AN INVESTIGATION INTO THE SEXUAL BEHAVIOURS OF ADOLESCENTS ATTENDING SEXUALLY TRANSMITTED DISEASE CLINICS IN THE WESTERN DISTRICT OF THE VAAL REGION

by

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submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS

in Nursing Science

at the

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JOINT SUPERVISOR: PROF JM DREYER

APRIL 1998
I declare that *AN INVESTIGATION INTO THE SEXUAL BEHAVIOURS OF ADOLESCENTS ATTENDING SEXUALLY TRANSMITTED DISEASE CLINICS IN THE WESTERN DISTRICT OF THE VAAL REGION* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE
(MD MAGAGULA)

DATE

98 04 30
Dedication

To: All the adolescents in the Vaal Region
My husband George, and my two children Themba and Thembi
SUMMARY

AN INVESTIGATION INTO THE SEXUAL BEHAVIOURS OF ADOLESCENTS ATTENDING SEXUALLY TRANSMITTED DISEASE CLINICS IN THE WESTERN DISTRICT OF THE VAAL REGION

STUDENT: MD Magagula
DEGREE: Master of Arts in Nursing Science
DEPARTMENT: Advanced Nursing Sciences, University of South Africa
SUPERVISOR: Prof MVLH Lock
JOINT SUPERVISOR: Prof JM Dreyer

Understanding the sexual behaviour patterns that can place the adolescent at risk for the development of sexually transmitted diseases is crucial in the HIV/AIDS epidemic era.

An explorative descriptive survey was conducted among adolescents in the age group 14 to 19 years attending sexually transmitted disease services in the Vaal Region clinics.

The purpose of the study was to explore the sexual behaviours of the adolescents and the impact the life style health education programme had on their sexual practices.

Of the 89 respondents who attended the sexually transmitted disease clinic more than half were found to be engaging in sexual intercourse on a weekly basis. The study further revealed that the adolescents lacked in-depth information on sex and sexuality and expressed the need for change in the implementation of the adolescent life style health education programme.

Key terms:

Health promotion; socioeconomic political factors; peer pressure; sexual behaviour patterns; reconstruction and development; sex and sexuality; health education programmes; life style behaviour
ACKNOWLEDGEMENTS

Thank you Lord, for giving me the courage and strength to complete this study.

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- The authorities at Sebokeng Hospital for granting me permission to collect the necessary statistics
- The authorities in the Western Vaal Metropolitan Local Council for granting me permission to gather data from adolescent patients attending the clinic services
- My colleagues at work, especially the nurses who assisted with the collection of data
- Ms Melanie van Rensburg from the Vaal ATIC (AIDS Training and Information Centre), who did the initial typing of the manuscript and assisted with the collection of statistics on HIV (Human Immuno-deficiency Virus) blood tests
- My family and friends, who gave me on-going support and encouragement; more especially my husband George, whose motivation, support, patience, tolerance and tirelessly fetching and returning books to the library made this work possible
- My love and gratitude to my two children, Themba and Thembi, who provided me with the space and time to work on the dissertation
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<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>ATIC</td>
<td>Acquired Immuno-deficiency Syndrome Training and Information Centre</td>
</tr>
<tr>
<td>DHS</td>
<td>District Health System</td>
</tr>
<tr>
<td>F</td>
<td>Frequency</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>n</td>
<td>Total sample</td>
</tr>
<tr>
<td>N</td>
<td>Portion of the sample</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>RDP</td>
<td>Reconstruction and Development Programme</td>
</tr>
<tr>
<td>SANCA</td>
<td>South African National Council of Alcoholics</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
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<td>TPA</td>
<td>Transvaal Provincial Administration</td>
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LIST OF ANNEXURES

Annexure A: Department of National Health and Population Development
Adolescent Sexuality Education Programme

Annexure B: Gauteng Provincial Health Department
Life Skills and HIV/AIDS Education Programme

Annexure C: Department of National Health and Population Development
Adolescent Contraceptive Clinic Card

Annexure D: Questionnaire given to the adolescent

Annexure E: Obtaining permission to conduct the study

Annexure F: Covering letter to the adolescent explaining the purpose of the study
CHAPTER 1

Orientation to the area of study

1.1 INTRODUCTION

Adolescent sexual activity worldwide, including South Africa, indicates a generally accepted behavioural pattern (Jacobson 1994:34; Lawson & Lawson 1992:14; Mayekiso & Twaise 1992:21; Rakesh 1992:1; Smailes & Cunningham 1992:16). The design of health programmes for adolescents to promote safe sex has thus become crucial, if a change in behaviour is to be promoted. To be effective, the programmes should be related to adolescent expectations, understanding and preconceived ideas. Understanding the risk factors of adolescents' sexual behaviour and their view of the programme is essential if it is to meet their needs and problems effectively.

1.2 BACKGROUND TO THE STUDY

A sexuality health programme for adolescents (Annexure A) was introduced in South Africa
in 1984 (Schoeman 1990:14). According to Welman in (Schoeman 1990:14), the main aim of the programme was to provide sexuality education and a contraceptive service to sexually active adolescents, both male and female, where the need for such a service existed. This programme formed part of the preventive and promotive health services in the Vaal Region in 1988. The programme was also given in schools by health workers of the Transvaal Provincial Administration Health Department.

Although this programme has been offered over the last 15 years, it would appear that adolescents in the Vaal Region are not practising safe sexual practices. Tables 1.1, 1.2, 1.3 and 1.4, reflect the health problems related to sexual activity among adolescents in the age group 14 to 19 years.

1.2.1 Teenage pregnancy

Table 1.1: Sebokeng teenage deliveries (1992 to 1996)

<table>
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<th>YEAR</th>
<th>TOTAL NUMBER OF DELIVERS</th>
<th>TEENAGE DELIVERIES 14 TO 19 YEARS</th>
<th>PERCENT (%)</th>
</tr>
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<tr>
<td>1992</td>
<td>6 498</td>
<td>1 226</td>
<td>18,8</td>
</tr>
<tr>
<td>1993</td>
<td>6 548</td>
<td>1 298</td>
<td>19,8</td>
</tr>
<tr>
<td>1994</td>
<td>6 807</td>
<td>1 430</td>
<td>21,0</td>
</tr>
<tr>
<td>1995</td>
<td>6 307</td>
<td>1 204</td>
<td>19,0</td>
</tr>
<tr>
<td>1996</td>
<td>6 492</td>
<td>1 596</td>
<td>24,5</td>
</tr>
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Source: Sebokeng Hospital maternity registers (1992 to 1996).
Table 1.1 shows that teenage deliveries in the age group 14 to 19 years made up 20,0% of the total deliveries between 1992 and 1996.

If deliveries in the age group 20 years were added, the percentage would go up to 25,0%, which means that these mothers were sexually active as teenagers. In these statistics a young girl aged 12 years delivered a baby in July 1995.

Teenage pregnancy and child birth have medical, economic and social complications (Davis & Harris 1982:471; Mayekiso & Twaise 1992:21; Mogotlane 1993:11; Sapi re 1986:421; Schoeman 1990:14). Sapi re (1986:422) and Kimane and Joseph (1996:48) summarise the consequences of teenage pregnancy as follows:

- Teenagers are more likely to have obstetric risks, such as hypertension, difficult labour and toxaemia, than older women.
- Babies born to teenage girls are prone to low birth weight and neurological disorders, and can also become victims of neglect, abuse and malnutrition.
- The adolescent may also not be in a position to withstand the demands of parenthood (emotionally, physically and economically). The challenges of parenting may lead to despair, depression or even attempted suicide.
- Adolescents’ education is disrupted and they may not be in a position to complete their schooling.
- If the teenagers are employed, they may settle for lower wages.
- If teenagers do marry, their marriages are likely to end in divorce.
- Teenagers who have been pregnant are more likely to experience another pregnancy whilst still in the teenage age period.

It is generally accepted that to curb such sexually related problems, children should be exposed to information on sex and sexuality at a much younger age (Smailes & Cunningham 1992:14).
1.2.2 Teenagers with positive Human Immuno-deficiency Virus (HIV) blood tests at the Vaal Acquired Immuno-deficiency Syndrome Training and Information Centre (ATIC)

Table 1.2: Teenagers with positive HIV blood tests at the Vaal ATIC

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<th>TEENAGERS 14 TO 20 HIV POSITIVE</th>
<th>YOUTHS 21 TO 24 HIV POSITIVE</th>
<th>TOTAL NUMBER HIV POSITIVE PERSONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NUMBER</td>
<td>%</td>
<td>NUMBER</td>
</tr>
<tr>
<td>1994</td>
<td>1</td>
<td>3.3</td>
<td>4</td>
</tr>
<tr>
<td>1995</td>
<td>9</td>
<td>6.9</td>
<td>18</td>
</tr>
<tr>
<td>1996</td>
<td>26</td>
<td>10.6</td>
<td>28</td>
</tr>
<tr>
<td>1997</td>
<td>20</td>
<td>9.2</td>
<td>58</td>
</tr>
</tbody>
</table>


The Vaal ATIC started operating in January 1994. This centre offers courses on sexually transmitted diseases, HIV (Human Immuno-deficiency Virus)/AIDS (Acquired Immuno-deficiency Syndrome) information and counselling, to health professionals and to the public. The centre also provides AIDS counselling, care of people living at home with AIDS and blood screening tests for HIV (Vaal ATIC Annual Report 1994:2).

Table 1.2 shows the number of young people whose blood was tested and found to be HIV positive. The rate at which the number of teenagers and young people who tested HIV positive has increased since the service started in 1994 is alarming. Of the 26 teenagers whose blood results were found to be HIV positive in 1996, one was 14, one was 15, two were 16, one was 17, three were 18, eight were 19 and 10 were 20. When those aged between 21 and 24 were added, the numbers doubled (table 1.2).
It should be pointed out, however, that these statistics do not reflect the whole HIV scenario in the Vaal Region, as those tested through private doctors, private hospitals, and the public hospitals are not included in these statistics. These results are of great concern and appear to confirm the report by the Department of Health (1996a:21; 1997a:108) which revealed that the rate of HIV infection is increasing in all age groups, and more rapidly among young people, in the age group 15 to 30 years.

According to the *Government Gazette White Paper on Transformation of the Health System in South Africa* (Department of Health 1997a:108) approximately 1.8 million people in South Africa are already infected with more than 700 new HIV/AIDS infections occurring every day. If multi-sectoral control strategies are not implemented urgently, the situation is likely to get out of control. One of the important strategies to prevent the spread of HIV/AIDS epidemic, is the effective management of sexually transmitted diseases.

