AN INVESTIGATION INTO FACTORS CONTRIBUTING TO SEXUAL BEHAVIOURS AMONG ADOLESCENTS IN RURAL KWA-ZULU NATAL

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Submitted in partial fulfilment of the requirements of a degree in Masters of Arts (Health Promotion), in the graduate Programme of Psychology, University of KwaZulu-Natal, Durban, South Africa

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March 2009

Dedication

I would like to dedicate this study to the special people in my life: my wife Gcina Yvonne Shoba, thank you for your support and encouragement. To my three beautiful children, Qhawe, Simekahle and Zekhethelo, thank you for not allowing me to do this work at home because you wanted your time and my attention.

Acknowledgements

I would like to express my sincere appreciation to the following people:

Prof Yvonne Sliep for your supervision and guidance throughout the proces of completing this project.

Prof Anna Meyer-Weitz for your great contribution especially in the methodology section and during analysis. Your paying attention to minute details indeed elevated the quality of this work.

All respondents who voluntarily participated in this project by answering questionnaires and made this study possible.

My colleagues, friends and others who constantly extended their support during difficult times. Thank you.

My family, especially my wife Gcina Shoba and children, thank you for believing in me and your patience and constant support over the years.

ABSTRACT

This study investigated the factors contributing to sexual behaviours and the extent of rural adolescent's involvement in risky sexual behaviour. A quantitative research design was used based on the Theory of Planned Behaviour which informed the questionnaire to be used. Participants comprised of 60 adolescents, 16-19 years old, who were recruited from a rural school in eThekwini Metro, KwaZulu – Natal province, in South Africa.

Data was collected using a self-administered questionnaire developed and adapted by the researcher. This questionnaire comprised of questions regarding socio-demographic issues, adolescent knowledge of HIV and AIDS, communication (with partner, friends and parents), self-efficacy in relationships, consequences of unprotected sex, perceptions regarding future risks of HIV/AIDS, STIs, and pregnancy, as well as various questions pertaining to sexual activity including use of condoms.

The Statistical Package for Social Scientists (SPSS 13) was used for the data analysis. Frequencies were calculated for each item. Chi-square analysis was conducted to determine the association between demographic variables of gender and age and the items related to HIV transmission that showed some variation on the response categories. Independent samples T-tests were conducted in order to explore whether significant differences occurred in the mean scores for the two groups male and female including younger and older age groups and various continuous variables.

The study revealed that the majority of adolescents have a high level of knowledge regarding HIV. The adolescents also seemed to have high level of self-efficacy regarding the use of condoms, which is a good foundation for the prevention of teenage pregnancies and HIV infection. The findings also indicate that family disorganization, lack of communication between adolescent and their parents, and poor access to health information are some of the factors influencing adolescent sexual behaviour. Even though adolescent knowledge about HIV, and skills involving communication with friends and

partners and condom use were found to be good, peer influence, gender-role expectations, norms and values still influences the engagement by adolescents in unsafe sexual activities. The study also revealed that issues like lack of access to health information still remain a challenge to most adolescents, which needs urgent attention from health authorities. The results of this study indicate a need for the department of health to revisit some of their programmes and strategies to deal with issues identified by this study as weaknesses, as most of the current health programmes are aimed at increasing knowledge and self-efficacy. It is also recommended that health programmes aimed at peers norms, values and cultures be implemented in order to positively influence adolescents' sexual behaviours.

The majority of adolescents (75%) indicated that they are using condoms when having sexual intercourse with their partners, while others showed positive attitude towards condom use and indicated intention to continue engaging in safer sex. These findings can be attributed to multi-sectoral interventions, especially interventions by the National Department of Health and Education as well as other Agencies.

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CHAPTER 1

1.1 INTRODUCTION

According to the UNAIDS Report (2008) an estimated 33 million are living with HIV/AIDS worldwide. It is estimated that about 2. 2 million people became newly infected with HIV, while approximately 2. 0 million died of AIDS related illnesses in 2007. The report further states that, globally, the AIDS epidemic appears to be slowing down. New infections are continuing to increase in certain regions and countries. According to UNAIDS (2006), estimated new HIV/AIDS infections occur every year, which threatens the prosperity, stability and development of nations. The UNAIDS Report (2006) further indicates that important progress has been made in countries' AIDS responses, including an increase in funding and access to treatment, and decrease in HIV prevalence among young people in some countries in some parts of the world. According to the UNAIDS Report (2008), the percentage of people living with HIV has stabilized since year 2000, which is encouraging even though new HIV infections are still occurring every year. The Global Youth Partners report (2003) states that over half of all new infections worldwide are among young people between ages 15 – 24. According to the Global Coalition on Women and AIDS Report (2006) it is estimated that in sub-Saharan Africa and the Caribbean, young women account for 3 out of 4 of all 15 – 24 year olds living with HIV, and the number of young women living with HIV is rising in every region of the world. According to the report by the UNAIDS (2006) young people and children are increasingly affected by the epidemic, and efforts to protect these and other vulnerable groups are not keeping pace with the epidemic's impact. On HIV prevention, the report further indicates behaviour changes including delays in sexual debut, increasing use of condoms by young people, all resulting in decreases in HIV prevalence in young people in some sub-Saharan countries. The use of VCT by young people to determine their HIV status and facilitate treatment and HIV prevention increased to 16.5 million in 2005.

According to the UNAIDS Report (2008), an estimated 5.7 million people were living with HIV in South Africa in 2007, which is the highest percentage in any one Country. Of this, 4. 9 million people are in the age group of 15 to 49 years (National Health Department, 2008). This provides justification for researchers to focus on, among other topics, factors influencing sexual behaviours, with the aim of finding an effective HIV prevention strategy.

In a survey conducted in South Africa, during the years 2005 - 2007, it was revealed that HIV prevalence rates show a decline from 30.2% in 2005 to 29.1% in 2006 and to 28% in 2007 (National Department of Health, 2008). The report on Annual Antenatal Survey of women attending public health facilities, shows a trend towards a decrease in the prevalence of HIV amongst pregnant women who attend public health facilities (29,1% in 2006 compared to 30.2% in 2005), suggesting the beginning of a decline in the HIV prevalence rates. In South Africa HIV prevalence among teenagers was estimated at 15. 9 million in 2005 in comparison to 16.1 in 2004, indicating a slight decline (National Department of Health, 2006). This still reflects lack of safe sexual behaviours among sexually active South Africans and adolescents in particular, which necessitates investigation, particularly into factors contributing to sexual behaviours among adolescents.

The HIV prevalence trends among pregnant women under the age of 20 years continued to show a significant decline from 16.1% in 2004 to 15.9% in 2005 and to 13.7% in 2006. The report further indicates a significant decline in prevalence in the 20-24 year age group. The decline in these two age groups is important also because the reduction of HIV prevalence in the 15 – 24 year age group is used as one of the key indicators for the Millennium Development Goals (National Health Department, 2007). The report further indicates that HIV prevalence has decreased slightly in KwaZulu-Natal from 40.7% in 2004 to 39.1% in 2005 and 2006 and to 37.4% in 2007.

Findings in the 2006 Report on the global AIDS epidemic appear encouraging:. Six of eleven African Countries reported declines of 25% in the prevalence among 15 – 24 year olds in Capital cities (UNAIDS, 2006). It is reported that among women aged 15-19 years, 8.5% have had sex by the age of 15 years. Of those, 21.2% reported using a

condom. On the other hand, among currently sexually active women aged 15-19 years, 51% use injectables as contraception, 33.6% use no contraceptives, and 4% report using a condom (South African National Youth Risk Behaviour Survey, 2003). In addition, same study has shown that gender was found to be a predictor of condom use, with more males than females reporting having used condoms. Similar studies also show that, more learners aged 17 years (49.8%), 18 years (59.8%), 19 years and older (60.2%) reported ever having had sex than learners aged 13years or under. It should be noted that in South Africa, condoms are freely available in all public health facilities and most South African youth report they know that condoms prevent HIV, Sexually Transmitted Infections (STIs), and unwanted pregnancy (Sayles et al., 2006)

Risky sexual behaviours among adolescents including failure to consistently sustain condom use remain a major problem as shown by the HIV prevalence among adolescents. Young people in developing countries are in growing danger of HIV infection because of forces beyond their control (Health Systems Trust, 2006; UNAIDS, 2006). Plan International (2006) also noted that, social, economic, and cultural factors were preventing the youth from protecting themselves, regardless of the availability of HIV/AIDS education. Although health education for adolescents had improved, there was a constant clash between the safety messages being taught and the realities that prevent young people from adopting them. In this study therefore, risky sexual behaviour among adolescents will refer to the inability of adolescents to practice safer sex including use of condoms. Studies by Buseh (2004) suggest that in reducing HIV and AIDS among adolescents through effective interventions, it is important to understand the factors influencing their sexual behaviours.

A study on sexual behaviour among adolescents in South Africa (Lovelife, 2002), showed that more than 50% of sexually active students never use condoms. No more than 10% have used condoms regularly during sexual intercourse; a variety of misconceptions about condoms resulted in rejection of their use. For example, some males hold a belief that having sex with a virgin will cure AIDS, which makes adolescent girls a target for rapes, unprotected sex and forced early sexual debut (Lovelife, 2002). The belief by rural adolescent girls in particular that using a condom will result in her being rejected by her

partner, or possibly lead to him questioning her faithfulness (Lovelife, 2002). Additionally, the belief by adolescents that males have a right to have multiple sex partners creates a problem (SHAPE, 2001). According to this study, in Zimbabwe, the following predictive factors for high-risk sexual practices by adolescents need to be addressed: embarrassment that accompanies discussing AIDS and sexual practices, shame associated with asking for or using a condom, and shame associated with asking a partner to use a condom.

Previous studies on HIV risk behaviours and sexual health have consistently shown that high self-efficacy regarding condom use is strongly associated with the practice of safer sex with recent partners and consistent condom use (Sayles et al., 2006) . This overwhelming data on young peoples' sexual behaviours as reflected by the prevalence of factors such as HIV, STI's, teenage pregnancies, lack of condom use, multiple sexual partners, and other risky sexual behaviours, provide sufficient grounds for investigation.

1.2 AIMS OF THE STUDY

The aim of this study will be to investigate factors contributing to sexual behaviours amongst adolescents in rural Kwa Zulu-Natal. Results of this study will help to improve the effectiveness of Governmental existing health strategies, interventions, programmes and campaigns directed at critical areas which affect adolescent's sexual behaviours.

1.3 OBJECTIVES

The objectives of this study are:

- To investigate adolescent's sexual practices
- To determine the level of knowledge regarding HIV/AIDS according to gender and ages differences.
- To determine adolescents' perceptions about the consequences of unprotected sex.
- To determine adolescents' communication with significant others about sexual issues.
- To determine self-efficacy regarding the use of condoms

- To investigate adolescents' perceptions regarding access to health services and information.

1.4 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the University of KwaZulu-Natal's Ethics Committee. Permission to conduct the study using learners as participants was granted by the Head of the school and the school governing body (Appendix A). Written informed parental consent was also obtained from the learners' parents (Appendix B).

CHAPTER 2

2. 1 LITERATURE REVIEW

Literature about the above mentioned topic has been undertaken by the researcher. Previous research findings and literature on the topic was considered and documented accordingly. To understand factors influencing sexual behaviours by adolescents, literature on the following issues was explored i.e. knowledge and beliefs about HIV and AIDS, adolescent's sexual behaviours, perceived risks about unprotected sex, communication about sexual issues with significant others, self-efficacy, condom use.

The Theory of Planned Behaviour was used to interpret results of the study and relevant literature on the theory will also be discussed in order to illustrate its appropriateness for the study.

2. 2 ADOLESCENT'S SEXUAL BEHAVIOURS

This section discusses the four main factors believed to be influencing adolescents' sexual behaviours, sexual activity, age of sexual debut, and protective sexual behaviours such as contraceptives, including condoms.

2. 2.1 Prevalence of sexual activity among young people

Sexual practices such as partnership characteristics sexual networking, and the timing and experience of sexual initiation as well as condom use may place young people at risk of contracting HIV/AIDS, especially since sexual intercourse is the predominant mode of HIV transmission for many young people in sub-Saharan Africa. In spite of the participation of many sexually active young people in steady relationships, studies reported a low frequency of sexual activity among young people, especially among young women (Simbayi, Chauveau, & Shisana, 2004).

The biggest challenge for researchers and government in dealing with HIV, STIs and teenage pregnancy is that self-reports on sexual behavior is subject to bias due to the highly sensitive nature of the topic, and could vary widely among men and women, between regions, and also between urban and rural areas. Some biases in self-reports

stem from gender expectations. Most studies have found that women report only one or two lifetime partners and thus might tend to underreport while men tend to exaggerate the number of sexual partners as a way to depict virility and thus conform to accepted traditional male gender norms (Sorrell & Rafaelli, 2005).
According to a study on adolescent sexual behaviour, knowledge and attitudes towards sexuality among school girls in Transkei, by Buga; Amoko & Ncayiyane (2003), there are high levels of unprotected sexual activity among school girls. Similar studies identified the following as factors influencing adolescent sexual behaviour: early sexual maturation, early onset of dating, and poor knowledge of reproductive biology and contraceptives. (Buga; Amoko & Ncayiyane, 2003).

Overall, the majority of school-going adolescents reported having one or more sexual partners and research also suggests that between 10% and 30% of sexually active young people have more than one sexual partner concurrently, with more men than women engaging in this behaviour (South African National Youth Risk Behaviour Survey, 2002). It has been found that sex education or family life education does not guarantee prevention of consequences, will not ensure abstinence, and has not been shown to decrease sexual experimentation. Teenagers who have been exposed to appropriate sex education tend to delay sexual debut, to use contraception when they have intercourse, and to avoid pregnancy (Department of Health, 2005). It is also important to understand issues of adolescent sexual initiation, which will assist in shaping appropriate health and behavioural interventions.

