key research question aimed to understand the influences on the understanding of sexuality and sexual and reproductive health. CCA gives a framework in analysing the influence of culture on the understanding of sexuality among adolescent girls.

Furthermore, coupled with Orem's self-care model, both theories provide a framework for understanding the nurse-adolescent relationship. CCA highlights the macro and micro structural influences on the attitudes, perceptions and knowledge of adolescent females' SRH decisions. Central to this study is establishing the self-care abilities of adolescent females in maintaining their SRH. Orem's self-care model identifies the self-care deficits and capabilities of adolescents, which impact on the self-care abilities. Through Orem's self-care model and CCA, agency in the form of self-care can be analysed in order to establish whether adolescent girls have the ability to negotiate and challenge the structural and cultural constraints that influence their sexual behaviours.

Research Trustworthiness

In social science, there is no method that is perfect. It is therefore vital that the researcher evaluate the measures and methodology in order to ensure validity and rigour in the research. The researcher can ensure certain standards in the way data is collected, analysed and presented in order to ensure the study is valid (Matthews and Ross, 2010). The quality of the research is also referred to the objectivity of the study, where “it pertains to the correspondence between the social scientist’s findings, i.e. the descriptions and explanations of a social phenomenon, and the phenomenon as it is experienced by the people in the field” (Boeije, 2010: 168). There are three central dimensions that need to be apparent in a study in order to give it rigour: validity/credibility, generalisability/transferability and reliability/dependability (Glaser and Strauss, 1967). This section will explain how rigour was ensured in this study.

Validity/Credibility

In the general sense, validity refers to the degree to which the research findings are sound (Van der Riet and Durrheim, 2006). In this study, validity and credibility were ensured through the cyclical process of PAR. In “action research the rigour is demonstrated through the cyclical process of revisiting the social problem through various phases” (Govender, 2013: 70). As data collection was a three-fold process, where participants were able to reflect on their understanding, it ensured that data collected was valid and credible. Participants were able to reflect on their bodymaps, by explaining what they understood by sexuality and sexual and reproductive health. Thus, this cyclical process reiterated the validity of the data collected. Furthermore, the researcher reached saturation in the data collected, ensuring the validity of the research.

Furthermore, interpretative validity was ensured in the analysis of the data. This refers to the extent to which appropriate conclusions were drawn from the data (Van der Riet and Durrheim, 2006). In this study, participants’ views and perceptions were presented as they were, substantiating analysis with direct quotes from the participants. Data was recorded for future reference and review in order to reduce bias and ensure validity. This is essential to the researcher’s role not only in data analysis but also in data collection (Boeije, 2010). As the researcher has an evident influence on the research, it is important for this to be acknowledged in order for the research to be valid and credible. In this study, the participants’ values, preconceived ideas and beliefs were articulated in the data analysis. Although it is impossible for the researcher to be value-free, it is the researcher’s responsibility to be non-judgmental in order to ensure validity and credibility.

Generalisability/Transferability

As this study is limited in its capacity and is interested in the meaning created by adolescent females around sexuality and sexual and reproductive health, generalisability is not sought. Rather, this study aims for transferability. This means “understandings can then be transferred to new contexts in other studies to provide a framework with which to reflect on the arraignments of meaning and action that occur in these new contexts” (Van der Riet and Durrheim, 2006: 92). The way that this is achieved is through producing detailed, rich descriptions of the context within which the study took place. In this study, a thorough description of the research context and assumption was undertaken, in order to ensure the transferability of the study. Rather than stating that the findings are relevant for a wider population, this study finds the conclusions to be true for different contexts.

Reliability/Dependability

As this study is not aimed at being repeatable, thus being reliable, it is rather focused on being dependable. As the study does not believe there is an unchanging, stable reality that can be comprehended, it does not expect to find the same results as in other studies. Rather, for a study to be dependable, it is interested in the “degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did” (Van der Riet and Durrheim, 2006: 93). The way that dependability was ensured in this study was through the rich and comprehensive descriptions “that showed actions and opinions [were] rooted in contextual interactions” (Van der Riet and Durrheim, 2006: 94). As the words of data were systematically recorded and analysed, the study represents the actions and opinions of the participants in a thorough and dependable way.

Ethical Considerations

Ethical considerations in research are deeply important, as research participants’ rights may be violated by the researcher, either knowingly or unknowingly. It is vital that the rights of participants are placed at the centre of the researcher’s decision-making process, so as to minimise the risk of infringing on the participants’ rights. As this study was conducted with a vulnerable population (girls younger than 18 years old), it was even more vital that ethical considerations were placed at the forefront.

Firstly, non-maleficence is the most basic consideration in research. This means that no participants are harmed by participating in the study (Bless, Higson-Smith and Kagee, 2006). Not only should the study not harm the participants, but it should also contribute to the well-being of the participants, namely beneficence (Boeije, 2010). Autonomy is essential to a study, allowing participants the freedom

of choice as to whether they wish to be involved in the study or not. There should be no coercion or deception in order to force participation (Bless, Higson-Smith and Kagee, 2006). Fidelity and justice are also very important. All participants' rights and dignity should be respected, and the participants should be treated equally and fairly (Bless, Higson-Smith and Kagee, 2006).

Ethical guidelines for research seek to minimize risks, burdens and harms; to increase the benefits of research for individual participants; to ensure that the consent given by the participants or their guardians is freely offered and informed by knowledge of what the participants are being asked to do; and to maintain participants' privacy and confidentiality (Leadbeater, Riecken, Benoit *et al*, 2006: 4).

In this study, non-maleficence was ensured through confidentiality and anonymity. In this study, all participants were assured that their identity in the study would be confidential and anonymous. All participants were given an informed consent form in both English and isiZulu (Appendices 2A, 2B, 2C and 2D). The informed consent form ensured that all participants were well informed and aware of what the study entailed. The researcher went through the informed consent form with the participants in order to ensure they understood the content and had the opportunity to ask any questions they had. The informed consent form provided details of the research process, how the study would be conducted and what was expected of the participants. In order to ensure the safety of participants from harm, appropriate referrals were listed on the informed consent form, should they feel they needed further help. The informed consent form ensured autonomy, as it stated the rights of the participants to choose freely to be involved and to discontinue their involvement at any point in the study.

Researching adolescent females under the age of 18 years old requires a strategic ethical recruitment strategy, so as to ensure the possibility of stigma and discrimination are eliminated. All participants had to gain the consent of their guardian in order to participate in the study. In order to ensure the anonymity and confidentiality of all potential participants, when participants were given the informed consent form they were encouraged to return the information and informed consent form, whether or not they wanted to be involved. This ensured confidentiality, as potential participants did not know who had agreed and who had not. Ultimately, this reduced stigma and discrimination. The information letter covered the informed consent certificate, thus it remained confidential who wanted to be involved. Potential participants were told that if they didn't want to participate, they could leave the consent form blank.

As has been stated, recruitment was facilitated through Hope2Educate, as they have an ongoing relationship with the students at Mayville Secondary School. Hope2Educate facilitators collected the signed informed consent forms from the participants, because they know the students and are involved in sexual and reproductive health education in the school. Thus, because of their relationship with the students, it was anticipated that students would feel comfortable to discuss the research with the Hope2Educate facilitators. Ensuring that all participants were aware that participation is voluntary was vital. It was emphasised that there was no pressure for any of the students to participate, and that they could withdraw at any point, even if they had agreed to participate. Lastly, it was important to ensure that there were no conflicting concerns. As the researcher had an impartial involvement in the school, there were no conflicting interests.

Hope2Educate have access to the school through the Department of Education. Gatekeeper access for this research was gained through Hope2Educate, as well as the Department of Education (Appendices 3A and 3B). Full ethical approval was granted through the Humanities and Social Science Research Ethics Committee (Appendix 4).

Limitations

This study is limited by the fact that it is only a slice of perceptions of adolescent females towards sexuality and sexual and reproductive health, rather than a generalisation of all adolescent females. The results cannot be generalised, but rather add to a greater understanding of adolescent sexual and reproductive health. As with all qualitative research, where the sample size is relatively small, one cannot assume the findings are general to all adolescent females. However, the findings do give an understanding of what adolescent females potentially understand about sexuality and their sexual and reproductive health. Furthermore this study does not allow for the assessment of perceptions, knowledge and attitudes over an extended period of time, but rather captures these at that specific time.

Due to logistical and financial constraints, the sample size for this study was fairly small and limited. The data collected was specific to one population, making transferability limited. Govender states that this “highlights the complexity in terms of time and resources to conduct participatory research, suggesting that there is no quick fix to addressing issues of participation” (2013: 71).

As this study was conducted with adolescent females, where participation was voluntary, participation was not guaranteed. Participants were informed of their right to pull out of the study at any point. Out of the eight participants who participated in the bodymapping workshop, only seven participated in the individual interviews. The bodymap of the participant who was not interviewed was still used as data. However, the interpretation was limited to the researcher's interpretation, rather than being explained by the participant herself. This limits the analysis of this bodymap (more discussion about the evaluation of the methodology will take place in the "Discussion" chapter).

In addition, the use of art methodologies, such as bodymapping, runs the risk of participants not feeling comfortable to express themselves because it requires them to draw and write. It may pose a constraint to communication, rather than creating openness. Furthermore, the conventional method of interviews may pose a further constraint to communication. Rather than being a group activity, participants may feel shy and intimidated by the one-on-one environment with the researcher. (This will be explored further in the "Discussion" chapter.)

Conclusion

This chapter has positioned the research within the critical theory paradigm, explained and explored the data collection process and outlined how data analysis was conducted. As this study was conducted with participants under the age of 18 years old, the ethical implications were pertinent to acknowledge and consider. The following chapter will present the data collected and analysed. The chapter will explore the data, in order to answer the research questions and gain an understanding of the perceptions of adolescent females towards sexuality and their sexual and reproductive health.

DATA PRESENTATION

Introduction

This study aims to understand the perceptions of adolescent females towards sexuality, and how this in turn impacts on their sexual and reproductive health decisions. In this dissertation, the background to sexual and reproductive health problems in South Africa has been established. Literature on adolescent females and their SRH experiences has been reviewed, providing an understanding of SRH barriers apparent in South Africa. The culture-centred approach and Orem's self-care model, as a theoretical guiding framework, have been outlined, and the methodological approach adopted in this study has been explained. This chapter aims to present selected data collected in this study. Four key themes are outlined as they guide the data presentation: sexuality, sexual and reproductive health, health care workers and art-based methodologies.

Participants' opinions, as well as their bodymaps, are presented throughout the chapter. As data collection was a threefold process, data is presented from the bodymapping workshop (W), the group debriefing discussion (D) and the individual interviews (I).

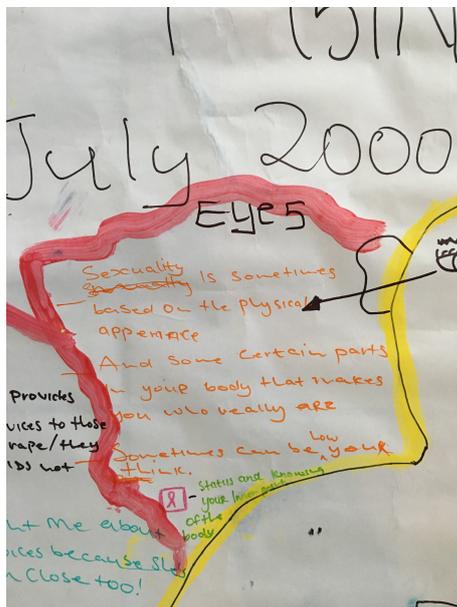
Sexuality

Understanding of Sexuality

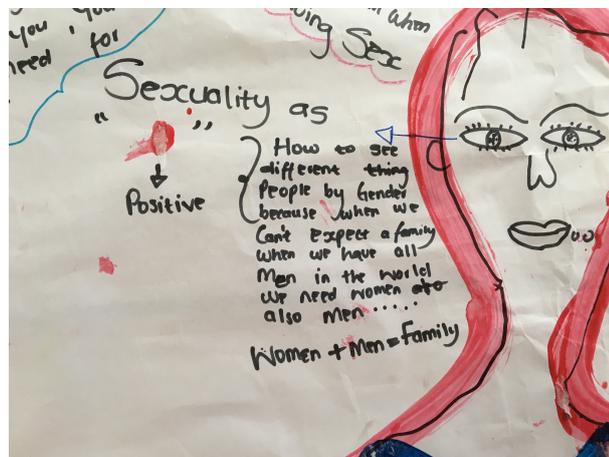
Fundamental to decreasing adolescent fertility and HIV infection is greater understanding of adolescent sexuality. In order to establish the key influences on adolescent sexuality, and how these influences have impacted on adolescent SRH, it is vital to establish what adolescent females understand about sexuality. This study defines sexuality as an adolescent's sexual and reproductive health, which includes puberty, emotional maturity, gender roles and sexual beliefs and values. The understanding of sexuality is embedded within one's understanding of sexual and reproductive health. This section highlights puberty and emotional maturity in the understanding of adolescent sexuality.

Participants highlighted that the biological make-up of a person forms the foundation of sexuality. One participant stated that it is the difference "between a man and a woman" (P7I, 26 January 2017). Another participant said that sexuality is "a thing that you have as a woman" (P8, 26 January 2017). There was an understanding that sexuality is a "growing stage" (P5I, 30 September 2016), establishing that the growth period between childhood and adulthood, namely puberty, forms part of the understanding of sexuality. Sexuality during this stage was identified as "how you understand yourself

as a woman” (P3I, 30 September 2016). However, not all participants were clear about what sexuality is. One participant asked, “So, [is gender] also part of your sexuality?” (P7I, 26 January 2017).



P7W



P1W

Emotional maturity was highlighted as part of the understanding of sexuality. A participant said that sexuality was “how ... you do things when you get older and how ... you follow your steps in life, like when to have sex, when to fall pregnant [...] when to be sexually active” (P3I, 30 September 2016). This participant highlighted that sexuality encompasses one’s understanding of sexual and reproductive rights. Another participant said that sexuality “helps you understand yourself and what your body is going through and why you are feeling the way that you [are] feeling” (P4I, 30 September 2016). The understanding of sexuality was highlighted as important as children move from childhood to adolescence, in order to make informed decisions about their SRH.

Perception of Sexuality Education

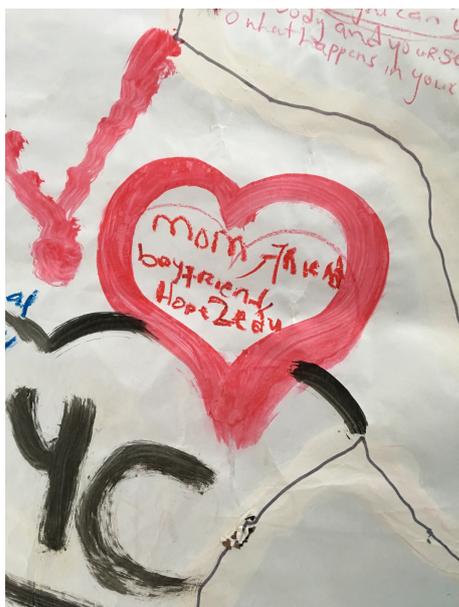
From the understanding of sexuality, participants were then asked whether they thought it is important to understand sexuality, and from what age they thought you should learn about it. Sexuality education impacts on the ability of adolescents to ensure SRH self-care. One participant stated that the lack of sexuality understanding influences social problems: “[It is an] important thing to do because most of the teens in my community are becoming pregnant and they don’t really know what sexuality is” (P6I, 30 September 2016). Participants stated that there is a need to understand one’s sexuality as it meant understanding one’s sexual and reproductive rights. One participant said, “I, as myself, because earlier I didn’t know how to treat myself, if someone says you must do it, I must do it because I don’t know my

rights... But now I know, if someone tells me something, which I don't like, I must say no and I understand my sexuality. I must get pregnant when I like, sexually active when I like" (P5I, 30 September 2016). By understanding sexuality, participants said that they were able to protect themselves from being infected with HIV or having an unintended pregnancy.

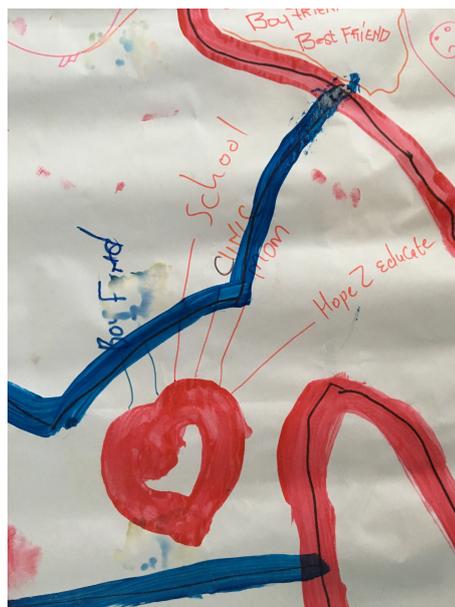
Participants also identified that, by understanding sexuality, one has knowledge of how to "take care of yourself" (P7I, 26 January 2017). Sexuality education gives you knowledge on "how you should behave" (P6I, 30 September 2016), so that you are able to maintain health. One participant stated that when adolescents do not understand their sexuality, they are confronted with barriers to SRH self-care. Another participant stated, "When you don't understand sexuality, you end up doing things that you don't know and get into trouble because you didn't understand" (P8I, 26 January 2017). Participants believed that adolescents should learn about sexuality from an early age so that they are prepared "when you get to that stage" (P1I, 30 September 2016). Another participant spoke of the need for sexuality education at a young age because of the different experiences adolescents go through. She stated, "You need to know ... our bodies are not the same... for example, I was [having] periods when I was nine" (P7I, 26 January 2017). There was an understanding that adolescent females need to be prepared before the adolescent growth stage, in order to ensure that they have the knowledge to ensure SRH self-care.

Influences

During the bodymapping workshop, participants were asked to represent who they thought had most influenced their understanding of sexuality. At the beginning of the workshop, participants agreed on the colour blue representing negative and the colour red representing positive. Participants were asked to represent the positive and negative influences in their understanding of sexuality.



P5W



P6W

There were two key influences participants identified as having affected their understanding of sexuality: mothers and Hope2Edu. The most important influence that participants believed shaped their understanding of sexuality was their mothers. One participant stated, “She is very open. She is the one who makes me understand what sexuality is” (P5I, 30 September 2016). Participants highlighted their mothers as a positive influence on their understanding of sexuality. Another participant said, “Even my mother, my mother is so kind to me; she will tell me anything if I ask” (P3I, 30 September 2016). This participant said that there was open communication between her and her mother about her sexuality, where her mother provided sexual education for her. This was further articulated through another participant, “She’s not shy; well, she’s not shy to talk about these things, because they are happening. Because if she doesn’t talk about it, people will tell me another story and I will do the opposite of this” (P5I, 30 September 2016). This establishes her understanding of her mother being her foundation of sexuality education.

Of the eight participants, one participant highlighted the lack of parental support in understanding her sexuality. She stated, “My parents are not like that much talking; they are not open” (P1I, 30 September 2016). She said that, because of this, Hope2Edu had influenced her understanding of sexuality the most. Hope2Edu was also identified as a key influence in the understanding of adolescent sexuality. One participant stated that Hope2Edu “encouraged us to learn about sexuality because they give us knowledge about how to behave as a girl and they are really, really helpful to us” (P6I, 30 September 2016). All participants identified Hope2Edu as a positive influence in their understanding of sexuality, as they were able to gain specific knowledge through them.

Participants identified three further influences: loveLife, community and interpersonal relationships. Three participants stated that the health campaign loveLife had positively influenced their understanding of sexuality. One participant stated, "Sometimes I went to loveLife; they also helped me a lot. And they helped me a lot so that I can't be scared of myself or I'll feel shy, that's why they teach me a lot" (P3I, 30 September 2016).