Researchers worldwide and in South Africa concur that the rate of HIV infections is always higher among STD (sexually transmitted diseases) patients than in the general public (Ballard 1997:5; Coetzee, Coetzee & Heugh-Gertse 1994:106; Department of Health 1997b:13).

In this context, Ballard (1997:5) points out that, while an HIV seropositive rate of 12,0% was detected among mothers attending antenatal clinics in Gauteng at the end of 1995, the comparable seropositive rate among STD clinic attenders was 38,0%. According to Ballard (1997:5), the behavioural factors that increase the risk of acquiring of STD's also place a person at risk of HIV/AIDS infection, namely alcohol or habit-forming drug abuse and prostitution.
1.2.3 Female teenage admissions with sexually related conditions at Sebokeng Hospital in the Vaal Region

Table 1.3: Female teenage admissions with sexually related conditions at Sebokeng Hospital in the Vaal Region

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TEENAGE (14 TO 19 YEARS) ADMISSIONS WITH SEXUALLY RELATED CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>184</td>
</tr>
<tr>
<td>1993</td>
<td>207</td>
</tr>
<tr>
<td>1994</td>
<td>197</td>
</tr>
<tr>
<td>1995</td>
<td>225</td>
</tr>
<tr>
<td>1996</td>
<td>287</td>
</tr>
</tbody>
</table>

Source: Sebokeng Hospital gynaecology admission records (1992 to 1996).

Table 1.3 shows that, according to the records kept at Sebokeng Hospital (Vaal Region), the total number of teenage girls admitted each year with sexually related conditions such as abortions, salpingitis (tubal inflammation), Bartholin abscess and pelvic inflammatory diseases. These statistics are of major concern in terms of medical, social and economic terms as they have long-terms implications for adolescents not only while they are teenagers but later when they are adults.

1.2.4 Teenagers treated for sexually transmitted diseases in Zone 7 clinic in the Vaal Region
Table 1.4: Teenagers treated for sexually transmitted diseases in Zone 7 clinic in the Vaal Region

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TEENAGERS (14 TO 19 YEARS) WITH STD'S</th>
<th>% OF TEENAGERS WITH STD'S</th>
<th>TOTAL NUMBER OF PATIENTS TREATED FOR STD'S</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>301</td>
<td>14,9</td>
<td>2 013</td>
</tr>
<tr>
<td>1993</td>
<td>342</td>
<td>17,3</td>
<td>1 974</td>
</tr>
<tr>
<td>1994</td>
<td>381</td>
<td>19,3</td>
<td>2 134</td>
</tr>
<tr>
<td>1995</td>
<td>357</td>
<td>17,8</td>
<td>1 999</td>
</tr>
<tr>
<td>1996</td>
<td>384</td>
<td>18,2</td>
<td>2 102</td>
</tr>
</tbody>
</table>


Table 1.4 shows the total number of patients, aged between 14 and 19 years, with sexually transmitted diseases treated at Zone 7 clinic between 1992 and 1996.

In view of the adolescent health education programmes given at clinics and schools, these statistics are disturbing, as it would appear that teenagers were not practising safe sex. In the wake of the HIV/AIDS epidemic, the prevalence of sexually transmitted diseases among adolescents is worrying as they are considered the precursors of HIV infections (Ballard 1997:5; Department of Health 1997a:108; Department of Health 1997b:12). Ballard (1997:5) maintains that sexually transmitted diseases increase the risk of acquiring HIV infection. According to the Department of Health (1997b:12), over three million South Africans are infected with a sexually transmitted disease each year, and up to 40,0% of women attending family planning clinics have a sexually transmitted disease. Antenatal surveillance programmes have shown that the age group between 15 and 29 years is the most likely group to be affected and is also the group most heavily infected with the HIV (Department of Health 1995:94). Ballard (1997:5) states that more females below the age of 20 present with STD's than males because the lining of the female genital tract makes younger women more susceptible to STD's. Under-reporting of STD's is also rife. In the researcher's experience, patients reporting for family planning methods who had vaginal
lacerations, cervical erosions and infected discharge, not one was even aware of the fact that they had any problems.

Of a total national sample of 13 005 women attending an antenatal clinic who tested HIV positive, 6,4% were under 20, 8,9% were in the age group 20 to 24 (Department of Health 1995:94). It would appear that the current preventive strategies are not effective at halting the spread of STD’s and HIV/AIDS infections.

Though only limited research has been done on STD among adolescents so far, there does appear to be an exponential relationship between teenage pregnancy and sexually transmitted diseases. Sapire (1986:421) found that of the total number of patients with STD where she worked, 10,0 to 15,0% were sexually active adolescents. Syden (1992:23) supports this view and states that the research conducted by the Family Planning Association of South Africa found a vast degree of sexual activity, illegal abortions and unplanned pregnancy. The growing HIV/AIDS epidemic makes the situation all the more critical.

In the light of the disease profile outlined above relating to the sexual activity of adolescents, it is apparent that, identifying behavioural patterns that pose a risk to the health of the adolescent is important for realistic health programme planning (Ballard 1997:3).

1.3 PROBLEM STATEMENT, CONCEPTUAL FRAMEWORK AND RESEARCH QUESTIONS

Adolescents in the Vaal Region have health problems related to sexual activity, despite the fact that healthy life style behaviour programmes have been offered in the clinics and schools in the area since 1988.

The research questions below, summarise the problem statement and formed the conceptual framework for the study.
• Who is the sexually active adolescent in the Vaal Region?
• What factors contribute to sexual behaviour among the adolescents in the Vaal Region?
• Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy life style behaviours?

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

The purpose of the study was to investigate factors that contributed to adolescent sexual behaviours and to determine whether the adolescent health education programme offered in clinics and schools increased knowledge on sexuality and motivated safe sexual practices among adolescents.

Objectives

The objectives of the study were to

• determine who the sexually active adolescents in the Vaal Region were
• identify factors that could contribute to these adolescents becoming sexually active
• identify the knowledge and understanding the adolescents had of safe sexual behaviour
• determine whether adolescents understood the healthy life style behaviour programme offered in schools and clinics

1.5 SIGNIFICANCE OF THE STUDY

The current health behaviour programme offered in schools and clinics in the Vaal Region could be reviewed against the findings of the study and a more reality-based integrated programme could then be drawn up to meet the total health needs of adolescents and, in particular, the needs pertaining to safe sexual practices of adolescents in the Vaal Region.
According to the *Policy on the Development of a District Health System* (1996), national policies should be transformed into reality-based programmes that meet the needs of the local communities (Department of Health 1996c:7-8).

### 1.6 ASSUMPTIONS OF THE STUDY

The following assumptions were made:

- **Assumption 1:** Adolescents in the Vaal Region are sexually active.
- **Assumption 2:** Adolescents engage in unsafe sexual practices.
- **Assumption 3:** Peer group pressure plays a role in promoting sexual activity among adolescents.
- **Assumption 4:** Knowledge and understanding of safe sexual practices is poor.
- **Assumption 5:** The current healthy lifestyle behaviour programme offered in schools and clinics does not promote safe sexual practices among adolescents in the Vaal Region.

### 1.7 DEFINITION OF TERMS

Terms and concepts used in the statement of the problem and research questions (questionnaire) are explained below for the purpose of providing clarity on and understanding of the research project.

**Adolescent:** The term *adolescence* is derived from the Latin “adolescere”, which means to grow up to maturity (Coates & Peterson: 1982:11, Gullotta, Adams & Montemager 1993:35; Louw 1991:377; Zabin & Hayward 1993:4). Adolescence thus means the stage during which a person moves from childhood and enters adulthood. Sometimes the terms *adolescent* and *teenager* are used interchangeably. Adolescent is a more comprehensive term, however, encompassing the teenage years and all aspects that are of a psychological, physiological, emotional and social nature.
Adolescence is thus seen as a process in attaining adulthood with arbitrary time frames, whereas teenager usually refers more to a chronological period approximated at between the age of 11 and 19.

Chilman (1983:2) defines adolescence as “the time in a person’s life that stretches from the onset of puberty to young adulthood”. Coates and Peterson (1982:11) define adolescence as “a transitional period between childhood and adulthood that starts with physical body changes and ends with social responsibilities”. Louw (1991:377) supports these definitions and highlights the fact that the beginning of the adolescent stage can readily be seen in the rapid physical growth and development of secondary sex organs, whereas the end does not have clear characteristics. Since the age boundaries of adolescence are variable and there are no clear characteristics to mark the end, Louw (1991:377) views the adolescent period as follows:

- Socially, the end of adolescence begins when the individual starts to fulfil adult roles, such as starting a career.
- From a legal point of view, at the end of the adolescent period the individual becomes eligible to vote (age 18 years).
- From a psychological point of view, the adolescence period ends when the individual is reasonably certain of his identity, is emotionally independent of his parents, has developed his own value system and is capable of establishing an adult love relationship.

The above definitions indicate that the period of adolescence is a socially defined one. However, it should be noted that adolescence is heralded by remarkable physiological changes in both males and females. The end is less clearly marked but could be indicated by the extent to which the adolescent starts to exhibit socially accepted adult roles and behaviours.
For the purpose of this study, the adolescent is defined as a male or female individual in the age group 14 to 19 years who lives in the Vaal Region and attends the sexually transmitted services offered at the four selected local health clinics in the Vaal Region.

**Sexuality and sex:** Sexuality and sex are two distinct, yet integrated terms.

- Sex relates to the anatomical and physiological aspects of reproduction. It is a narrow word focusing on the genetic characteristics of male and female reproductive systems (Davis & Harris 1982:474; Syden 1992:39).

- Sexuality is a broad term. It entails physical, emotional, social and intellectual aspects of an individual’s personality which expresses maleness or femaleness.

For the purpose of this study, the broader term *sexuality* is used.

**Sexual behaviour:** Sexual behaviour pertains to behaviour patterns showing the moral aspect of sexual involvement such as the number of sexual partners a person has at a point in time, the frequency of sexual intercourse the rate at which sexual partners are changed as well as the age at which one starts engaging in sexual activities. In this study sexual behaviour refers to the conduct of sexual practices, the number of sexual partners, the use of contraceptives and the frequency of sexual intercourse among the adolescent in the Vaal Region.

**Healthy life style behaviour programmes:** Sexuality education and sex education are two distinct but linked terms. Sex education pertains to education related to the anatomy and physiology of reproductive systems. It may include aspects of contraception, pregnancy, abortion and those relating to sexual activity, such as masturbation, homosexuality and sexually transmitted diseases.