2. 2.2 Sexual Debut

Initiation of sexual debut places young people at high risk for HIV, STI's, and unplanned pregnancy. In the context of HIV/AIDS, age at sexual debut is an important risk factor which determines length of exposure to infection. Those who begin sexual activity in the early teen years are likely to have a higher chance of infection than those who delay, although the risk is also dependent on the choice of partner, e.g. sexual activity with an older partner with multiple sex partners increase the risk of being infected. Sexual initiation at a younger age has also been associated with greater sexual risk as these

individuals are less likely to resist peer pressure to become sexually active, to negotiate safer sex, and to use condoms because of their age and lack of experience (Macphail & Campbell, 2001; Brook *et al*., 2006; Peltzer & Pengpid, 2006). Early sexual initiation, especially among young adolescent males seems to facilitate patterns of sexual networking that contribute to increased numbers of lifetime sexual partners (Harrison, Cleland, Gouws & Frohlich, 2007; White, Cleland & Carael, 2000). An increase in age at sexual debut is now commonly cited as a contributing factor in the decline in the overall HIV infection rate in Uganda (Green, 2003). It is unfortunate that similar trends have not been observed elsewhere; in South Africa a higher proportion of young men are sexually active in their early teen years (Pettifor et al., 2004; Peltzen & Pengpid, 2006; Reddy *et al*., 2003) and about half of teenage men and women report being sexually active (Eaton, Flisher, & Aaro, 2003; Simbayi, Chauveau, & Shisana, 2004). Study suggests that at least 50% of young people in South Africa are sexually active by age of 16, and probably 80% by the age of 20. Boys report earlier sexual debut than girls, and Africans are more likely to start sexual activity in their teens than are other ethnic groups (Eaton, Flishera & Aaron, 2002; South African National Youth Risk Survey, 2002.).

A study by Hartell (2005) indicates that more than a third of adolescents in South Africa are sexually active and that they commence sexual activity at an early age. The average age of onset for sexual activity is 15 years. Reasons may include peer pressure, curiosity, coercion and material gain. The next section in this thesis will look at issues of adolescent sexual behaviours in relation to pregnancy, condoms and HIV/AIDS.

2. 2.3 Protective sexual behaviour (contraceptives and condoms)

It can be argued that the HIV epidemic among teenagers and young adult women in Sub-Saharan Africa has created an added burden on the health situation as these countries are already faced with issues related to high levels of unplanned pregnancies (Pettifor *et al.*, 2005). In some communities, the use of hormonal contraceptive methods is delayed until after the birth of a first child, which implies that many adolescent women do not experience the benefits of prevention (Garenne, Tollman & Kahn, 2000) resulting in high levels of sexual risk behaviours among young women in underdeveloped Sub-Saharan Africa. Also, non-use of contraception by those who have recently become sexually

active means that opportunities for counseling regarding condom use and dual protection against HIV and pregnancy are missed, leaving young women vulnerable. Unprotected sex among young people should be considered against the background of gender issues.

2.2.4 Gender and the heightened vulnerability of young people

Socio-cultural norms and gender role expectations about sexual activities reduce choices for adolescent females regarding the practice of preventive behaviours, which then increases potential exposure to conditions and diseases related to risky sexual behaviours. (Hoosen & Collins, 2004)

Studies have found that in some communities, women's engagement in sex was influenced by their gender-role expectations about love, sex, and compliance with male partners' desires (Ackerman & De Klerk, 2002; Kalichman, Simbayi & Kaufman et al., 2005).

2.3 SELF-EFFICACY AND CONDOM USE

2.3.1 SELF-EFFICACY AND SEXUAL ACTIVITY

Peltzer (1999) and Reddy *et al* (2000) suggest that young adults' levels of self-efficacy regarding condom use is indeed linked to higher self-reported condom use , although the direction of causality is not proved by the correlation methods used.

2.3.2 Self-Efficacy and negotiations for condom use

The cognitive expectation that one can successfully perform behaviors such as condom use is understood to be an important predictor of whether one attempts the behaviour (Azjen, 1985; Bandura, 1991). Personal control and self-efficacy in sexual negotiation are associated with increased contraceptive use among adolescents. Although it is not know whether these associations differ for adolescent boys and girls. It was found that perceived personal control and self-efficacy in sexual negotiation are significantly associated with safer sex behaviour, and are often more important for girls than for boys

in predicting pregnancy risk (Pearson, 2006). Previous research has found links between personal control, self-efficacy and contraceptive behaviour among adolescents. The results of the study by Pearson (2003) found that personal control and sexual self-efficacy are significantly related to safer sexual behaviour.

2.3.3 BELIEFS AND ATTITUDES ABOUT CONDOMS

While studies have shown increased acceptability of condom use among young people where consistent messages are promoted and support for continued use is provided (Goldstein, Usdin, Scheepers, & Japhet, 2005; Pettifor *et al*., 2005), the increased prevalence of HIV infection among adolescents reflects a more complex picture of condom use. From the review of studies by Eaton *et al* (2003) it was estimated that only about 20% of South African adolescents use condoms consistently. Reddy *et al*. (2003) reported condom use among youth 15 years to 18 years old to range between 45% to 53% during the last act of coitus. Simbayi *et al*. (2004) found that 53% of males and 48% of females used condoms during the last act of intercourse, and Maharaj (2006) found that among 2067 adolescents between the ages of 14 and 20 years, 60% reported using condoms during the last coitus. It is concerning that condoms may not be promoted within reproductive health services as a regular contraceptive method. The avoidance of male responsibility for contraception in general including condom use might increase the likelihood of unprotected sex among youth (Hoosen & Collins, 2004). A study by Maharaj (2006) in KwaZulu-Natal reported that condom use was less likely for adolescents who consider themselves to be at medium and high risk than those who believed that they were at low risk of HIV infection. Another challenge is that of condom disapproval by sexual partners and friends, which remain a major barrier to condom use (Boer & Mashamba, 2005; Macphail & Cambell, 2001. Consistent condom use with sexual partners remains the biggest challenge facing the National Health Department and other agencies in their efforts to influence adolescents' sexual behaviour and the prevention of HIV infections and teenage pregnancy.

Various obstacles to condom use have been documented in the literature and include negative beliefs and attitudes about condoms, often as a result of gender differences. Previous studies conducted in South Africa about youth sexual behaviours indicate that the majority of sexually active young people use condoms irregularly, if at all. Young people are involved in risky sexual behaviours, which put them at risk for HIV infection and unplanned pregnancies through unprotected sex, starting in their teens (Eaton et al., 2002; South African National Youth Risk Behaviour Survey, 2002). The recent report by UNAIDS on HIV prevention, documents behaviour changes including delays in first sexual experience, increase use of condoms by young people, and resulting decrease in HIV prevalence in young people in some Sub-Saharan African countries. Condom use with a non-regular partner increased although overall use of condoms remains below 50% (UNAIDS 2006).

The survey, HIV and Sexual Behaviour among Young South Africans (2004), found that among sexually experienced youth (15-19 years), 52% reported using a condom during most recent sexual intercourse and condom use was almost identical among sexually experienced men and women aged 15-19 years. Access to health messages, condoms, and contraceptives is important in influencing adolescent sexual behaviours and prevention of consequences of unprotected sex.

2.4 KNOWLEDGE ABOUT HIV

This section will discuss literature on adolescent knowledge about HIV by looking at three main issues: beliefs and knowledge about HIV, school as a source of information and knowledge about adolescent sexual behaviours, and knowledge and beliefs in general.

2.4.1 Beliefs and knowledge of HIV

Generally, adolescents have been found to have high knowledge and awareness regarding transmission and prevention of HIV/AIDS. On the contrary, adolescents also show lack of commitment and understanding of benefits of preventive behaviours and still have misconceptions about HIV/AIDS and sexuality issues in general.Reports by the National

Health Department (2007) indicated a reduction in the incidence of HIV infection is mainly attributed to the greater focus on education and awareness. It should be noted that the influential role of the positive peer pressure and the role played by mass media are also likely to contribute to the reduction in the incident of HIV.

Studies about young people suggest that youth with high access to media show a satisfactory level of knowledge about HIV and AIDS. In addition, adolescents in rural and poor areas where media infiltration is low clearly require alternate sources of health information like village health educators, pamphlets and posters (Kelly, 2000; Eaton, et al., 2002).

Previous research findings indicate that although awareness and knowledge about HIV/AIDS is high (97% of respondents) among adolescents in South Africa, this has not translated into substantial behaviour change, *(*Hartell, 2005; National Youth Risk Behaviour Survey, 2002)**.** It is critically important to look at the school setting as one of the main source of knowledge for adolescents especially on sexuality and HIV/AIDS.

2. 4.2 SCHOOL AS A SOURCE OF INFORMATION AND KNOWLEDGE ABOUT ADOLESCENT SEXUAL BEHAVIOURS.

General knowledge of adolescents about transmission of disease was found on the whole to be inadequate to provide a foundation for developing positive attitudes and safer sexual behaviours. It was found that many young people receive conflicting messages about sex and sexuality. According to the Global Coalition on Women and AIDS Report (2005) education of girls has been made a top priority, given the importance of education as an HIV prevention strategy and the many barriers that young people, especially girls, are confronted with while still at school.

A review of 113 studies from five continents found that teaching about AIDS in schools was effective in reducing early sexual activity and high risk behaviour (Global Coalition on women and AIDS Report., 2005). In a recent analysis of eight Sub-Saharan African countries, women with eight or more years of schooling were up to 87% less likely to have sex before the age of 18 compared to women with no schooling (Global Coalition on women and AIDS Report., 2005). Evidence from Zimbabwe shows that among 15-18 year old girls, those who are enrolled in schools are more than five times less likely to

have HIV than those who have dropped out (UNAID Report, 2006). Surveys in Haiti, Malawi, Uganda, and Zambia have shown a strong link between higher education and fewer sexual partners' reference (UNAID Report, 2006)**.** Links between education and improved sexual health outcomes, such as reduced incidence of teen pregnancy, have been observed globally. Available evidence does suggest that school enrolment or attendance lowers sexual risk for young people. This implies that the majority of those in school may be less likely to be involved in sexual relationships, more positively engaged in other activities, and thus less likely to be sexually active. However, this correlation may not be that easy to explain considering other factors such as educator-student sexual relationships, sexual coercion by males that are relevant within the school setting. Young women, for instance, may leave school because they are pregnant, thus making it appear as if those remaining in school are at lower risk. Studies indicate that comprehensive school programmes aimed at developing a positive school climate and facilitating a shared identity and connectedness among pupils appear to promote mental well-being, competence, social skills and school achievement.(Jané-Llopis, Barry, Hosman & Patel, 2005) that might not contribute to engagement in sexual risk behaviours.

This is particularly pertinent in light of the greater socialization role schools need to play because of the erosion of existing family and support structure due to AIDS and other factors.

2.5 PERCEIVED RISKS PERTAINING TO CONSEQUENCES OF UNPROTECTED SEX

2.5.1 CONSEQUENCES OF UNPROTECTED SEX

Risky sexual behaviours such as engaging in unprotected sex may result in adolescents experiencing consequences like HIV/AIDS, STIs and unplanned pregnancy.
Sexual risk behaviours were found to be mostly related to situational temptation, self-efficacy for negotiating safer sex, and anticipated benefits and costs of unprotected sex. Among late adolescents, perceived benefits of unprotected sex are better determinants of sexual risk-taking than perceived benefits associated with the healthy behaviour like using a condom. These findings support previous work identifying adolescents as more driven by their perceptions of the positive benefits associated with risky behaviours, rather than knowledge of the costs or dangers involved in risk-taking (Parsons; Halkitis; Bimbi; & Borkowski, 2000).

2. 5.2 PEER AND PARTNER INFLUENCE

Decision-making and negotiation of safer sexual practices, in particularly condom use, remains difficult even where awareness and knowledge of reproductive health are high, and the risks of HIV and pregnancy are well understood. The prevailing gender-power imbalances dictate that men are to exert authority in all matters, including reproductive decision-making. This approach may therefore not always be perceived as possible in young women's minds and behavioural priorities. It is a fact that in many settings, gender imbalances are so entrenched that, in some cases, the male partner's domination of all aspects of decision-making, including the protection and timing of sex, may be viewed as acceptable by their female partners. Furthermore the absence of any formal communication between partners about safer sex is a common characteristic of adolescent relationships (Varga, 2003). Lack of effective communication between adolescents and their parents about sexuality and sexual behaviours often compounds these problems. It has been found that parents act as a strong protective shield for adolescents as well as decreasing their risk vulnerability (Bhana & Petersen, in progress; Petersen & Bhana, 2003 in progress). There are challenges emanating from the family

construct currently existing in many African societies where female headed households are often the norm (Preston-Whyte & Zondi, 1991), where both parents are absent due to among other reasons migrant labour, or because they have died of AIDS, which will necessitate the creative use of other available supportive social relationships for youth. Communication for adolescents is a distinct process influenced by a combination of factors, including the physiological changes of adolescence, the importance of peer influences, and a different understanding of risks and their consequences. The adolescent phase provides an opportune time to intervene and improve young people's capabilities in this area. The role of peer pressure in determination of sexual behaviours of adolescents is important as it helps to determine relevant intervention programmes.

2. 5.3 PEER SEXUAL BEHAVIOUR

Communication with one's partner about STI risk and condom use has been found to be strongly correlated with willingness to use condoms and self reported use. It is a fact that talking about condoms use has been a difficult subject for adolescents, which needed serious interventions by the Department of National Health. Introducing condoms into a sexual encounter is perceived to break the intimacy and romance of the moment (Eaton et al., 2002). Several research findings indicate that both girls and boys experience considerable same sex peer pressure to be sexually active. For boys the pressure has to do with manliness, and having many sexual partners wins a young man status and admiration. Young men often encounter negative peer attitudes towards condoms. For girls pressure sometimes comes from sexually experienced peers who exclude inexperienced girls from group discussions because they are still children. It must also be acknowledged that peer pressure does not, however, have the same negative influence on all youth. Individuals differ in their susceptibility, and young men appear to be influenced to a greater extent than young women. It is also a fact that peer pressure is also not necessarily always a negative influence and in most adolescent behaviour change interventions, positive peer influence is successfully used to achieve positive results. Positive examples set by friends and role models can promote safer sexual behaviour (Eaton et al., 2002; Hartell, 2005; South African National Youth Risk Behaviour Survey, 2002; Wolf & Pulerwitz, 2003). Communication between parents and adolescents about

positive values, healthy sexual behaviours, sexuality issues and other consequences of unprotected sex remain critically important in the prevention of negative adolescent sexual behaviours.