Participants also highlighted the influence of interpersonal relationships on their understanding of sexuality. Two relationships were identified: friendships and romantic relationships. These relationships were seen as positive and negative influences. Participants stated that friendships were a positive influence because they gave them the opportunity to discuss their sexual and reproductive health among each other. One participant stated, "We bring different stories and help each other, and now when someone is having a problem, [...] we find a solution as friends [and] I also gain and learn from her mistakes" (P7I, 26 January 2017). Within friendships, they were able to identify commonalities in SRH problems, thus supporting each other to find a solution. However, one participant stated that not all friendships were positive influences, where some "tell you to have a boyfriend and sleep with that boyfriend and get pregnant. They don't encourage you to have a healthy sexual life and go to hospital" (P7I, 26 January 2017). The positive or negative influence of friendships varied among participants.

Romantic relationships were also established as an influence in their understanding of sexuality. Most participants said their boyfriends were a positive influence in their understanding of sexuality, as they were able to discuss their sexual health with their partners. One participant said her boyfriend was "very supportive" (P5I, 30 September 2016). However, not all participants believed their partners were positive influences. One participant stated that she believed boyfriends were a negative influence because "they like to have sex with us but they don't know their status. They want to spread the HIV" (P6I, 30 September 2016). Once again, the positive or negative influence of romantic relationships varied among participants.

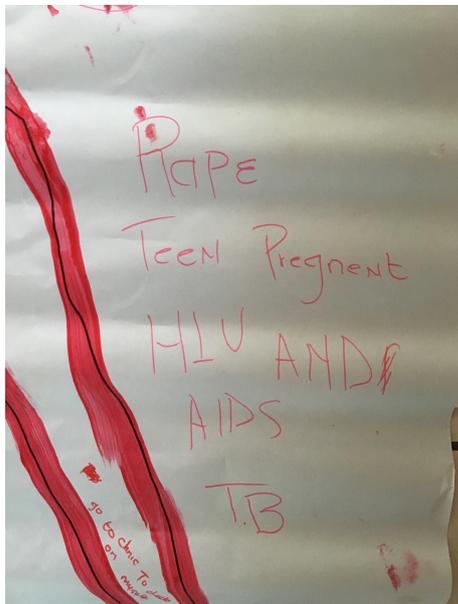
Finally, two participants identified the negative influence of their community on their understanding of sexuality. One participant stated, "I don't like the community, because there are people out there who [speak about ...] family business, and they don't say it as it is; they just say anything which [is] wrong. So, in my community, there are people who are like this, who are telling my mother some false things – their opinion [of] things which I didn't do..." (P3I, 30 September 2016). She believed that the community did not always support adolescents.

Sexual and Reproductive Health

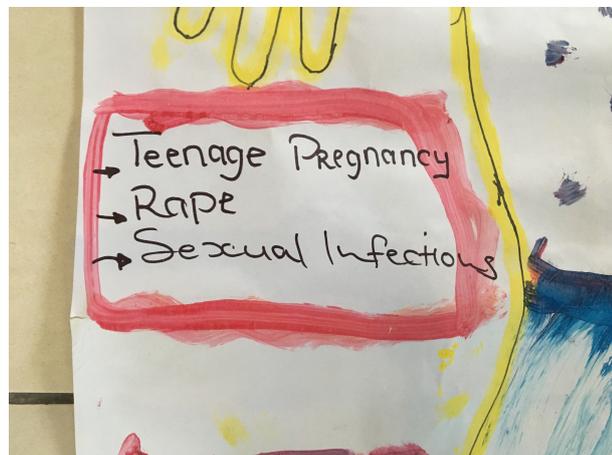
This study aims to understand SRH self-care among adolescent females at Mayville Secondary School. By understanding the attitudes, beliefs and knowledge of adolescent females towards good sexual and reproductive health, this study aims to establish the self-care capabilities and deficits of adolescent females.

Problems Faced in the Community

Participants were asked to represent on their bodymaps what they thought were the greatest social problems faced in their community. Notably, rape, HIV/AIDS and teenage pregnancy were highlighted. Two participants spoke of poverty being a large social problem in their community, where there are “families out there who are suffering, with no food” (P3I, 30 September 2016). One participant commented on teenage pregnancy, saying, “It’s a high rate. I don’t know how to explain it, because even children that you would never believe would get pregnant at that age, just get pregnant. To them, I don’t know whether it’s like a style or something, but they are getting pregnant” (P7I, 26 January 2017). Another participant stated, “In my school, there are a lot of girls who are pregnant and at a young age.” Furthermore, two participants commented on the use of drugs being a large social problem in their community.



P6W



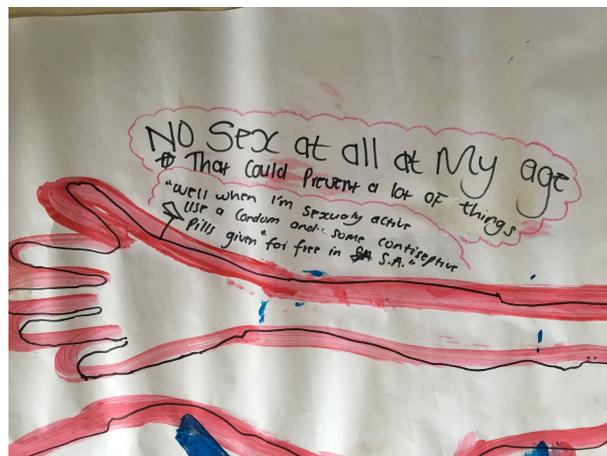
P7W

Beliefs, Knowledge and Attitudes

This part of the data presentation will outline the beliefs, knowledge and attitudes of adolescent females towards SRH self-care. Through the thematic analysis, data collected in the individual interviews was analysed. Initial codes were generated, which were then placed into relevant themes. From the data, three main themes emerged: abstinence (belief), contraceptive use (knowledge) and clinic use (attitude).

Abstinence Versus Sexual Activity

Participants were asked what they understood as good sexual and reproductive health. Out of the eight participants, four stated that they believed that abstinence was the most effective way to ensure their SRH. One participant stated, "I'm thinking that I should only be sexually active when I'm married" (P3I, 30 September 2016). For cultural and religious beliefs, these four participants felt that sexual activities should only be engaged with in a marriage, or in a healthy relationship. As stated in the picture below, some participants believed that abstaining from sexual activities would best protect one from HIV/AIDS or adolescent fertility. Another belief was that they were too young to be engaging in sexual activities, "not having sex at my age because I am still young" (P7I, 26 January 2017).

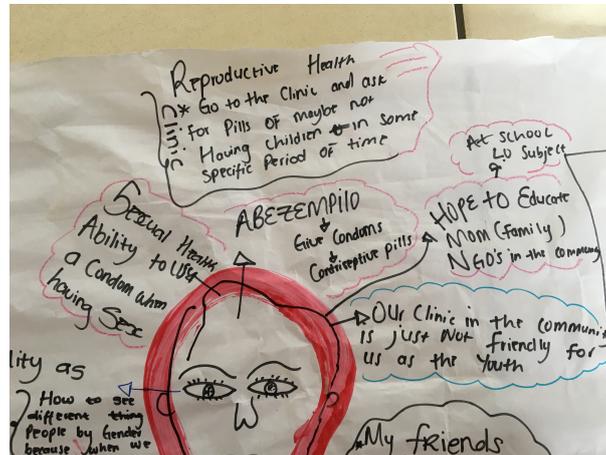


P1W

Contraceptive Use

During the bodymapping workshop, participants were asked to write and draw above their heads what their understanding of sexual and reproductive health was. Participants highlighted their understanding of the contraceptive methods available to them to protect themselves from HIV/AIDS and from falling pregnant. The most common contraceptive method identified was condoms, with contraceptive pills being second. Only one participant mentioned contraceptive injections as a method to protect oneself

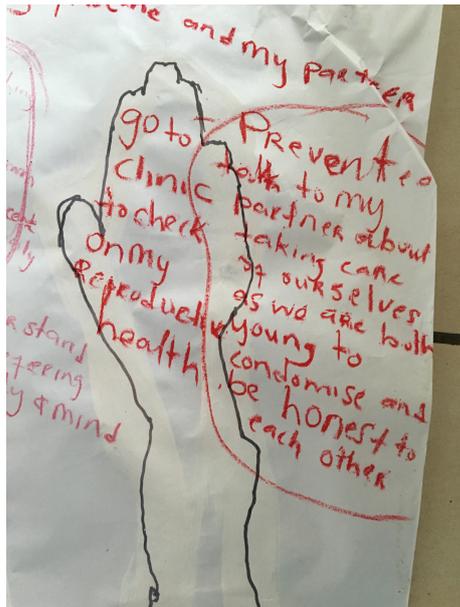
from pregnancy. Three participants mentioned the need to be tested for HIV regularly in order to look after one's sexual and reproductive health. One participant said, "You have to make sure, so I have to take care of my body; that's the thing I have to do" (P5I, 30 September 2016).



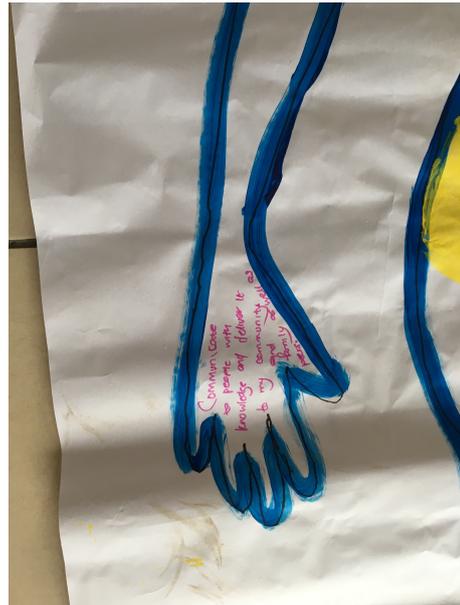
P1W

Clinic Use

This study aimed to understand the attitude of adolescent females towards SRH self-care. Participants were asked what they should actively be doing to maintain their health. Utilising clinic services was the key action all participants identified. They highlighted the need to use SRH services in order to obtain condoms and contraceptive pills. Many participants also highlighted the need to gain information and knowledge from other people about how to look after themselves. However, a key statement was made by one participant: "We do have the knowledge, but we don't want to use the knowledge. Let me say it's like this: we do have the knowledge, but we are scared, or something, to use the knowledge" (P8I, 26 January 2017). This statement touches on the experiences of adolescents in accessing health care services. This will be further explored under "Health care workers" in this chapter.



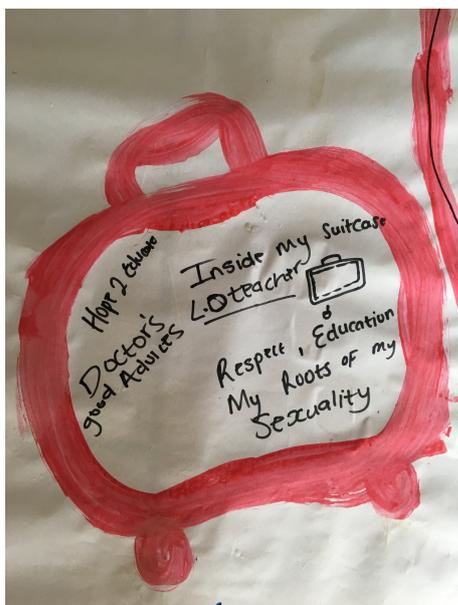
P5W



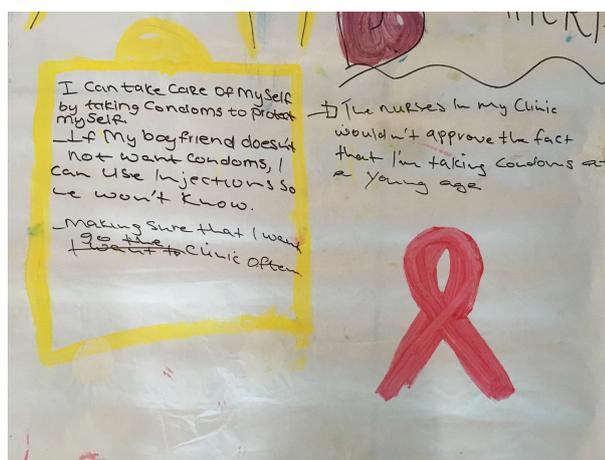
P2W

Capabilities and Deficits

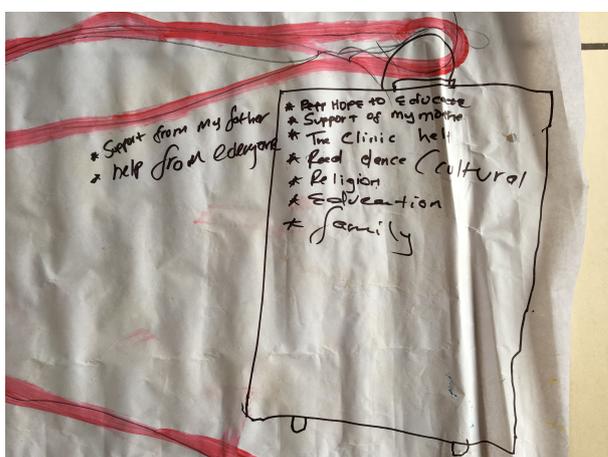
This study aims to understand the self-care abilities and deficits of adolescent females in maintaining their sexual and reproductive health. During the bodymapping workshop, participants were asked to draw and write what they thought they had that helped them maintain their SRH. They were also asked to represent what they believed they still needed in order to look after their health. Below are two examples of the perceived capabilities and deficits of the participants.



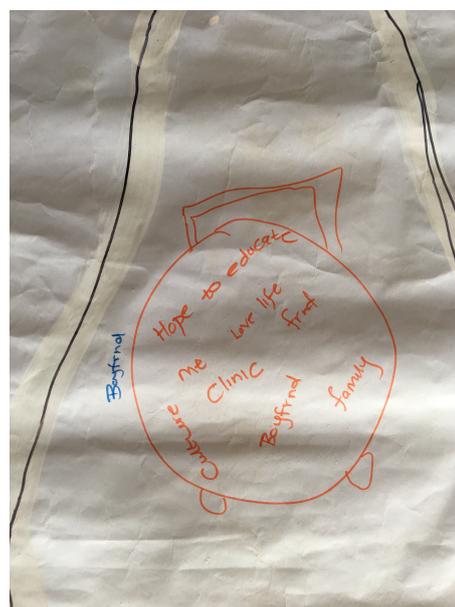
P1W



P7W



P3W



P4W

Capabilities

This section will present data on who/what adolescent females believe influence their ability to maintain their sexual and reproductive health. Participants were asked to draw and write what they believed they had for ensuring SRH self-care. The main point raised by all participants was that Hope2Educate was the most beneficial tool in helping them maintain their SRH. One participant stated, "They teach me how to control myself" (P6I, 30 September 2016). Furthermore, another participant said, "Hope2Educate help me very [much], because with the knowledge I have, they help me to know [more, in addition to] the knowledge that I already have" (P8I, 26 January 2017). As mentioned, most participants highlighted the influence Hope2Educate had had on their perceptions of sexuality, which had further translated into their SRH self-care understanding. All participants said that Hope2Educate

helped them ensure their sexual and reproductive health. Hope2Educate increased the self-care capabilities of adolescent females in maintaining their SRH.

Furthermore, as mentioned earlier, all participants highlighted the influence of mothers in their understanding of sexuality. This also further translated into their understanding of their sexual and reproductive health self-care. Participants stated that their mothers were the ones who encouraged them to go to the clinic for health care services. One participant said that her mother had encouraged her to “go to the clinic and check my status” (P6I, 30 September 2016). One participant specifically stated that she was lacking the support of her mother in maintaining her health: “I need my mom” (P1I, 30 September 2016). Not only do mothers play a substantial role in forming the understanding of sexuality, as they are the foundation of sex education, but, in turn, they also influence the ability of adolescent females to engage in self-care and maintain their own sexual and reproductive health.

Participants further highlighted two other key factors: culture and religion. Two participants stated that their culture specifically helped them maintain their sexual and reproductive health. One participant spoke of *Umkhosi woMhlanga* (reed dance), where virginity testing takes place before adolescent females can participate in a royal dance. Religion was also highlighted as beneficial in maintaining sexual and reproductive health. However, there were mixed responses regarding the influence of religion. Four participants spoke of church being helpful in understanding self-care and maintaining health: “There [are] always youth meetings where they tell us things” (P1I, 30 September 2016). However, one participant stated, “They do talk about it [sexual and reproductive health], but they just don’t get straight to the point; they just don’t tell it like it is” (P1I, 30 September 2016). This participant highlighted that church was not always helpful for adolescent females, as church leaders did not always address SRH problems directly.

Deficits

This study identified two key deficits adolescent females believed they had in terms of maintaining their sexual and reproductive health. As mentioned above, the influence of mothers is key for adolescent females in ensuring good sexual and reproductive health. However, many participants highlighted that they needed further support from other family members: “I don’t have much family support, except from my mom” (P5I, 30 September 2016). Participant three stated that she needed “support from everyone who is related to me”, specifically saying she needed “support from my father” (P3I, 30 September 2016). Participants highlighted the influence mothers have on their understanding of sexuality, but

further highlighted the need for additional family support in order to maintain their sexual and reproductive health.

The second key deficit participants highlighted in maintaining their sexual and reproductive health was protection from HIV/AIDS. Participants were asked whether they believed they had everything they needed in order to engage in SRH self-care, to which one participant responded, “Well, in falling pregnant, I think I have it all, because I won’t be having sex yet, so I think that that is the engine, and in HIV, you will never be sure. You never know what tomorrow brings ... So, also, I won’t actually be sure [about] getting HIV and all that stuff, but in being pregnant I’m 100%” (P7I, 26 January 2017). Two participants spoke of the risk of being raped, saying that, no matter what they did to protect themselves, if they were raped they would still be infected with HIV. Specifically, one participant retold the story of a young girl being raped by four people in her community, where the girl was infected with HIV. She then stated, “I feel like I will also be raped because I live in the same area” (P6I, 30 September 2016). Sexual and reproductive self-care was limited within the confines of adolescent females’ ability to protect themselves from risks.

Health Care Workers

The Influence of Health Care Workers

Previously, this dissertation outlined the characteristics that are essential to ensure that health care facilities are adolescent friendly. This part of the chapter will outline the responses of the participants towards health care workers and health care facilities, and the influence health care workers have on the SRH experiences of adolescent females.

Equitable

For adolescent friendly services to be equitable, all adolescents should be able to obtain the health services they need. When asked about the health care services in their community, participants stated that various barriers to services were apparent. SRH services should be available to all adolescents, despite age. However, the majority of participants reported that services were denied them because they were “too small in your age” (P3I, 30 September 2016). They often said that, because of this, health care workers would insult them and were “not friendly at all” (P5I, 30 September 2016). Health care workers are expected to treat all adolescents with equal care and respect. However, participants did not feel that the health care workers had respect for them or their sexual and reproductive health

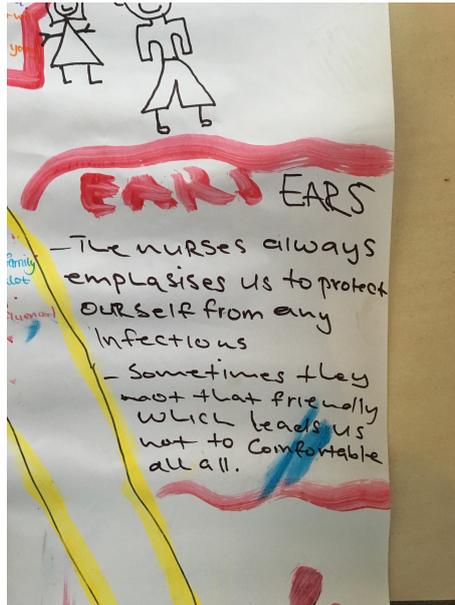
needs. The health care workers' personal beliefs that adolescent females should not be engaging in sexual activities from a young age, impacted on the services they provided.