Sexuality education is a wider-based programme that not only teaches the physical aspects of sexual orientation but also looks at all aspects of human development. According to the
Gauteng Provincial Health Department, Life Skills and HIV/AIDS Education Programme (Annexure B), sexuality education should provide full, honest information about physical, social, emotional aspects of human sexual development from conception to old age, to enable people to have a positive and happy acceptance of their own sexuality, thus increasing self-value and self-esteem and promoting responsible behaviour. Sexuality education should include the nature of love, personal relationships and family life. In this study the healthy life style behaviour programme is the health education programme on sexuality given to adolescents in the clinics and schools in the Vaal Region.

**Sexually transmitted diseases:** The term *sexually transmitted diseases* is used for all infections that are transmitted from person to person, mainly through sexual contact. Most sexually transmitted diseases affect the genital parts of both males and females (Ballard 1997:3). Other sexually transmitted diseases can cross the placental barrier and infect the unborn baby, or be transmitted to the baby during the process of birth. Some STD's can affect other parts of the body, such as the eyes, mouth, nerves, heart or urinary tract. HIV/AIDS is also mainly transmitted through sexual contact and is classified as a sexually transmitted disease (Department of Health 1996a:12). All sexually transmitted diseases, including HIV/AIDS, are non-notifiable diseases (Department of Health 1997a:108).

For the purpose of the study, the term *sexually transmitted disease* will refer to classical conditions which are transmitted through sexual contact and affect mainly the genital tract organs of either male and female adolescents. This will include the diagnosis of a disease classified as STD detected through examination of the genital tract or confirmed through a blood test. HIV/AIDS is not included in this definition.

**Teenage pregnancy:** Teenage pregnancy refers to pregnancy of the female prior the age of 20 years. For the purpose of this study, teenage pregnancy would not only include the female adolescent who has fallen pregnant but would also refer to the male adolescent who has made a female pregnant.
The Vaal Region: The Vaal Region is one of the six regions in Gauteng Province. The region is situated about 64 km south of Johannesburg and borders on the Free State Province at the Vaal River, forming the southern border of Gauteng Province. The Vaal area is predominantly urban. Like most regions in Gauteng Province, the area has been experiencing an influx of people from rural areas in search of work. The problems associated with the influx of people from rural areas seem to have worsened since the sociopolitical changes following the 1994 elections. The population in the Vaal Region is estimated at 1,7 million and this is expected to increase, to judge by the proliferation of informal settlements in the area.

The disease profile in the Vaal Region and in particularly conditions affecting children and youth, reflect mainly the urbanisation and industrial nature of the area as well as its political history, dating as far back as the 1961 pass laws uprisings, the Boipatong massacre in 1993, and the 1984 rental uprisings, where the youth in the Vaal Region were at the forefront of destroying the apartheid structures. The 1984 uprisings disrupted schooling in the area and the repercussions still affect the area today (Everett & Sisulu 1992:4).

In accordance with the development of District Health System (Department of Health 1996c:6), the Vaal Region has been divided into two districts, namely the East and the West. The research was conducted in the Western district of the Vaal Region at four of the 13 clinics that provide sexually transmitted disease services.

1.8 CONCLUSION

This chapter outlined the background to the problem, stated the purpose of the study and defined the terms used in the research. Tables reflecting the statistics on teenage pregnancy, sexually transmitted diseases and gynaecological conditions among adolescents were provided.
1.9 OVERVIEW OF THE STUDY

The study is presented as follows:

- Chapter 1: Introduction, background to the study, problem statement, conceptual framework and research questions, purpose and objectives of the study, significance of the study, assumptions and definition of terms
- Chapter 2: Literature study, the conceptual framework, an overview of the problem of adolescent sexual behaviour and the adolescent health education programme, worldwide and in South Africa
- Chapter 3: Research methodology, type of research, sample size, sampling method and data collection methods
- Chapter 4: Data analysis and discussion
- Chapter 5: Conclusions, recommendations and limitations of the study
CHAPTER 2

Literature review

2.1 INTRODUCTION

The literature review was done with the aid of computer-assisted databased bibliographies namely:

• CD ROM Search of references to periodical articles and books
• OPAC Search of references to books in the Unisa library
• SABINET Search of references to South African material, for example, references to periodicals, articles, books, theses and dissertations

The area of reference concentrated on the sexual behaviour of adolescents and the extent to which life style behaviours and adolescent sexuality education programmes appear to have had an impact on adolescent attitudes and sexual behaviour patterns in the Vaal Region.
The review revealed that, although there was no specific studies done on the sexual behaviour of adolescents in the Vaal Region, sexual activity is extensive among the adolescents and appears to be on the increase worldwide as well as in South Africa (Barker & Rich 1992:199; Bout 1991:16; Jacobson 1994:10; Mayekiso & Twaise 1992:22; Sapire 1986:418). Mogotlane (1993:11), Brooks-Gunn and Furnstenbergh (1989:249) and Brown and Childers (1990:62) state that in the United States of America during the early seventies, one in every seven adolescents had sexual intercourse and by 1986 the ratio had increased to more than one in four. This trend appears to be continuing and, because of the lack of reliable statistics on the general population, the incidence of teenage pregnancy has been commonly used to measure the extent of teenage sexual activity (Brook-Gunn & Furnstenberg 1989:249; Montessoro & Blixen 1996:33; Davis & Harris 1982:471).

In this context Barker and Rich (1992:199) report that in some African countries as many as 40,0% of women have their first child before the age of 18 years, which suggests a need for an improved understanding of factors affecting adolescent sexuality. A similar situation appears to prevail in South Africa. According to the Department of Health (1997c:22), in every 1 000 deliveries, 392 are teenagers, that is, below the age of 20 years.

The statistics shown in table 1.1 in chapter 1 reflect a similar situation in the extent of teenage pregnancy in the Vaal Region. In the researcher's view, the problems associated with teenage pregnancy and sexually related conditions and what is being done about them are also major areas of concern.

2.2 CONCEPTUAL FRAMEWORK FOR THE LITERATURE REVIEW

Using the research questions as the conceptual framework, the views of different authors and the findings of relevant research are discussed and, where possible, linked with research in South Africa under the following questions:

- Who is the sexually active adolescent in the Vaal Region?
What factors contribute to sexual behaviour among the adolescents in the Vaal Region?

Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy lifestyle behaviours?

2.3 WHO IS THE SEXUALLY ACTIVE ADOLESCENT IN THE VAAL REGION?

In this section the literature review covered the following aspects:

• the extent of sexual activity among adolescents
• the age at which the adolescent commenced sexual intercourse
• the frequency of sexual intercourse among adolescents
• male and female adolescents’ sexual behavioural patterns
• contraceptive use among adolescents who are sexually active

2.3.1 The extent of sexual activity among adolescents

The general view is that, compared to past generations, sexual activity among adolescents today appears to be increasing (Brown & Childers 1990:62; Dusek 1987:205; Montessoro & Blixen 1996:33; Mohamed & Masona 1991:316; Rakesh 1992:1; Smailes & Cunningham 1992:16; Syden 1992:25).

Montessoro and Blixen (1996:33), Brown and Childers (1990:62), Chilman (1983:92), Melchart and Burnett (1990:293), Smailes and Cunningham (1992:16) and others agree that a turning point in increased sexual activity among adolescents occurred around the sixties and seventies. In this regard, Chilman (1983:92) states that “from around the sixties onwards, old moralities were discarded, and society appeared to have reached a turning point, and those aspects that had previously been regarded as deviant, such as premarital intercourse, were becoming normative. In support of this statement, Smailes and Cunningham (1992:16) maintain that the sexual revolution of the seventies in the Western
World is still having repercussions worldwide. It would appear that there are conflicting values on sexual moral behaviours and different messages of sexual behaviours, which could be confusing and tend to contribute to increased numbers of adolescents engaging in sexual activities.

Fergenhum and Weinstein (1996:10), in a study of college students in America, report that more than 80,0% of the students in their sample had had sexual intercourse. In South Africa, Kau (1989:70) reports that 78,0% of the sample among 200 high school male students in Molopo Region of Bophuthatswana (now North-West Province) were found to be sexually active. In a similar study carried out in Soweto high schools, Magwentshu (1990:23) found that 45,0% of the male students and 22,0% of the females in her sample of 250 were found to be sexually active.

This study shows that a similar situation of adolescent sexual activity exists in the Vaal Region, as shown by the statistics in tables 1.1, 1.2, 1.3 and 1.4. Even though sexual practices among adolescents may not be universally approved, teenage sexual activity and teenage pregnancy are increasing more than before (Montessoro & Blixen 1996:33).

2.3.2 The age at which adolescents commence sexual intercourse

Whereas earlier studies reported the average age at which adolescents became sexually active as being between 14 and 16 years (Dusek 1987:48; Chilman 1983:4), it is currently generally accepted that adolescents commence coitus at a much earlier age (Magwentshu 1990:123; Mogotlane 1993:13; Santelli & Beilenson 1992:272; Yaber & Parillo 1992:332; Zabin & Hayward 1993:27).

Preston-Whyte and Zondi (1991:1389) found that by the time adolescents in KwaZulu, Natal were 13 years old, they had been sexually active. In a study of 250 Soweto high school students to analyse sexual knowledge, Magwentshu (1990:123) also found earlier ages at which adolescents commenced sexual intercourse, namely as early as 11, 12 and 13 years. It would appear that though sexual activity among adolescents is generally accepted, the age
at which coitus begins is worrying, because it seems to be getting even younger. Santelli and Beilenson (1992:272) state that the average age for first intercourse had decreased from 19 years in 1971 to approximately 16 years in 1988.

Implications of the age at which adolescents become sexually active

The age at which adolescents commence coitus seems to have far-reaching implications in terms of safe sex. It would appear that the younger adolescents are when commencing sexual intercourse, the less likely they are to be knowledgeable on sex education. This could lead to unprotected sex as well as sexual exploitation.

Zabin and Hayward (1993:27) state that “the age at which adolescents start sexual intercourse affects the context of sexual activity, its frequency and the quality of relationship”. Concern was also expressed as to the responsibility that goes with the early commencement of sex among adolescents. Are adolescents at this age knowledgeable about the consequences of involvement in sex? Are they knowledgeable about safe sex, protection against sex related conditions and unwanted pregnancy?

In South Africa, Mogotlane (1993:12), Sapiere (1988:21) and Setiloane (1990:44) reported that girls as young as 12 and 13 years old were found to be pregnant. This situation indicates that sex education and sexuality information is needed at a much younger age and should be given before children start engaging in sexual activity.