2.5.4 PARENTAL INFLUENCE

A study conducted by the University of Cape Town in 2002 on risky sexual behaviour by youth revealed that South African adolescents report poor communication with their parents about sexual matters. Findings of the study further indicate that, when there is poor communication within the family about sex, and lack of supervision from parents may contribute to unsafe sexual behaviour (Olley, Seedat, Gxama, Reuter& Stein, 2005). It is common knowledge that in addition to parents, staff at public health clinics could play a significant role in young people's lives. These Primary Health Care clinics are providing free condoms as well as general sexual health and reproductive health services, but young people report negative attitude of clinic staff and clinic services are perceived to lack privacy and confidentiality (Health Systems Trust, 2004)

Poor communication between adolescents and their parents or guardians, often compounds these problems as parents are regarded by the general public as a very useful source of health information. A strong communication channel between parents or adults and young people has been found to decrease their risk vulnerability in as far as risky sexual behaviours are concerned (Bhana & Petersen, in progress; Petersen & Bhana, 2003 in progress). A long standing body of literature shows that adolescents who communicate with their parents about sex are less likely to engage in risky sexual behaviours than those who do not engage in such conversations (Holtzman & Robinson, 1995Jacard & Dittus, 1993). Issues of adolescent self-efficacy in relation to their sexual activities are important in the understanding of consequences of adolescent sexual behaviours.

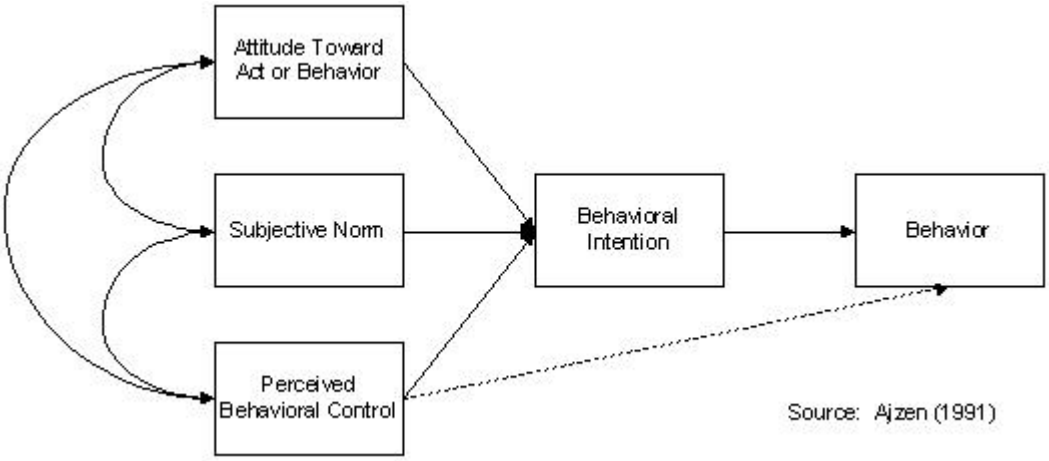
2.6 ACCESS TO HEALTH INFORMATION

Globally, access to services and accurate health information about prevention and reproductive health for young people still remains a challenge. A number of reports have documented the poor quality of care that young people receive in the public health services in most countries (Du Plessis et al; Wood & Jewkes, 2006). In South Africa, this poor quality of care for young people encompasses limited access to information, poor reception and treatment from service providers, and non-availability of preventive methods that young people need, most notably condoms (Wood & Jewkes, 2006). Lack of condom accessibility in public health facilities and institutions in general has been reported to impact negatively on the use of condoms (Colvin, 1997; Gilmour, Karim, & Fourie, 2000). Some have suggested the need for separate youth services, in response to problems encountered by young people in accessing contraceptives or other prevention services (Meyer-Weitz & Steyn, 1997). Research findings by Maharaj & White (2005) indicate that many youth expressed embarrassment about visiting health centres to obtain condoms, get health education and suggest that prevention initiatives should seek to extend their messages to health care workers in clinics and hospitals, stressing the importance youth friendly services in all health facilities to encourage youth to use condoms and health services. Particular attention should be given to strategies that will increase accessibility of condoms and other reproductive health services to youth. Access to condoms in South Africa currently does not appear to be a major problem as young people use a variety of sources to obtain condoms, however access to free condoms maybe restricted by the negative attitudes of clinic staff. Lack of planning may also be a problem since young people do not always have a condom when they need one, and this does not prevent them from having sex (Speak Out, 2005). The next section will discuss the Theory of Planned Behaviour as a theory of choice and convenient to use in this study, in order to explain certain issues which might need some clarity.

2.7 THE THEORY OF PLANNED BEHAVIOUR

Theory of Planned Behaviour (TPB) is used in this study to explain the behaviour of adolescents in relation to their sexual behaviors.

2.7.1 Figure 1. Schematic diagram of theory of Planned Behaviour



2.7.2 DESCRIPTION OF A THEORY

The historical antecedents of the TPB lie in the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1995).This identified the proximal determinant of behaviour as the strength of an intention whether or not to engage in that behaviour. In turn, behavioural intentions are derived from two parallel cognitive processes: The first involves consideration of individual's own attitude towards the behaviour.The second involves consideration of the relevant behavioural norm. Personal attitudes are derived from measures of belief about the behaviour under consideration and values attached to those beliefs.

Behavioural norms also comprise two elements:
An appraisal of the likelihood that salient others would wish the individual to engage (or not) in the behaviour under consideration, and their motivation to comply with these expectations.

Salient others include people such as parents, friends and health professionals whose opinions are important to the individual. In this case it is expected that adolescents will therefore adhere to the expected sexual behaviours (parental teachings, professional advises and community teachings) as opposed to engaging in risk sexual behaviours. Ajzen and Fishbein (1980) suggested that intentions accurately predict behaviour only if the behaviour is under the individual's volitional control. Such behaviour may vary according to circumstances, the individual skills and their behavioural repertoire. It is every parent's expectation that their adolescent children will abstain from sexual activities until they are old enough to handle the responsibility and implications of such behaviours. On the other hand even if adolescents are willing to refrain from sexual activities, but they are not empowered or lack skill to say no to sex, or negotiate safer sexual practices, they will continue to engage in risky sexual behaviour.

To account for such factors Ajzen (1998) incorporated a third variable in the TRA: Perceived Behavioural Control (PBC; Ajzen & Madden, 1986) This factor reflects past experiences as well as external factors, anticipated impediments, obstacles, resources and opportunities that may influence the performance of behaviour (Ajzen, 1991).

2.7.3 FACTORS INFLUANCING OR INHIBITING THE PERFORMANCE OF A BEHAVIOUR

The extended model proposes that attitudes and subjective norms exert their influence towards a specific behaviour through their impact upon intentions, while PBC may influence both intention to perform the behaviour and actual behaviour (Ajzen & Madden, 1986).

Theory of Planned Behaviour suggests that behaviour is influenced by intention (whether intention is positive or negative towards a particular behaviour), intention is determined by attitude (behavioural beliefs), subjective norms (normative beliefs) and perceived behavioural control (control beliefs). The next section will discuss the actual adolescent sexual behaviours with the aim of identifying the extent of the problem, and factors influencing the situation.

2.8 SUMMARY

Current literature on adolescent sexual behaviours indicates that they are involved in dating, sexual activities and to some extent have multiple sex partners. The age of sexual initiation is 15 years or early adolescent to some while others prefer to delay until late adolescent stage. Factors influencing adolescent sexual behaviours among others include peer pressure, gender – role expectations about love, sex and compliance with male desires. Most literature indicates that adolescents have high knowledge on HIV awareness and prevention, and high self-efficacy in their relationships and condom use. It is also clear that high knowledge and skills does not necessarily translate into responsible behaviour. Literature further suggests that adolescents in schools are better protected or empowered to deal with issues of pregnancy, HIV, and condom use, than those with limited/no exposure to school environment. Communication between parents and adolescents on matters of sex, condom use, pregnancy and HIV is non-existent, which contributes to the prevalence of risky sexual behaviours. Adolescents do not have access to health information especially in public sectors facilities and institutions; this also represents a major contributor to the prevalence of risky behaviours among adolescents. The Theory of Planned Behaviour Change will be use to support and justify research findings as it been to more appropriate for use in this study.

CHAPTER 3

3.1 RESEARCH METHODOLOGY

Chapter 3 explain how the study was conducted including background about the research site, research design used and how the data collection tool was developed. Data collection procedures will also be explained . The analysis of the data will be addressed as well. Lastly, the research will explain how ethical considerations were taken care of during the study and beyond.

3. 2 BACKGROUND TO THE RESEARCH SITE

The study was conducted at Adams Secondary School situated in Ethekwini Metro in South Sub-District, KwaZulu-Natal.
This is a public school with boarding facilities, which was advantageous to the researcher in ensuring access to subjects during the study. The school has a mixture of males and females, boarders and non-boarders and the majority of learners are from rural areas.
The selection of this school was based on the convenience to the researcher as it was easily accessible, based in a rural area, and had sufficient learners in terms of sampling.

3.3 RESEARCH DESIGN AND SAMPLING

A quantitative research design was used as it was considered an appropriate method to investigate the factors influencing adolescent sexual behaviours in relation to HIV/AIDS and other sexually transmitted infections (STIs) as well as other related issues among adolescents living in rural areas.

The target population for this study comprised of learners from one of the high schools in eThekwini with learners mainly living in rural areas throughout the province of KwaZulu-Natal. Convenience sampling was used to select the participants from Grades

10, 11 and 12. The study was discussed with all the learners and the researcher requested volunteers to participate in the study. The minimum age to participate was 16 years. The participants were then grouped into three age groups (16 - 17 years, 17 - 18 years, and 18 - 19 year. From these groups random quota sampling was used to select 20 participants from each age group. A total of 60 participants were selected.

3. 4 INSTRUMENT DEVELOPMENT AND MEASURES USED

A questionnaire (Appendix C) previously used in an Oakland, USA study was adapted and used for this study because of its success in measuring adolescent risk sexual behaviours and related issues. The adaptation was done on the basis of the theoretical framework (Theory of Planned Behaviour), objectives and the literature review which suggested the inclusion of specific items.

The questionnaire included both closed and open–ended questions pertaining to the socio-demographic characteristics of the participants (gender, age, place of residence, family construction and number of family members). Different questions were asked regarding knowledge of HIV/AIDS, self-efficacy to communicate about sex, STIs, pregnancy, and condom use as well as about perceived consequences of unprotected sex, and opinions on behaviours that contributes to the popularity of boys and girls among the opposite sex. Furthermore, questions were asked about the role of substance use in unprotected sexual activities. The role of peer influence in relation to risk sexual behaviours also received attention. These knowledge items were measured by True and False statements while most of the other questions were measured on either a 4 or a 5-point Likert scale.

In order to reduce the number of items, composite measures were developed according to guidelines provided in Babbie and Mouton (2001). Indexes and composite measures were constructed based on the summing of the items after obtaining satisfactory Pearson's correlation coefficients and an inter-item reliability coefficient (Cronbach's alpha) of = .7580 or higher. The next chapter will deal with the descriptive details of the measures.

3.5 DATA COLLECTION PROCEDURE

Data was collected by means of a self-administered questionnaire to participants. Sixty questionnaires were handed out by the researcher and the research assistant to the participating learners in the presence of one schoolteacher and five Ground Breakers from Lovu area, at Amanzimtoti. Ground Breakers are adolescents or teenagers employed by an NGO called LoveLife to educate young people about healthy sexual behaviours, HIV/AIDS awareness and sexuality matters. Their role in the study was to assist with the data collection process and to assist the researcher in addressing queries and concerns from the participants. The purpose of youth involvement in the collection of the data was to put the participants at ease and to encourage greater openness about reporting on their beliefs, attitudes and behaviours. Participants were informed of their rights, the nature of the study, and that participation was voluntary. They were also informed and assured of the confidentiality of information collected and that their names would not be required or used. Written informed consent was obtained before the administration of the questionnaires (Appendix 2). A total of 60 questionnaires were collected, but one questionnaire was not completed and was omitted.

3. 6 DATA ANALYSIS

The Statistics Package for Social Scientists (SPSS13) was utilized in data analysis. In this regard, editing and coding of raw data was undertaken where logically inconsistent data was identified and excluded from analysis and non-response items were also identified in order to determine the missing values that were utilized in data coding. Following this, a coding template was established in order to capture the key coding instructions for each variable, e.g. how responses relate to variables, labels of variables, whether a particular variable was numeric or alphanumeric. All questionnaires were pre-coded prior to data capturing in order to reduce errors that may have resulted from incorrect data entry.

Frequencies were calculated for each item. Chi-square analyses were conducted to determine the association between demographic variables (sex, age) and the items related to HIV transmission that showed some variation on the response categories, namely respondents felt that HIV can be transmitted via kissing, use of syringes, breastfeeding, and mosquitoes or insects, sex with gay people, sex with people who share drug needles. The following two knowledge items were also included: Firstly, that HIV manifests immediately in symptoms, and secondly that contraceptives protect women from HIV/AIDS. Chi-square analyses were further conducted to investigate the relationship between sex, age and communication with parents about sexual matters i.e. about sex, STIs, HIV/AIDS, pregnancy as well as condoms.

Independent sample T-tests were conducted in order to explore whether significant differences occurred in the mean scores for the two groups of male and females as well as for the younger and older age groups on the following continuous variables: Communication with friends and partners about sexual issues and AIDS; self-efficacy to insist on using contraceptives even if a partner does not want to; to tell a partner to stop sexual touching; requesting a partner to spend time with you; telling a partner that you do not want to have a date with him/her and telling a partner that you do not want to have sex.