Accessible

Health care services need to be obtainable by adolescents. This means that all adolescents need to be well informed about the SRH services available, and health care workers should support the provision of them. All participants identified that they did not feel that health care workers were supportive in providing SRH services to them. One participant stated that health care workers "didn't give information" to them (P5I, 30 September 2016). Various participants did not feel that health care workers were a source of information; therefore, they were not well informed about the SRH services available to them. Another participant said, "They don't care about you or how you [are] feeling" (P3I, 30 September 2016). They were not providing the support that adolescent females felt they needed in order to obtain appropriate sexual and reproductive health care services.

Acceptable

For adolescent friendly health care services to be acceptable, they need to be provided in a ways that meets the expectations of adolescents. There is a need for services to be confidential and private. Participants identified that health care workers did not respect their privacy, and one participant stated that, because "some of them [health care workers] know us, they will go and spread some lies in our community" (P3I, 30 September, 2016). They did not believe their utilisation of the health care facilities was private or confidential, because health care workers "talk a lot" (P8I, 26 January 2017). All participants said that health care workers shouted at them when they went to the health care facilities, with one participant saying that when the health care worker shouted at her, "everyone at the clinic just turns to look at you and you feel ashamed" (P7I, 26 January 2017). Participants identified the feeling of shame and guilt with using SRH services at their local clinic.



P7W

For health care providers to provide acceptable health care services, they need to be non-judgmental and considerate. However, in this study, one participant stated that health care workers were “not friendly because they are judgmental” (P7I, 26 January 2017). The environment should be appealing to adolescents; however, all participants mentioned that they did not know of any specific adolescent and youth friendly services at their local clinic. One participant said that they “don’t do anything for the youth” at the clinic (P3I, 30 September 2016).

Appropriate

The health care services for adolescents need to be appropriate. In order for health care services to be appropriate, they need to fulfil the needs of adolescents. It is necessary for health care workers to provide the full package of health care services that adolescents require. In this study, participants highlighted the mixed messages they received regarding health care services. One participant stated, “They are telling the opposite of what they were telling us” (P5I, 30 September 2016). She spoke of nurses from the local clinic coming to their school to tell them about the SRH services available to them, in order to encourage them to use them. However, when they went to the clinic, the health care workers would judge them for wanting to use the SRH services. Furthermore, another participant said, “The thing I don’t understand [is that] they say we should go there and take it to protect ourselves, and then, at the clinic, they ask us why” (P8I, 26 January 2017). This means that adolescent females in this community are not given access to the full package of health services that they require, because health care workers pose a barrier. Communication between adolescent females and health care workers was

highlighted, regarding which a participant said, “It’s not easy to communicate with them” (P7I, 26 January 2017). This identified that health care services are not appropriate to the needs of adolescents.

Effective

In order for health care services to be effective for adolescents, they need to make a positive contribution towards adolescent health. Health care workers are required to have competency in adolescent health provision. All the factors outlined thus far directly impact on the effectiveness of adolescent friendly health services in this community. Participants highlighted that, because health care workers were not friendly, it meant that participants were reluctant to use SRH services, thus impacting on their effectiveness. One participant stated, “You just feel like the person doesn’t want to help you” (P8I, 26 January 2017). As health care workers may create a barrier to health care services, they impact on the effectiveness of services, as one participant stated: “Because you don’t get what you came to get, you just leave like that” (P8I, 26 January 2017). A key statement by one participant highlights how the lack of efficiency of health care services directly impacts on the increasing HIV infection and adolescent fertility rates: “You don’t wish to go back there and get help, and in that way [your] not going back there means now you [may get] infected with something, because you are scared to go and get help” (P7I, 26 January 2017).

When Are Nurses Effective?

The previous section highlighted the influence of health care workers on adolescent SRH. Consistency in services was a key area highlighted by participants in influencing the effectiveness of health care provision. One participant stated that most of the time health care workers were not friendly; however, it depended on “who [you found] at the time” (P5I, 30 September 2016). There was not a consistency in the services health care workers provided, as some health care workers were described as friendly, helpful and supportive. Another participant spoke of health care workers being unfriendly and judgemental, but she also said, “There are some others that are okay; they understand your situation. You are pregnant and you are young, and they should give you the best service” (P1I, 30 September 2016). Health care workers were effective when they were understanding, considerate and friendly.

Furthermore, when participants were asked when health care workers are most effective in helping them maintain their sexual and reproductive health, ARV therapy was the key area highlighted. Participants felt that health care workers were supportive in the way “they are helping us to understand these pills” (P5I, 30 September 2016). Another participant stated, “They are supportive when it comes to pills; they [tell] you to take these pills and they give you the model [of] how to take them” (P8I, 26

January 2017). The effectiveness of health care provision was centred on HIV/AIDS treatment, as opposed to HIV/AIDS prevention.

What Do Adolescent Females Need?

This section has presented data on the influence of health care workers on adolescent health, further highlighting when health care workers are most effective in SRH provision. This last section on health care workers will present data on adolescent females' perceptions of what they need in order to maintain their SRH. Firstly, participants highlighted that health care workers were difficult to relate to, and were not sympathetic to their SRH needs. They highlighted the need for health care workers to understand that they are young, just as the health care workers were young before; "they don't understand that we are living in the same time that they lived" (P8I, 26 January 2017). They felt health care workers were not understanding towards adolescent health needs, because "they make it look as if they have never been ... our age" (P7I, 26 January 2017). There was an understanding that health care workers needed greater compassion, "because we are also children; we [make] mistakes" (P7I, 26 January 2017).

Participants stated that their greatest need was for health care workers to be friendly: "not more than to be friendly" (P5I, 30 September 2016) and "not to judge people" (P6I, 30 September 2016). One participant stated that "someone needs to teach them how to treat the patient better, how to treat the community, because they don't understand; they are shouting" (P3I, 30 September, 2016). Participants identified that friendly and accepting health care workers would enhance their SRH self-care. Health care services are hindered when shame and guilt are present, thus discouraging adolescent females to utilise SRH services at their local health care facility.

Art-Based Methodologies

One of the research questions guiding this study was to evaluate the effectiveness of art-based methodologies in researching sensitive topics, such as sexuality. Furthermore, this study aimed to understand whether art-based methodologies, such as bodymapping, either aided or inhibited effective communication around sexual and reproductive health. An art-based methodology, as a research method and a communication tool, was evaluated in terms of its potential in successfully engaging with adolescent females as a key population. This part of the chapter will present data collected from the debriefing discussion that was conducted after the bodymapping workshop. In this section of the data presentation, participants will be referred to generally, as the data were collected from a group

discussion, where individual participants were unidentifiable. This group debriefing discussion took place on 12 September 2016.

Evaluation of the Experience

When the group was asked whether they had enjoyed the bodymapping workshop, there was a general consensus of agreement that the workshop had been an enjoyable experience. Various participants stated that it had been “very exciting” and “very fun”, and that they had “had a great time”. One participant stated that she had enjoyed the whole experience, to which the whole group agreed. The step of the bodymapping workshop they had enjoyed the most was the “ears”, which related to what they were hearing about their sexual and reproductive health from health care workers (Appendix 1A). This part of the body also dealt with whether health care workers were helpful in understanding sexual and reproductive health. They had been asked to draw or write what they were hearing health care workers say to them.

From the perspective of the researcher, the bodymapping workshop was a very positive experience. To the researcher, there was visual excitement, interest and enjoyment by the participants. After the bodymapping workshop had been conducted, the Hope2Educate facilitator, who had helped assist in the workshop, stated that the participants were notably excited and interested, compared to the usual Hope2Educate meetings she usually facilitated with them. The researcher experienced a sense of inclusivity during the bodymapping workshop, where participants were very chatty, laughing and holding discussion throughout the workshop. The researcher highlighted the sense of ownership of the research process by the participants, rather than by only the researcher. Participants had the power to choose their level of involvement as they chose how to respond to each step.

The practicalities of the bodymapping workshop did pose a potential barrier. The facilities at the school were limited, with access only to a school classroom. With the number of participants (eight), space within the classroom was a problem. A space that was bigger would have been more ideal, as participants were forced to work in very close proximity. Furthermore, the classroom did not have functioning windows, which meant that the wind blew into the classroom, proving problematic for working with large pieces of paper. The school uniform of the participants also proved problematic, as the participants were expected to wear skirts, thus making sitting on the floor to draw and write harder. Finally, the researcher provided paint for the participants to use; as the school only had one running water tap, the practicalities of using paint were a challenge. The paint proved messy and inconvenient.

Commonality

A key evaluation of the bodymapping workshop by the participants was that they saw their personal experiences as part of a collective commonality. Although the bodymaps produced were each an individual reflection of the participant's attitudes, beliefs and knowledge of sexuality and sexual and reproductive health, the participants highlighted that the experience reassured them that there are commonalities between themselves and their peers. One participant stated, "We saw we actually have things in common about how we look, or [how] we take care of ourselves, or how we [experience] sexual and reproductive health". As mentioned previously, during the bodymapping workshop there was discussion between the participants while they worked through the steps. They discussed their opinions as they decided what to represent on their bodymaps. Participants highlighted that establishing commonalities in their sexual and reproductive health experiences was a positive experience, because as they freely discussed these with other participants, they were able to clarify what they believed. The idea of commonality in experiences creates an environment of inclusivity, acceptance and collective support.

Drawing Versus Writing

The evaluation of bodymapping, as an art-based methodology, highlights the effectiveness of the methodology in creating an environment for communication. Participants were asked whether they enjoyed writing or drawing more when creating their bodymaps. There were mixed responses as to which was better. One participant stated that she preferred drawing, because "if someone was going to read this, he will get a more clear understanding by looking at the pictures than reading the whole thing". Some participants felt that by drawing pictures and symbols, they would give a better understanding of what they believed and understood about sexual and reproductive health. Some participants enjoyed the use of colour, and used different colours to represent different ideas, such as positive (red) and negative (blue) influences on their understanding of sexuality. Participants seven and eight are examples of participants who used colour and drawing to represent their understanding, as shown below.

However, some participants stated that they did not enjoy drawing, but rather preferred writing their responses on their bodymaps. Participant four used only words to represent her responses. She used little colour and no symbols, but rather wrote inside and around her body outline. One participant stated, when asked whether she preferred writing or drawing, that "I don't know how to draw, and besides, I hate symbols". One participant said, "I actually enjoyed writing, because that was the easiest way of mine of expressing my feelings, because I can't draw." Some participants felt that expressing

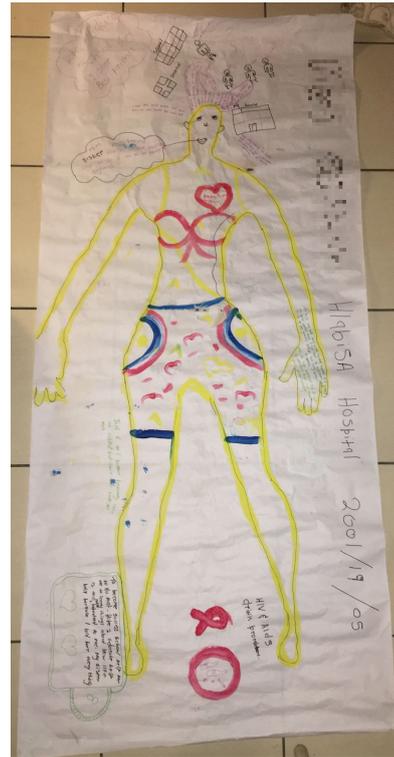
themselves through words was easier than drawing. We can see that participant one used a mixture of both drawing and writing. This shows the freedom in the method to express oneself as one feels most comfortable. Art-based methodologies do not require certain levels of skills in order to create a bodymap. Participants have the ability to choose what is most comfortable for them to communicate, and in the method with which they feel most comfortable.

Drawing



P7W

Drawing



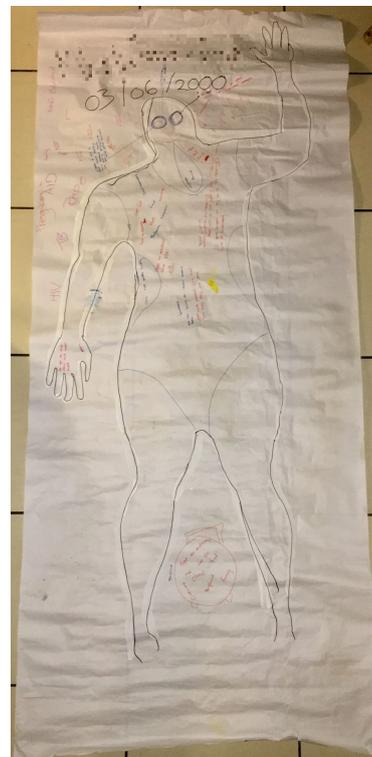
P8W

Drawing and writing



P4W

Writing



P1W

Aiding Versus Inhibiting

A sub-question of this study was to establish whether bodymapping aids or inhibits communication around SRH with adolescent females. Participants were asked during the group discussion whether the bodymapping workshop had made it easier or harder to discuss sexuality and sexual and reproductive health. There was a group agreement that the bodymapping workshop had made it easier for them to discuss their sexuality. One participant stated, "It wasn't hard at all, because we kind of go through these things on a daily basis when we go to the clinic; we come across all these things ... in this thing, we had to write down and express our feelings." Another participant stated, "I am very happy to do this, because it has helped me to [remember] some things and to speak out what I have in my mind – to feel free." The participants had a sense of freedom to represent themselves as they wanted to, as they had the control over the research process.

The bodymapping workshop required the participants to think about their attitudes and beliefs towards sexuality, and how these impact on their sexual and reproductive health. This was articulated through one participant who stated that the bodymapping workshop had been challenging because it had required the participants to evaluate intently what they understood by SRH: "It did make it harder, because you had to think ... what do I see in sexuality or what should I do about my sexuality? So, it makes it a little harder, because it makes you think about yourself." The bodymapping steps required self-evaluation and self-assessment in order for the participants to represent themselves on their bodymaps. Participants had to be actively involved in the research process, thus requiring them to engage actively with themselves and those around them.

Conclusion

This chapter has presented all the data collected through the bodymapping workshop, group debriefing discussion and individual interviews. This chapter has outlined the data collected related to adolescent sexuality, sexual and reproductive health and the experiences of art-based methodologies. The following chapter will analyse this data in relation to the literature reviewed and through the theoretical framework, in order to answer the research questions that guided the study.

DATA ANALYSIS

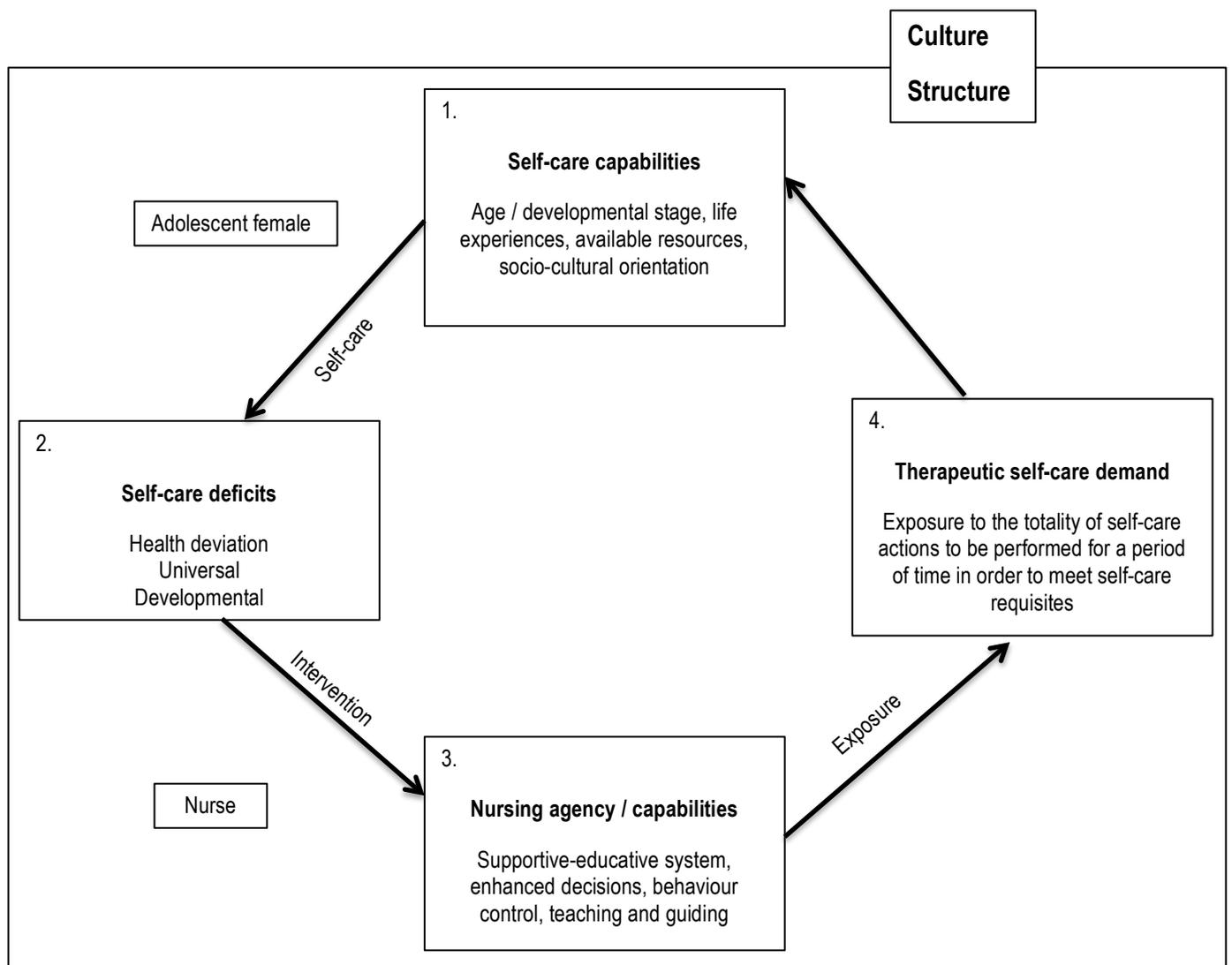
Introduction

This study aimed to grasp adolescent females' understanding of sexuality, and the influence this understanding has on their self-care abilities in maintaining their sexual and reproductive health. This chapter will analyse the data collected in this study through the lens of the guiding theoretical framework. It will also evaluate the data collected in relation to the literature reviewed on studies previously conducted on adolescent sexual and reproductive health in South Africa. Furthermore, this study aimed to explore adolescent females' perceptions of art-based methodologies in researching and communicating about SRH. This chapter is therefore divided into two sections. The first section will apply a culture-centred self-care model in understanding adolescent SRH. The second section will analyse the potential of art-based methodologies, specifically bodymapping, in effectively researching adolescent sexuality. These two themes are interrelated, as the potential of art-based methodologies directly impacts on the ability to conduct research and communicate with adolescent females on sexuality.

Culture-Centred Self-Care Model

This study has adopted Orem's general nursing theory in order to understand the self-care capabilities and deficits of adolescent females (Orem, 1980). However, this study further advocates the need to understand the self-care capabilities and deficits of adolescent females within the culture and structures through which they are mediated (Dutta, 2008). The ability of adolescent females to meet their self-care requisites highlights the self-care agency of adolescent females. This model has been represented below. This section of the chapter will analyse the data collected, in order to establish the self-care capabilities and self-care deficits of adolescent females in this study. Furthermore, the perceptions of adolescents towards the capabilities of health care workers in meeting their self-care deficits will be explored. Finally, it will conclude with establishing whether the therapeutic self-care demands of adolescent females are being met in order for them to maintain good SRH.