The Vaal Region appears to be experiencing similar problems. During this study, a 12-year-old girl was recorded among the deliveries at Sebokeng Hospital in July 1995. Among the statistics collected at the Vaal ATIC, adolescents of 12, 14 and 15 were found to have tested HIV positive. Both Zabin and Hayward (1993:277) and Rice (1992:368) assert that adolescents who start engaging in sexual intercourse at an early age tend to be sexually permissive and to change partners more frequently. Such patterns of sexual behaviours are risk factors for the occurrence of teenage pregnancy, sexually transmitted diseases and HIV/AIDS infection.
2.3.3 The frequency of sexual intercourse among adolescents

The frequency of coitus among adolescents is not as easy to determine as the age at which sexual intercourse commences. Zabin and Hayward (1993:55) report that no adolescents had had sex in the last month prior to their study. Kau (1989:82) also reports such infrequent and sporadic sexual episodes in a study conducted among male adolescents in Bophuthatswana.

Varying responses have been identified regarding the frequency of sexual contact among adolescents in the Vaal Region. The adolescent contraceptive clinic cards (Annexure C), designed by the Department of Health contained statements enquiring about the frequency of sexual intercourse. Adolescents gave varied responses, such as

- I am not sexually active but need contraceptive for protection if I am raped.
- My parents persuaded me to use contraceptives even if I am not sexually active.
- I engage in sexual intercourse frequently.

Infrequent and sporadic sexual contact could be attributed to factors such as:

- conflicting feelings about involvement in coitus (Adolescents may acknowledge the sanctity of marriage, and yet the environment is displaying varying practices of sexual behaviour, such as cohabitation and immoral sexual acts among adults and the young.)
- lack of appropriate venue or time to have sex
- instability of sexual partners

2.3.4 Contraceptive use among adolescents

Another controversy in determining who the sexually active adolescents are, is aligning those who use contraceptive methods with sexual activity. According to the researcher’s experience some adolescents visiting the family planning clinics requesting contraceptives were found not to be sexually active. Others were found to have been persuaded by parents,
who, realising the state of physical change and development, became suspicious of sexual activity.

Yet contraceptive use by adolescents has been implicated as influencing adolescent sexual promiscuity. Contrary to this view, Chilman (1983:108), Flanigan, Mclean, Hall and Propp (1990:206), Greydanus and Shearin (1990:194), Kau (1989:103), Kornfield (1985:23), Mayekiso and Twaise (1992:21) and Syden (1992:57) concur that contraceptive use by adolescents has been inconsistent, erratic and delayed, especially before the first coitus.

Sapire (1986:421) suggests the following reasons and problems related to the apparent poor use of contraceptives by adolescents:

- The service that provide contraceptives may not be friendly or adequately equipped to deal with adolescents.
- Adolescents feel ambivalent about contraceptive usefulness.
- Community norms do not advocate contraceptive use.
- They have problems with the contraceptive methods themselves.
- Their families have low socioeconomic status.
- They have sex sporadically.
- Their religious affiliation restrains or helps them to refrain from sexual activity.

In South Africa, Kau (1989:103), Mayekiso and Twaise (1992:22), Sapire (1988:21) Setiloane (1990:46) and Van Coeverden De Groot (1991b:1370) support the views and findings that contraceptive use among adolescents is poor. In their study, Mayekiso and Twaise (1992:22) report that 55,2% of the adolescents claimed to be sexually active but only 12,3% used some form of contraception. Similarly, Mogotlane (1993:13) revealed poor use of contraceptive by adolescents. Of 43 respondents among pregnant adolescents at Garankuwa Hospital, Mogotlane (1993:13) reported that only three had been on contraceptives. The erratic and inadequate use of contraceptives by adolescents may suggest that measuring the extent of sexual activity in terms of contraceptive use would not be an accurate reflection because, seemingly, not all adolescents who are sexually active use
contraceptive measures.

2.3.5 Differences in male and female adolescents' sexual behavioural patterns

The extent of sexual activity among male and female adolescents is well documented. The general view is that males appear to be more sexually active than females, though the repercussions of unprotected sex are usually elicited through pregnant girls (Antonovasky 1980:61; Dryfoos 1990:66; Dusek 1987:48; Jacobson 1994:10; Smith 1985:1200). Dusek (1987:48) comments that Kinsey (1948) was most probably the first to report differences in adolescent male and female behaviours. These differences outlined below were supported later by Antonvasky (1980:61), Chilman (1983:41), Dryfoos (1990:66), Jacobson (1994:10) and Smith (1985:1201).

- **Age at commencement of sexual activity**

Research has found that males commence sexual intercourse at an earlier age than females. In his study Kinsey (1948) found that by the age of 15, 55.0% of the males in his study as compared to 3.0% of females at the age of 16 years had experienced sexual intercourse (Dusek 1987:48). This view appears to be strongly supported by South African researchers (Kau 1989:103; Kimane & Joseph 1996:14; Louw 1991:400; Schoeman 1990:16; Setiloane 1990:47). Kau (1989:77) found that of 200 male adolescents, many (37.0%) had commenced sexual intercourse at the age of 12 years, 28.0% were 14 years old and a further 28.0% were 16 years old. In a study of 250 high school students Magwentshu (1990:123) found more males (45.0%) than females (22.0%) to be sexually active.

- **Number of sexual partners**

Generally, it would appear that males have more sexual partners than females. Gullotta, Adams and Montemager (1993:69) reported that males had more partners (an average of 5.1%) than females.
Similar findings have been reported in South Africa. Kimane and Joseph (1996:46) reported that in a study carried out in Alexandra Township, 43.0\% males as against 90.0\% females had only one partner. This would appear to be similar to findings in the Vaal Region. This study found that some of the male adolescents visiting the clinics claimed to have up to six sexual partners.

- **Physiological changes and differences in the sexual practices of the adolescent**

The difference in sexual practices appears to be attributed to physiological changes as well as sociocultural factors among teenager boys and girls.

- **Physiological changes**

From a physiological point of view, Zabin and Hayward (1993:33) point out that boys' sexual urges are more urgent and can respond purely to physical stimuli, whereas girls usually require emotional involvement in order to respond fully. Card (1993:1), Chilman (1983:2) and Louw (1991:400) concur with this.

According to Dryfoos (1990:24), “no aspect of adolescent development is more readily apparent than that of the onset of puberty”. During this stage there is an increase in hormonal secretions, which bring about physiological changes and bodily changes (Louw 1991:385).

Table 2.1 below (Bodibe 1994:27) outlines some of the secondary sex characteristics for females and males.
Table 2.1: Secondary sex characteristics of adolescents

<table>
<thead>
<tr>
<th>SECONDARY SEX CHARACTERISTICS OF FEMALES</th>
<th>SECONDARY SEX CHARACTERISTICS OF MALES</th>
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<tbody>
<tr>
<td>• Growth and enlargement of the breasts</td>
<td>• Growth of hair on face and body</td>
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<tr>
<td>• Fat deposit on hips</td>
<td>• Increase in muscles, mass and strength</td>
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<tr>
<td>• Growth and enlargement of ovaries</td>
<td>• Growth of penis and testicles</td>
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<tr>
<td>• Onset of menstruation</td>
<td>• Growth of voice box and breaking of voice</td>
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Secondary sex characteristics in table 2.1 are inevitable and appear to play a vital role in the sexual behaviour of adolescents as they seem to trigger sexual arousal. Depending on circumstances, adolescents may interpret the meaning and importance of these physical changes in terms of sexual behaviours either positively or negatively. In this context, Chilman (1983:15) maintains rapid growth and changes result in intense self-consciousness and for this reason adequate information needs to be provided.

Adolescents are more likely to want to understand these changes in the light that they are perceived by society and, in particular, the peer group. Of great significance and interest today are findings that physiological changes now appear to occur earlier than in the past. Chilman (1983:5), Dryfoos (1990:24), Masters, Johnson and Koloduy (1986:14) and Zabin and Hayward (1993:8) concur that menarche occurs three months earlier in every decade. Craig, Richter and Strydom (1983) indicate a mean age for menarche as being in the range of 11 to 12 years of age (Bodibe 1994:28). In research conducted among 236 Tswana school boys at Medunsa University, to test spermatorrhoea of boys in the age range 10 to 16 years, Ramasodi and Schulenburg (1990:463) reported the presence of spermatorrhoea among boys between the ages of 14,1 and 15,8 years.

On 15 May 1990 the Sowetan reported that a nine-year-old Zimbabwean girl was six months pregnant (Setiloane 1990:44). Similarly, on 9 December 1997, the Sowetan (1997d:2) again
reported that an eight-year-old Pakistani girl gave birth to an underweight but healthy baby after allegedly being raped by two men. These reports could be significant and tend to confirm the view that puberty could be occurring earlier than it did some decades ago.

The researcher found that, some parents reported that their daughters started menstruating at the age of 10 and 11. It is not known whether the earlier occurrence of menarche could influence adolescent sexual behaviours, but it is apparent that some of the incidences and research findings necessitate children being provided with sexuality and life skills information at an earlier age.

2.4 WHAT FACTORS CONTRIBUTE TO SEXUAL BEHAVIOUR AMONG THE ADOLESCENTS IN THE VAAL REGION?

2.4.1 Sociocultural factors that influence the sexual practice of adolescents

Physiological factors do not take place in a vacuum. Dryfoos (1990:24) argues that the environment has much more impact on development than genetic factors. Rogers (1974:13) had similar views. According to Rogers (1974:13), “sexual behaviour is basically an appetite that is learned”. He points out that human erotic urges in adolescence stem more from sociocultural than physiological factors and argues that “it is as a result of thinking, cultural influences, art, comic entertainment and advertisement that affect human sexual orientation”.

Though physiological factors may lay the primary ground for sexual drive, it would appear that the environment in which adolescents find themselves plays a vital role in interpreting the physiological changes. Chilman (1983:18), Dusek (1987:125), Gullotta et al (1993:60) and Rogers (1974:12) concur that cultural norms and values, socioeconomic status, religion and family background influence sexual practices and behaviour to some extent.

Eichler (1988:28) and Louw (1991:399) support these views and focus on socialisation and culture as being more lenient on males than females with regard to sexual practices. According to Eichler (1988:28) “the social universe permitted man to have more than one
wife at a time, though it is rare for women to share equal social status”. Setiloane agrees with Eichler and points out that South Africa is in general a male-oriented society that socialises boys and girls into believing that males have more sexual rights than females.

However, there are social and political changes which emphasise recognition of the rights of women (Montessoro & Blixen 1996:33). Among these, the rise of feminism, the development of contraceptive use and the legalisation of abortion are important. These developments appear to give women, firstly, control over their reproductive lives and secondly, recognition and equal status to that of men (African National Congress 1994:46).