Independent sample T-tests were also conducted in order to explore whether there are significant differences in the mean scores for the two gender groups (male and female) as well as for the younger and older age groups in terms of the following composite measures that were created: knowledge; communication with parents about sexual issues; anxiety about consequences of unprotected sex; friends' condom use ; perceptions about youth sexuality among boys and girls; perceived future risks of unprotected sex; condom use, and self-efficacy and beliefs about the meaning of condom use in relationships.

3. 7 ETHICAL CONSIDERATIONS

Informed consent was obtained from all research participants in the study after the purpose of the study was explained, they were informed of their rights to withdraw from the study at any stage and that participation in the study was voluntary. In addition they were also informed and assured of the confidentiality and anonymity of the data collected and that no names would be required nor used. The results of the study will be discussed in the next chapter.

CHAPTER 4

4.1 RESULTS

This chapter deals with the presentation of results of this study, which is presented in tables, percentages and a brief description of findings. Results are presented according to the different themes that were explored in the study: socio-demographic background of respondents, adolescent sexual behaviours, adolescent's knowledge (of HIV/AIDS, Sexually Transmitted Infections and reproductive health issues); communication with significant others, perceived risks pertaining to consequences of unprotected sex, adolescent self-efficacy in relationships, perceptions about sexual activity and condom use, perceptions about adolescent popularity and sex, and access to health information by adolescents. The last aspect that is presented addresses self-efficacy in terms of relationships in general, sexual relationships and condom use.

The results of adolescents' perceptions are also presented with special focus on perceived future risks (about HIV/AIDS, STIs, and pregnancy), sexual activity and condom use by friends and condom use in general, adolescent popularity and sex. Presentation of results will also focus on adolescents' sexual behaviours, adolescents' reproductive health behaviours, sources of health information and influence of alcohol and drugs.

4. 2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

In Table 1 information about the socio-demographics of the sample is presented. The majority of adolescents (87%) who participated in the study come from rural areas in different parts of KwaZulu-Natal, while only 13% were from urban areas. Among the total number of participants (n=60), 24 were males (41%) and 35 females (59%). Because of the stratified sampling procedure, the age group distribution was evenly (20%) among the four age groups (16, 17, 18 and 19 year olds respectively).

The majority of adolescents (45%) are brought up by single parents (40% live with only a mother while only 5% live with their fathers). A smaller group (36%) lives with both

parents while 20% live with other relatives or guardians. The study also revealed that 34% of adolescents live in small families of between 1 – 5 members, while 31% live in bigger families of between 8 - 16 people. The majority of participants (35%) live in big households of –6 - 7 people. This information can be seen in Table 1 below.

Table 1. Socio-demographic characteristics of the participants (n=60)

Characteristics	**n**	**%**
Sex		
Male	24	41
Female	35	59
Family construction		
Live with both parents	20	36
Live with mother only	22	39
Live with father only	3	5
Live with other relatives/guardian	11	20
Household size		
1 – 5 people	18	34
6 - 7 people	19	35
8 – 16 people	17	31
Living area		
Rural	51	87
Urban	8	13

4.3 ADOLESCENT SEXUAL BEHAVIOURS

The frequencies in Table 2 indicate that adolescents are involved in various dating behaviours. The majority (82%) indicated that they have spoken to a girl or a boy that they like, while only 55% indicated having gone out on a date and the same percentage(55%) indicated having touched a girl's or boy's private parts. The majority of participants (66%) indicated that they've never had sexual intercourse and the same percentage (66%) indicated that they are currently abstaining from having sex with their partners. Of those that indicated that they have had sex, 34% said that they have used condoms.

Table 2: Adolescent's dating and sexual behaviours

ITEMS	n	**RESPONSE CATERGORIES**	
		YES %	**NO %**
Talked to boy/girl you like	55	82	18
Gone out on a date with girl/boy	56	55	45
Kiss boy/girl on lips	56	86	14
Tongue kiss/French kiss	52	77	23
Touched boy'/girl' private parts (penis, vagina)	52	55	45
Chosen to abstain	52	66	34
Had sexual intercourse	55	34	66
Had oral sex	55	21	79

The chi-square analysis indicated that boys were more likely to report having had sexual intercourse than girls (X^2 =4.78, df1, p=0.03).

4.3.1 PERCEIVED RISKS PERTAINING TO UNPROTECTED SEX

The responses from these three questions, which were used to test whether adolescents understand consequences of unprotected sex, indicate that to some extent adolescents understand the implications of risky sexual behaviours. On the question of being worried about getting infected with HIV or getting AIDS the majority (45%) reported being very worried about being infected. Similarly the majority of the adolescents (48%) indicated that they are very worried about getting STIs. However, on the question about being worried about pregnancy the majority (36%) reported not being worried at all, while the same number 36% were very concerned about pregnancy.

Table 3: Frequencies regarding concern for consequences of unprotected sex

Items	**n**	**RESPONSE CATERGORIES***		
Concern for:		**Not at all concerned %**	**Somewhat concerned %**	**Very concerned %**
AIDS	53	39	16	45
STIs	53	29	23	48
Pregnancy	53	36	28	36

*** Coding**: not at all concerned=1, somewhat concerned=2, very concerned=3

The descriptive statistics for the concern of consequences of unprotected sex measurement in Table 4 shows relatively high levels of concern (M=6.3). The results of the independent samples t-test showed no significant difference in the mean concern scores for males and females and for the younger and older age groups.

Table 4: Descriptive statistics for the concern for consequences of unprotected sex measure

Measurement re concern for consequences of unprotected sex [1]	n=56	Number of items	Cronbach alpha	Range of scale	Mean	Std.Dev
Concern for AIDS, STIs and pregnancy	56	3	0.85	3-9	6.3	2.3

[1] Low score=less concern; High score=higher levels of concern

4.3.2 Perceived future risk pertaining to AIDS, STIs and pregnancy.

Table 5 below indicates that the majority of adolescents (52%) felt that they might become infected with HIV in future and 16% thought that is very likely to happen. Similarly about half the adolescents (42%) felt that they might become infected with an STI in the future, while 20% thought it very likely. However, the majority (64%) of the adolescents did not perceive themselves at risk of falling pregnant (in the case of females) or making someone pregnant (in the case of males) before the age of 20 years old, while 16% thought it might happen; 16% also felt that it is very likely to happen and only 4% indicated a youth pregnancy. Table 5 below indicates the frequencies on these questions.

Table 5: Perceived future risks for AIDS, STIs and Pregnancy.

ITEMS	n	RESPONSE CATERGORIES			
Perceived future risk for:		No chance at all %	Might happen %	Very likely to happen %	Happened already %
AIDS	53	32	52	16	0
STIs	53	38	42	20	0
Pregnancy before 20 yrs	53	64	16	16	4

The independent sample T–test results indicate that there were significant differences in the mean scores of the perceived risk measure between males (M=6.1, SD=2.1) and females (M=4.7, SD=1.6, t(54) =2.8, p=0.007] and between younger (M=4.41, SD1.7) and older [M=6.1, SD=1.8; t(54)= -3.762, p<0.001] adolescents. More males see themselves as being at risk of getting HIV/AIDS, STIs and getting girl pregnant, while females do not share the same perceptions. Older adolescents irrespective of gender perceive themselves as being likely to get HIV/AIDS, STIs, and either becoming pregnant or making a girl pregnant.

Table 6: Descriptive statistics for perceived future risk for AIDS, STIs and pregnancy

Measurement re perceived future risk [1]	**N**	**Number of items**	**Cronbach alpha**	**Range of scale**	**Mean**	**Std.Dev**
Risk for AIDS, STIs and pregnancy	56	3	0.764	3-9	5.3	1.9

[1] Low score=low perceived risk; High score=high perceived risk

4.3.3 PERCEPTIONS ABOUT ADOLESCENT POPULARITY AND SEX

In Table 7 below, the frequency distribution on the items are presented. Most adolescents either disagreed (24%) or strongly disagreed (46%) that having sex makes a boy popular or that it is “cool” for a boy to do so. The majority (56%) indicated that sex with multiple partners does not make a boy popular. With regards to female popularity and sex, the greater majority (63%) strongly disagreed that having sex makes a girl popular and 58% disagreed that it is “cool” for a girl to be having sex. Multiple sexual partners by girls were strongly disapproved of as 76% disagreed that having multiple sex partners makes girls popular.

Table 7: Perceptions about adolescent sex and popularity

ITEMS	N	RESPONSE CATERGORIES			
		Strongly agree %	Agree %	Disagree %	Strongly disagree %
Perceptions about male popularity					
Having sex makes boys popular	54	16	13	25	47
Youth sex is "cool" for boys	54	11	20	24	46
Sex with multiple partners	54	13	13	19	56
Perceptions about female popularity					
Having sex	54	11	5	21	63
Youth sex is "cool" for girls	54	4	11	27	58
Sex with multiple partners	54	4	4	16	76

With regards to the composite measures constructed for popularity among boys and girls from the above items, the descriptive statistics can be viewed in Table 8. Mean scores indicate that females strongly disagree that adolescent sex makes the girl popular (M=10.5), while on the other side boys to some extend tend to agree that adolescent sex makes the boy (M=9.3) popular.

Table 8: Descriptive statistics for adolescent popularity through sex

Measurement re adolescent popularity through sex [1]	n	Number of items	Cronbach alpha	Range of scale	Mean	Std.Dev
Male popularity: having sex, youth sex is cool; having multiple partners	54	3	0.76	3-12	9.3	2.7
Female popularity: having sex, youth sex is cool; having multiple partners	55	3	0.77	3-12	10.5	2.1

[1] Low score=Agreement; High score= Disagreement

The results of the independent samples t-tests showed that the male and female sex popularity measures differ significantly for males and females. A significant difference in scores for males (M=7.23, SD=2.72) and females (M=10.57, SD=1.67, t(29.77)=-5.04, p<0.001) was found for male sex popularity. Similarly a significant difference in the mean scores for males (M=9.28, SD=2.47) and females (M=11.17, SD=1.42, t(28.32)=-3.19, p=0.003) were found for female sex popularity. On the male and female sex popularity, female adolescents believe that being sexually active at adolescent stage makes males popular, but do not share the same perception with females. Adolescent males believe that sexual activity makes the boy popular while they disagree on female sex popularity.

4.4 SELF-EFFICACY AND CONDOM USE

4. 4.1 ADOLESCENT SELF-EFFICACY IN RELATIONSHIPS

The majority of participants (68%) indicated that they definitely could tell their partners that they did not want to have sex. Surprisingly, only 55% indicated that they definitely could tell their partners to stop touching them sexually and only 34% could insist on contraceptive use. See Table 9 for the frequency distribution.

Table 9: Reponses re self-efficacy in relationships

Items	**N**	**Response categories**			
Ability to tell partner:		**Definitely could %**	**Probably could %**	**Probably not %**	**Definitely Not %**
To spend time with him/her	53	62	30	4	4
That you do not want to go out with him/her	53	54	20	12	14
That you do not want to have sex	53	68	16	5	11
To stop touching you sexually	53	55	13	6	26
To use contraceptives even when partner does not want to	53	34	16	11	39

The majority of the adolescents (67%) also indicated that they have talked to a girl/boy that they like but less have indicated (55%) that they have gone out on a date. The chi-square test did not show a significant association between the different gender groups and age groups.

The descriptive statistics for the self-efficacy in sexual relationship measure is depicted in Table 10. The mean score of M=9.5 shows that the adolescents had relatively high levels of self-efficacy in their sexual relationships.

Table 10: Descriptive statistics for the self-efficacy in sexual relationship measure

Measurement re Self-efficacy in sexual relationships[1]	**N**	**Number of items**	**Cronbach alpha**	**Range of scale**	**Mean**	**Std.Dev**
Ability to: break off the relationship; tell partner that you do not want to have sex; to stop touching you sexually	**56**	3	.788	3-12	9.5	2.87

[1] Low score=lower self-efficacy; High score=higher self-efficacy

The results of the independent samples t-test indicate a significant difference in the mean scores of adolescent males (M=7.3, SD= 2.9) and females (M=10.9, SD=1.7, t(30.20) =-5.4, p<0.001] on the self-efficacy in sexual relationship measure. More adolescent females showed high level of self-efficacy meaning that they believed that they are in control of their relationships, compared to their male counterparts. The age groups did not differ significantly in their mean scores on this self-efficacy measure.

4. 4.2 PERCEPTIONS ABOUT SEXUAL ACTIVITY AND CONDOM USE BY FRIENDS

The majority of the adolescents perceived most of their friends to have had sexual intercourse. Only 21% indicated that their friends have not had sex, 34% said that a few have had sex while 14% indicated that half of their friends have had sexual intercourse, 21% said that most of their friends have had sex and 9% said that all of their friends have had sex.

Slightly more than half (54%) of the adolescents believed that their friends do not think that condoms are too much trouble to use. However a significant group about 36% indicated that their friends do think that condoms are to some extent too much trouble to use. In Table 11 we read that more than half (53%) indicated that most or all of their friends use condoms.

It is clear that condom use is low when under the influence of alcohol or drugs (64% and 75% respectively).

Table 11: Perceived sexual activity and condom use by friends

ITEMS	RESPONSE CATERGORIES					
	N	None %	A few %	About half %	Most %	All %
Perceived sexual activity by friends						
Friends have had sex	**56**	21	34	14	21	9
Friends' perceptions about condoms						
Condoms too much trouble to use	**56**	54	18	9	9	10
Perceived condom use by friends						
Use condoms when having sex	56	14	20	13	32	21
No condom use when using alcohol	56	64	23	4	7	2
No condom use when using drugs	56	75	21	4	0	0

4.4.3 PERCEPTIONS ABOUT CONDOM USE

In Table 12 the frequency distributions regarding condom use is presented. The overwhelming majority of participants (73%) definitely believed that a partner cares if a partner suggests using a condom when having sex, and 14% probably would, while 7% of participants probably would not and 5% would definitely not feel that a partner cares when suggesting condom use. On the other hand the majority of participants (84%) revealed that they would definitely respect their partners if they suggest using a condom. The majority (75%) indicated that they would use a condom to prevent AIDS even in the heat of the moment, 9% indicated that they would have sex despite the unavailability of condoms with 14.3% indicating that they probably would have sex while about half (54%) said that they would definitely not have sex when condoms are not available.