Figure 5.1 Culture-centred self-care model



(Adapted from Ramathuba *et al*, 2012b: 224)

Self-Care Capabilities

Self-care is understood as the activities individuals initiate and perform on their own behalf in order to maintain health (Orem, 1980: 35). In this study, two key research questions were outlined: firstly, establishing the understanding of sexuality among adolescent females, and secondly, how this understanding impacts on their SRH self-care practices. Orem's self-care model delineates when nursing is needed, by establishing the balance between adolescent females' self-care capabilities and self-care deficits (Orem, 1980; Foster and Bennett, 2002; Ramathuba *et al*, 2012b). In order to understand the self-care deficits of adolescent females, this study aimed to understand their self-care capabilities, which impact on their deficits. Specifically, this study aimed to understand their perceptions

of SRH self-care capabilities, by understanding their attitudes, beliefs and knowledge regarding good SRH practices.

This section of the data analysis will outline the self-care capabilities of adolescent females, as explained by the participants. The influences on adolescent females' perceptions of sexuality will be defined, as well as how these have impacted on their understanding of sexuality and their sexual and reproductive health. By establishing these, this study will be able to identify the self-care capabilities of adolescent females in maintaining their sexual and reproductive health. However, as this study was conducted only with adolescent females between the ages of 14 and 17 years old, and on a small scale, this analysis is in no way an indication or representation of the broader adolescent population. Instead, it offers an in-depth understanding and perspective of a specific group of adolescent females.

Influences

Adolescent sexuality is influenced by three factors: the person, the proximal context and the distal context. The personal influence relates to cognition, feelings and thoughts about oneself (self-efficacy and self-esteem). The proximal context refers to the influence of interpersonal relationships and the physical and organisational environment. The distal context refers to the cultural and structural influences (Eaton *et al*, 2003: 149). As found with a study conducted on unsafe sexual behaviour in South Africa, this study highlighted that the most powerful impact on adolescent females' understanding of sexuality comes from the proximal and distal contexts.

The two main influences on adolescents' understanding of sexuality found in this study were the proximal influence of Hope2Educate and parental relationships. In the theory of self-care, self-care is learnt through one's interpersonal relationships, communication and culture (Pearson *et al*, 2005: 106). In this study, participants highlighted the positive influence their mothers had on their understanding of sexuality and on the maintenance of their sexual and reproductive health. Mothers formed the foundation of sexuality education, as the majority of participants highlighted that communication was open and free between them and their mothers. There was the exception of one participant, who highlighted that the lack of open communication with her mother was her greatest deficit in understanding her sexuality. This supported the findings of previous studies which highlighted that when adolescents can freely communicate with their parents about their sexuality, their health risks are reduced (Kharsany *et al*, 2014: 964). Furthermore, in this study, participants highlighted that their mothers encouraged their SRH self-care. They stated that their mothers encouraged them to go to their local clinic in order to obtain SRH services. The influence of maternal relationships on their

understanding of sexuality, which in turn impacts on their self-care capabilities, is highlighted as pivotal in the engagement of adolescent SRH.

The second key positive influence on adolescent sexuality identified was Hope2Educate. Hope2Educate focuses on educating peer educators on SRH in schools around the eThekweni district. Participants stated that Hope2Educate greatly influenced their understanding of sexuality, which translated into SRH self-care knowledge. Hope2Educate influenced the sexual beliefs, values and practices of adolescent females by increasing their self-care capabilities through the provision of knowledge. The influence of loveLife, a health communication campaign in South Africa, was also highlighted as a factor in forming their understanding of sexuality.

Health communication is highlighted as key in influencing the understanding of sexuality among adolescent females, as they highlighted the importance of these campaigns and programmes in understanding themselves in relation to the developmental stage of adolescent sexuality. Participants in this study were involved in the Hope2Educate programme, where SRH is a focus of the programme. This was the most common source of health communication to support their understanding of sexuality and the need for SRH self-care. This was further supported by a number of participants stating that loveLife increased their understanding of sexuality. These specific health communication campaigns and programmes were highlighted, because the knowledge gained through these programmes impacted on the capabilities of the adolescent females as self-care agents.

CCA highlights the influence of the meso level of structure on the understanding of health (Dutta, 2011). This relates to the surrounding environmental influences, such as communities and family. The influence of mothers has been highlighted; this study further identifies the influence of interpersonal relationships, such as peers and romantic relationships. Participants in this study stated that friendships were important in their understanding of sexuality, as the participants shared commonalities in life experiences, and they were able to learn from each other. Participants stated that SRH knowledge was shared between peers. Furthermore, participants identified the influence of romantic relationships on their SRH self-care. Some participants highlighted that their partners were supportive, ensuring the maintenance of their SRH. In some cases, maintenance of good SRH was encouraged and supported, as the adolescent females were encouraged to be self-care agents. However, not all participants identified interpersonal relationships as positive influences. Some participants stated that these relationships were negative influences, where they posed as a deficit in self-care.

The varying perceptions of interpersonal relationships establishes that capabilities and deficits cannot be generalised for all adolescent females. What is considered a capability for one may be a deficit for another. Adolescent sexuality is complex, and thus a contextualised definition is required in order to understand it (MacPhail and Campbell, 2001: 1614). This study highlighted that, not only is the definition of sexuality deeply complex, but the influences on the understanding of sexuality are also complex. This study established the key influences of Hope2Educate and maternal relationships. However, this study also established that influences on adolescent sexuality vary, where a positive influence for one participant was identified as a negative influence for another.

It is vital that sexuality knowledge is comprehensive, in order for all influences to be effective in encouraging good SRH self-care among all adolescent females. There is a pertinent need to ensure that adolescents comprehensively understand their sexuality, in order to ensure that interpersonal relationships influence their sexual education appropriately, correctly and effectively. These findings supported the findings of previous studies, which highlighted the powerful influence of the surrounding environment on the understanding of sexuality, where all community members need a comprehensive knowledge of sexuality (Khoza, 2004; Mkhwanazi, 2010).

Supporting the findings of a study conducted in South Africa on sexual behaviour among youth, this study also identifies the key influences of the proximal and distal contexts on personal understanding of sexuality (Eaton *et al*, 2003). This study highlights the proximal influence of interpersonal relationships, parental relationships and health communication campaigns and programmes. In this study, these factors have a powerful influence on the perceptions, knowledge and understanding of female adolescents regarding sexuality.

This study further highlights the distal influence on the understanding of sexuality. Some participants identified culture and religion as positive influences on their understanding of sexuality. Once again, there were varying perceptions of the positive influence that religion and culture had on their understanding of sexuality. Some participants stated that cultural events, such as the reed dance, helped them maintain their SRH. These cultural events encourage abstinence from sexual activities until marriage. This was paired with religious influence on their understanding of sexuality. Some participants stated that religious organisations positively influenced their understanding, and, in turn, increased their SRH self-care capabilities. This once again highlights the influential impact of the proximal and distal factors on personal understanding of sexuality, where health meanings are negotiated within the culture and structures through which they are mediated.

Understanding of Sexuality

In this study, the understanding of sexuality encompasses the knowledge of one's sexual and reproductive health, including puberty, emotional maturity, gender roles and sexual beliefs and values (WHO, 2006). The biological understanding of sexuality was a key aspect of understanding among participants in this study. Some participants further highlighted their understanding of emotional maturity within sexuality, which incorporated their sexual and reproductive rights to choose if and when to engage in sexual activities. Participants highlighted the need to understand one's sexuality in order to meet the developmental self-care deficits that occur during the transition from childhood to adolescence. Furthermore, participants believed that sexuality education should take place before adolescence in order to exhibit increased self-care capabilities once reaching the adolescence life stage. Knowledge of sexuality was identified as a self-care capability of adolescent females, as they stated that those in their community who did not understand their sexuality were at risk of engaging in risky sexual behaviour.

Attitudes, Knowledge and Beliefs

Abstinence, contraceptive knowledge and clinic use were identified as self-care capabilities of adolescent females in the Data Presentation chapter. Half the participants in this study stated that they did not engage in sexual activities for cultural and religious beliefs, as they because they did not believe in early sexual debut. This supported the findings of previous studies conducted on adolescent sexuality in South Africa, specifically those of a study where Orem's self-care model was applied (Peltzer *et al*, 2006; Coovadia *et al*, 2009; Ramathuba *et al*, 2012b). This highlighted the ability of adolescent females to engage in SRH self-care by practising, within their sexual and reproductive rights to choice, when to engage in sexual activities. This highlighted the self-care agency among participants, as they had the ability to engage in good SRH.

Furthermore, participants stated that, in order to ensure their sexual and reproductive health, they needed to obtain SRH services through clinics, in order to receive contraceptives. Participants also had knowledge of the need for regular testing of HIV, as part of maintaining good SRH. Participants understood that they needed to be active participants in maintaining their sexual and reproductive health.

Self-Care Deficits

The self-care capabilities identified by adolescent females have been outlined in this chapter. The influences on and the understanding of sexuality have been explored, highlighting the impact of this understanding on the self-care ability of adolescent females to carry out actions effectively in order to ensure health promotion and risk prevention. In this section, the self-care deficits will be explored, where the negative influences on adolescent sexuality understanding will be identified. Furthermore, the SRH self-care deficits will be highlighted, as they impact on the health care decisions of adolescent females. Self-care deficits in this study are highlighted as factors that negatively impact on the ability of adolescent females to be self-care agents in maintaining good SRH.

Participants identified two key self-care deficits: family support and prevention from risk. Furthermore, the negative influence of interpersonal relationships, community and religion were highlighted in influencing the understanding of sexuality. These factors were explored under the self-care capabilities of adolescent females. This further supports the understanding that the self-care capabilities and deficits of adolescent females vary, and cannot be generalised for all. A capability for one adolescent female may be seen as a deficit for another. Interpersonal relationships, community and religion were perceived differently by different participants, as the influences and experiences varied. Finally, this section will outline the deficits in knowledge of adolescent females in maintaining good SRH.

Family Support

Although participants stated that they had the support of their mothers, they believed they lacked the support of extended family members, specifically fathers, in maintaining their sexual health. The support of family members in influencing the understanding of sexuality, and ultimately in influencing their ability to engage in effective sexual and reproductive health, was a key deficit adolescent females identified. The family system is understood at the meso level of structure (Dutta, 2008). It forms part of the proximal context in influencing the understanding of sexuality. The deficit in family support in increasing the self-care capabilities of adolescent females was highlighted by participants with regard to the lack of open communication between family members.

The influence of the family structure on adolescent sexuality is supported by previous studies, which stated that cohesive family structures are important in the determinants of risk. The pivotal role of family members to instil and reinforce messages of protection from risky behaviour was highlighted (Mudhovozi *et al*, 2012). As was stated by Kunene (1995), the breakdown in the family structure in South Africa, due to the political history, has meant that there is a breakdown in sexuality education

among families. The deficit of family support may indicate a weightier historical influence, where the political environment in South Africa has shaped sexual education. The meso level of structural influence of the family system highlights how the ability of adolescent females to engage in self-care is mediated through the meso level of structural constraints within their context. This study supported the findings of previous studies, which highlighted that the family structure strongly influences the ability of adolescent females in negotiating safe sexual practices (Kharsany *et al*, 2014).

Prevention of Risk

A second key deficit adolescent females identified was the ability to protect themselves from risk, where the circumstances were beyond their control. The greatest social issues participants identified in their community were rape, HIV/AIDS and adolescent fertility. Of these, participants believed that they were at high risk of being infected with HIV/AIDS through rape. They believed they had the ability to maintain their reproductive health, by utilising clinic services to gain contraceptives. However, they believed that the ability to prevent and protect themselves from the risk of HIV/AIDS was often out of their control. One participant specifically spoke of the risk of being raped based on the reason that she lived in this specific community. As stated in CCA, the health beliefs, values and meanings are in continuous flux with the broader macro structures surrounding them (Dutta, 2008). Sexual and reproductive health self-care goes beyond the knowledge, attitudes and sexual beliefs of adolescent females, being further influenced by their ability to negotiate the structures within which they find themselves. The basic universal self-care requisite of prevention of risk needs to be met, before developmental self-care requisites can be achieved.

These findings highlighted that, despite access to protective measures such as condoms (which protect from STIs and prevent pregnancy), not all adolescent females believe they are able to protect themselves from the risk of HIV infection. Notably, HIV is the greatest risk to them, beyond the risk of any STI. This establishes the need for further empowerment of adolescent females in maintaining their SRH where the circumstances go beyond their level of negotiation. The self-care agency of adolescent females is contained within the greater structural constraints of their community and society.

Influences

This study aimed to understand the influences on adolescent sexuality. By understanding the influences on sexuality, this study would be able to understand how these influences impact on the self-care abilities of adolescent females, by understanding their knowledge, attitudes and beliefs. The positive influences, as identified by participants, have been stated earlier in this chapter. Parental

relationships, health communication campaigns and programmes, interpersonal relationships, culture and religion were identified as positive influences on the understanding of sexuality. This section will outline the negative influences identified by participants, as they impact on the self-care capabilities and deficits of adolescent females. What was perceived as a positive influence by one participant was seen as a negative influence to another, which is a key finding pertaining to adolescent females' understanding of sexuality.

The negative influences on the understanding of sexuality that participants identified were within their proximal context. Interpersonal relationships, community and religion were highlighted. Although some participants highlighted the positive influence of interpersonal relationships and religion, they agreed that these were not always positive influences. As stated in previous literature, interpersonal relationships are key in the influence of adolescent sexuality (Pearson *et al*, 2005). Specifically, peer pressure among friendship groups was highlighted as a negative influence in previous studies (Harrison, 2001; Khoza, 2004; Osaikhuwuomwan and Osemwenkha, 2013). This was supported in this study, where participants stated that some friendships encouraged risky sexual behaviour among peers. This further translated into romantic relationships, where unprotected sex was identified as a negative influence of adolescent sexual and reproductive health (Harrison *et al*, 2005; Pettifor *et al*, 2009; Zuma *et al*, 2010). This was also supported in this study, where participants stated that their partners did not always encourage SRH, as they would not disclose their status and would engage in unprotected sex, thus infecting adolescent females with HIV. This, once again, highlighted the meso level of structural influence on the ability of adolescent females to protect themselves from the risk of HIV. Self-care is reliant on the self-care capabilities of their sexual partners, where their perceived risk, their level of knowledge and their self-care capabilities influenced and impacted on the understanding of sexuality among adolescent females. This ultimately impacted on the ability of adolescent females to ensure SRH self-care, as self-care agents.

Furthermore, participants highlighted the influence of their community and religion on their understanding of sexuality. In a previous study conducted in South Africa that applied Orem's self-care theory, it was identified that adolescents face self-care deficits when there is a lack of open communication between adolescents and their community (Ramathuba *et al*, 2012b). This was further supported in this study, where participants highlighted that their community did not always influence their understanding of sexuality positively, thus failing to support their sexual and reproductive health. Although some participants highlighted the positive influence of religion, some participants rearticulated the need for open communication between adolescents and religious leaders, stating that religious

leaders do not openly speak about sexuality and how to maintain one's sexual and reproductive health. The sexual understanding of adolescent females is mediated through the cultural, traditional and religious beliefs of community members, which ultimately impacts on the effectiveness of adolescent females to engage in SRH practices.

Knowledge, Attitudes and Beliefs

According to Orem, developmental self-care requisites are associated with human growth, where the self-care capabilities and deficits change as a person develops from one life stage to another (Orem, 1980). Central to this study are the developmental self-care capabilities and deficits of participants as they move from childhood into adolescence. As this chapter has highlighted, there are multiple positive and negative influences that impact on adolescent females' knowledge, attitudes and beliefs regarding SRH.

The self-care capabilities have been mentioned in this chapter, specifically the belief of abstinence, as well as adolescent females' self-care agency in their ability to visit local SRH services. However, this study identified that there was a deficit in adolescent sexuality and SRH knowledge. Specifically, not all participants were clear in their understanding of sexuality, with the majority only stating the biological understanding of sexuality. One participant stated that sexuality had never been explicitly explained to her. There was a lack of a comprehensive understanding of sexuality. Furthermore, participants understood the need to use SRH services in order to get contraceptives; however, there was a lack of comprehensive knowledge of the various contraceptive methods available to them. There are various contraceptive methods offered in PHC in South Africa (DOH, 2012). However, in this study, condoms and contraceptive pills were the only methods identified, with one participant also mentioning contraceptive injections.

These findings support findings from previous studies conducted in South Africa which identified a deficit in knowledge of the available SRH services available to adolescents (Wood and Jewkes, 2006; Kanku and Mash, 2010; Holt *et al*, 2012; Ramathuba, Khoza and Netshikweta, 2012a; Geary *et al*, 2015). Comprehensive knowledge of sexuality and SRH services was also lacking among these adolescent females. This raises the question of whether the primary problem is a lack of knowledge of the various contraceptive methods available to adolescent females, or whether there is a structural constraint in these methods not being available at all local public health clinics.

This section of this chapter has outlined the self-care capabilities and deficits of adolescent females. Through the use of a participatory research methodology, this study was able to gain a better understanding of the self-care capabilities and deficits of adolescent females. Adolescent females were able to identify their self-care capabilities and deficits, how these influenced their health decisions, and the further support they needed in order to maintain good SRH. Bodymapping in this study created an environment for engagement, where dialogue was created between participants and the researcher. The potential of art-based methodologies is highlighted as these methodologies have created a research space where the researcher and the researched are co-constructors of knowledge.

Furthermore, participants also highlighted the deficit in support from health care workers in effectively ensuring their SRH. This will be explored in greater detail in the section below.

Nursing Agency/Capabilities

This chapter has explored the self-care capabilities of adolescent females in maintaining their sexual and reproductive health. It has further highlighted the self-care deficits of adolescent females, and the impact of these on the effectiveness of maintaining good sexual and reproductive health care. Orem's theory of self-care deficits delineates when nursing is needed (Orem, 1980; Foster and Bennett, 2002; Ramathuba *et al*, 2012b). In this study, nursing capabilities are seen as the actions performed by health care workers, in order to increase the capabilities of adolescent females to reduce their SRH self-care deficits. This, then, highlights the capabilities/agency of health care workers in helping adolescent females meet their self-care requisites, in order to maintain good SRH as self-care agents.

This study aimed to explore the understanding of self-care among adolescent females, in respect to their sexual and reproductive health. A sub-question to this study is to understand the perception of adolescent females towards health care facilities, and health care workers, in influencing their SRH practices. This study aimed to understand the influence of AYFS and health care workers in maintaining their sexual and reproductive self-care. This sub-section of this chapter will outline nursing capabilities, as defined by Orem's theory of nursing systems (Foster and Bennett, 2002). It will also analyse data collected in this study, evaluating the perceptions of adolescent females towards the capabilities and deficits of health care workers.

Orem's theory of nursing systems suggests that, in order to meet the self-care deficits of adolescent females, a supportive-educative nursing system should be adopted (Orem, 1980). This nursing system aims to teach and support adolescent females in order to effectively meet their self-care requisites. This

system provides support, guidance, teaching and the provision of a developmental environment. The aim of a health care worker using a supportive-educative nursing system is to expose adolescent females to the total spectrum of self-care actions for them to perform on their own behalf (Orem, 2001). Ultimately, the effectiveness of health care workers is evaluated in terms of their ability to encourage SRH self-care agency among adolescent females.

This study, however, is focused on the user's perception, rather than the provider's perception. The perceptions of adolescent females are analysed, highlighting their attitudes and perceptions towards health care workers and health care facilities; however, this study does not cater for the health care workers' perspective. This is highlighted as an area for further research. This study highlights the need for establishing the perspective of adolescent females towards health care workers and health care facilities, as it creates a foundation for further research in accessing the perceptions of health care workers. As explored by Dutta (2008), health meanings are deeply rooted within patients' and health care workers' identities, and the influences that these have on their perceptions. This study accounts for the identity of adolescent females, and their perceptions of health care workers.