Though sexual (gender) discrimination is still apparent, in time as girls are socialised into a nonsexist era, equality in sexual issues may be achieved.

Cultural norms and values that influence the sexual practice of adolescents

Stanhope and Lancaster (1988:90) define culture as “a set of rules that provide people with means of behaving and interpreting the behaviour of others”. Culture, which is usually transferred from society to children, influences how people are socialised in various aspects of life, including masculine and feminine roles. With the passage of time and social change, culture changes.

In this context, Montessoro and Blixen (1996:35) state that “in Colonial America, sexual activity and child bearing among adolescents was not a problem; values of virginity were held high, until the nineteenth century when American attitudes towards early childbearing were relatively permissive”. The increased rate of early childbearing among adolescents during the 1920's was attributed to the liberalisation of sexual moves and urbanisation occurring after World War I (Montessoro & Blixen 1996:33). In support of this view, Van der Zanden (1989) (Louw 1991:392) states that before 1915, approximately 75,0% of the American girls in his sample were virgins, and by 1920, this figure had dropped to 50,0%.
In traditional African and Asian societies, though early marriages were encouraged, cultural morals and practices provided mechanisms for the transmission of information on sexuality and sexual behaviours (Barker & Rich 1992:199; Setiloane 1990:45). In this context, Llewelyn-Jones (1974) (Setiloane 1990:45) states that “though Indians encouraged early marriages, the young girl was not subjected to sexual penetration until she reached a more mature age”. Such mechanisms and moral behaviours helped prevent teenage pregnancies and other sexually related conditions among adolescents.

Among the Black ethnic groups in South Africa, cultural practices at initiation ceremonies play a major role in controlling sexual behaviours among adolescents (Kau 1989:31; Setiloane 1990:45). Kau (1989:31) states that “through initiation school, instructions on abstinence, reliability and avoidance of adultery were taught to the young. Virginity was very highly valued, as it influenced the lobola to be paid”.

However, the deteriorations of many tribal and rural traditions in the face of rapid urbanisation and industrialisation has led to people relinquishing some of these values and norms, and sexual behaviours have become more permissive. It is unfortunate that, with the deterioration of these cultural practices, it would appear that no effective practical measures were taken to serve as guidelines for sexual behaviour. In terms of health programmes for adolescents, Montessoro and Blixen (1990:36) maintain that even in those countries which designed healthy life style behaviour programmes, the programmes lacked consistent policies as well as coordinated effort by educators, parents and health professionals. Moreover, the educational approaches used were directed mainly to adolescents females.

In the researcher’s view, the collapse in cultural patterns of controlling sexual behaviours as well as the lack of effective measures for educating the youth are also prevalent in the Vaal Region. The area is predominantly urban and industrialised, and it would appear that specific cultural practices to enforce sexual patterns and behaviour would be difficult to achieve with such multiracial and ethnic groups residing in the area. This indicates the need for a multisectoral approach in drawing up appropriate health education programmes for children and the youth.
2.4.2 Socioeconomic factors that influence the sexual practice of adolescents

Measuring the socioeconomic status of adolescents does not seem to be a simple matter as it is generally looked at in the context in which the adolescent lives, and the socio-economic status of the family. For this reason, socioeconomic factors as they affect the sexual behaviour of adolescents were looked at in relation to the social standing of the family as well as the environment in which the adolescents live.

The socioeconomic status of the family


Throughout the world impoverished communities generally cluster in confined areas. This creates a complex situation related to lack of facilities, educational, health and recreational facilities together with lack of adult support. These factors seem to negate health promotion messages, and it thus becomes difficult to separate the social status of the family and the environment in which the adolescent lives. Better educated parents are better able to give their children support, to educate them and be receptive to health messages that can be passed onto their children. Children of educated parents tend to aspire to education, making them also more receptive to health education messages (Brooks-Gunn & Furstenbergh 1989:251).

In a focus group study conducted among multiparous adolescence in Port Elizabeth in the
Cape Province, Bout (1991:14) found that all the participants had a history of low socioeconomic status and an increased level of illiteracy and ignorance on sexual matters. Similarly, a study by Mogotlane (1993:12) among 43 teenage pregnant girls aged 19 years and younger in Winterveldt (North-West Province) revealed that the majority were slow at school, with the average educational level for the sample being Standard 7 (now Grade 9), while 34.7% of the total sample were not yet in high school.

Similar situations of lack of recreational facilities and impoverished communities are found in the Vaal Region. During counselling sessions done by the researcher, some adolescents would indicate that engagement in sexual activities is regarded as a way of passing the time.

- **The social environment in which the adolescent lives**

As mentioned earlier, adolescent sexual behavioural patterns, appear to be intrinsically related in their influence to the social environment and socioeconomic status of the family. It is not clear whether the environment or the economic status of the parents has a more negative impact on sexual behaviours or vice versa. However, Dryfoos (1990:7-9) suggests that treating specific behaviour patterns without treating antecedent variables, such as social setting, family poverty, occupation, education and housing, would not yield much result.

Preston-Whyte and Zondi (1991:1372) state that children living in ghetto conditions often lack parental control and have few recreational facilities to take up their spare time and energy and thus could find themselves engaging in risk behaviours including sexual activities. Although there is a tendency to align negative sexual behaviours with ethnicity, the influence of socioeconomic factors and the environment is most probably best captured by Bodibe (1994:9) and Santelli and Beilenson (1992:273). Santelli and Beilenson (1992:273) maintain that ethnic differences diminish or disappear when the effect of socioeconomic status and other social factors are identified.

To indicate the South African situation, Bodibe (1994:9) comments that "teenage pregnancy is not a Black or White problem, rather it is a problem of all, and that most vulnerable
members of society are those who bear the brunt of societal ills”. It would appear that the social ills prevalent among South African Blacks, such as unemployment, poor housing and lower educational status, make Black adolescents appear more sexually permissive (Bodibe 1994:9; Smailes & Cunningham 1992:16). The African National Congress (1994:22) through the RDP aims to address the above social ills in an effort to improve the lives of mostly the impoverished communities.

Other social factors are also prevalent in the Vaal Region which have an influence on sexual behaviours of the adolescents are:

- marriage problems within the family
- divorce
- alcoholism

(Eberhardt & Schill 1984:99; Gordon et al 1979:30; Sapire 1986:419)

These factors appear to lessen control and affect disciplinary measures over adolescents who also may lack an adequate role model.

The home environment and how it influences adolescents’ sexual behaviour

The home environment is the primary environment for human development. It is in the home environment that the socialisation process begins and the child starts to develop self-concept, trusting relationships, feeling of security, social skills and behaviours. Freudian theory firmly upholds that imperfect family environments produce ill personalities and behaviours (Louw 1991:410).

The literature was examined to determine the home environment and its influence on sexual behaviours of the adolescents in relation to

- parents’ communication on sexual behaviours
- parent-child relationship
Parents’ communication on sexual behaviour

Parents are expected to not only act as role models, but also to communicate freely on issues relating to sexuality development and sexual behavioural patterns. From the literature reviewed it would appear that parents have difficulty in communicating with their adolescent children on issues relating to sexual matters (Chilman 1983:33; Gordon et al 1979:16; Jacobson 1994:12; Zabin & Hayward 1993:145).

As far back as the late seventies Gordon et al (1979:10) emphasised the importance of parent-adolescent communication on sexual matters. In their view, sex education should start at home and adolescents should learn about sex from their parents in preference to any other sources. Gordon et al (1979:9) believe that “information communicated by parents has a special importance and meaning to children”, and that a lot of sexually related problems that occur during adolescence could be reduced “if the home climate is acceptable and honest about sex related issues”.

Thompson and Thompson (1981) support this view and point out further that “lack of sex education from parents makes peers and the mass media become important sex educators” (Kunene 1988:37). In South Africa, this view is also held by Kimane and Joseph (1996:50), Mayekiso and Twaise (1992:23) and Syden (1992:115).

In assessing parental involvement in imparting sexual knowledge to adolescents, Mayekiso and Twaise (1992:23) found that 58,0% of the adolescents in the study attributed the increased rate of teenage pregnancy to lack of communication between parents and teenagers. Though parents are viewed as not communicating sufficiently on sexually related matters, the greatest problem appears to be how and what to communicate.

Chilman (1983:33) states that “it is no easy task for parents to learn how to share information with their children”. It takes hard work and energy, especially if the family suffers from
oppression of racism or other problems, such as substance abuse, and poor housing. Kimane and Joseph (1996:50) point out that in South Africa “parents are notoriously bad in discussing sex-related issues with their children”.

According to the researcher’s experience, parents often bring their children for contraceptive measures without first giving them the basic information on sexually related issues or explaining why they are visiting the clinic. This practice could be a possible indication that the parents have difficulty in imparting information on sexual aspects to their children, and could also be as a result of the termination of initiation schools as well as a lack of alternative social systems to replace these schools.

Communication on general issues between parents and children and close relationships with the family appear to be the most important elements of a family structure. Contrary to the view that sex and sexuality education by parents is important, Santelli and Beilenson (1992:274) are of the opinion that communication on sexual matters with parents is not that important. According to Santelli and Beilenson (1992:274) the emphasis should be on relationships between adolescents and parents and there should be firm and consistent rules.

Chilman (1983:91) supports this view and claims that studies have shown that adolescents who grow up in families that lack affection and where there is a poor parent-child relationship generally engage in coitus early in life. Though there is little research on parent-child relationship as it affects sexual behaviour, it would appear that the home environment and, more importantly, the closeness of the family structure is generally considered most important in adolescents’ sexual involvement.

Family structure

According to Sapire (1986:419), factors which disturb the family structure, such as parents’ separation, divorce, death, alcoholism and a history of premarital conception, may influence adolescent sexual behaviour. Sometimes the situation becomes even more complex as men in urban areas are tempted to form extramarital relationships to the extent of establishing
another family. This practice perpetuates poverty, poor housing, the breakdown of family structures, norms and values in sexual relations, and sexual permissiveness. Urbanisation has also subjected many African families to a congested home environment (African National Congress 1994:22; Smailes & Cunningham 1992:17). In these circumstances, then, the traditional four-roomed ("matchbox") houses in the townships for the urban Black families are inadequate. Families consequently add on an outside shack for their adolescent sons, little realising that in so doing they might be relinquishing control. The South African government is currently attempting, through the Reconstruction and Development Programme, to address the lack of adequate housing and basic services, especially in townships and the rural areas (African National Congress 1994:22-33).