The descriptive statistics for the composite measure re perceptions of condom use (items pertaining to care and respect) can be viewed in Table 13. The mean score of M=7.3 indicate positive perceptions about condom use.

Table 12: Perceptions about condom use

ITEMS	**N**	**RESPONSE CATERGORIES**			
		Definitely would %	**Probably would %**	**Probably not %**	**Definitely not %**
Partner cares if condom use is suggested	53	73	14	7	5
Respect for partner if condom use is suggested	53	84	9	4	4
Will use condom to prevent AIDS even in heat of moment	53	75	21	2	2
If condoms are not available will have sex anyway	53	9	14.3	23	54
Will use a condom even when drunk	53	54	20	14	13

With regards to the t-tests for independent samples that were conducted on the individual items, not all differences in the mean scores for males and female or for the younger and older adolescents were significant. For the perception that it is too much trouble to use condoms the mean score between the males (M=2.6 SD=1.33) and females [M=3.4, SD=1.01, t(36.4)=-2.51, p=0.017] differed significantly. Similarly the mean scores for the younger (M=3.41, SD=1.1) and older adolescents [M=2.7, SD=1.3, t(50.64)=2.4, p=0.02] also differed significantly. More female adolescents indicated that it is too much trouble

to use condoms compared to their male counterparts. Also younger adolescents share the same perception that condoms are too much trouble to use while older adolescents don't.

The mean scores on the item regarding the perception that people who carry condoms have multiple sexual partners differed significantly between males (M=2.23, SD=1.1) and females [M=3.1, SD=1.1, t(54)=-2.9, p=0.005] and between younger (M=3.1, SD=1.2) and older [M=2.4, SD=1.05, t(54)=2.23, p=0.03] adolescents.
More female participants believed that people who carry condoms have multiple sexual partners, compared to very few males who share the same belief. Younger adolescents (16 -17 years) also believe that people who carry condoms have multiple sexual partners compared to those who are older (18 -19 years) irrespective of gender.

Table 13: Descriptive statistics for condom use perceptions

Measure re condom use perceptions [1]	**n=56**	**Number of items**	**r**	**Range of scale**	**Mean**	**Std.Dev**
Partner care and be respected when suggesting condom use.	56	2	0.53	2-8	7.3	1.4

[1] Low score= less positive perceptions; High score= more positive perceptions

No significant differences were found between males and females or between the younger and older adolescents in the t-tests that were conducted.

4.5 KNOWLEDGE OF HIV

The majority of participants 95% have heard about HIV and AIDS, 93% of the participants reported correctly that HIV is transmitted through contact with blood from a HIV-infected person. Further, 86% of the participants in this study indicated that HIV can be transmitted when a person engages in unprotected sex with a HIV-positive person. See Table 14 below for detailed information. With regard to the transmission of HIV through breastfeeding, the chi-square analysis indicated that boys were more likely to indicate

that HIV cannot be transmitted through breastfeeding than girls (X^2 =3.93, df1, p=0.047). Girls were also more likely to answer correctly that not only people who have sex with homosexuals get AIDS (X^2=9.96, df1, p=0.002). Regarding knowledge about HIV, girls appeared to be more knowledgeable than boys, and age did not play a significant role in the knowledge items.

Table14: Knowledge re HIV/AIDS transmission modes

Items related to HIV/AIDS transmission	**n**	**Correct %**	**Incorrect %**
HIV can be transmitted through:			
Blood contact with HIV positive person	55	93	7
Unprotected sex	56	91	9
Touching others	54	9	91
Kissing	53	25	76
Multiple sex partners	53	89	11
Injection with used syringes	51	59	41
Food or water	54	9	91
Breastfeeding	55	53	47
Mosquito or insect bites	52	25	75
Can get HIV through hugging	55	91	9
Perceptions about HIV-transmission			
Only people who look sick can spread HIV	55	80	20
One can get HIV if you have sex without a condom even once only	58	79	21
Only people who have sex with gay people get HIV	56	73	27
One can get AIDS by having sex with people who share drug needles	55	45	55

In further testing adolescents' knowledge about HIV and AIDS, the majority of respondents (71%) disagreed with the statement that most people who are HIV positive

show signs of being sick right away. No statistically significant differences were found between males and females and between younger and older adolescents..

The adolescents' knowledge about HIV/AIDS prevention was unexpected as only 79% believed that condoms reduce the risk of being infected with HIV. While not statistically significant, more female respondents (49%) agreed that condoms reduce HIV risk, while 30% of male respondents agreed with the statement. Age did not play a significant role in their responses. Some adolescents (34%) incorrectly believed that other contraceptives protect women from getting HIV/AIDS. No significant differences between males and females or between younger and older respondents were found.

With regards to adolescents' perceptions about groups of people at risk of getting HIV/AIDS, the majority of participants/adolescents believed that people who are at high risk are males who have sex with more than one partner (91%), females with more than one sexual partner (96%), having sex with prostitutes (84%) and girls who have been raped (69%). No significant association was found between these beliefs and the demographic variables sex and age. This information will be found in Table 15 below.

Table 15: Adolescents' perceptions about people at risk of getting HIV/AIDS

Perceptions about who is at risk of getting HIV/AIDS	**N**	**True %**	**False %**	**Don't know %**
Married women	55	24	56	20
Men having many sexual partners	56	91	9	
Men having sex with prostitutes	55	84	9	7
Girls with more sex partners	56	96	4	
Girl who was raped	55	69	16	15
Homosexuals	55	31	27	42
Men using drugs	55	46	24	31

4.6 CONSEQUENCES OF UNPROTECTED SEX

In this section the ability of the participants to communicate about sexual issues with their partners, friends and significant adults (parents or guardians) is presented. The frequencies for the individual items will be presented followed by the t-tests conducted to determine the mean differences in the scores of males and females as well as between younger and older adolescents in terms of the self-efficacy measures.

4.6.1 Peer and Partner influence

In Table 16 the frequencies are depicted of the items pertaining to communication with friends and partners. The majority of the participants (75%) indicated that they would be able to talk to their friends about sex and 67% said that they would be able to discuss who they would like to have as a boyfriend or girlfriend with their friends. With regards to discussions about STIs and AIDS the majority said that they would be able to talk to their friends about it (60% and 68% respectively).

Being able to talk about AIDS with one's partner was reported by 74% of the respondents. Less than half of the respondents indicated that they would be able to talk about sex with their boy- or girl fiends without feeling embarrassed (43%). Less than half of the participants (41%) indicated that they would be able to start a conversation about condom use with their partners. Slightly more than half the participants (54%) indicated that they would be able to talk about STIs with their partners Reproductive health issues seem to remain a confusing subject to adolescence as reflected by the participants' responses on the question about starting a conversation about contraceptives with their partners. Only 38% indicated they could definitely initiate this discussion.

Table 16: Responses re communication self-efficacy with friends and partners

Items	N	Response categories*			
Ability to talk to friends about:		**Definitely %**	**Probably %**	**Probably not %**	**Definitely Not %**
Someone to have as partner	52	67	27	0	6
Sex	52	75	16	2	7
STIs	52	60	24	7	9
AIDS	52	75	13	6	6
Ability to talk to sex partners about:					
Sex without being embarrassed	53	43	34	13	11
Condoms	53	41	32	20	7
AIDS	53	68	21	7	4
STIs	53	54	21	18	7
Pregnancy	53	63	23	9	5
Contraceptives	53	34	16	11	39

*Coding: Definitely =1; Probably=2; Probably not=3; Definitely not=4

Table 17 shows the descriptive statistics of the composite measures that were developed regarding the adolescents' self-efficacy to communicate with their friends and partners about sexual issues.

Table 17: Descriptive statistics for the communication self-efficacy measures

Communication Self-efficacy Measurement[1]	Number of items	Cronbach alpha	Range of scale	Mean	Std.Dev
Ability to talk to friends about: sex, STIs, AIDS	3	.706	3 -12	10.53	2.0
Ability to talk to partners about: sex, condoms, STIs, contraceptives.	4	.704	4-14	7.66	2.9

[1] Higher score = Higher self-efficacy, Lower score = Lower self-efficacy

An independent-samples t-test was conducted to compare the mean scores on communication self-efficacy with friends about sexual issues between males and females. The independent samples t-test showed that there was a significant differences between the mean scores of the adolescent males (M=9.72, SD=2.45) and females [M=11.09, SD=1.46, t(31.32)=-2.56), p=0.026] The results indicate that adolescent females are more likely to talk to their friends about sexual issues as compared to their male counterparts.

The results of the independent-samples t-test indicated that there was a significant difference on the mean scores of the communication self-efficacy with partners measure between the male (M=8.95, SD=2.78) and females [M=6.82, SD=2.63, t(54)=2.89, p=0.006]. The results indicate that adolescent males are more likely to communicate with their partners about AIDS, STIs, condoms and sex than their female counterparts.

4.6.2 Parental influence

From the responses on the four questions asked about whether the participants have talked to their parents about sexual issues it can be seen that parental communication is inadequate. As depicted in Table 18, the majority (57%) of the participants talked about pregnancy with their parents and 45% talked about AIDS, 39% talked about STIs and 31% talked with their parents about sex, and only 30% talk to their parents about using condoms.

Table 18: Responses re talking about sexual issues with parents

Items	N	Response categories	
Ever talked to parents about:		**Yes %**	**No %**
Pregnancy	53	57	43
HIV/AIDS	53	45	55
STIs	53	39	61
Sex	53	31	69
Using condoms	53	30	70

According to the chi-square analysis adolescent females were more likely to talk to their parents about HIV/AIDS and about pregnancy than adolescent males (X^2=7.042, df1, p=0.008 and X^2=3.899, df1, p=0.048 respectively). The older adolescents i.e. those of 18 and 19 year old were more likely to talk to their parents about condoms than the younger adolescents group of 16-17 year old (X^2=4.89, df1, p=0.027).

With regards to the extent that the participants felt comfortable in talking to their parents about sexual issues we can see from Table 19 that the participants are generally not comfortable to talk to their parents about sexual issues. Slightly more participants indicated that they feel very comfortable to talk to their parents about HIV/AIDS and pregnancy (38% HIV/AIDS and 30% pregnancy respectively) than about using condoms (18%), about STIs (14%) and about sex (9%).

Table 19: The extent of feeling comfortable when talking to parents/guardians about sexual issues

Items	**N**	**Response Categories**			
Extend of feeling comfortable when talking to parents about:		**Very comfortable %**	**Somewhat comfortable %**	**Somewhat uncomfortable %**	**Definitely Not comfortable %**
HIV/AIDS	53	38	25	29	8
Pregnancy	53	30	39	18	13
Using condoms	53	18	29	17	36
STIs	53	14	32	32	22
Sex	53	9	21	32	38

In Table 20 the descriptive statistics for the measure pertaining to adolescents' ability to talk about sexual issues with their parents/guardians are presented. With regards to the t-tests that were conducted to compare the mean scores of adolescent males and females as well as between the younger and older adolescents on the composite measure of communication self-efficacy with parents, no significant differences were found in the scores for males and females as well as between the younger and the older adolescents..

Table 20: Descriptive statistics for the measure on communication self-efficacy with parents/guardians about sexual issues

Communication self-efficacy with parents[1]	**Number of items**	**Cronbach alpha**	**Range of scale**	**Mean**	**Std.Dev**
Ability to communicate about: STIs, AIDS, condom use, pregnancy.	4	.798	4-16	9.5357	3.26393

[1]Low score = low feelings of discomfort, Higher score = higher feelings of discomfort.

CHAPTER 5

5.1 DISCUSSION OF RESULTS

The threat of AIDS and HIV has provided a major impetus into the study of factors influencing sexual behaviours especially among adolescents, and in particular those which relate to the use of safer sex practices, including the use of condoms. The prevalence of conditions and diseases related to risk sexual behaviours by adolescents has perhaps for the first time, exposed adolescents to the health threat against which the only effective prevention is behavioural change. Accordingly, it is important to identify factors contributing to adolescent's sexual behaviours particularly attention being paid to the negative factors which contribute to risky sexual behaviours. Communication mainly about HIV and AIDS, STIs, sex and pregnancy, with friends, partners and parents is critical in reducing the prevalence of risky sexual behaviours among adolescents. It is also important to understand adolescent's self-Efficacy level on relationships, condom use and their level of understanding of consequences of unprotected sex, future risks on AIDS, STIs, and pregnancy, and their sexual behaviours in general. This section will discuss the results of the study according to the themes identified in chapter 4 and one of them being the socio-demographic issues.

5. 2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

The results on family construction indicate that the majority of participants were brought up by single parents. Previous studies and Sociology literature indicate that poor socialization and family disorganization contribute to adolescent's deviant behaviours which include risky sexual behaviours (Ackerman & De Klerk, 2002; Kalichman, Simbayi & Kaufman et al., 2005).

Other studies indicated that a strong parent-adolescent communication on sexuality issues and risk sexual behaviours has been found to decrease their risk vulnerability (Bhana & Petersen, in progress; Petersen & Bhana, 2003 in progress). Also in support of these

findings are results of a study by Preston-Whyte & Zondi, 1991, which confirmed that adolescents who are raised by single parents are likely to engage in risky sexual behaviours and will require some targeted creative social relationship programmes for the youth. The next sections will focus on the adolescent sexual behaviours in relation to the prevalence of sexual activity, protective sexual behaviours and perceptions about adolescent sexual activities.