In this study, the equitability, accessibility, acceptability, appropriateness and effectiveness of health care facilities and health care workers was explored. These characteristics are highlighted as vital in providing adolescent friendly SRH services (WHO, 2012).

Equitability

In this study, participants were asked to explain their experiences with health care facilities and health care workers in accessing sexual and reproductive health services. A key finding from the study was that participants highlighted that they are denied SRH services because health care workers believe they are too young to engage in sexual activities. Orem's nursing practices highlight the need for health care workers to respond to the requests, desires and needs of adolescent females (Orem, 1980; Orem, 2001; Foster and Bennett, 2002; Pearson *et al*, 2005; Ramathuba *et al*, 2012b). Despite the need for health care workers to encourage self-care agency among adolescent females, the denial of SRH services due to age highlights the lack of equitability among health care workers in supporting adolescent females in meeting their self-care requisites.

The self-care abilities of adolescent females are mediated through the culture and structures that surround them. At a macro level, national health care policy dictates the right of adolescent females to access SRH services. Constitutionally, adolescents as young as 12 years old have the legal right to all

sexual and reproductive health services (DOH, 2012a). This study highlighted that, despite policy implementation giving access to SRH services, participants were still denied access because of their age. This finding supported previous studies conducted on adolescents' access to health care services, where health care workers were reported to deny services even to those over the age of 18 years old (MiET Africa, 2011; Holt *et al*, 2012; Geary *et al*, 2015). These studies highlighted that health care workers believed that adolescents should not engage in sexual activities before marriage. When adolescents tried to access health services, they were ridiculed and taunted by nurses. Participants in this study highlighted similar experiences, where nurses would insult them when they tried to access services.

These findings highlight the need to acknowledge the cultural, religious and traditional value systems of health care workers, which influence the perceptions of SRH service provision (Godia *et al*, 2013). CCA identifies the influence of values on health decisions. Values conceptualise the problems we consider important, as well as the corresponding solutions we develop to these problems (Dutta, 2008: 64). Furthermore, CCA establishes that the identity of health care workers influences their perceptions of adolescent females, which, in turn, influences the way the health care worker interacts with them. Therefore, despite adolescent females' right to SRH services, and the need for health care workers to respond to their needs, desires and requests, there is a need to acknowledge the cultural context that surrounds the health values and beliefs of health care workers, as these influence their perceptions of SRH provision.

This is a key limitation of this study, where the perceptions of health care workers are not explored, with regard to understanding their cultural, religious and traditional values. This study has identified that adolescent females are denied SRH services due to their age. However, further understanding is needed in order to understand the health provision choices of health care workers.

Accessibility

In regard to SRH, the role of the nurse as a supportive educator establishes her ability as a nursing agent to provide support, enhance the decision-making process of adolescents, encourage behaviour control and how effectively to implement this, as well as teach and guide adolescents in effective self-care (Ramathuba *et al*, 2012b). Orem's theory of nursing systems highlights the role of health care workers as teachers, as they provide knowledge of the self-care requisites of adolescent females. Nursing is needed when a self-care system requires specialised knowledge and skills in order to support adolescent females in meeting their self-care deficits (Foster and Bennett, 2002). Orem also

defines the role of health care workers in guiding and directing adolescent females, as being responsible for providing factual information in order for them to meet their self-care requisites (Orem, 1980). Health care workers' role as supportive educators requires them to support adolescent females in meeting their self-care needs, by imparting knowledge and information that increase their self-care capabilities.

In this study, participants highlighted that health care workers were not perceived as educative in providing information of health care services. Some participants did not feel health care workers were a source of knowledge, therefore meaning that they were not well informed on the SRH services available to them. Furthermore, some participants stated that health care workers were also not supportive in helping them achieve SRH self-care. Where participants stated that health care workers did not care about them, or how adolescent females were feeling, it was highlighted that health care workers were not providing psychological support for them, as Orem identifies they should as per the role of health care workers in meeting the self-care deficits of adolescent females (Orem, 1980).

These findings highlight the nursing care deficits in helping adolescent females increase their self-care abilities, in order to meet their self-care deficits. These findings highlight the deficit experienced by adolescent females, with regard to health care workers applying a supportive-educative nursing system, in order to increase their self-care capabilities. The negative experiences of health care facilities create a barrier to the accessibility of health care services, thus reducing the ability of adolescent females to be self-care agents. There is a need to create an environment where health care services are more supportive and educative, in order to increase the self-care capabilities of adolescent females, and, in turn, reduce their self-care deficits.

Acceptability

A youth friendly services programme has been implemented in South Africa, in order to increase the uptake of SRH services among adolescents (Geary *et al*, 2014). Acceptability within adolescent health services is key in increasing the uptake of SRH self-care. Orem defines nursing practices which aim to guide health care workers in ensuring that adolescent females are given an opportunity to voice their desires, requests and needs, devoid of all judgement, personal opinion and negative consequences (Ramathuba *et al*, 2012b). The feeling of acceptance by health care workers is essential in helping adolescent females increase their self-care abilities, and thus decrease their self-care deficits in maintaining their sexual and reproductive health.

Participants in this study highlighted that they were not aware of any adolescent and youth friendly services available at their local health care facility. They stated that their clinic did not do anything specific for youth, in order to make health care services more acceptable. Orem states that nurses need to provide an environment that supports development. This study highlighted the lack of environmental support for bettering the experiences of adolescent females. The South African health care system has faced challenges in providing health services, due to the complexities of its history coupled with financial and human resource constraints (Coovadia *et al*, 2009).

The macro structural influence on health care services is highlighted by the lack of AYFS provision in this community. Participants stated the need for AYFS in their community; however, the challenges of the practicalities of implementing these facilities in health care clinics are seen as a structural barrier.

The lack of youth friendly services in this clinic is apparent through the lack of acceptability identified by the participants. Participants identified a breach in confidentiality and privacy by health care workers. Participants believed that health care workers were not friendly, because they were judgemental towards the decisions of adolescent females. Rather than providing an 'understanding presence', as defined by Orem's nursing practices (Orem, 1980), health care workers in this clinic were identified by participants as judgemental and difficult to relate to. These findings are supported by the findings of previous studies which highlighted the influence of breaches in confidentiality and privacy as key in the uptake of SRH services (Mathews *et al*, 2009; MiET Africa, 2011; Holt *et al*, 2012; Geary *et al*, 2014; Geary *et al*, 2015). In this study, the feeling of acceptance directly impacted on the effective uptake of SRH services. Participants stated that their negative experiences with health care workers directly influenced their self-care capabilities, causing them to discontinue SRH service uptake because of feelings of judgement. The need for an accepting environment directly impacts on the ability of adolescent females in increasing their self-care capabilities, in order to maintain good SRH self-care. Health care workers pose a barrier, negatively influencing their SRH decision-making process.

Appropriateness

Studies have highlighted the need for adolescent-health-specific training for health care workers, in order to ensure that services are appropriate, beneficial and sustainable (Wood and Jewkes, 2006; Thomas, 2009; Jaspan *et al*, 2010; MiET, 2011; Holt *et al*, 2012; Mburu *et al*, 2013; Godia *et al*, 2013; Schiver *et al*, 2014; Geary *et al*, 2014; Schiver *et al*, 2014; Tanner *et al*, 2014; Geary *et al*, 2015). It is vital that health care services and health care workers provide appropriate adolescent health care. In this study, participants highlighted that it was not easy to communicate with health care workers.

Communication is key in health care workers' ability to expose adolescent females to the total range of self-care actions they need to perform in order to ensure their SRH. Participants believed that they were not exposed to the total range of health care actions they needed to perform, because health care workers communicated mixed messages regarding their SRH. Participants in this study stated that health care workers needed further training in how to provide appropriate health care services to adolescents. This finding supports findings of previous studies conducted in South Africa. Despite the implementation of youth friendly services, adolescent females believe there is a lack of appropriate SRH service provision in this community.

The influence of culture is highlighted here, as self-care is mediated through the cultural context surrounding health decisions. Participants highlighted that when they asked for SRH services, health care workers questioned why they required services. The appropriateness of health care services for adolescents is vital to increasing SRH uptake. However, the cultural context, which influences communication between adolescent females and health care workers, has to be acknowledged. The values and beliefs of adolescent females and of health care workers influence the perception of the appropriateness of health care services, which, in turn, influences the exposure to the total range of self-care actions needed to be performed by adolescent females. Once again, this study further identifies the need to gain a greater understanding of the values of health care workers, as these influence health care provision.

Effectiveness

This chapter has explored the influence of health care workers on the provision of SRH services among adolescent females. Although this chapter has highlighted that participants perceived health care workers as unfriendly and judgemental, the study also highlighted that this was not always perceived of all health care workers. Participants stated that sometimes the health care workers are friendly, but it is not consistent. Participants stated that most health care workers are unfriendly, but some are accepting and considerate. They stated that health care workers are most effective when they are understanding, considerate and friendly.

Furthermore, participants believed that health care workers are most effective in the provision of ARV therapy treatment. It was stated that health care workers helped them understand the treatment method, providing a model for how to take the medication. This highlights the potential of nursing agency and capabilities to help meet the self-care demands of adolescent females. Participants highlighted the ability of health care workers to be supportive educators in the provision of HIV

treatment. However, health care workers were identified as being effective in the treatment, rather than the prevention, of HIV/AIDS.

In light of the increasing SRH problems faced by adolescent females in South Africa, there is a need for all SRH self-care requisites to be met. As participants have stated, health care workers are the most effective in ARV therapy treatment. However, as this chapter has highlighted, there is a lack of equitability, accessibility, acceptability and appropriateness in adolescent SRH service provision, where the effectiveness of health care workers in increasing the self-care capabilities of adolescent females is insufficient. In order for adolescent SRH provision to be effective in preventing and treating their SRH problems, the proper development of all these characteristics is vital.

This section concludes by addressing the guiding research question this study aimed to answer, in order to understand the perception of adolescent females towards health care facilities and the influence they have on their SRH practices. Through exploring the equitability, accessibility, acceptability, appropriateness and effectiveness of health care facilities and workers, this study concludes that health care workers pose a potential barrier to health care access among adolescent females. Participants identified the influence health care workers have on their decision-making process, where health decisions were marred by shame and guilt. The analysis of the data has highlighted the deficit in health care workers' ability to assist adolescent females in meeting their therapeutic self-care demands, thus negatively influencing their SRH self-care. It is concluded that, because of negative experiences with health care workers, SRH services are underutilised by adolescent females. The effectiveness of health care services is directly impacted by their experiences with health care workers. The negative perception of health care workers and health care facilities creates an adverse influence on the SRH practices of adolescent females.

Finally, this section concludes with analysing the potential of art-based methodologies in creating an engaging environment for adolescent females, in order to gain a greater understanding of their perceptions of health care workers and health care facilities. As a participatory methodology, it created an environment for dialogue, where the voices of adolescent females could be heard in order for them to identify health care problems, as well as possible solutions, as appropriate to their context. As this section stated, there is a need to understand the cultural, traditional and religious values of health care workers. This further suggests the possibility of art-based methodologies, specifically bodymapping, in creating an environment for dialogue between adolescent females and health care workers. This has the potential to create agency among adolescent females and health care workers, where they are

empowered to identify health care problems and solutions that are applicable not only to them, but also to their community.

Therapeutic Self-Care Demand

This study aimed to understand the ability of adolescent females to carry out actions effectively, as to form a pattern and sequence, in order to ensure health problem prevention and health promotion (Orem, 1980). In Orem's self-care model, adolescent therapeutic self-care demand is the exposure to the total care measures in order to meet their self-care requisites as to ensure sexual and reproductive health and well-being.

This chapter has identified mothers, health campaigns and organisations, interpersonal relationships, culture, community and religion as the greatest influences on adolescent sexuality. These influences have, in turn, impacted on the sexual beliefs, values and meanings of adolescent females. Furthermore, they have influenced the self-care capabilities of adolescent females in maintaining their sexual and reproductive health. This chapter has established abstinence, contraceptive knowledge, and clinic use as part of the attitudes, beliefs and knowledge of adolescent females in good sexual and reproductive health. Participants identified their need to be active participants in their SRH self-care. However, family support and prevention of risk were identified as the greatest deficits adolescent females have in ensuring their SRH. Orem's theory of self-care deficits delineates when nursing is needed. However, this study highlighted that health care workers, rather than increasing the self-care capabilities of adolescent females in order to reduce their deficits, actually pose a barrier to health care services.

This study has established that, although adolescent females have knowledge and understanding of SRH self-care, their self-care deficits outweigh their abilities. Central to ensuring adolescent females' SRH is the need to empower them further as self-care agents by providing risk prevention options that place self-care in the hands of the adolescent females. Agency is achieved when adolescent females have the ability to enact their choices and participate actively in negotiating the structures which surround them (Dutta, 2008). The negative influence of health care workers on the self-care capabilities of adolescent females directly impacts on their self-care agency, as they negotiate their self-care within the structural constraints of health care facilities. This, then, means that the therapeutic self-care demands of adolescent females are not being fulfilled.

Sexual and reproductive health self-care is mediated within the culture and structure that surrounds it. In order for adolescent SRH self-care to be achieved, the self-care deficits need to be addressed and reduced, for adolescent females to be self-care agents.

Given the complexity of adolescent sexuality and the barriers highlighted between adolescent females and health care workers, this study has established the importance of adopting a participatory approach in researching and communicating sexuality among adolescent females. The self-care capabilities and deficits of adolescent females in maintaining good SRH are intricate and complex, where a self-care capability of one adolescent female may be seen as a deficit for another. This chapter has highlighted the possibility of a participatory approach, specifically bodymapping, in creating a more engaging environment for researching and communicating with adolescent females about sexuality. As a guiding research question, this study aimed to understand the perceptions of adolescent females towards art-based methodologies as an alternative methodology in researching adolescent sexuality. The next section of this chapter further explores the potential of art-based methodologies, drawing on CCA and previous literature stated, in order to analyse and evaluate the methodology.

Art-Based Methodologies

Central to curbing the HIV/AIDS and adolescent fertility rates is increasing the understanding of female adolescent sexuality (Kunene, 1995). As discussed in previous chapters in this dissertation, there has been an increasing need to address the challenges of traditional qualitative research methods, in order to create spaces of effective communication with adolescents (Harrison *et al*, 2001; Hoosen and Collins, 2004; Khoza, 2004; Govender, 2013). This study aimed to establish the perceptions of adolescent females towards art-based methodologies as an alternative research method in effectively researching sexuality. Furthermore, and related, the study aimed to establish how bodymapping, as an art-based methodology, either aided or inhibited sexual and reproductive health communication.

Regarding these methodologies, this study identified four aspects that establish how bodymapping, and art-based methodologies in general, are effective tools in researching and communicating with adolescent females about sexuality and their sexual and reproductive health. Agency, conscientisation, real-life experience, and freedom and flexibility were highlighted as aiding factors in SRH research and communication. These aspects will be explored in more detail in the following sections, concluding with the potential of the method in future research and health communication.

Agency

CCA advocates that dialogue creates a space for reflection and action, in order to bring social change (Dutta and Basu, 2008). Furthermore, through dialogue with cultural members, agency is created. This study established that bodymapping creates an opportunity for engaging in dialogue; participants are given agency through dialogue, which, in turn, creates a space for reflection and action. When dialogic spaces are created with adolescent females, collaboration through participation is allowed, where their voices are heard. A previous study conducted on the use of bodymapping in HIV communication established the effectiveness of the methodology in creating dialogue with participants (Govender, 2013). This study further highlighted the effectiveness of bodymapping in creating dialogue among participants, which, in turn, created agency among participants. The active involvement of the participants highlighted the effectiveness of a participatory art-based methodology in engaging with participants, in order for dialogue to be created with cultural members.

Through dialogue with cultural members, communication with adolescent females was encouraged in order to re-establish power dynamics between the researcher and the researched.

As power relations between the researcher and the researched were placed into question, participants were given full participation in the research process (Reason, 1994). The bodymapping workshop created an environment for dialogue between the participants and the researcher, where participants had ownership over their involvement in the research process. Agency was created when participants had the power to choose their level of involvement in the bodymapping workshop, as they chose what they wanted to represent. The researcher functioned as a resource for the knowledge creation of the participants (Babbie, 2011). Participation in the research process was seen in the ability of participants to choose how best to represent themselves on their bodymaps. As highlighted in the Data Presentation chapter, participants responded individually to the research process, by engaging in whichever way they were most comfortable with. This gave participants the power to control the research process, where participants were knowledge creators. We can specifically see this through the choice between drawing and/or writing on their bodymaps.

Placing into question traditional qualitative methods, art-based methodologies require the participants to be active knowledge creators, that is, co-constructors of knowledge (Kelly, 2006: 297). Active participation in the research process creates agency within the participants as they choose their level of involvement. The study conducted by Govender (2013) identified that bodymapping increased the confidence of participants to engage and participate. This study also highlighted the increased

confidence of participants to be active participants in the bodymapping workshop. The researcher noted the visual excitement, interest and enjoyment of the participants as they engaged in the bodymapping process. Participants stated their enjoyment of the whole bodymapping workshop. As participants discussed their responses to the bodymapping steps, dialogue was created not only between the participants and the researcher, but also between participants. The positive response to the bodymapping workshop highlights the usefulness of art-based methodologies in creating an effective space for SRH research, where communication is aided through agency.

This study highlights how bodymapping, as an art-based methodology, redefines the researcher-researched relationship, thus recreating the research space (Dutta and Basu, 2011). Through bodymapping, participants are mobilised towards their own empowerment. This highlights the effectiveness of art-based methodologies in creating dialogic spaces where the voices of adolescent females can be heard. By adopting a participatory approach to this research, the researcher ensured that the self-care deficits and capabilities of adolescent females were heard, thus creating dialogue for their empowerment, as they could identify health agendas. Bodymapping created an engaging environment where it was possible to understand the perceptions of adolescent females towards SRH, thus creating agency among them as they were given a voice. Through the creation of agency among adolescent females, this study states the effectiveness of bodymapping as an art-based methodology in aiding sexual and reproductive health communication.

Conscientization

Conscientization is explained by Paulo Freire as the process of “self-awareness through collective self-inquiry and reflection” (Fals-Borda and Rahman, 1991:16). By engaging in dialogue with cultural members, the researcher allows conscientization to take place among participants. Dialogue allows for collective self-inquiry, where participants are given the opportunity for self-evaluation and self-assessment, thus creating agency among participants. Govender (2013) identified how bodymapping, as a methodology, can be used as an educative tool in order for participants to understand themselves and their community better. As participants are required to ask questions of themselves, they are able to reflect on their understanding of themselves in relation to their community. In this study, self-inquiry was central to adopting an art-based research methodology.

As one participant stated, the bodymapping process required participants to ask questions of themselves. As stated, “...because it makes you think about yourself.” It required self-assessment and self-inquiry into what they understood about sexuality and their SRH. This participant stated that the

bodymapping process made sexuality research harder because it required self-evaluation about what they believed SRH self-care meant. Although this participant stated that the bodymapping process made sexuality communication harder, this process of conscientization is deeply rooted in critical theory and PAR, where participants are required to ask questions of themselves in order for research to have real-life value (Guba and Lincoln, 1994).

The process of self-inquiry in research creates agency among participants for problem identification. As the researcher and the researched create a shared critical space through dialogue, co-construction of knowledge takes place, where participants are able to identify problems relevant to themselves and their community (Dutta, 2008). The participants and the researcher move into a transactional relationship, where participants are able to identify and define health problems in their community, as well as possible relevant solutions.