**Peer influence**

Peer pressure is widely assumed to be a significant causal factor in the initiation of habits, such as smoking, drug use and sexual involvement among adolescents. As children slowly emancipate from their parents, they spend a lot of time with their peers, who in turn, influence them on various life issues (Chilman 1983:87; Louw 1991:422; Syden 1992:81).

In this context, Harris (1986) examined the reasons why adolescents became sexually active and found that teenagers feel that social pressure and especially peer pressure made them go further with sex than they wanted to go (Syden 1992:81). However, Louw (1991:424) maintains that variables such as personality and family relationships will determine who has the greater influence, parents or peers. However, Louw points out that conformity to peer groups is often the result of too little attention and interest given at home and also lack of parental warmth and understanding.

Similar views are shared by Treboux and Busch-Rosnagel (1990:176) who maintain that sexual behaviours are learned, and that parents and peers are the two major socialisation agents. It would appear, then, that if family relationships are good and adolescents are well-nurtured and supported within the family circle, dependence on peers will be minimal, or the peer group will best be used to measure their own development. According to Louw
(1991:422), the peer group has a significant role in assisting and supporting adolescents to adjust to life changes and development, and in providing a supportive environment for adolescents to face life challenges. Dryfoos (1990:25), Hurrelman and Losês (1990:10) and Louw (1991:379) indicate a number of tasks as challenges adolescents should accept to gain adult characteristics.

Louw (1991:379) outlines these tasks as follows:

- accepting their changed physical appearance
- developing a masculine or feminine sex role
- developing a philosophy of life
- developing independence from parents and other adults
- developing moral concepts that can serve as guidelines for behaviour
- selecting and preparing for a career
- accepting themselves as persons of worth and developing their own identity
- preparing for marriage and family responsibility

Clearly, achieving these tasks and others will not be easy for adolescents who sometimes have to do it through trial and error. Louw (1991:419) maintains that peers act as a reference group which gives adolescents the opportunity to assess their own problems, needs and goals in relation to achieving these goals.

**Sexual information provided by peer group**

In most instances the extent to which peer group influences sexual behaviours is apparently determined by the extent to which peer groups are used as the source of information on sexually related aspects (Barker & Rich 1992:201; Davis & Harris 1982:475; Schoeman 1990:17; Treboux & Busch-Rosnagel 1990:176-177).

In a survey of 288 Anglos, Hispanics and native Americans, Davis and Harris (1982:475) found that the most common source of sexual information was friends, followed by schools,
books/magazines and parents. Prior to their study Davis and Harris (1982:475) mentioned two previous studies which differed from their findings, where it was found that the family was the primary source of sexual information and in another, the school was found to be the most important.

In a focus group study among adolescents in Kenya and Nigeria, Barker and Rich (1992:201) reported that the young people interviewed said that they turned to their peers as their principal sources of information on issues related to sexuality. Similarly, in 1991 in Kenya Ajayi found that 68,0% of a sample of 3 000 young people aged 12 to 19 years received information on sexuality from school friends (Barker & Rich 1992:201).

Similar studies in South Africa also revealed that peer groups are the main source of sexual information among adolescent. In a study to assess parent involvement Mayekiso and Twaise (1992:21) found that the highest percentage in the sample (45,0%) obtained information on sex matters from peers. This confirmed earlier studies by Magwentshu (1990:116) and Disler (1991:88).

The researcher found that in the Vaal Region the information received from peers was not always accurate. Adolescents often received information from friends who very often were also misinformed. The belief that drinking a lot of water prior to sexual intercourse will prevent conception is an example of such myths and misconceptions. It is unfortunate that peers are reported as usually the main source of information when they themselves also lack the correct information on sexually related issues. This could indicate the need for effective health programmes that could involve peer groups as educators. To point out the possibility of peer groups giving inaccurate information, Schoeman (1990:17) uses the concept of “street talk” and suggests that the street talk can be turned into straight talk by training volunteer adolescents and encouraging them to share their knowledge on either a formally structured or a conversational level.
The influence of the media on adolescent sexual behaviours

Very little research is available on the effects of the mass media on adolescent sexual behaviour. However, Greenberg, Brown and Buerkel-Rothfuss (1993:66), Jacobson (1994:11) and Smailes and Cunningham (1992:16) share the view that the mass media do influence children’s sexual behaviours to some extent.

Brown and Newcomer (1991:63), who studied the sexual content of television programmes and the effect of this content on adolescent sexual references, best explain the influence the media have on adolescent sexual practices. Brown and Newcomer (1991:635) state that in “the past two decades, the sexual content of the mass media has become increasingly frequent and explicit, and in the same period the rate of teenage pregnancy in the United States of America was higher than in any other industrialised country”. The view is that television content somehow influenced adolescents to engage in sexual intercourse, earlier than they might otherwise do. Assessing the effect of sexy programmes on adolescents, Brown and Newcomer (1991:87) found that there was a significant relationship between proportions of “sexy” programme viewing and sexual involvement. Non-virgins were more likely to watch sexy programmes than virgins. Many television programmes, like soapies, visually reinforce aspects of sexual matters, such as cohabitation, homosexuality and premarital sex.

South Africa today appears to be experiencing the same effects of similar sexy television programmes. Several of these programmes show sex as exciting and glamorous. Young people may not be able to interpret media content in a morally mature way because they have relatively little experience, thus television can play a major role in their sexual socialisation. If institutions like the school and the church and parents are silent on sexual information, the media can become the only source of information.

Adolescents life style behaviours and their influence on sexual behaviour

The use of harmful substances such as alcohol and other drugs, has been as a common
practice among adolescents (Diclemente 1992:26; Dryfoos 1990:47). It is debatable whether
drug use has a direct influence on sexual behaviour among adolescents. However, Disler
(1991:477) and Lowry, Holtzman, Truman, Kana, Collins and Kolbe (1994:118) contend that
many adolescents initiate sexual activities and at the same time begin experimenting with
drugs, alcohol and cigarette smoking.

Research in South Africa also supports this view as there seems to be a reciprocal
relationship between drug use and early sexual involvement (Disler 1991:47). Kantel and
Zubin state that the initiation of either behaviour may lead to the other (Santelli & Beilenson
drugs would seem to support the reciprocity of the situation. Santelli and Beilenson
(1992:274) maintain that among adolescents drugs are frequently used before intercourse and
may decrease inhibitions. If inhibitions are decreased, it could mean that adolescents could
engage in activities which under normal circumstances would not have taken place. With
respect to sexual intercourse, this could lead to coercion, rape, failure to use contraceptives
or even multiple sex partners. These, in turn, could result in unintended pregnancies and
sexually transmitted diseases. Of the harmful substances used, that could decrease
inhibitions, alcohol has consistently been indicated as the most common substance used

On 7 December 1997, the Sunday Times reported shocking results in a survey carried out in
Cape Town, where primary school children admitted to frequently using drugs and alcohol.
According to the report, alcohol was found to be the worst problem facing school children,
and that 70,0% of Standard 6 pupils used alcohol, with 50,0% of these children having been
drunk (Sunday Times:1997b:10).

In the Vaal Region, young girls are often seen in the company of older men sharing liquor
in drinking places. Such elderly men are referred to as “sugar daddies” and are kept as
companions for economic reasons. A most disturbing situation is the frequent report in the
community and the schools that teachers have become drinking partners with their pupils.
Some media reporters attribute the high rate of matric failures in 1997/8 to lack of
commitment on the part of the teachers and the fact that teachers have become drinking partners with their pupils (*Sunday Times* 1998:14). In addition to these reports, the Minister of Education, Professor Sibusiso Bhengu, appealed to teachers in a news broadcast on 24 January 1998 and spoke out strongly against drinking with students as this was considered a crime and the misuse of teaching time.

It would appear that, as with sexual activity, the reasons for alcohol and drug use are varied and complex. These findings support the view that there could be a correlate relationship between the use of drugs and alcohol and early involvement in sexual activity. Unfortunately, there is only limited research on drug and alcohol use as it relates to sexual activity. However, it is generally viewed that drug use and more especially, alcohol use is initiated during adolescence.

In the Vaal Region, the situation on alcohol use appears to be compounded by economic needs and unemployment. Many homes in the townships are used as “taverns” and “shebeens” where liquor is sold. Young people visit these places, particularly over weekends, to drink. Clubs, termed “stokvels”, are formed where groups of young people get together to dance and drink.

2.5 IS THE ADOLESCENT IN THE VAAL REGION KNOWLEDGEABLE ABOUT SAFE SEXUAL PRACTICES AND THE IMPORTANCE OF HEALTHY LIFE STYLE BEHAVIOURS?

According to Brooks-Gunn and Furnstenbergh (1989:255), several strategies and healthy life style behaviour programmes for adolescents have been designed and implemented throughout the world in order to

- offer access to contraceptives
- provide knowledge about sex and sexuality
- promote change in sexual behaviour
Examples of such programmes for American societies include

- family life and sex education
- media sexuality programmes
- family planning services
- school-based clinic programmes
- peer counselling
- peer resistance training
- behavioural skill training

Syden (1992:102) also provides an outline of sex education programmes in other countries, such as Great Britain and Australia, which were evaluated by Bongers and De Klerk (1981). According to Syden (1992:112), these programmes have the following in common:

- Most of them were linked to school programmes though the methods and approaches differed.
- No formal training existed for teachers.
- They increased knowledge to some extent but seemed to have very little effect on values, attitudes and sexual behavioural practices.
- In Australia specifically, there was a lack of specific policy, with the result that sex education was infrequent, fragmented and superficial.

In South Africa, adolescent sexuality programmes were non-existent until 1984 (Schoeman 1990:14). In this context Burns and Young (1987) comment that where such programmes existed in South Africa their relevance, approach and comprehensiveness were questionable (Syden 1992:96).

2.5.1 Healthy life style behaviour programmes in South Africa

According to the literature reviewed, many countries introduced school-based healthy life style behaviour programmes in the last 20 to 30 years (Syden 1992:2). In South Africa
sexuality programmes were only introduced in 1984 (Schoeman 1990:14). According to Schoeman (1990:14), in the programme introduced, the Department of National Health and Population Development decided on an approach specifically tailored to the adolescent youth. The programme was implemented mainly by health workers. In the Vaal Region, the sexuality programme was implemented as part of the comprehensive health services provided at the local clinics. Community health nurses rendering family planning services provided this programme, which, at a later stage, became an integral part of family planning services. As an extension of this clinic service, educational programmes were carried out by health promoters under the Transvaal Provincial Administration Health Department. Health promoters visited schools and addressed schoolchildren on sexually-related aspects. This did not include the teachers.