5.3 ADOLESCENT SEXUAL BEHAVIOURS

The results indicate that the majority of adolescents between ages 16 to 19 years are involved in dating behaviours and sexual activities. This confirms findings of other previous studies like (South African National Youth Risk Behaviour survey, 2002) about adolescent sexual behaviours. This study confirms that boys are more likely to report having had sexual intercourse that the girls, while previous studies like (Sorrell & Rafaelli, 2005) indicates that girls tend to lie about their involvement in sexual activities. In this study the majority of participants were girls and the majority indicated that they are abstaining from sexual intercourse, which might not be necessarily true. It will be important and critical that sexuality education will target young people at puberty stage before they enter into adolescent stages. This might reduce the number of adolescents who engages on unprotected sex and prevent teenage pregnancies, and HIV infections.

5.3.1 PERCEIVED RISKS PERTAINING TO UNPROTECTED SEX

The results indicate that adolescents seemed to believe that they are at risk of being infected with HIV or STIs in future. The results further indicate that most adolescents irrespective of gender and age are concerned about the consequences of unprotected sex. Lessons from previous studies like Parsons et al., (2000) indicated that what adolescents are worried about does not necessarily mean that they will avoid such behaviours, but instead they continue engaging in unprotected sex. The high level of knowledge on HIV, high communication self-efficacy level in relationships and condom use will empower adolescents to refrain from risky sexual behaviours provided health messages are consistently sustained by the National Health Department and its Agencies. This is

supported by the theory of Planned Behavior Change by Ajzen et al, (1991) which state that attitude and intention influences the direction of the behaviour. This means that as adolescents who are concerned about consequences of unprotected sex, are more likely to accept positive health messages which will result in their positive behavioual change. The majority of adolescents also do not believe that they are at risk of being pregnant or getting the girl pregnant. It might be possible that most adolescents responded like this because the majority of participants in the study (66%) were not sexually active. The other reasons behind this belief may need further investigation as adolescents are being currently, taught about sexuality, including reproductive system at a school level. The results indicate that adolescent males seemed to have high level of perceived risk with HIV, STIs and getting a girl pregnant than their female counterparts. This is difficult to explain as there is no literature or previous study found to support these findings maybe future studies will reveal the meaning of these perception differences between males and females.

The results also indicate that older adolescent (18 to 19 years) seemed to have higher perceived risk level with HIV, STIs and pregnancy that the younger adolescents (16 to 17 years). It is a fact that older adolescents would know more about sexuality, pregnancy, HIV/AIDS and STIs than their younger counterparts because it is expected that older adolescents would have acquired more knowledge and skills to have insight and understanding of their sexual behaviours. This is also supported by the observed decline in HIV infections among the same group between the years 2005 to 2007.

5.3.2 PERCEPTIONS ABOUT ADOLESCENT POPULARITY AND SEX

The majority of adolescent females seemed to strongly disagree that engaging in sexual activity at an adolescent stage makes the girl popular, while adolescent males to some extent believe that adolescent sex makes the boy popular. This can be explained in the context of different gender-roles which are still at play among this group. Study by Sorrell & Rafaelli, 2005, also indicated that both boys and girls tend to lie about their sexual activities, with boys exaggerating their involvement and girls under reporting their involvement, which might have been to some extent the case in this study. The next

section will discuss adolescent self-efficacy in relationships and condom use including peer influence as an attempt to understand their capacity to protect themselves from the implications of risky sexual behaviours.

5.4 SELF-EFFICACY AND CONDOM USE

5.4.1 ADOLESCENTS SELF-EFFICACY IN RELATIONSHIPS

The results of this study indicate that adolescents have relatively high levels of self-efficacy in their sexual relationships. The results also revealed that adolescent females seemed to have high self-efficacy levels in their sexual relationships than their male counterparts. This means they are more likely to say no to sex, no to unprotected sex and to also more likely to negotiate condom use. Socially, girls are usually portrayed as being unable to assert themselves equally in their relationships while boys play more dominant roles. It will be essential for future health interventions to build on these findings and continue to reinforce this positive behaviour.

This is also a positive behavioural shift from findings of previous studies by SHAPE, (2001), where adolescents are portrayed as irresponsible, coerced to have sex, have shame and embarrassment to discuss sexual issues with their partners. It is encouraging that girls in particular have high self – efficacy levels in their relationships, which will empower them to deal with consequences of unprotected sex.

5.4.2 PEER INFLUENCE WITH REGARD TO CONDOM USE AND SEXUAL ACTIVITY

The results generally, indicate that adolescents believe that their friends and peers are sexually active. The majority of adolescents also believe that their friends and peers are practicing safe sex or using condoms when having sexual intercourse.

The results of this study clearly points out what other studies like Hartell, 2005; Buga, Amoko & Ncayiyane, 1993, have been saying that the majority of adolescents are sexual active. It is also good that they have high level of knowledge about HIV, high self-

efficacy levels within sexual relationships and condom use, which will help them engage in responsible sexual behaviours and safe sex. It will be critical for the department of health to provide and continue to sustain sexuality education and other support programmes for young people, in order to minimize existence of risky sexual behaviors.

5.4.3 PERCEPTIONS ABOUT CONDOM USE

The majority of adolescents seemed to have high positive perceptions about condom use, and indicated their intention to use condoms when having sexual intercourse. The results also indicate that the majority of adolescent males seemed to believe that they have the ability and skills to correctly use condoms when having sexual intercourse as compared to their female counterparts. The results also indicate that older adolescents seemed to believe that using condoms is not a problem compared to responses by their younger counterparts. The responses by both girls and younger adolescent boys clearly indicate lack of practical experience in condom use. This can be explained by the fact that the majority of participants in this study reported being not sexually active, which means that they might have lacked practical experience in using a condom.

The results indicate that adolescent females seemed to believe that people who carry condoms have more sexual partners of which their male counterparts do not share that belief. The results also indicate that younger adolescents seemed to also believe that people who carry condoms have multiple sexual partners, of which their older counterparts do not share that belief. Despite adolescents having high knowledge of HIV, high self-efficacy level, but females and young adolescents still have some dangerous misconceptions about condoms. The only explanation for this belief might be as a result of their lack of experience or they answered in terms of female gender roles expectation, this is also confirmed by the study conducted by Ackerman & De Klerk,2002; Kalichman, Simbayi & Kaufman et al.,2005. The acquisition of knowledge of HIV and other protective behaviours remain being the fundamental building block for any other health interventions with regard to the preventions of proliferation of risky sexual behaviours among adolescents. The next section will then discuss adolescent knowledge,

beliefs, access to health information and services about HIV and other protective behaviours.

5. 5 KNOWLEDGE OF HIV

5.5.1 Adolescent's knowledge and beliefs about HIV

The majority of adolescents irrespective of gender or age have good knowledge about HIV. This represents a paradigm shift, where previous studies were indicating that lack of knowledge is contributing to young people's involvement in unprotected sex (Buga; Amoko & Ncayiyane, 1996). The results of this study also indicate that adolescents have adequate knowledge about HIV especially its transmission and prevention, with girls having more knowledge than boys. The empowerment of young people with knowledge on sexuality and HIV did lay a foundation to finally and effectively reduce new HIV infections. This improvement could be accredited to Government HIV/AIDS strategies and interventions including efforts by Non-Governmental Agencies.

5.5.2 ACCESS TO HEALTH INFORMATION

The results of this study revealed that adolescent do not get sufficient health information from schools, government health facilities and institutions. Despite adolescents indicating willingness to collect condoms and contraceptives from their local clinics, but the results shows the opposite, this result in high teenage pregnancies and high prevalence rates of HIV infection amongst this particular age group.

Previous study by Wood & Jewkes, 2006, identified a number of factors which might prevent adolescents from using health services (access to health information), like staff attitudes, values and norms in relation to parent figure, lack of access due to long distances or clinic closing early while they are still at school. The results of this study show that only 63% of learners admit they have received health information from school. It is therefore important that existing health programmes within a school be strengthened and complimented with Health Promoting School Programme in order to deliver comprehensive health awareness programmes which will prevent risk sexual behaviours among adolescents in schools.

Improving access to health facilities by removing all barriers is essential in ensuring that adolescents have easy access to health information, condoms, contraceptives and counseling without any difficulty. It is therefore recommended that Health Promoting Schools Programme be promoted and implemented in all health facilities at primary health care level (mobile clinics, fixed clinics and community health centres).
Results of this study also show that adolescents believe that they would buy or collect condoms without fear or embarrassment. This indicate improvement in their self-efficacy level as compared to findings of previous research studies, which might be as a result of comprehensive health programmes aimed at encouraging young people to use condoms. The next section is focusing on the ability of adolescents to communicate about sexual issues with friends, partners and parents.

5. 6 CONSIQUENCES OF UNPROTECTED SEX

5. 6.1 Peer and partner influence

The results revealed that adolescents are able to communicate with their friends and partners about dating, sex, pregnancy and condoms and have also indicated intention to talk about STIs and HIV infection. The results also indicate that adolescent females seemed to have a higher level of communication self-efficacy with friends about sexual issues than adolescent males. This means that positive peer education can be successfully used to influence behaviour change among adolescent females than boys as they feel more comfortable to communicate about sexual issues with their female friends. While on the other side adolescent males have higher communication self-efficacy with partners about sexual issues than adolescent girls. This means that adolescent males feel more comfortable to communicate about sexual issues with their girl friends than adolescent females. It is common knowledge that in traditional African communities adolescent males are encouraged to initiate discussions about sexual issues with girls while it would be regarded as taboo for a girl to initiate discussions about sexual issues with the boy or male partner. These findings confirms what other previous studies have been saying that males still dominate sexual relationships including negotiating sex, and condom use with females playing a very submissive role. Other studies found that women’s engagement in

sexual relationships is influenced by their gender-role expectations about love, sex and compliance with male partners' desires (Ackerman & de Klerk, 2002; Kalichman, Simbayi & Kaufman et al., 2005). Future health interventions in influencing sexual behaviours among adolescents will have to focus on the use of positive peer education. Parents or caregivers will have to also play a meaningful role in eliminating gender stereo typed and sexual misconceptions including the issue of gender-role clarification.

5.6.2 PARENTAL INFLUENCE

Generally, the results indicate that adolescents are unable to talk to their parents or adults about sexual issues and verse visa. The majority of adolescents irrespective of gender or age also seemed to have high levels of discomfort with communication to parents or adults about sexual issues. In traditional African society it is taboo for an adolescent to talk to their parents about sex, condoms and contraception; this has been confirmed by a number of previous studies such as the study conducted by the University of Cape Town in 2002 pertaining to risky sexual behaviours by youth which had similar findings. The Theory of Planned Behaviour Change by Ajzen, (1991) also emphasis the importance of normative beliefs or parental teachings together with intention in influencing the direction of the behaviour. Future behaviour change programmes must include empowerment of both parents and adolescents to communicate about sex, condoms and pregnancy issues.

The results also indicate that adolescent females are more likely to talk to their parents about HIV/AIDS and pregnancy than their male counterparts. It is a well known fact that parents often feel more comfortable in talking to adolescents about pregnancy and to a lesser extent HIV/AIDS. The results of this study also indicate that older adolescents seemed to be more likely to communicate with their parents about condoms than the younger group irrespective of gender differences. The next section is focusing on adolescent perceptions, myths and beliefs about HIV/AIDS, STIs and pregnancy, which will be important to understand in order to plan some future health interventions.

CHAPTER 6

This chapter will be dealing with limitations of the study, conclusion and recommendations for future studies and implementation of the research findings.

6.1 LIMITATIONS

- Sample size might have been too small and is made up of learners from a single school and their responses might not be representative of the views of other adolescents in the KwaZulu-Natal province.
- Sample consisted of learners in school and excluded adolescents out of school and their responses might not represent views of those outside the school setting.
- It is possible that some of the learners may not have been entirely truthful in their responses. Their answers may not have represented their honest opinions, beliefs and attitudes about condoms, HIV and AIDS, pregnancy and drug usage. This supported by the findings by Sorrel et al, (2005) that boys tend to exaggerate their sexual activities and girls under report their sexual activities.

6.2 CONCLUSIONS

It is important that certain studies be conducted especially, covering the bigger sample and with the aim of addressing the possible short comings of this study as indicated by limitations. The Departments of Education and Health will have to focus extensively on empowering young people at puberty stage on body concepts, sexuality, including subjects on reproductive health systems in order to improve the understanding sexuality issues and prevent teenage pregnancy, and the spread of HIV/AIDS and STIs.

The results of the study have direct implications for government and non-governmental bodies such as National department of health, at National, Provincial and Local levels, private sector, FPOs Youth Organisations and other agencies of interest. Generally, the results of this study indicate progress that has been achieved by government, and non-governmental organizations and other agencies in the area of creating health awareness.

This progress also includes achievements in promotion of condom use, impacting knowledge about HIV and AIDS, STIs, thus addressing misconceptions about HIV and AIDS. It is highly recommended that the efforts of the health department in addressing health issues affecting young people and adolescents in particular be sustained in order to continue producing even better results.

Special attention will have to be paid by the department of health and other agencies in promoting contraceptives and also address issues of access to services and health information by adolescents. The fact that adolescents have high knowledge of HIV transmission, skills for condom use and often communicate with partners and their peers, proves that similar strategies can be used improve knowledge and utilization of contraceptives in order to prevent and reduce the high teenage pregnancy problem in the country.

The results of this study also indicate that adolescent communicates freely with their partners and friends about sexual issues, which then mean that positive peer education, can be used to influence sexual behaviours change among adolescents.

Health programmes and intervention will have to be put in place by the department using NGOs and CBOs to empower parents or care givers to freely discuss sexuality issues with their children. It is also critical that the Department Health continues to strengthen the dissemination of health information especially on reproductive health issues, using existing school programmes, electronic and print media, make EIC material freely available all government institutions which are frequently visited by adolescents. This will also call for strengthening the existing school based sexuality education programmes with the aim of improving health outcomes on sexual issues like HIV/AIDS, STIs and teenage pregnancies.

6.3 RECOMMENDATIONS

6.3.1 Health Interventions to improve parent-adolescent communication on sexual issues

- Identification and implementation of strategies and Programmes like narrative theatre to improve communication between adolescents and parents or adults on sexuality issues and risk sexual behaviours.
- It is also recommended that specific programmes on gender-role expectations, culture, values and norms be developed in order to deal with their implications in promoting risky sexual behaviours.