Self-inquiry and problem identification were key to sexuality communication in this study. The bodymapping process placed the participants in a space where sexuality self-inquiry could take place. Participants were required to assess their understanding, attitudes and beliefs regarding sexuality and their sexual and reproductive health. Through this self-inquiry, problem identification took place, where participants highlighted the problematic nurse-adolescent relationship and their level of access to SRH services in their local community. The bodymapping process required the participants to assess their perceptions towards health care workers, and how these impacted on their ability to ensure SRH self-care. The bodymapping process allowed for self-inquiry into the deficits adolescent females have in effectively ensuring their sexual health.

The process of conscientization empowers adolescent females, as they have the ability to identify health problems. Bodymapping, as an art-based methodology in this study, is seen as an effective tool in sexuality research, because it creates a space for conscientization to take place. The research process is no longer purely aimed at data collection for the benefit of the researcher; rather, the participants are given a space for self-inquiry, where they are able to understand themselves in relation to their community. The participants highlighted their ability to express their feelings through the bodymapping process. As an effective research tool, bodymapping not only allowed the researcher to gain a greater understanding of adolescent sexuality, but also allowed participants to speak their mind about their understanding of sexuality. Furthermore, not only does bodymapping create an effective space for sexuality research, but it also aids SRH communication, as participants are able to determine health agendas as they perceive them. This study supported the findings of Govender (2013), which

highlighted the effectiveness of bodymapping in creating an environment for introspection and self-reflection, thus creating an environment for conscientization.

Real-Life Experience

As this chapter has highlighted, art-based methodologies as a research tool create a space for agency and conscientization among participants as the researcher and the researched are brought into a dialogic relationship. Agency and conscientization highlight the effectiveness of bodymapping in researching sensitive topics, as adolescent females are mobilised towards their own empowerment through self-inquiry. Bodymapping not only allows for problem identification among adolescent females, but also allows for problem solving. Critical theory and PAR advocate for the value-determined nature of inquiry where actions are determined from the real-life benefit of research (Guba and Lincoln, 1994).

This study aimed to understand the real-life SRH experiences of adolescent females, and the influences on their understanding of sexuality. By engaging with adolescent females through dialogue, the researcher used the bodymapping process to create a space where the participants could identify health problems, as well as health solutions, which were relevant to their community. As mentioned previously, the participants highlighted the problematic relationship between adolescent females and health care workers, in accessing SRH services. The bodymapping process empowered adolescent females to identify health care problems that were relevant to them. However, furthermore, the bodymapping process created an environment where participants were able to identify health care solutions for themselves. Adolescents suggested solutions to the problematic relationship between health care workers and adolescents. Participants identified what their SRH self-care deficits were, but also suggested what they needed in order to meet these deficits. By engaging in dialogue with participants, the researcher allowed real-life actions to be suggested by participants in order for them to help maintain their sexual and reproductive health.

As stated in the Data Presentation chapter, adolescent females highlighted the need for health care workers to be more understanding and empathetic to their SRH needs. The bodymapping process not only allowed adolescent females to identify how health care workers create barriers to SRH services, but also enabled them to identify what is needed in order for them to reduce their self-care deficits. Participants highlighted the need for adolescent friendly services and an adolescent friendly environment in their local clinic, in order to increase clinic utilisation.

The ability of adolescent females to identify their problems, as well as the appropriate health care solutions, is central to establishing the effectiveness of art-based methodologies in researching sexuality. In order for the SRH self-care needs of adolescents to be met, greater understanding of their self-care capabilities and deficits is needed. As a methodology in this study, bodymapping aided the communication process between the participants and the researcher in understanding the real-life experiences of adolescent sexuality.

When participants are given a space to engage in dialogue, commonalities are highlighted. Govender (2013) highlighted that the bodymapping process identified similar challenges between participants, where they were able to highlight commonalities in their experiences. It is through commonality in experiences that an environment of inclusivity, acceptance and collective support is created. This, in turn, creates agency among participants, where they are mobilised towards their own empowerment. In this study, participants highlighted that the bodymapping process made it easier to discuss sexuality, because they saw that they had things in common with regard to how they looked after themselves. They stated that sexual and reproductive health was an everyday, real-life experience. Bodymapping encouraged them to evaluate their everyday SRH experiences, where real-world actions were highlighted.

Bodymapping, as an art-based methodology, creates an environment where participants are able to engage in order to suggest context-specific health solutions. The ability of art-based methodologies to have real-world benefits highlights the effectiveness of alternative methodologies in engaging with adolescent females. Participants in this study highlighted their ability, through the use of an art-based methodology, to understand themselves in relation to those around them. This created open communication, where participants were able to represent their attitudes, beliefs and knowledge, and the researcher was able to outline the collective health care problems faced in the community.

Freedom and Flexibility

Bodymapping, as an art-based methodology, provides adolescent females with a method to explore themselves in relation to others, in order for their voices to be heard. Art-based methodologies create an environment for a bottom-up approach to communication (Dutta, 2008). There has been an increasing need to address the challenges of traditional qualitative research methodologies in researching sensitive topics, specifically adolescent sexual and reproductive health. Many times, adolescent sexuality is wrapped up in silences, taboos and privacy, where group discussions and interviews create a barrier to communication and research (Tamale, 2011). In this study,

communication was identified as most free and flexible during the bodymapping workshop. The researcher identified that the group discussion held the least discussion among the participants, while the bodymapping workshop held the most. Participants seemed most comfortable during the bodymapping workshop. They were generally comfortable during the individual interviews, and were least comfortable during the group discussion.

Throughout the whole research process, the bodymapping workshop was identified as the most effective methodology in researching sexuality among adolescent females. Participants were excited about the workshop and stated their enjoyment during the process. This highlights the effectiveness of the methodology, as it aided communication between the researcher and the researched. It further aided communication between the participants, as an environment of inclusivity was established, where participants had the freedom and flexibility to choose their level of involvement.

As participants had the freedom to choose their level of involvement in the bodymapping workshop, the ways in which they engaged within the bodymapping workshop highlighted the flexibility of the method. Govender (2013) highlighted in a previous study that bodymapping created a flexible environment where there was freedom to communicate, as participants decided what they wanted to represent, and how they would represent it. In this study, the flexibility of drawing and writing during the bodymapping process was highlighted. Some participants stated that they were not comfortable with drawing during the workshop, so they rather wrote down their responses. Some participants chose to use a mixture of drawing and writing, and a few chose to use mostly colour and drawing to represent their understandings. The bodymapping process allowed for participants to create their own interpretations, and to explore their own ideas in a safe, comfortable space. This finding was highlighted in Govender's study (2013). Although not all participants were comfortable with drawing, the bodymapping workshop gave them the opportunity to represent themselves in the way they felt most comfortable with.

The freedom and flexibility of bodymapping, and of art-based methodologies in general, create an environment of inclusivity. The freedom and flexibility of bodymapping highlight the effectiveness of the methodology in researching adolescent sexuality, as the method allows participants control over the research process as they negotiate their involvement in the research process. As a methodology in this study, it aided communication among adolescent females, as it addressed the challenges of traditional methods. This study highlighted the effectiveness of the bodymapping workshop, as opposed to the group debriefing discussion, in communicating with the participants.

Potential of the Method

This study aimed to understand the perceptions of adolescent females towards art-based methodologies, specifically bodymapping, as an effective methodology in researching sensitive topics, such as sexuality. Furthermore, this study aimed to understand how bodymapping either aided or inhibited effective communication around sexual and reproductive health among adolescent females. As has been identified throughout this chapter, this study highlights the effectiveness of art-based methodologies, as they create agency among participants, where self-inquiry is encouraged. It allows for problem identification and problem solving, where a researcher collaborates with the participants, creating dialogue around real-life social phenomena. New knowledge is created which is beneficial for both the researcher (new knowledge) and the researched (social change/action) (Chevalier and Buckles, 2013).

The freedom and flexibility of the method aided communication, as the participants were not confined within the borders of traditional qualitative research methodologies. This chapter has highlighted the effectiveness of bodymapping in aiding communication around sexual and reproductive health, as a free, safe and flexible environment is created.

This study advocates the high potential of art-based methodologies in researching sensitive topics among adolescent females. The challenges of the practicalities of the bodymapping workshop are highlighted, where resources may be limited, which impacts on the effectiveness of the methodology. However, regarding this approach as a methodology and, furthermore, a communication tool, this study highlights its effectiveness in effectively engaging with adolescent females and encouraging active participation, where culturally and contextually relevant health problems and solutions are identified.

Furthermore, as has been highlighted throughout this chapter, the relationship between adolescent females and health care workers was identified as a barrier to accessing health care services. This study advocates the effectiveness of art-based methodologies, such as bodymapping, in creating a more engaging environment for adolescent females and health care workers to interact, in order to understand the cultural nuances of health care access and provision. There is a need to understand adolescent females' and health care workers' identities within health care services, and how these influence their perceptions of one another (Dutta, 2008).

Conclusion

In conclusion, this chapter has analysed data collected in this study in order to answer the guiding research questions. Influences on adolescents' understanding of sexuality have been explored, and this chapter has stated how this understanding has impacted on the self-care abilities of adolescent females, in order to ensure good sexual and reproductive health. Finally, the potential of art-based methodologies as an alternative research methodology has been evaluated, establishing the effectiveness of bodymapping in aiding communication with adolescent females.

In the final concluding chapter which follows, the collective meaning of the data analysed will be presented. This chapter will summarise the findings of this study in order to draw together the answers to the research questions. It will state the recommendations highlighted from this study and suggest further research to follow from this study.

CONCLUSION

Introduction

Adolescent females bear a disproportionate burden of HIV infection in sub-Saharan Africa and, even more specifically, in South Africa. However, not only are adolescent females vulnerable to the increased risk of HIV, but they face the risk of adolescent fertility as well. Early sexual debut has been associated with increased sexual and reproductive health risks. It is therefore pertinent to understand adolescent sexuality at the age of sexual debut, in order to ensure that adolescent females are well informed and educated and can ensure their SRH self-care.

This study aimed to explore the understanding of sexuality among adolescent females, identifying the key influences on their perceptions and, in turn, how these influences have impacted on their sexual and reproductive health decisions. Furthermore, this study aimed to outline the self-care capabilities and deficits of adolescent females in maintaining their sexual and reproductive health. This study aimed to establish the ability of adolescent females to prevent and protect themselves from disease and unwanted pregnancy. Along with this, the influence of health care workers on the capabilities and deficits of adolescent females was analysed. Using Orem's self-care model, this study highlighted the influence of health care workers in increasing the self-care capabilities in order to reduce the self-care deficits of adolescent females in maintaining good SRH. Finally, as an evaluation of alternative qualitative methodologies, bodymapping as an art-based methodology was explored. The perceptions of adolescent females towards bodymapping as an alternative methodology in researching sensitive topics, such as sexuality, were investigated.

The Introduction chapter outlined the focus of the study and the background to the study, by establishing the sexual and reproductive health issues faced in South Africa. This dissertation then reviewed literature on adolescent sexuality, SRH in South Africa, adolescent and youth friendly services and the influence of health workers, and the use of art-based methodologies in HIV/AIDS research in South Africa. Situating this study within CCA, the Theoretical Framework chapter explained culture, structure and agency within this study. Orem's self-care model was also explained, as it guided the understanding of adolescent females' self-care capabilities and deficits. These two theories were then combined in order to apply a culture-centred self-care model. The next chapter provided an outline of the methodological approach that guided data collection and data analysis. The data collected was then presented in the following chapter and, finally, the data was analysed in relation to the literature reviewed and the guiding theoretical framework in the fifth chapter. This concluding chapter seeks to

give an overview of the study, summarising the main findings, suggesting recommendations and highlighting further areas of research.

Summary of the Main Findings

This section will summarise the research findings. This will be done by summarising the research findings in line with the research questions and objectives as highlighted in the Introduction chapter of this dissertation.

Understanding of Sexuality

This study aimed to understand the key influences on the understanding of sexuality among adolescent females. By understanding the key influences on adolescent sexuality, this study aimed to establish how these influences impacted on the SRH health decisions of adolescent females. This study established that parental relationships and health communication campaigns and programmes positively influenced their understanding of sexuality. These formed the foundation of their sexual education and sexuality knowledge.

This dissertation also established the socio-cultural influence on the understanding of sexuality, highlighting interpersonal relationships, culture and religion. However, the perceptions of these influences varied among participants, where a positive influence for one was potentially seen as a negative influence for another. This study then highlighted how these influences have impacted on the SRH decisions of adolescent females. Firstly, participants identified how the positive influences on their understanding of sexuality ultimately positively influenced their ability to engage in effective SRH self-care. Participants further identified negative influences on their understanding of sexuality, where SRH was not encouraged and assisted, thus creating a deficit in meeting their therapeutic self-care demands.

As highlighted in this dissertation, this study further articulated that, in order for adolescent females to be well informed and educated about effective self-care, they need a comprehensive understanding of adolescent sexuality. When there is a deficit in sexuality understanding, there is an increase in sexual and reproductive health risks. Furthermore, in order to ensure that adolescent females can be effective self-care agents, there is a need to reduce the negative influences on their understanding of sexuality, as these directly impact on the ability of adolescent females to engage in SRH self-care.

Self-Care Deficits and Capabilities

The second key research question guiding this study was to establish the understanding of self-care among adolescent females, in order to explore their self-care deficits and capabilities. This study highlighted abstinence, contraception knowledge and clinic use as self-care capabilities of adolescent females. However, comprehensive knowledge of all the SRH services available to them was lacking. Furthermore, clinic use was often hindered by health care workers. Adolescent females identified areas of SRH self-care agency; however, structural, cultural and religious barriers determined the effectiveness of their self-care actions.

Once again, health communication programmes and parental relationships were highlighted as key in creating self-care agency among adolescent females. However, lack of further family support was identified as a deficit in engaging in self-care. Protection from risk was established as the greatest deficit among adolescent females. Self-care goes beyond the ability of adolescent females to access health care services. There is a need to address the social and structural constraints that surround adolescent females, which, in turn, impact on their self-care agency. Self-care agency among adolescent females is the combination of comprehensive knowledge of SRH, the influence of nursing agency and the reduction of structural and social barriers and risks.

Health Care Workers

As was highlighted in the review of the literature in this study, health care workers have often been identified as a barrier to SRH services. This study further identified health care workers as a deficit in creating self-care agency among adolescent females, where use of services is terminated due to the influence of health care workers. This study aimed to understand the perceived role of health care workers by adolescent females, and the influence they have on their sexual health decisions. This study established that SRH services and health care workers negatively influenced the experiences of adolescent females in regard to SRH, which, in turn, negatively impacted on their capabilities in maintaining their sexual and reproductive health. This study outlined that health care services were lacking equitability, accessibility, acceptability and appropriateness in meeting the self-care needs of adolescent females. This ultimately impacted on the effectiveness of health care services, where negative experiences were associated with reduced utilisation of SRH services.

Art-Based Methodologies

This study aimed to explore the benefits and disadvantages of art-based methodologies in creating dialogue among adolescent females. This dissertation has highlighted the effectiveness of bodymapping, in particular, in aiding research and communication around sensitive topics, such as sexuality. The benefits of creating agency and conscientization among adolescent females were identified, where participants were given full participation in the research process, so as to provide understanding of the real-life SRH experiences of adolescent females. This study established the benefit of bodymapping as a methodology, as it aided communication between the researcher and the researched through the flexibility and freedom created through the method. This dissertation has explained the potential of art-based methodologies as an effective tool for researching and communicating with adolescent females, in order, firstly, to expand the overall knowledge of adolescent sexuality within the context of HIV/AIDS in South Africa, and, secondly, to educate, inform and empower adolescent females to maintain their sexual and reproductive health.

Given the complexities of sexuality, coupled with the barriers highlighted by adolescent females to accessing SRH services, this study has identified the potential of art-based methodologies in creating a space for dialogue where their self-care capabilities and deficits can be explored. This study highlighted the potential of bodymapping in creating not only a more engaging environment for adolescent females to engage with the researcher about their SRH, but also the opportunity to engage with other adolescent females in order to highlight the commonalities in SRH self-care.

Recommendations

In light of the main findings of this study, this dissertation makes the following recommendations for adolescent female SRH in South Africa, in order to curb the increasing HIV and adolescent fertility rates. Firstly, this study suggests a further need to engage all facets of communities in creating self-care agency among adolescent females. There is a need for multiple target group specific health communication campaigns for all community members, in order to encourage, inform and assist SRH self-care among adolescent females. There is a need for comprehensive sexuality knowledge among all adolescents, as the relationships between adolescents form an important influence in how adolescent females engage in self-care. Specifically, noting how mothers formed the foundation of adolescent females' sexual education, there is a need to engage and support parents, in order for them to provide the emotional, physical and psychological support adolescent females need in order to be effective self-care agents.

This study further supports suggestions made by previous studies on the nurse-adolescent relationship. Despite policies implemented by the South African government, health care workers and facilities still pose a barrier to SRH services. This study recommends further training in adolescent-specific health care, where health care workers are trained specifically for the role of providing adolescent and youth friendly services. This study recommends further decentralising of SRH services in communities, where adolescents are actively involved in the design, implementation and evaluation of adolescent and youth friendly services. Considering the structural and financial constraints which often inhibit health care services in South Africa, there is a need to find attainable ways of creating youth friendly environments within health care facilities that are effective and sustainable. This study recommends the use of art-based methodologies in facilitating communication between health care workers and adolescent females, in order to create an environment for dialogue where they can collectively identify health care problems and solutions within their community.

Finally, this study further recommends the use of alternative methodologies in researching and communicating with adolescents, and specifically adolescent females, around sexual and reproductive health. This study has highlighted the benefits of art-based methodologies in aiding communication between the researcher and the researched, as well as the benefit they provide as a communication tool. SRH in South Africa is complex, intertwined with socio-cultural influences. There is a need to research and communicate effectively with adolescent females, in order to understand the complexities around sexuality, and thus reduce SRH incidences. Furthermore, given the traditional, religious and cultural influences on the understanding of sexuality, and the barriers to provision of SRH services by health care workers, this study recommends the use of alternative research methodologies in creating a research space where participants are able to be co-constructors of knowledge, in order to provide understanding of these influences within the context of sexual and reproductive health in South Africa.

Areas for Further Research

This study highlights four areas of further research within adolescent sexuality and SRH research in South Africa. The key area of further research highlighted in this study is greater understanding on the provider perspective in SRH services provision. This study was centrally focused on the adolescent females' perception of sexuality, SRH and health care workers. However, given the traditional, cultural and religious influences on the identity of health care workers, there is a need to better understand how these influences have impacted on the perceptions of health care workers towards SRH provision. This study has highlighted the lack of effective communication between health care workers and adolescent

females, where health care workers have been identified as a barrier to services. This study highlights the need for further understanding of how to create an environment for effective engagement between health care workers and adolescent females.

Secondly, this study highlighted the positive influence of health communication programmes, specifically Hope2Educate, on the self-care capabilities of adolescent females. Hope2Educate is a peer-education programme centred on SRH. This study suggests further research on understanding the influence and impact of peer-educators in disseminating knowledge to their peers in schools. Considering how health communication programmes shape the understanding of SRH, this study suggests further research in exploring the effectiveness of these programmes in creating knowledgeable peer-educators that positively influence their peers.

Prevention of risk was highlighted as a central deficit among adolescent females in ensuring SRH. This study suggests that further research is needed regarding how to reduce social and structural barriers and risks, which negatively impact on the ability of self-care among adolescent females. There is a need for further understanding on how to empower adolescent females to have total control over their sexual and reproductive health, as they negotiate the structural constraints that surround them.

Finally, this study suggests further research on the potential of art-based methodologies in sexual education. This study has highlighted the potential of art-based methodologies in effectively researching sexuality among adolescent females. However, this study suggests further research is needed in exploring the potential of art-based methodologies in sexual education, where bodymapping is used as an educational tool in providing sexual education in schools. This study has highlighted the potential of bodymapping as a communicative tool in research; it further suggests the need to explore its potential in communicating about sexual health with adolescents in schools.