2.5.2 The content of the sexuality programme in South Africa

According to the policy document guidelines (Annexure A), the Department of National Health and Population Development (now the Department of Health) aimed to provide a two-faceted service to the youth, namely:

- a clinical component focusing on reproduction, contraception and general health
- the education component, in which the youth were taught topics related to
  - communication skills
  - decision-making and problem-solving skills
  - conception, pregnancy and health care
  - reproductive anatomy and physiology
  - sexually transmitted diseases
  - population issues

The basic aim of the programme was to establish youth advisory centres and family planning clinics, away from adult family planning services (Annexure A). In practice, however, it was not always possible to establish such centres. As a result some areas used clinics for youth
services. To provide this service clinics set aside certain days or afternoons specifically for adolescents. Adolescents would be addressed as a group or counselled individually where the need arose.

In the Vaal Region, the clinics were used as described above, setting separate days, aside mainly in the afternoon to present youth programmes. According to Schoeman (1990:15), who did a preliminary exploration of the programme in two black townships in South Africa, the following problems were highlighted:

- The programme was found not to be in line with the prevailing conditions in the townships. According to Schoeman, the manner in which the programme was offered was often misdirected or not practically applicable.

- The programme was designed by policymakers who were not acquainted with the real-life circumstances of the target group.

- There was seldom sufficient nursing staff in the clinic to provide all the services needed.

- The budget allocated to the youth services was basically insufficient to provide for all requirements, such as video machines and teaching material.

- There were insufficient trained staff to implement the programme, thus the goals of the programme could not be reached.

- No cooperation existed between schools and clinics.

Problems identified with the healthy life style behaviour programmes in the Vaal Region

In the Vaal Region, the researcher found similar problems to those described by Schoeman
There were no facilities to establish separate services for the youth. As a result, clinics which were too small were used which did not provide the teenagers the privacy required.

The clinics were often crowded and overloaded with clinic work, thus it was often not possible for the clinic nurses to do proper counselling. Consequently, providing contraceptive services was the aspect of the programme emphasised.

There was a lack of coordination between the work of the health promoters in the Transvaal Provincial Administration Health Department and the local authority nurses who were rendering the service at the clinic.

The effectiveness of the programme was rarely evaluated.

Though the aim of the programme was to reach adolescents, male and female, before their first sexual experience, most children at schools were not reached. Similar problems were experienced in other areas. For example, in a study among pregnant teenagers in GaRankuwa Hospital (Pretoria Region), Mogotlane (1993:13) reported that in a sample of 46 pregnant teenagers in the age group 13 to 19 years, 27 reported that they never saw health professionals in their school whilst seven mentioned that the health promoters only addressed girls in senior classes. This indicates that most children could not be reached early enough.

It should also be pointed out that mostly teenage girls attended the sessions at the clinics, yet the emphasis of the programme was on educating and counselling both male and female adolescents. This shows that there is a need for more effective strategies to involve both males and females equally.
The impact of the healthy life style programme on adolescent knowledge and sexual behaviour

It is generally held that in countries where youth health programmes were implemented systematically, knowledge on sexually related matters has increased to some extent. However, Becker (1988:9), Jacobson (1994:10), Montessoro and Blixen (1996:34), Moran and Corley (1991:858), Santelli and Beilenson (1992:275), Sapire (1988:21 and Smailes and Cunningham (1992:16) argue that behavioural changes as a result of these programmes are in fact, minimal.

According to Montessoro and Blixen (1996:33), countries with lower rates of adolescent pregnancy and childbirth have achieved these rates by implementing a consistent policy on sex education, accessible, affordable health care delivery systems and a relatively equitable distribution of income and opportunities. In South Africa, health care systems have been fragmented, uncoordinated and inaccessible to most communities. In addition, where adolescent health programmes were implemented, very limited work was done to evaluate the programmes and measure the knowledge on sexual related issues. In a study to critically analyse the knowledge and attitude among high school students in Soweto high schools, Magwentshu (1990:136) found that most of the respondents in her sample had poor knowledge of sex-related matters.

Relationship between attitudes towards sexual practices and the extent to which adolescents are knowledgeable on sexually related matters

According to Kau (1989:70), the majority (75,0%) of the 200 male adolescents in her study who reported to be sexually active did not regard the use of contraceptives as part of their responsibility. It would appear that contraceptive use by male adolescents, mainly “condom use”, is generally poor. This is of great concern, more especially with the HIV/AIDS epidemic and the spread of sexually transmitted diseases, as barrier methods, such as the use of condoms, are considered useful in the prevention of STD’s and are recommended for use by males. It would appear that the community and, more importantly, the youth still have
misconceptions about the use of condoms.

Findings of major concern of the use of condoms are reported by Varga (1996:15) in a study to assess condom use among sex workers and their partners in Durban. According to Varga (1996:15), the acceptability of condom use was higher among both commercial sex workers and their paying clients, and yet the acceptability of condom use with personal partners was extremely low. Varga (1996:15) also points out that condoms are severely stigmatised and associated with filth, mistrust and promiscuity in personal relationship.

Such findings illustrate the lack of knowledge that still exists on sex-related issues as well as the use of condoms. Such misconceptions and negative attitudes towards the use of condoms are also apparent among the youth in the Vaal Region. Responses commonly given for the non-use of condoms are that contact should be “flesh to flesh” to show intimacy and trust and also to enhance pleasure. Such attitudes and beliefs clearly indicate the lack of knowledge and the misconceptions that still exist and the need for meaningful health education programmes.

2.5.3 The HIV/STD life skills education programme in South Africa

In the wake of the HIV/AIDS epidemic and the restructuring of the health system in South Africa, the National Department of Health, in consultation with various non-governmental organisations and the Department of Education, committed itself to providing HIV/STD and sexuality education for children and the youth (Department of Health 1997a:110). The main aim of the programme is to develop and promote an age-related HIV/STD life skills programme that will meet the emotional, social and physical needs of children, adolescents and young adults (Annexure B). The programme is envisaged as being a component of a broader lifestyle behaviour, which will include other aspects of health and family life education. According to policy guidelines, the programme will form part of the core curriculum for both teacher training as well as an integral part of the education curriculum of learners at school, starting at preprimary level (Annexure B).
To plan and implement the HIV/AIDS life skills programme, the following strategies were followed:

- Broad-based multisectoral consultation was done with all major role players in communities for the purpose of ensuring the commitment and active participation of all those involved in the programme.

- A national project committee with functioning subcommittees on marketing and curriculum development was established.

- Training of master trainers to subsequently train other trainees in the region was commenced.

- A training programme for teachers was planned and is being implemented.

- A public relations campaign was designed to support the implementation of the HIV/AIDS life skills programme.

Looking at the plans and progress made so far, it is hoped that for the first time a broad-based multisectoral school-based sexuality programme for the youth will be implemented. However, it should be pointed out that much work still needs to be done if strategies for continuous evaluation and replanning are to be drawn up to ensure that the programme remains fully effective.

The researcher is of the opinion that if this programme is to be fully effective, the following aspects need to be taken into account:
• socioeconomic factors that underlie the spread of HIV/STD as well as the factors that contribute to adolescents sexual behaviours

• the problems experienced by the schools such as work-overload and the reports about sexual abuse and drinking patterns going on between teachers and pupils (media reports)

• the sexually active child/youth who is no longer at school and is not exposed to these programmes

To facilitate the planning and implementation of the programme, the following aspects should continually be kept under review:

• the training of health workers and other major community role players to equip them with skills for counselling, educating and giving information on sexually related issues to adolescents no longer at school

• ensuring that health services are comprehensive and accessible for the management of HIV/AIDS and STD’s and counselling for contraceptives

• ensuring that condoms are available and accessible in places other than health centres

• continuous monitoring and evaluation of services and programmes to ensure that they comply with the objectives of the programme

• the involvement of target groups in the planning and evaluation of the programme. (Such involvement will help shape the programme in order to meet the needs and problems in a specific area.)
2.6 CONCLUSION

From the literature review it is apparent that the aspect of sexual activity among adolescents remains complex worldwide and that a multitude of factors influence adolescent sexual behaviour.

The literature further revealed that many countries, including South Africa, have implemented different life style sexual behaviour programmes for youth in an effort to curb possible problems that might emanate as a result of adolescent sexual activity. These programmes have not always been successful in meeting the objectives. In South Africa, socioeconomic factors and the breakdown of traditional practices played a significant role in influencing sexual practices amongst adolescents.

In view of the above findings and the fact that the adolescent who is sexually active is the group at major risk in terms of STD/HIV/AIDS, it is imperative that healthy life style behaviour programmes offered for adolescents in a community be reviewed and amended in terms of changing circumstances and the needs at local level. It was for these reasons that the study among adolescents in the Vaal Region was undertaken.
CHAPTER 3

Research methodology

3.1 INTRODUCTION

The main purpose of the study was to investigate adolescents’ sexual behaviour patterns and to determine whether the adolescent health education offered in the clinics and schools had an effect in increasing knowledge on sexuality and motivating safe sexual practices among adolescents. This chapter presents the methodology used to conduct the study.

3.2 DESCRIPTION OF THE STUDY AREA

The Vaal Region is situated about 64 kilometres south of Johannesburg, on the Vaal River, the southern border between Gauteng and the Free State. With the restructuring of health services and the setting up of district health systems, the region was divided into two health districts, namely the east and the west districts. The study was carried out in the west district, which at the time of the study had thirteen clinics.
Only four of these clinics provided sexually transmitted diseases services at the time the study was planned. This situation changed during the period the data was collected. During this period comprehensive health services were introduced throughout the region and as a result of this all 13 clinics in the western district of the Vaal Region gradually introduced services for sexually transmitted diseases as part of the comprehensive services they offered (Department of Health 1996a:7; Department of Health 1996c:8).

This change had a significant effect on the sample size as the number of adolescents attending STD clinics at the original four clinics selected for the study was reduced substantially.

3.3 RESEARCH METHODOLOGY

LoBiondo-Wood and Haber (1990:29) state that “the purpose of a research design is to provide a scheme for answering specific research questions”. In this study a quantitative, exploratory, descriptive research approach was used to collect the data on sexual behaviour patterns and the knowledge of adolescents in the Vaal Region.

A descriptive survey was selected for this study as this method was considered the most appropriate for observing, describing and classifying the factors that influenced involvement in unsafe sexual practices among adolescents. According to Polit and Hungler (1987:126), the survey method can be used to examine the characteristics, opinions, or intentions of a population. Polit and Hungler (1987:155) also maintain that a survey is designed to obtain information from populations on the prevalence, distribution and interrelationships of variables within those populations. Information on the characteristics of the sample and their sexual behaviours was obtained by using a questionnaire.