6.3.2 Health Interventions within the school setting

- Reproductive health education and awareness programme be extensively promoted to adolescents in schools, in order to improve adolescent knowledge and awareness of contraceptives as methods of preventing unplanned pregnancies.
- Strengthening of health education programmes on sustainable safer sex practices by adolescents in schools in order to further reduce incidents of HIV infections among adolescents in schools.

6.3.3 Health Interventions by the National Department of Health

- Implementation of Youth Friendly Clinic Services Programme in all health facilities to deal with factors that limit access to health services and information by adolescents in schools, focusing on staff attitudes, closing times and quality of services.
- Implementations of Health Promoting Schools Programme in all schools in order to keep school settings as safer and healthy environment for young people, and improve relationship and partnership between schools and local clinics.

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APPENDIXES

1. Appendix A: Permission to conduct a study obtained from the Head of the school and the School Governing Body

2. Appendix B: Written informed parental consents

3. Appendix C: Questionnaire

153 LONGACRES DRIVE
KINGSBURGH
4126
01.04.2004

THE PRINCIPAL
ADAMS COLLEGE
PO. AMANZIMTOTI
4125

APPLICATION TO CONDUCT A RESEARCH PROJECT

DEAR SIR / MADAM

I am currently completing Masters Programme in Health Promotion with the University of Durban – Westville. As part of the requirements of the course, student is expected to conduct a research project, in this case am focusing on the **"Risky Sexual Behaviours Among Rural Adolescents"**

I have chosen your school because it will be convenient for me, school has both rural and urban learners and I am managing Health Services and Health Interventions in the same area (South), which will make it easier to implement the findings of the study.

Permission is therefore requested to use some of your students as subjects to this quantitative study, involving responding to questionnaires.

Attached is the tool or questionnaire to be used.

Yours Faithfully

D.W. SHOBA (MR)

PARENT CONSENT FORM

Mr Dumisani William Shoba a Masters Programme student at the University of KwaZulu-Natal, rest your permission for your child to participate in a research project. Participants will be required to respond to questionnaires which will take about 10 minutes to complete.

Participation to this exercise is voluntary and no physical or psychological harm is anticipated.

The results of the study will assist in the fight against teenage pregnancy, HIV infections and general empowerment of young people.

If you agree that your child can voluntarily participate in this study, please fill in information as indicated below.

PARENT NAME AND SURNAME……

PHSICAL & POSTAL ADDRESS……
……

CONTACT DETAILS……..

I MR/MRS…….WHO IS A PARENT OR LEGAL GUIDIAN OF……., AGREE THAT SHE/HE MAY PARTICIPATE IN THIS RESEARCH PROJECT UNDER THE CONDITIONS STIPULATED ABOVE AND DEPENDING ON HIS/HER WILLINGNESS TO PARTICIPATE.

I UNDERSTAND THAT THIS CONSENT CAN BE WITHDRAWNED AT ANY GIVEN TIME IF NECESSARY.

Signature…….

Witness……..

Date……..

RISKY SEXUAL BEHAVIOURS AMONG RURAL ADOLESCENTS.

We are interested in learning more about your thought, opinion, and feelings about health and what you do to stay healthy.

We hope you will help us by completing this survey. We will use your answers to improve the quality of life for adolescents by designing relevant health promotion intervention. None of your answers will be available to anyone at anytime. All information you give us will be kept private. Do not put your name anywhere on this questionnaire.

PLEASE REMEMBER:

1 Do not put your name on this form.
2 Your answers are private, we will not tell anyone what you write.
3 Please take your time and answer carefully.

1

a**) Gender**

Male……..1. Female……2. (Tick one)

b) When were you born?

Month……Date…….Year……..

c) Where do you stay? (please tick)

1 Urban Area……...1.

2 Rural Area……2.

3 Township……..3.

d**) Do you live with your parents? (please tick one answer below)**

4 I live with both my parents……..1.

5 I live with my mother only……2.

6 I live with my father only……..3.

7 I live with other relatives / guardian……4.

e) How many family members or other people live in your home? (including brothers, sisters, cousins and yourself) **Write the number in the space below**.

……People live in my home.

2.KNOWLEDGE AND ATTITUDE ON HIV / AIDS, STI & PREGNANCY.

a) Have you heard about HIV/AIDS?

Yes……1.

No……...2.

b) Do you know how one can contact or get infected with HIV virus that causes AIDS?

Indicate yes or no.

	YES	***NO***
1. Blood contact with HIV infected or positive person	1	2
2. Unprotected Sex	1	2
3. Touching others	1	2
4. Kissing	1	2
5. Multiple sexual partners	1	2
6. Syringes used by various people	1	2
7. Food or water	1	2
8. Mother to child (breast feeding)	1	2
9. Mosquito or insect bite	1	2
10. Other (specify)		

BELOW ARE SOME STATEMENTS ABOUT HIV / AIDS.

1 *If you don't know the answer, tick the box labelled – don't know*.

REMEMBER: WE ARE VERY INTERESTED IN WHAT YOU THINK – FOR EACH QUESTION; TICK THE BOX FOR THE ANSWER YOU THINK IS CORRECT:

3. ***(Please tick)***

	TRUE	***FALSE***	***DON'T KNOW***
a) Only people who look sick can spread the HIV virus	1	2	3
b) Condoms reduce the risk of getting HIV virus	1	2	3
c) A person can get the HIV/AIDS even if he or she has sexual intercourse (putting a penis in a vagina) just one time without a condom.	1	2	3
d) A person can get AIDS by touching or hugging someone with AIDS.	1	2	3
e) Most people who are HIV positive show signs of being sick right away	1	2	3
f) Only people who have sexual intercourse with gays (homo sexual) get AIDS	1	2	3
g) You can get HIV / AIDS by having sexual intercourse with someone who has shared drug needles.	1	2	3
h) Birth control pills or injection protect a women from getting the HIV / AIDS	1	2	3

4.Who in your opinion is at high risk of getting **HIV / AIDS**?

	TRUE	*FALSE*	*DON'T KNOW*
a) Married women	1	2	3
b) Men having many sex partners	1	2	3
c) Men having sex with prostitutes	1	2	3
d) Girls having more than one sexual partner	1	2	3
e) A girl who was raped	1	2	3
f) Homosexuals	1	2	3
g) Men using drugs	1	2	3

BELOW ARE SOME QUESTIONS ABOUT EXPRESSING YOUR OPINIONS TO OTHERS.YOU MAY NOT HAVE ACTUALLY DONE THESE THINGS, BUT WE WOULD LIKE YOU TO TELL US HOW CONFIDENT YOU ARE THAT YOU COULD DO THEM.

Please tick only one box for each question below.

5.

a) Could you talk with your friends about someone you would like to have as a boyfriend or girlfriend?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

b) Could you talk about sex with your friends?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

c) Could you talk with your friends about diseases you can get from having sexual intercourse?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. ☐ 2. ☐ 3. ☐ 4. ☐

d) Could you talk about sex with your boyfriend / girlfriend without being embarrassed?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. ☐ 2. ☐ 3. ☐ 4. ☐

e) Could you start a conversation about condoms with your boyfriend / girlfriend?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. ☐ 2. ☐ 3. ☐ 4. ☐

f) Could you talk about AIDS with your friends?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. ☐ 2. ☐ 3. ☐ 4. ☐

g) Could you talk about AIDS with your friend?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. 2. 3. 4.

h) Could you talk about diseases you could get from having sex with your boyfriend / girlfriend?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. 2. 3. 4.

i) Could you ask your boyfriend / girlfriend to spend time with you or go out with you?

Definitly could **Probably could** **Probably could not** **Definitely could not**

1. 2. 3. 4.

j) Could you tell your boyfriend / girlfriend that you don't want to go out with him / her?

Definitely could **Probably could** **Probably could not** **Definitely could not**

1. 2. 3. 4.

k) Could you tell your boyfriend / girlfriend that you don't want to have sex with him/ her?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

L) Could you tell your girlfriend / boyfriend to stop touching you sexually?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

m) Could you talk about pregnancy with your boyfriend / girlfriend?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

n) Could you use birth control methods even if your girlfriend / boyfriend says no?

Definitely could Probably could Probably could not Definitely could not

1. ☐ 2. ☐ 3. ☐ 4. ☐

o) Could you start a conversation about use of contraception / birth control pills, injection, condoms with your boyfriend / girlfriend?

Definitely could	Probably could	Definitely could not	Probably could not
1.	2.	3.	4.
☐	☐	☐	☐

THESE QUESTIONS ARE ABOUT YOU AND YOUR PARENT (S) OR THE ADULT (S) YOU LIVE WITH.

HAVE YOU EVER TALKED WITH YOUR PARENT (S) OR THE ADULT (S) YOU LIVE WITH ABOUT THE FOLLOWING TOPICS?

Please tick only one box for each topic below.

6.

a) Have you ever talked with your parent(s) or adult (s) you live with about sex?

Yes	No
1.	2.
☐	☐

b) Have you ever talked with your parent (s) about diseases you can get from having sexual intercourse?

Yes	No
1.	2.
☐	☐

c) Have you ever talked with your parents about HIV/AIDS?

Yes	No
1.	2.
☐	☐

d) Have you ever talked with your parents about pregnancy?

Yes	No
1	2
☐	☐

e) Have you ever talked with your parents about using condoms?

Yes	No
1	2
☐	☐

HOW COMFORTABLE DO YOU FEEL TALKING ABOUT EACH OF THESE TOPICS WITH YOUR PARENTS OR ADULTS YOU LIVE WITH?

Please tick only one box for each topic below

7.

a) How comfortable do you feel talking with your parents or adults you live with about sex?

Feel very comfortable	Feel somewhat comfortable	Feel somewhat uncomfortable	Feel very uncomfortable
1.	2.	3.	4.
☐	☐	☐	☐

b) How comfortable do you feel talking with your parents or adults you live with about diseases you can get from having sex?

Feel very comfortable	Feel somewhat Comfortable	Feel somewhat uncomfortable	Feel very uncomfortable
1. ☐	2. ☐	3. ☐	4. ☐

c) How comfortable do you feel talking with your parents or adults you live with about HIV / AIDS?

Feel very comfortable	Feel somewhat Comfortable	Feel somewhat uncomfortable	Feel very uncomfortable
1. ☐	2. ☐	3. ☐	4. ☐

d) How comfortable do you feel talking with your parents or adults you live with about using condoms?

Feel very comfortable	Feel somewhat Comfortable	Feel somewhat uncomfortable	Feel very uncomfortable
1. ☐	2. ☐	3. ☐	4. ☐

e) How comfortable do you feel talking with your parents or adults you live with about pregnancy?

Feel very comfortable	Feel somewhat Comfortable	Feel somewhat uncomfortable	Feel very uncomfortable
1. ☐	2. ☐	3. ☐	4. ☐

f) How worried are you that you might get AIDS?

Not at all worried	Somewhat worried	Very worried
1. ☐	2. ☐	3. ☐

g) How worried are you that you might get a disease from having sex?

Not at all worried	Somewhat worried	Very worried
1. ☐	2. ☐	3. ☐

h) How worried are you that you might get pregnant if you are a girl, or that you might get a girl pregnant if you are a boy?

Not at all worried	Somewhat worried	Very worried
1. ☐	2. ☐	3 ☐

WE ARE INTERESTED IN YOUR THOUGHTS ABOUT WHAT YOUR FRIENDS (OR) THE KIDS YOU HANG AROUND WITH) THINK AND DO.

YOU MAY NOT KNOW EXACTLY WHAT THEY THINK OR DO. THAT'S OKAY. JUST PUT DOWN YOUR BEST GUESS.

Please check the box that shows what you think.

8.

a) How many of your friends think condoms are too much trouble to use?

None	A few	About half	Most	All
1. ☐	2. ☐	3. ☐	4. ☐	5. ☐

b) How many of your friends do you think have had sexual intercourse?

None	A few	About half	Most	All
1. ☐	2. ☐	3. ☐	4. ☐	5. ☐

c) How many of your friends do you think use condoms when they have sex?

None	A few	About half	Most	All
1.	2.	3.	4.	5.
☐	☐	☐	☐	☐

d) How many of your friends do you think have had sexual intercourse without a condom because they were high from drinking alcohol?

None	A few	About half	Most	All
1.	2.	3.	4.	5.
☐	☐	☐	☐	☐

e) How many of your friends do you think have had sexual intercourse without a condom because they were high from using crack or marijuana (weed / pot)

None	A few	About half	Most	All
1.	2.	3.	4.	5.
☐	☐	☐	☐	☐

THIS TIME WE WANT TO KNOW WHAT YOU THINK MAKES A PERSON "COOL" OR POPULAR.

Please tick the box that shows what you think.

9.

a) Having sexual intercourse makes a boy popular.

Strongly Agree	Agree	Disagree	Strongly Disagree
1.	2.	3.	4.
☐	☐	☐	☐

b) Having sexual intercourse makes a girl popular.

Strongly Agree	Agree	Disagree	Strongly Disagree
1.	2.	3.	4.
☐	☐	☐	☐

c) Having sexual intercourse at my age is a “cool” thing for a boy to do.

Strongly Agree	Agree	Disagree	Strongly Disagree
1. ☐	2. ☐	3. ☐	4. ☐

d) Having sexual intercourse at my age is a “cool” thing for a girl to do.

Strongly Agree	Agree	Disagree	Strongly disagree
1. ☐	2. ☐	3. ☐	4. ☐

e) Having sexual intercourse with someone besides her steady partner makes a girl “**cool”** or popular.

Strongly Agree	Agree	Disagree	Strongly disagree
1. ☐	2. ☐	3. ☐	4. ☐

f) Having sexual intercourse with someone besides his steady partner makes a boy “cool” or popular.

Strongly Agree	Agree	Disagree	Strongly disagree
1. ☐	2. ☐	3. ☐	4. ☐

YOU’RE DOING GREAT!!!!!!!!!!!!!!!!!!!!!!!!!!!!FULL SPEED AHEAD

PLEASE TICK THE 3 PLACES WHERE YOU HAVE LEARNED THE MOST ABOUT AIDS.