CONCLUSION

In order to curb the increasing health problems that face adolescent females in South Africa, there is a need to ensure adolescent females have the potential to be effective self-care agents, where their SRH capabilities outweigh their deficits. As summarised by Lerato Lagamorulane, speaking at the launch of the She Conquers campaign in South Africa:

“This is not a campaign, but a movement, which I believe has the power to change and transform the lives of millions of young women, girls and men across our beloved country by ensuring that they are informed, educated, healthy and able to take full control of their bodies and future.”

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APPENDIX

Appendix (1A): Bodymapping Steps

Part One: Introduction (30 minutes)

Choose a partner: draw with any colour markers around each other's bodies. NB: Lie in any position you choose.

Write your name, where and when you were born on the cardboard- nice and big- outside of your body outlines. Add any family details, details of your school, community etc.

Choose a colour to represent you and paint around the outline of your bodies.

Choose another colour that represents you, and do hand prints on your body maps

Give your map a face with ears, eyes, mouth etc.

Write down some of the sexual and reproductive health (HIV, STI's, pregnancy) challenges in your community/ or that you are aware of (outside your body)

Write down some of the sexual and reproductive health challenges that directly affect you through your immediate family and friends (write this inside your body)

Part Two: What do I see? (10 minutes)

How do you see sexuality? How would you define sexuality? Write words or draw pictures of how you see sexuality. This could appear near your eyes to show how you see it, or anywhere else on the body.

Part Three: What do I feel? (15 minutes)

Move to the middle of your body map, close to your heart, either write or draw imagines about who or what do you feel has influenced your perceptions of sexuality? This could be your parents, friends, family, culture, school, health campaigns etc.

Do you think these have been positive or negative influences? (heart)

Part Four: What do I speak? (10 minutes)

How do you speak about sexuality and sexual and reproductive health? Who do you talk to? Is female sexuality spoken about positively or negatively?

Draw signs/ symbols or write next to the mouth or as a speech bubble coming out of the mouth.

Part Five: What do I understand? (15 minutes)

On the top of your body map, where the head is, mark, draw symbols or write about what you understand about the sexual and reproductive health services available to you? This could be contraceptives available, HIV testing, counselling etc.

What do you understand about Adolescent and Youth Friendly services?

How did you learn about what is available to you?

Part Six: What do I hear? (10 minutes)

What do you hear health care workers (like nurses) saying to you about sexual and reproductive services?

Are they helpful in understanding your sexual and reproductive health?

Next to your ears draw or write what is being said to you by health care workers about your access to sexual and reproductive health.

Part Seven: What am I doing? (10 minutes)

What do you feel you should do in order to take control of your sexual and reproductive health?

Do you feel that you are at risk and need to do something?

Along the hands of your body map, draw or write your role in sexual and reproductive health.

Part Eight: What can I do next? (5 minutes)

Working on the feet, walking forward- how well equipped do you feel you are in taking control of your sexual and reproductive health?

Draw or write ways in which you feel would help you in the future?

Part Nine: Colour in your body map (10 minutes)

Appendix (1B): Debriefing Discussion

- 1. How did you find the body mapping process?**
 - a. What did you like?
 - b. What didn't you like?
- 2. Did you enjoy the use of art, drawing and writing?**
 - a. Were there any methods with you preferred more than others (ie: drawing instead of writing etc?)
- 3. Which step did you enjoy the most? Ears, eyes, mouth, head, heart, hands or feet**
 - a. Why?
- 4. Did the exercise make it easier to talk about sexuality?**
 - a. In what way was it easier?
 - b. In what way has it harder?
 - c. Do you think it is a good way to get young people to talk about sexuality and sexual and reproductive health?

Appendix (1C): Interview Schedule Guide

Need to start off interview by clarifying what self-care means

Also need to explain that this is a narrative and storytelling interview, participants are free to tell stories to explain what they want to say.

Mind:

1. What does the word sexuality mean to you?

- a. Can you tell a story of someone who influenced/ or helped you understand what sexuality means?
- b. On your body map you drew who you thought had influenced your understanding of sexuality, can you tell me about whom you chose?
- c. Do you think female sexuality is positive? Do you have any examples of this?

Body:

2. Who/ what has taught you the most about sexual and reproductive health?

- a. Can you tell me about how sexuality and sexual and reproductive health is spoken about? Do you have an example of how people around you speak about it?
- b. Do you feel you have everything you need to protect yourself from HIV or falling pregnant?
- c. Do you feel you are at risk of falling pregnant?

Community:

3. Can you tell me any experiences you've had with health care workers in your community?

- a. Do you feel you could ask nurses about things you don't understand?
- b. What do you think they could do better?
- c. Do you have any stories of how nurses have helped you or stopped you from looking after yourself in terms of your sexual and reproductive health?

Appendix (2A): Informed Consent Form: Guardian Letter

Letter of invitation to adolescent females to participate in this study

Dear Sir/Madam

My name is Gina Coetzee (student No: 213570198), a registered student at the University of KwaZulu-Natal (UKZN). This letter is to request your permission for your child to participate in this study. I want to research the experiences of teenage girls towards health care services in your community. The main reason I am doing this is to understand how we can help girls care for themselves properly, so they can live a healthy life. This research is conducted under the supervision of the Centre of Communication, Media and Society at UKZN. My supervisors name is Dr. Eliza Govender.

Whenever research is conducted with teenagers, the researcher needs to ask for the permission of the guardian first. After you have read more about the study, and if you agree, then the next thing I will do is ask the girl you are a guardian to for her agreement as well. Both of you have to agree independently before I can begin. You do not have to agree for her to participate. I know the decision can be difficult when it involves young girls and sensitive topics. You can ask as many questions as you like and I will take the time to answer them. Participation is voluntary and participants are free to withdraw from the study at any stage, for any reason. Participants have the right to decide to stop participating in the discussion at any time that they or you wish.

The purpose of this research is to understand whether the clinics in your community are providing the services that are important for teenage girls. In this study I will talk to teenage girls about what they know about caring for their bodies in a healthy way, including sexual and reproductive health. I will invite them to share their knowledge and understanding with me so that I can find ways of meeting their needs at the local clinics. This research aims to understand what teenage girls know about their sexual and reproductive health, as well as understand what information or services they think teenage girls need.

These girls will take part in an art workshop with 10 other girls of a similar age, guided by myself. After this workshop, she will participate in an interview with myself. The group workshop will start with me making sure they feel comfortable. I will also answer questions they might have about the study. Then I will ask questions about the health care system in your community. I will talk about where they go for

information about health, and whether they get the information and services they need and want. I will not ask them to share any personal stories that they are not comfortable to share.

If she does not wish to answer any of the questions during the interview, she may say so and the interviewer will move on to the next question. She does not have to answer any questions or take part in the discussion if she doesn't wish to do so. She does not have to give any reason for not responding to any questions, or for refusing to take part in the interview.

A community developer from *Hope2Educate* will be available to translate instructions into isiZulu, should they want. The interview will be electronically recorded and kept confidential. The recording will be kept securely for 5 years at UKZN. I will not share information about her outside of the research team. Any information about your child will have a number on it instead of her name to ensure confidentiality.

I am asking your child to participate in an art workshop, which will take about 2 hours of her time. I can do this outside of school hours. There will also be an interview that will take about 30 minutes to do. There will be no immediate and direct benefit to these girls or to you, but her participation is likely to help me find out more about the health needs of teenage girls and I hope that these will help the local clinics to meet those needs in the future. She will not be provided with any payment to take part in this research. However, she will be given a small gift and refreshments at the workshop.

At the end of the study I will give feedback to the participants and *Hope2Educate*. Firstly, feedback will be given to the participants. This will be in the form of a presentation and a summarized version of the finding. Secondly, feedback will be given to *HopeEducate*, in the form of presentation, a hard copy of the dissertation, as well as a summarized version of the findings for all facilitators. I will do this first by meeting with the participants and then with *Hope2Educate*. A written report will also be given to the participants, which they can share with their families. I will also publish the results in order that others interested may learn from the study.

Should you have any questions our contact details are:

Researcher	Gina Coetzee	0846964979	atginacoetzee@gmail.com
Department	Centre for Communication, Media and Society	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)	Howard Campus, Masizi Kunene Ave, Glenwood, Durban, South Africa	
Supervisor	Dr. Eliza Govender	031 260 4690	Eliza.govender@caprisa.org
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za
Committee Clerk, UKZN Human Sciences Committee	Ms P. Ximba	+27-31-2603587	ximbap@ukzn.ac.za
<i>Hope2Educate</i>	Mr S. Nzimande	s.nzimande@thinksa.org.za	
Toll Free Counselling	Life Line	0861 322 322	
	Stop Gender Abuse	0800 150 150	
	Child Line	08000 55 555	
	Marie Stopes Clinic	0800 11 7785	

Thank you for taking the time to read about this study.

CERTIFICATE OF CONSENT

I have been asked to give consent for the girl I am the guardian of to participate in this research study, which will involve her completing one art workshop and one interview. **I have read the forgoing information. I consent voluntarily for my child to participate as a participant in this study.**

Informed consent – permission to interview.		
<i>Please note that this document is produced in duplicate – one copy to be kept by the respondent, and one copy to be retained by the researcher.</i>		
Signed consent		
<ul style="list-style-type: none"> • I understand that the purpose of this interview is solely for academic purpose. The findings will be published as a dissertation, and may be published in academic journals. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand she will remain anonymous. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand that she will not be paid for participating but a souvenir will be given. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand that she reserves the right to discontinue and withdraw her participation any time. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand she will not be coerced into commenting on issues against her will, and that she may decline to answer specific questions. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand she reserves the right to schedule the <i>time</i> and <i>location</i> of the interview. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I consent to have this interview recorded. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
* By signing this form, I consent that I have duly read and understood its content.		
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Guardian	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Researcher	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date

Appendix (2B): Informed Assent Form: Participant Letter

Letter of invitation to participate in the study

Dear Participant

My name is Gina Coetzee, a registered student at the University of KwaZulu-Natal (UKZN). This letter is to request your participation in this study. I want to research the experiences of teenage girls towards health care services in your community, specifically sexual and reproductive health services. The main reason I am doing this is to understand how we can help girls care for themselves properly, so they can live a healthy life. This research will be conducted under the supervision of the Centre for Communication, Media and Society. My supervisors name is Dr. Eliza Govender. Your understanding and perceptions will add considerable value to this study.

You can choose whether or not you want to participate. I have given information to your parent(s)/guardian about this research. If you are going to participate in the research, your parent(s)/guardian also have to agree too. But if you do not wish to take part in the research, you do not have to, even if your parent(s)/guardian have agreed. You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not, you do not have to decide immediately.

The purpose of this research is to understand whether the clinics in your community are providing the services that are important for teenage girls. In this study I want to talk to you to find out what you know about caring for your body in a healthy way, including your sexual and reproductive health. This research hopes that you can share your knowledge and understanding with me so that I can find ways of meeting your needs at the local clinics. This research aims to understand what teenage girls know about their sexual and reproductive health, as well as understand, what information or services they want for themselves. I would like to talk to you because this is important to understand at your age (14 and 17 years old).

You don't have to be in this research if you don't want to be. Participation is voluntary and you are free to withdraw from the study at any stage, for any reason. If you decide not to be in this research study there will be no negative consequences. Even if you say agree now, you can change your mind at any

point. I know this decision can be difficult because sexuality is a sensitive topic, so you are free to ask as many questions as you like and I will take the time to answer them.

If you agree, you will take part in an art workshop with 10 other girls of a similar age. This workshop will be guided by myself. After this workshop, you will participate in an interview with myself. You do not need to be good at drawing to participate, there are lots of ways you can represent what you want to say. I am going to ask questions about the health care system in your community. I will talk about where you go for information about health, and whether you get the information and services you need and want, specifically for sexual and reproductive health. I will not ask you to share any personal stories that you are not comfortable to share.

If you do not wish to answer any of the questions during the interview, you may say so. You do not have to give any reason for not responding to any questions, or for refusing to take part in the interview. A community developer from *Hope2Educate* will be available to translate instructions into isiZulu, if you would prefer. The interview will be electronically recorded and kept confidential. The recording will be kept securely for 5 years at UKZN. I will not share information about you outside of the research team. Any information about you will have a number on it instead of your name.

I am asking you to participate in an art workshop, approximately 2 hours long. There will also be an interview that will take about 30 minutes to do.

There will be no immediate and direct benefit to you, but your participation is likely to help me find out more about the health needs of teenage girls and I hope that these will help the local clinics to meet those needs in the future. You will not be provided with any payment to take part in this research. However, you will be given a small gift and refreshments at the workshop.

At the end of the study I will give feedback to the you and *Hope2Educate*. Firstly, feedback will be given to you, in the form of a presentation and a summarized version of the findings. Secondly, feedback will be given to *HopeEducate* in the form of presentation, a hard copy of the dissertation, as well as a summarized version of the findings for all facilitators. A written report will be given to you, which you can share with you family if you wish to do so. I will also publish the results in order that others interested may learn from the study.

Should you have any questions our contact details are:

Researcher	Gina Coetzee	0846964979	atginacoetzee@gmail.com
Department	Centre for Communication, Media and Society	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)	Howard Campus, Masizi Kunene Ave, Glenwood, Durban, South Africa	
Supervisor	Dr. Eliza Govender	031 260 4690	Eliza.govender@caprisa.org
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za
Committee Clerk, UKZN Human Sciences Committee	Ms P. Ximba	+27-31-2603587	ximbap@ukzn.ac.za
<i>Hope2Educate</i>	Mr S. Nzimande	s.nzimande@thinksa.org.za	
Toll Free Counselling	Life Line	0861 322 322	
	Stop Gender Abuse	0800 150 150	
	Child Line	08000 55 555	
	Marie Stopes Clinic	0800 11 7785	

Thank you for taking the time to read about this study

CERTIFICATE OF ASSENT

I have read this information (or had the information read to me). I have had my questions answered and know that I can ask questions later if I have them. **I consent voluntarily to participate in one art workshop and one interview**

Informed assent – permission to interview.

Please note that this document is produced in duplicate – one copy to be kept by the respondent, and one copy to be retained by the researcher.

Signed assent

<ul style="list-style-type: none"> I understand that the purpose of this interview is solely for academic purpose. The findings will be published as a dissertation, and may be published in academic journals. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I will remain anonymous. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I give permission for photos of my body map to be taken and appear in the dissertation. Your name will be removed to ensure you remain anonymous 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I will not be paid for participating but a souvenir will be given. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I reserve the right to discontinue and withdraw my participation any time. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to be frank to give the information. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview. 	Yes <input type="checkbox"/> No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to have this interview recorded. 	Yes <input type="checkbox"/> No <input type="checkbox"/>

*** By signing this form, I consent that I have duly read and understood its content.**

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Participant	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Name of Researcher	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date

Appendix (2C): iFomu Yemvume: iNcwadi Yogadile

Incwadi yesicelo kubantu besifazane abadala sokuzibandakanya kulolu cwaningo

Ngiyabingelela Baba/Mama

Igama lami nginguGina Coetzee (student No: 213570198), ongumfundi eNyuvesi YaKwaZulu-Natal (UKZN) Le ncwadi icela imvume yakho ukuthi ingane yakho izibandakanye kulolu cwaningo. Ngifisa ukucwaninga ngolwazi lwezingane mayelana nosizo lokunakekela ngezempilo emphakathini wakho. Isizathungqangi sokwenza lolu cwaningo ngukuqonda ukuthi singawasiza kanjani amantombazane ukuthi azinakekele wona ngendlela efanele ukuze akwazi ukuphila impilo enempilo. Lolu cwaningo lwenziwa ngaphansi kukameluleki we-Centre of Communication, Media and Society at UKZN. Igama likameluleki wami uDr. Eliza Govender.

Noma ngabe yinini uma kwenziwa ucwaningo ezinganeni ezisathomba, umcwaningil ucela imvume yomgadi/yomuntu ogadile kuqala. Uma sewufunde kabanzi ngalolu cwaningo, futhi uma uvuma, okulandelayo ukuthi ngizocela imvume yengane oyigadile. Nina nobabili kufanele nivume ngokuhlukana ngaphambi kokuba ngiqale. Awuphoqelekile ukuthi uvume ukuthi ingane izibandakanye. Ngiyazi ukuthi isinqumo singaba nzima uma sibandakanya izingane zamantombazane asemancane ngesihloko esibucayi. Ungabuza imibuzo ngendlela othanda ngayo kanti ngiyozinika isikhathi ukuthi ngiyiphendule. Ukuzibandakanya kungukuzithandela kanti nabazibandakanyayo bakhululekile ukuhoxa ocwaningweni nanoma yingasiphi isikhathi, ngenxa yanoma yisiphi isikhathi. Abazibandakanyayo banelungelo lokunquma ukuyeka ukuzibandakanya engxoxweni nanoma yingasiphi isikhathi uma befisa.

Inhloso yalolu cwaningo ukuqonda ukuthi ngabe imitholampilo yangakini iyanikezela yini ngosizo olubalulekile ezinganeni zamantombazane ezisezincane. Kulolu cwaningo ngizokhuluma namantombazane asemancane ukuthi yini ayaziyo ngokunakekela imizimba yawo ngendlela enempilo, kuhlanganisa ezocansi nokuthola abantwana. Ngizocela amantombazane asemancane ukuthi babelane nami ngolwazi nokuqonda kwabo ukuze ngizokwazi ukuthola izindlela zokuhlangabezana nezidingo zawo emitholampilo yangakubo. Lolu cwaningo luhlose ukuqonda ukuthi amantombazane asemancane yini ayaziyo ngezocansi kanye nokuthola abantwana, kanye nokuqonda ukuthi oluphi ulwazi noma usizo oludingwa amantombazane asemancane.

La mantombazane azozibandakanya emhlanganweni wokucobelelana ngezobuciko namantombazane ayishumi alinganayo ngeminyaka, azobe eholwa yimina. Emva kwal mhlango, ingane yentombazane izozibandakanya engxoxweni nami. Lo mhlango (wokucobelelana) weqembu

uzoqala ngokuthi ngibuze ukuthi ngabe bakhululekile yini. Ngizophinde ngiphendule imibuzo abangase babe nayo ngocwaningo. Ngizobe sengibuza imibuzo ngohlelo lokunakekelwa ngokwezempilo emphakathini wakho. Ngizokhuluma ngokuthi baya kuphi uma befuna ulwazi ngezempilo, nanokuthi bayaluthola yini ulwazi kanye nezidingo abazidingayo nabazifunayo. Angeke ngibacele ukuthi babelane nami ngezindaba ezithina bona ngqo abangakhululekile ukukhuluma ngazo.

Uma engafisi ukuphendula nanoma emiphi imibuzo ngesikhathi sokuxoxisana, angasho bese lowo omxoxisayo aqhubekele embuzweni olandelayo. Akuphoqelekile ukuthi aphenndule nanoma omuphi umbuzo noma azibandakanye engxoxweni uma engathandi ukwenza kunjalo. Akuphoqelekile ukuthi anikeze isizathu sokungaphenduli imibuzo, noma sokunqaba ukuzibandakanya engxoxweni.

Othuthukisa umphakathi oqhamuka kwa-Hope2Educate uzobakhona ukuhumusha imiyalelo ngeSizulu uma ufuna. Ingxoxo iyoqoshwa ngomshini bese igcinwa iyimfihlo. Okuqoshiwe kuyogcinwa kuphephile iminyaka emihlanu e-UKZN.

Angeke ngabelane ngolwazi lozibandakanyayo ngaphandle kwethimba locwaningo. Nanoma oluphi ulwazi ngengane yakho luyoba nenombolo esikhundleni segama lakho ukuze kuqinisekise ubumfihlo.

Ngicela ukuthi ingane yakho izibandakanye kulo mhlango wokucobelelana ngezobuciko ozothatha cishe amahora amabili. Ngingakwenza lokhu sekuphume isikole. Kuyoba nengxoxo eyothatha cishe imizuzu engama 30 ukwenza lokhu.