IF YOU HAVE LEARNED ABOUT AIDS FROM ONLY 1 OR 2 PLACES, JUST TICK THOSE PLACES.

Please tick up to 3 places.

10.

a) School…….1.

b) Television……2.

c) Radio……..3.

d) Doctors……4.

e) Church…….5.

f) Newspapers or magazines…….6.

g) Friends……...7.

h) Parents or adults relatives……..8.

i) Sisters, brothers or teenage relatives……9.

j) Boyfriend / girlfriend……10.

k) Pamphlets or flyers……11.

l) Billboards……12.

m) Other (what?)……..13.

PLEASE TICK ONLY ONE BOX FOR EACH QUESTION

11.

a) What do you think the chances are that you will get AIDS someday?

No chance at all	Might happen	Very likely to happen	Happened already
1.	2.	3.	4.
☐	☐	☐	☐

b) What do you think the chances are that you will get a disease that you can get from having sex?

No chance at all	Might happen	Very likely to happen	Happened already
1.	2.	3.	4.
☐	☐	☐	☐

c) What do you think the chances are that you will get pregnant or get a girl pregnant before you are 20?

No chance at all	Might happen	Very likely to happen	Happened already
1.	2.	3.	4.
☐	☐	☐	☐

PLEASE TICK THE BOX THAT BEST DESCRIBES WHAT YOU WOULD DO PLEASE THINK ABOUT HOW MUCH YOU WOULD HANDLE THESE SITUATIONS.IF YOU 'VE NEVER HAD SEXUAL INTERCOURSE, JUST TELL US WHAT YOU WOULD DO.

12.

a) I would refuse to have sexual intercourse without a condom.

I definitely would Refuse	I probably would refuse	I probably would not refuse	I definitely would not refuse
1.	2.	3.	4.
☐	☐	☐	☐

b) I would insist on using a condom even if my partner didn't want to.

I definitely would Refuse	I probably would refuse	I probably would not refuse	I definitely would not refuse
1.	2.	3.	4.
☐	☐	☐	☐

PLEASE TICK THE BOX THAT BEST DESCRIBES HOW YOU FEEL ABOUT USING CONDOMS.

13.

a) If the person I was about to have sex with suggested using a condom, I would feel like that person cared about me.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

b) I would respect my partner if he or she suggested using a condom.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

c) If the person I was about to have sex with suggested using a condom, I would feel less worried.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

REMEMBER, WE WOULD LIKE ALL OF YOU TO ANSWER THESE QUESTIONS, WHETHER YOU HAVE HAD SEXUAL INTERCOURSE OR NOT. IF YOU HAVE NEVER HAD SEXUAL INTERCOURSE, TELL US HOW YOU THINK YOU WOULD FEEL.

Please tick the box that best describes how you feel.

14.

a) It would really bother me to stop having sexual intercourse to put on a condom.

I definitely would	I probably would Not	I probably would not	I definitely would
1. ☐	2. ☐	3. ☐	4. ☐

b) Condoms would be too much trouble to use.

It definitely would	It probably would	It probably would Not	It definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

c) It would not feel as good to use a condom during sexual intercourse.

It definitely would	It probably would	It probably would not	It definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

d) I would be embarrassed to buy condoms.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

NOW WE'D LIKE TO KNOW WHAT YOU THINK IS TRUE ABOUT CONDOMS. YOU MAY HAVE USED THEM BEFORE OR MAY BE NOT, BUT TELL US WHAT YOU THINK.

For each statement, please tick the box that shows what you think is true.

15.

a) Condoms break easily.

They definitely do	They probably do	They probably do not	They definitely do not
1. ☐	2. ☐	3. ☐	4. ☐

b) If you choose to have sexual intercourse, using condoms correctly is the best way to prevent getting the AIDS virus and other diseases you can get from having sex.

It definitely is	It probably is	It probably is not	It definitely Is not
1. ☐	2. ☐	3. ☐	4. ☐

c) Condoms slip off easily.

They definitely do	They probably do	They probably Do not	They definitely do not
1. ☐	2. ☐	3. ☐	4. ☐

d) People who carry condoms have sex with a lot of people.

Definitely they do	They probably do	They probably Do not	They definitely do not
1. ☐	2. ☐	3. ☐	4. ☐

PLEASE TICK THE BOX THAT BEST DESCRIBES WHAT YOU WOULD DO IN THESE SITUATIONS.

THINK ABOUT THE SITUATION, THEN TELL US WHAT YOU WOULD DO. IF YOU HAVE NEVER HAD SEXUAL INTERCOURSE, OR IF YOU'RE NOT PLANNING TO HAVE SEXUAL INTERCOURSE RIGHT AWAY, TELL US WHAT YOU THINK YOU WOULD DO.

16.

a) I'm worried about catching AIDS so I would be sure to use a condom, even in the heat of the moment.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

b) If I did'nt have a condom, I would have sexual intercourse anyway.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

c) I would use a condom even if I were drunk or high.

I definitely would	I probably would	I probably would Not	I definitely would not
1. ☐	2. ☐	3. ☐	4. ☐

YOU!!!!!!!!!!ARE!!!!!!!!!!!!!!!ALMOST!!!!!!!!!!!!!!!!! DONE!!!!!!!!

THESE NEXT QUESTIONS HELP US TO FIND OUT WHAT YOUNG PEOPLE IN GENERAL ARE DOING SO WE CAN KNOW WHAT TO TEACH YOU ABOUT HEALTH.

17.

a) Tick **YES** or **NO** to tell us whether you have done the following things.

Have you ever talked to a girl you like, if you ‘re a boy? Talked to a boy you like, if you ‘re a girl.

Yes	No
1.	2.
☐	☐

(b) Have you ever gone out on a date?

Yes	No
1.	2.
☐	☐

(c) Have you ever kissed a girlfriend on the lips, if you’re a boy? Kissed a girlfriend on the lips, if you’re a girl?

Yes	No
1.	2.
☐	☐

(d) Have you ever tongue kissed (French kissed)?

Yes	No
1.	2.
☐	☐

(e) Have you ever touched a girl's breasts, if you're a boy? Had your breasts touched, if you're a girl?

Yes	No
1.	2.
☐	☐

(f) Have you ever touched a girl's vagina, if you're a boy? Touched a boy' penis, if you're a girl?

Yes	No
1.	2.
☐	☐

(g) Have you ever had sexual intercourse? (By sexual intercourse, we mean putting a penis in a vagina)

Yes	No
1.	2.
☐	☐

h) Have you ever had oral sex? (By anal sex, we mean one person's mouth touching the penis or vagina of another person)

Yes	No
1.	2.
☐	☐

i) Up to this time, I have chosen not to have sexual intercourse.

Yes	No
1.	2.
☐	☐

18.

a) If you've had sexual intercourse, how young were you the first time you had sexual intercourse? (putting a penis in a vagina)

Please write your age at that time in the space below.

2 I have never had sexual intercourse----------1.

3 I was ----------years old the first time I had sexual intercourse.

b) If you've had sexual intercourse (putting a penis in a vagina), how many different people have you had sexual intercourse with in your lifetime?

Please tick only one space.

1 I have never had sexual intercourse…….1.

2 2-3 people……..2.

3 4-5 people……3.

4 6-7 people…….4.

5 8-9 people……..5.

6 10 or more people……..6.

c) How often do you have sexual intercourse?

Please tick only one space.

1 I have never had sexual intercourse……..1.

2 About once a month or less…….2.

3 2-4 times a month…….3.

4 Twice a week……4.

5 3 times a week or more……..5.

d) If you're a boy, how often do you use a condom (rubber) when you have sexual intercourse (putting a penis in a vagina)? Or if you're a girl, how often does the guy use a condom when you have sexual intercourse?

Please tick only one space.

1 I have never had sexual intercourse……..1.

2 Always……2.

3 More than half the time……3.

4 About half the time……4.

5 Less than half the time……..5.

6 Never……..6.

e) Did you or the other person use a condom (rubber) the last time you had sexual intercourse?

Please tick only one space.

I have never had sexual intercourse.

Yes	No
1.	2.
☐	☐

THESE QUESTIONS ARE ONLY ABOUT THE PAST 2 MONTHS.

19.

a) In the past 2 months, how many times did you have sexual intercourse?

1 Please write the number of times you've had sexual intercourse in the space below.

2 If you have never had sexual intercourse, put a zero (o) in the space.

3 I have had sexual intercourse----------times in the last 2 months.

b) If you've had sexual intercourse in the last 2 months, how many times did you or your partner use a condom (rubber)?

1 Please write the number of times in the space below

2 If you have never had sexual intercourse, put a zero (o) in the space.

3 I / my partner have used a condom----------times in the last 2 months.

c) In the past 2 months, how many different people have you had sexual intercourse with?

Please tick only one space.

1 I have not had sexual intercourse in the past 2 months…….1.

2 I have had sexual intercourse with one person in the past 2 months……..2.

3 I have had sexual intercourse with 2 people in the past 2 months……..3.

4 I have had sexual intercourse with 3 people in the past 2 months……..4.

5 I've had sexual intercourse with 4 or more people in the past 2 months…….5

d) In the past 2 months, how often have you or your sex partner(s) used a condom when you had sexual intercourse?

Please tick only one space.

1 I have not had sexual intercourse in the past 2 months……..1.

2 Always…….2.

3 More than half the time……3.

4 About half the time…… .4.

5 Less than half the time……..5.

6 Never…….6

20. In the last 2 months, have you used any of the following methods to prevent pregnancy?

1 I haven't had sexual intercourse in the last 2 months……..1..

IF YOU HAVEN'T HAD SEXUAL INTERCOURSE IN THE LAST 2 MONTHS, LEAVE THESE BLANKS!

Condoms

Yes	No
1. ☐	2. ☐

Birth control pills

Yes	No
1. ☐	2. ☐

Birth control injections

Yes	No
1. ☐	2. ☐

Morning after pill

Yes	No
1. ☐	2. ☐

IUCD (Loop)

Yes	No
1. ☐	2. ☐

Withdrawal (pulling out)

Yes	No
1. ☐	2. ☐

Sexual intercourse with no method of birth control

Yes	No
1. ☐	2. ☐

21.

a***) IF YOU HAVE EVER TRIED ALCOHOL, HOW YOUNG WERE YOU WHEN YOU HAD YOUR FIRST DRINK (NOT JUST A SIP OR A TASTE).***

Please write your age at that time in the space below.

1 I have never had more than a sip or taste of alcohol----------

2 I was----------years old the first time I drank alcohol.

b) How often do you drink?

Please tick only one space.

1 I have never had more than a sip of alcohol…….1.

2 Only on religious occasions with my family…….2.

3 I've tried it only once…….3.

4 Only a few times a year……..4.

5 Once or twice a month…….5.

6 Once or twice a week……6.

7 3 times or more a week – but not every day……..7.

8 Almost every day……8.

c) How often do you get "really drunk" (drink so much alcohol that you are out of control)?

Please tick only one space.

1 I have never been really drunk…….1.

2 I've only been really drunk once……2.

3 Only a few times a year……..3.

4 Once or twice a month……4.

5 Once or twice a week……..5.

6 3 or more times a week- but not every day…….6.

7 Almost every day…….7

d) If you have ever drunk alcohol before having sexual intercourse, how often did you or your partner use a condom after drinking?

Please tick only one space

1 I have never had sexual intercourse after drinking…….1.

2 Always used a condom after drinking……..2.

3 Usually used a condom……..3.

4 Used a condom about half of the time……4.

5 Usually did'nt use a condom……..5.

6 Never used a condom after drinking……6.

e) If you have ever tried dagga (insangu), how young were you the first time you tried it?

Please write your age at that time in the space below.

1 I have never tried dagga----------

2 I was----------years old the first time I used dagga.

f) How often do you use dagga?

Please tick only one space

1 I have never tried dagga……..1.

2 I've tried marijuana only once…….2.

3 Only a few times a year……3.

4 Once or twice a month……..4.

5 Once or twice a week……5.

6 3 times or more a week- but not every day……6.

7 Almost everyday…….7.

g) How often do you get "really high" or "really stoned" on dagga (smoke so much that you are out of control)?

Please tick only one space.

1 I have never tried dagga……1.

2 I've only been really high once…….2.

3 Only a few times a year…….3.

4 Once or twice a month……4.

5 Once or twice a week……..5.

6 3 times or more a week – but not every day……6.

7 Almost every day…….7.

i) If you have ever smoked dagga before having sexual intercourse, how often did you or your partner use a condom after smoking?

Please tick only one space.

1 I have never had sex after smoking dagga……..1.

2 Always used a condom after smoking marijuana……2.

3 Usually used a condom…….3.

4 Used a condom about half of the time……..4.

5 Usually didn't use a condom……5.

6 Never used a condom after smoking marijuana……6.

HOW OLD ARE THE BOYS OR GIRLS THAT YOU GO OUT WITH?

22.

a) Please tick only one space below

1 I've never gone out with anyone……1.

2 Younger than me by 3 or more years……..2.

3 A little younger than me (1-2 years)……3.

4 My age---------- 4.

5 A little older than me (1-2 years)……..5.

6 Older than me by 3 or more years……6.

HOW OLD ARE MOST OF YOUR FRIENDS

b) Please tick only one space below.

1 Younger than me by 3 or more years…….……..1.

2 A little younger than me (1-2 years)……..2.

3 My age……3.

4 A little older than me (1-2 years)……4.

5 Older than me by 3 more years……5.

PLEASE TICK THE BOX, WHICH SHOWS HOW YOU FEEL ABOUT EACH STATEMENT AT THIS MOMENT.

23.

a) I feel that I can change what will happen tomorrow by what I do today.

Completely true	somewhat true	not true
1.	2.	3.
☐	☐	☐

b) I believe most of what happens in life is just meant to happen.

Completely true	somewhat true	not true
1.	2.	3.
☐	☐	☐

YOU FINISHED!

FANTASTIC!

THANK YOU FOR YOUR HELP.