Angeke kube nemihlomulo ngqo eyotholwa yilamantombazane noma wena, kodwa ukuzibandakanya kwakhe kungase kungisize ukuthi ngazi kabanzi ngezidingo zezempilo emantombazaneni asemancane kanti ngethemba ukuthi lokhu kuyosiza imitholampilo yasendaweni ukuhlangabezana nalezo zidingo esikhathini esizayo. Angeke akhokhelwe ngokuzibandakanya kulolu cwaningo. Nakuba kunjalo, uyonikezwa isipho esincane bese ethola okokuthiba indlala ngesikhathi kuqhubeka umhlango.

Ekupheleni kwalolu cwaningo ngizonikeza abazibandakanyile ngokwenzeka ocwaningwei kanye ne-Hope2Educate. Okokuqala, okwenzeka ocwaningweni kuyonikezwa, ngendlela yokwethulwa i-Hope2Educate, ikhophi yocwaningo kanye neqoqa lokutholwe abanikazi bocwaningo. Ngiyokwenza lokhu ngokuqale ngihlangane nabazibandakanyile bese kuba yi-Hope2Educate. Umbiko obhaliwe uyophinde unikezwe abazibandakanyile, abangabelana ngawo nemindeni yabo. Ngiyophinde ngishicilele imiphumela ukuze abanye abanentshisekelo bengafunda kulolu cwaningo.

Uma usenemibuzo ungaxhumana nathi kule mininingwane:

Researcher	Gina Coetzee	0846964979	atginacoetzee@gmail.com
Department	Centre for Communication, Media and Society	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)	Howard Campus, Masizi Kunene Ave, Glenwood, Durban, South Africa	
Supervisor	Dr. Eliza Govender	031 260 4690	Eliza.govender@caprisa.org
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za
Committee Clerk, UKZN Human Sciences Committee	Ms P. Ximba	+27-31-2603587	ximbap@ukzn.ac.za
<i>Hope2Educate</i>	Mr S. Nzimande	s.nzimande@thinksa.org.za	
Toll Free Counselling	Life Line	0861 322 322	
	Stop Gender Abuse	0800 150 150	
	Child Line	08000 55 555	
	Marie Stopes Clinic	0800 11 7785	

Siyabonga ngokuthatha isikhathi sakho sokuthi ufunde ngalolu cwaningo.

ISITIFIKETI SEMVUME

Ngiceliwe ukuthi ngivume ukuthi ingane engiyigadayo izibandakanye kulolu cwaningo, oluzohlenganisa ukuqedelwa komhlangano wokucobelelana ngezobuciko kanye nengxoxo eyodwa. **Ngilufundile ulwazi enginikwe lona. Ngiyavuma ngokuzithandela ukuthi ingane yami izibandakanye kulolu cwaningo.**

Imvume – imvume yokuxoxisana		
<i>Sicela uqaphele ukuthi le phepha lakhiwe laphindwa – ikhophi eyodwa izogcinwa yilowo ophendulayo, enye ikhophi izogcinwa wumcwaningi.</i>		
Imvume esayiniwe		
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi inhloso yale ngxoxo ingeyezemfundo kuphela. Okutholakele kuzoshicilelwa njenge-dissertation, kanti kungashicilelwa kumajenali ezemfundo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi angeke igama laziswe (Sicela ukhethe noma ufisa ukuthi igama lakhe lifihlwe yini) 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda igama lakhe liyocashunwa. (Sicela ukhethe noma uyafisa ukuthi okuphawulile kubhekiswe kuwena uma sekwenziwa umqulu wocwaningo wokugcina) 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi angeke akhokhelwe ngokuzibandakanya kodwa kukhona ayophiwa kona okuyisikhumbuzo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi unalo ilungelo lokungaqhubeki futhi ahoxe nanoma yingasiphi isikhathi 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyavuma ukuthi uzonika ulwazi lunjengoba lunjalo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi angeke aphoqwe ukuthi asho izinto eziphambene nezifiswa uyena, nanokuthi anganqaba ukuphendula imibuzo eqonde ngqo. 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyaqonda ukuthi unelungelo lokuhlela isikhathi nendawo yalapho kuzoxoxelwa khona 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyavuma ukuthi iqoshwe le ngxoxo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
* Ngokusayina le fomu, ngiyavuma ukuthi ngikufundile futhi ngakuqonda okuqukethwe yilo		
<hr style="width: 200px; margin: 0 auto;"/> <p>Igama lomgadi</p>	<hr style="width: 200px; margin: 0 auto;"/> <p>Isiginisha</p>	<hr style="width: 200px; margin: 0 auto;"/> <p>Usuku</p>
<hr style="width: 200px; margin: 0 auto;"/> <p>Igama lomcwaningi</p>	<hr style="width: 200px; margin: 0 auto;"/> <p>Isiginisha</p>	<hr style="width: 200px; margin: 0 auto;"/> <p>Usuku</p>

Appendix (2D): iFomu Yemvume: iNcwadi Yozibandakanyayo

Incwadi yokukucela ukuthi uzibandakanye ocwaningweni

Ngiyabingelela

Igama lami nginguGina Coetzee. ongumfundi eNyuvesi YaKwaZulu-Natal (UKZN) Le ncwadi icela imvume yakho ukuthi ingane yakho izibandakanye kulolu cwaningo. Ngifisa ukucwaninga ngolwazi lwezingane mayelana nezinsiza zokunakekela ngezempilo emphakathini wakho. Isizathungqangi sokwenza lolu cwaningo ngukuqonda ukuthi singawasiza kanjani amantombazane ukuthi azinakekele wona ngendlela efanele ukuze akwazi ukuphila impilo enempilo. Lolu cwaningo lwenziwa ngaphansi kukameluleki we-Centre of Communication, Media and Society at UKZN. Igama likameluleki wami uDr. Eliza Govender. Ukuqonda kwakho nendlela obuka nothatha ngayo izinto kuzosiza kakhulu kulolu cwaningo.

Ungakhetha ukuthi uyazibandakanya kulolu cwaningo noma cha. Nginike abazali bakho/okugadile ulwazi ngalolu cwaningo. Uma uzozibandakanya kulolu cwaningo, abazali bakho/okugadile kufanele naye avume. Kodwa uma ungathandi ukuzibandakanya kulolu cwaningo, awuphoqelekile ukuthi uzibandakanye, noma ngabe abazali/okugadile evumile. Ungaxoxa nanoma yingani ekule fomu nabazali bakho noma nabangane bakho noma ubani nje omunye ozizwa ukhululekile ukukhuluma naye. Ungakhetha ukuthi uyazibandakanya noma cha, akudingeki ukuthi ukhethe manje.

Inhloso yalolu cwaningo ukuqonda ukuthi kungabe imitholampilo yangakini iyanikeza yini ngosizo olubalulekile emantombazaneni asemancane. Kulolu cwaningo ngifisa ukukhuluma nawe ukuze ngithole ukuthi uyazi yini ngokunakekela umzimba wakho ngendlela enempilo, kuhlangukisa ezocansi nokuthola abantwana. Kwethenjwa ukuthi kulolu cwaningo uzokwabelana nami ngolwazi nokuqonda kwakho ukuze ngikwazi ukuthola izindlela zokuhlangabezana nezidingo zemitholampilo yasendaweni. Lolu cwaningo luhlose ukuqonda ukuthi amantombazane asemancane ayazi yini ngempilo yezocansi nokuthola abantwana, kanjalo nokuqonda ukuthi oluphi ulwazi noma usizo alufunayo wona. Ngizothanda ukuxoxa nawe ngoba lokhu kubalulekile ukuthi ukuqonde njengoba unaleminyaka (iminyaka ewu 14 newu 17 yobudala).

Awuphoqelekile ukuba kulolu cwaningo uma ungathandi. Ukuzibandakanya kungukuzithandela futhi ukhululekile ukuthi uhoxe kulolu cwaningo nanoma yingasiphi isikhathi, ngenxa yanoma yisiphi isizathu. Uma ukhetha ukungazibandakanyi kulolu cwaningo, angeke kube nemiphumela engemihle. Noma ngabe uyavuma manje kodwa usengawushintsha umqondo nanoma yingasiphi isikhathi. Ngiyazi

ukuthi lesi sinqumo sinzima ngoba isihloko sezocansi sibucayi, ngakho-ke ukhululekile ukubuza nanoma imibuzo emingakhi, ngiyozinikeza isikhathi ukuthi ngiphendule imibuzo yakho.

Uma uvuma, uzozibandakanya emhlanganweni wokucobelelana ngobuciko namanye amantombazane ayishumi aneminyaka elingana neyakho. Lo mhlango wokucobelelana ngolwazi uzobe uholwa yimina. Emva kwalo mhlango wokucobelelana, uzozibandakanya engxoxweni nami. Akubalulekile ukuthi ukwazi ukudweba ukuze uzibandakanye, ziningi izindlela ongaveza ngazo ofuna ukukusho. Ngizokubuza imibuzo ngohlelo lwezempilo yakho emphakathini wakho. Ngizokhuluma ngokuthi uyaphi uma udinga usizo ngezempilo, nanoma uyaluthola ulwazi kanye nosizo oludingayo nolufunayo, ikakhulukazi ngezocansi kanye nezokuthola abantwana. Yilona hlobo lwemibuzo engizolubuzela lolu. Angeke ngikubuze izindaba eziqondene nawe ngqo ongakhululekile ukukhuluma ngazo. Angeke ngikucele ukuthi uxoxe ngezindaba ezithinta wena ngqo ongakhululekile ukuxoxa ngazo.

Uma ungathandi ukuphendula nanoma emiphi imibuzo ngesikhathi sengxoxo, ungasho. Awuphoqelekile ukuthi unikeze isizathu sokungaphenduli nanoma omuphi umbuzo, noma ukunqaba ukuzibandakanya engxoxweni. Othuthukisa umphakathi ovela kwa-Hope2Educate uyobakhona ukuze ahumushe imiyalelo ngesiZulu, uma ukudinga lokho. Ingxoxo iyogqoshwa ngomshini bese igcinwa iyimfihlo. Okuqoshiwe kuyogcinwa endaweni ephaphile iminyaka emihlanu e-UKZN. Angeke ngitshale omunye umuntu ongaphandle kwethimba locwaningo. Nanoma oluphi ulwazi ngawe luyoba nenombolo esikhundleni segama lakho.

Ngicela ukuthi uzibandakanye emhlanganweni wokucobelelana ngobuciko, othatha cishe amahora amabili. Kuyoba nengxoxo futhi eyothatha cishe imizuzu engamashumi amathathu. Angeke kube nemihlomulo ebhekiswe kuwe ngqo, kodwa ukuzibandakanya kwakho kungase kungisize ukuthi ngazi kabanzi ngezidingo zempilo emantombazaneni asemancane kanti ngethemba ukuthi lokhu kuzosiza imitholampilo yasendaweni ukuthi ihlangabezane nalezi zidingo esikhathini esizayo. Angeke ukhokhelwe ngokuzibandakanya kulolu cwaningo. Nakuba kunjalo, uyonikezwa isipho esincane kanye nokokuthiba indlala emhlanganweni.

Ekupheleni kocwaningo ngiyokwazisa i-Hope2Educate ngokwenzeke ocwaningweni. Okokuqala, okwenzeke ocwaningweni kuyonikezwa wena ngendlela yokwethulwa neqoqa lokutholakele. Okwesibili, okwenzeke ocwaningweni kuyonikezwa i-Hope2Educate ngendlela yokwethulwa, bese kuba ikhophi ephrintiwe yocwaningo, kunjalo neqoqa lokutholiwe kunikezwe ithimba locwaningo. Umbiko obhaliwe uyophinde unikezwe abazibandakanyile, abangabelana ngawo nemindeneni yabo. Ngiyophinde ngishicilele imiphumela ukuze abanye abanentshisekelo bengafunda kulolu cwaningo.

Uma usenemibuzo ungaxhumana nathi kule mininingwane:

Researcher	Gina Coetzee	0846964979	atginacoetzee@gmail.com
Department	Centre for Communication, Media and Society	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)	Howard Campus, Masizi Kunene Ave, Glenwood, Durban, South Africa	
Supervisor	Dr. Eliza Govender	031 260 4690	Eliza.govender@caprisa.org
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za
Committee Clerk, UKZN Human Sciences Committee	Ms P. Ximba	+27-31-2603587	ximbap@ukzn.ac.za
Hope2Educate	Mr S. Nzimande	s.nzimande@thinksa.org.za	
Toll Free Counselling	Life Line	0861 322 322	
	Stop Gender Abuse	0800 150 150	
	Child Line	08000 55 555	
	Marie Stopes Clinic	0800 11 7785	

Siyabonga ngokuzinikeza isikhathi sokufunda ngalolu cwaningo

ISITIFIKETI SEMVUME

Ngilufundile lolu lwazi (noma ngifundeliwe). Imibuzo yami iphenduliwe futhi ngiyazi ukuthi ngingabuza imibuzo esikhathini esizayo uma ngisenayo. **Ngiyavuma ngokuzithandela ukuzibandakanya emhlanganweni owodwa wokucobelelana ngobuciko Kanye nengxoxo eyodwa.**

Imvume – imvume yokuxoxisana		
<i>Sicela uqaphele ukuthi le phepha lakhiwe laphindwa – ikhophi eyodwa izogcinwa yilowo ophendulayo, enye ikhophi izogcinwa wumcwaningi.</i>		
Imvume esayiniwe		
<ul style="list-style-type: none"> • Ngियाqonda ukuthi inhloso yale ngxoxo ingeyezemfundo kuphela. Okutholakele kuzoshicilelwa njenge-dissertation, kanti kungashicilelwa kumajenali ezemfundo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuthi angeke igama laziswe (Sicela ukhethe noma ufisa ukuthi igama lakho lingaziswa yini) 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Nginika ilungelo ukuthi zithathwe izithombe zokuma komzimba wami ukuze zivele kwi-dissertation. Igama lakho liyosuswa ukuze kuqinisekiswa ukuthi awaziwa. 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuthi angeke ngikhokhelwe ngokuzibandakanya kodwa kukhona engiyophiwa kona okuyisikhumbuzo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuthi nginalo ilungelo lokungaqhubeki futhi ngihoxe nanoma yingasiphi isikhathi 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyavuma ukuthi ngizonika ulwazi lunjengoba lunjalo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuthi angeke ngiphoqwe ukuthi ngisho izinto eziphambene nokufiswa yimina, nanokuthi nginganqaba ukuphendula imibuzo eqonde ngqo. 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuthi nginelungelo lokuhlela isikhathi nendawo yalapho kuzoxoxelwa khona 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyvuma ukuthi iqoshwe le ngxoxo 	Yebo <input type="checkbox"/>	Cha <input type="checkbox"/>
* Ngokusayina le fomu, ngiyavuma ukuthi ngikufundile futhi ngakuqonda okuqukethwe yilo		
_____	_____	_____
Igama lozibandakanyayo	Isiginisha	Usuku
_____	_____	_____
Igama lomcwaningi	Isiginisha	Usuku

Appendix (3A): Gatekeeper Permission: Hope2Educate



Hut 10 Howard College| University of KwaZulu Natal| Durban 4001
031 8372080| 0733330272
hope2educate@live.co.za
Peer Education| Youth Development |SRHR Advocacy Consultant NPO: 088 456

14 May 2016
Ms Gina Coetzee
c/o Centre for Communication, Media and Society (CCMS)
University of KwaZulu-Natal

RE: Permission to access information for Masters Research

Hope2Educate is a non-profit organisation (NPO). It is a youth-led organisation which uses dialogue to engage different components of the community on social and economic development whilst addressing the challenges associated with HIV. We have partnered with 5 schools to implement a 3 to 4 year structured peer education programme. This quality assured programme addresses the behaviours and beliefs that are at the root of the HIV pandemic amongst young people, like substance and alcohol abuse, low self-esteem, lack of knowledge about HIV, sexually transmitted infections (STI) and risky sexual behaviour, gender inequality and limited access to resources and services.

Gina Coetzee, Masters in Social Sciences at the Centre for Communication, Media and Society (Student number: 213570198), has proposed to conduct research titled, "Mapping Sexuality: Understanding the knowledge, attitudes, and perceptions of adolescent females towards sexuality and sexual and reproductive health in KwaZulu-Natal, South Africa".

I therefore grant permission to Gina Coetzee to access information for her Masters Research at Mayville Secondary School, Durban, KwaZulu-Natal.

Best regards,

Siyabonga Nzimande
Centre Director
0733330272



Directors: S Nzimande (CEO), JJ Johnson, D Lembethe and ZL Xhoba

Appendix (3B): Gatekeeper Permission: Department of Education



education

Department:
Education
PROVINCE OF KWAZULU-NATAL

Enquiries: Phindile Duma

Tel: 033 392 1004

Ref.:2/4/8/853

Miss GK Coetzee
209 Garlington Estate
Private Bag X6009
Hilton
3245

Dear Miss Coetzee

PERMISSION TO CONDUCT RESEARCH IN THE KZN DoE INSTITUTIONS

Your application to conduct research entitled: **"MAPPING SEXUALITY: UNDERSTANDING THE KNOWLEDGE, ATTITUDES AND PERCEPTIONS OF ADOLESCENT FEMALES TOWARDS SEXUALITY AND SEXUAL AND REPRODUCTIVE HEALTH IN KWAZULU-NATAL, SOUTH AFRICA"**, in the KwaZulu-Natal Department of Education Institutions has been approved. The conditions of the approval are as follows:

1. The researcher will make all the arrangements concerning the research and interviews.
2. The researcher must ensure that Educator and learning programmes are not interrupted.
3. Interviews are not conducted during the time of writing examinations in schools.
4. Learners, Educators, Schools and Institutions are not identifiable in any way from the results of the research.
5. A copy of this letter is submitted to District Managers, Principals and Heads of Institutions where the Intended research and interviews are to be conducted.
6. The period of investigation is limited to the period from 01 July 2016 to 01 December 2017.
7. Your research and interviews will be limited to the schools you have proposed and approved by the Head of Department. Please note that Principals, Educators, Departmental Officials and Learners are under no obligation to participate or assist you in your investigation.
8. Should you wish to extend the period of your survey at the school(s), please contact Miss Connie Kehologile at the contact numbers below
9. Upon completion of the research, a brief summary of the findings, recommendations or a full report / dissertation / thesis must be submitted to the research office of the Department. Please address it to The Office of the HOD, Private Bag X9137, Pietermaritzburg, 3200.
10. Please note that your research and interviews will be limited to schools and institutions in KwaZulu-Natal Department of Education.

Mayville Secondary School

Adv. MB Masuku
Acting Head of Department: Education
Date: 21 July 2016

KWAZULU-NATAL DEPARTMENT OF EDUCATION

POSTAL: Private Bag X 9137, Pietermaritzburg, 3200, KwaZulu-Natal, Republic of South Africa ...dedicated to service and performance
PHYSICAL: 247 Burger Street, Anton Lembede House, Pietermaritzburg, 3201. Tel. 033 392 1004 beyond the call of duty
EMAIL ADDRESS: kehologile.connie@kzndoe.gov.za / Phindile.Duma@kzndoe.gov.za
CALL CENTRE: 0860 596 363; Fax: 033 392 1203 WEBSITE: www.kzneducation.gov.za

Appendix (4): Ethical Clearance Certificate



29 August 2016

Ms Gina Coetzee 213570198
School of Applied Human Sciences
Howard College Campus

Dear Ms Coetzee

Protocol reference number : HSS/0724/016M

Project title: Mapping Sexuality: Understanding the knowledge , attitudes and perceptions of adolescent females towards sexuality and sexual and reproductive health in KwaZulu-Natal, South Africa.

Full Approval – Full Committee Reviewed Protocol

In response to your application received 1 June 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

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Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Dr Eliza Govender
cc Academic Leader Research: Professor Steven Collings
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

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