3.4 POPULATION AND SAMPLING METHOD

Polit and Hungler (1987:207) define a population as “the entire aggregation of cases that meet a designated set of criteria”. To determine the number or percentage of adolescents
who attended health service suffering from STD's or gynaecologicals condition in the Vaal Region, statistics were obtained from Sebokeng Hospital and the four clinics that offered STD services (tables 1.1, 1.2, 1.3 and 1.4 in chapter 1).

On the basis of these statistics and after discussion with the statistician it was decided to carry out a survey for the study in the four original clinics that offered these services. These findings assisted in deciding the sample size and sampling method, and setting time frames for the study. A sample size of 100 subjects was planned. It was initially estimated that the actual data collection would be completed in June 1997. This could not be accomplished because all 100 subjects could not be reached as planned. After consultation with the statistician and the promoters, the cut-off date for collecting data was extended to 31 August 1997. At the end of August, 89 questionnaires had been completed and this was accepted as the sample size for the study.

3.5 CRITERIA FOR SELECTING THE SAMPLE

According to Leedy (1993:187), when using a descriptive survey method, it is important “to carefully choose, clearly define and specifically delimit the population in order to set precise parameters for ensuring discreteness”. The population selected for the study included Black adolescents, males and females, in the age group 14 to 19 years, attending the four sexually transmitted disease clinics in the Vaal Region. The adolescents attending the STD clinics were seen as the group at risk for unsafe sexual practices, for both males and females. Though pregnant adolescents were also seen as the group at risk, they were not included in this study as this group would only comprise females. The purpose of the study was to concentrate on both male and female adolescents at risk.

Based on the preliminary data obtained in tables 1.1, 1.2, 1.3 and 1.4, where it was found that adolescents as young as 14 years were sexually active and attended STD clinics or were admitted for teenage pregnancies or gynaecological conditions associated with active sexual practices, the age group 14 to 19 years was selected. The generally accepted upper limit of the teenage period, namely 19, was also considered appropriate for this study.
3.6 SAMPLING METHOD

A non-probability convenience sampling method was used, in which every adolescent in the age group 14 to 19 years, who attended the four STD clinics in the period 1 February 1997 to 30 August 1997 were selected by the sisters at the clinics.

Polit and Hungler (1997:210) point out that “though convenience sampling is the least desirable form of sampling where the phenomenon under study is homogenous within the population, the risk of bias may be minimal”. In this context LoBiondo-Wood and Harber (1990:270) see convenience sampling as a process of selecting a portion of the designated population to represent the entire population.

A non-probability convenience sampling method was chosen in this study for the following reasons:

- The total number of adolescents with sexually transmitted diseases was not known as under-reporting of STD is common.
- The number of adolescents in the age group reporting at the four clinics on daily basis was very small.
- The decentralisation of STD services to other clinics after commencement of the study thus made the number attending these four clinics even smaller.

3.7 DATA COLLECTION

Using the research questions as the conceptual framework, an open-ended and closed questions computer-coded questionnaire was designed by the researcher to obtain data for this study. The content of the questionnaire was determined from the literature review and the content of the sexuality education programme offered in the Vaal Region (Annexure A).
A questionnaire was seen as the appropriate data collecting instrument for the following reasons:

- A sensitive area, relating to personal information on sexual behaviour patterns was being studied. It was felt that the respondents would feel more comfortable about giving truthful answers to a questionnaire than in a personal interview.

- A questionnaire would also provide a degree of anonymity, which is important when dealing with sensitive issues.

Polit and Hungler (1997:243) and LoBiondo-Wood and Harber (1990:238) maintain that

- "the absence of an interviewer ensures that there will be no interviewer bias". This was important for the study as a judgemental attitude had to be avoided at all costs.

- "questionnaires are less costly and less time consuming for the researcher".

In this study the time factor was a major concern and by using a questionnaire more respondents could be targeted during a clinic period. Privacy and confidentiality were also a major contributing factor as the possibility of arranging individual interviews at these clinics that ensured privacy was a problem.

3.8 DEVELOPMENT OF THE QUESTIONNAIRE

In accordance with the conceptual framework used for the study and using an open-ended and close question format the questionnaire was designed to provide data on

- the sexually active adolescents in the Vaal Region

- factors that contribute to sexual behaviour among the adolescents in the Vaal Region
• the extent to which the adolescent in the Vaal Region is knowledgeable about safe sexual practices and the importance of healthy life style behaviours

3.9 FORMAT OF THE QUESTIONNAIRE

The content of the questionnaire was based on the literature reviewed as well from experts in the field. Mainly closed questions were used. Very few open-ended questions were used as these questions are time consuming to complete and the adolescents whose English is a second language may have had difficulty in expressing themselves accurately. In this context questions with a number of alternative responses were also used to enable respondents to select the responses which reflected their opinions more realistically (Annexure D).

➤ Who is the sexually active adolescent in the Vaal Region? (Questions 1.1 to 1.5, 2.1 to 2.5)

To provide information to this research question, questions about the personal details of the adolescent were asked, such as age, sex, educational standard, school attendance, family structure, location at which sexual practices took place, ages at first sexual intercourse, frequency of sexual activity, number and type of sexual partners, strongest feeling during sexual intercourse and reasons for first act of coitus.

➤ What factors contribute to sexual behaviour among the adolescent in the Vaal Region? (Questions 1.6 to 1.9, 2.6 to 2.7 and 3.1 to 3.5)

To provide information on this research question, the questions dealt with the factors that could contribute to the adolescent in the Vaal Region becoming sexually active, namely educational level of parents, the environment in which the adolescent lives, life style practices of the adolescent, peer influences, use of habit forming substances before sexual practices, adolescents' perceptions on sexual behaviour and reasons why adolescents engage in sexual intercourse.
Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy life style behaviours? (Questions 4.1 to 4.14)

To provide information on this research question, the questions dealt with adolescents’ perceptions on sexual behaviours, life style practices, the use of pregnancy prevention methods, the extent of sexually transmitted diseases among adolescents, the pregnancy rate among adolescents, knowledge of sexuality topics, sources of education on topics, and adolescents’ perceptions of the new life skills programme.

3.10 PRETESTING OF THE INSTRUMENT

3.10.1 Validity of the research instrument

*Validity* refers to whether an instrument measures what it is supposed to measure (LoBiondo-Wood and Harber 1990:250). Content and face validity of the instrument was tested by presenting it to three community health nurses working with adolescents in STD clinics. Some items of the questionnaire were taken off and others added. According to LoBiondo-Wood and Harber (1990:250), *content validity* represents “the universe of content that provides the framework and basis for formulating the items”. *Face validity* is defined as “an intuitive type of validity content in terms of whether it appears to reflect the concept the researcher intends to measure” (Lobiondo-Wood & Harber 1990:251).

The questionnaire was also presented to the promoter, co-promoter and statistician. Further adjustments in the organisation and layout followed. Personal and more sensitive questions were arranged so that they did not follow each other sequentially, so that the response to one question would not influence the next.

3.10.2 Reliability of the research instrument

LoBiondo-Wood and Harber (1990:255) define reliability of a research instrument as “the extent to which the instrument yields the same results or repeated measures”. Reliability is
concerned with "consistency, accuracy, precision, stability and homogeneity". Pre-testing for reliability was done by administering the questionnaire to four adolescents (two males and two females) who reported at a sexuality transmitted disease clinic. This was done to ensure that the questions were worded clearly and that questions were not ambiguous.

The time taken to complete the questionnaire was also noted and found to be 15 minutes on average. Care was taken to avoid genotypical questions as subjects were both males and females. Eichler (1988:92) maintains that "if different questions for the two sexes are asked, different answers will be received". This may introduce bias or double standards.

3.11 DATA COLLECTION

The questionnaire was given out by the four registered nurses working in the four sexuality transmitted district clinics to all the adolescents attending the clinic during the period February to August 1997. The purpose and objectives of the study were explained to these nurses and the questionnaire discussed item per item, so that they had a clear understanding of the questions asked, if they needed to assist the adolescents completing the questionnaire. The target group were asked to complete the questionnaire at the clinic and place the completed forms in a box provided.

3.12 RESPONSE RATE

In terms of the sample size recommended, a total of 100 questionnaires were distributed for completion by adolescents attending the four sexually transmitted disease clinics. The response rate was so slow that by the end of June 1997, only 56 questionnaires had been returned. After discussion with the statistician, the cut-off date was extended to 31 August 1997. On this date 89 questionnaires were returned. This was taken as the final response rate.
3.13 ETHICAL CONSIDERATION

Eichler (1988:115) maintains that “research is founded on willing cooperation of the public and the organisation. The public and the organisation should feel confident that the research is conducted in an honest and objective manner without intrusion or harm to the subjects.”

Ethical considerations were ensured by the following:

- Permission to conduct the study was obtained from the authorities concerned, namely the local government health department and the authorities of the regional hospital at Sebokeng (Annexure E).

- Voluntary informed consent was secured from the respondents at the clinic. A covering letter explaining the purpose of the study, voluntary participation and anonymity was provided (Annexure F). No adolescent was coerced into participating in the study.

- The respondents were assured of anonymity and confidentiality and told that their names would not appear anywhere in the questionnaire.

- The respondents had to complete the questionnaire by themselves, though permission was given to ask questions if they did not understand a question.

- After completion, the questionnaire was sealed in an envelope, dropped into a box and collected by the researcher.

3.14 CONCLUSION

This chapter discussed the research methodology. Chapter 4 will present the findings and analyses of the data.
CHAPTER 4

Analysis and presentation of data

4.1 INTRODUCTION

This chapter discusses the analysis of the data obtained from the questionnaire.

4.2 METHOD USED FOR THE ANALYSIS OF DATA

The data was analysed using the SAS computer program. A total of 89 (n = 89) adolescents responded to the questionnaire. The items are presented and discussed in numerical sequence according to the format of the questionnaire.

4.3 CONCEPTUAL FRAMEWORK USED FOR THE ANALYSIS AND PRESENTATION OF DATA

In terms of the conceptual framework used for the study, the items for each research question are given below:

4.3.1 Who is the sexually active adolescent in the Vaal Region?

- Items 1.1 to 1.5 (pages 59 to 63)
- Items 2.1 to 2.5 (pages 68 to 73)
4.3.2 What factors contribute to sexual behaviour among the adolescents in the Vaal Region?

- Items 1.6 to 1.9 (pages 64 to 67)
- Items 2.6 to 2.7 (pages 74 to 75)
- Items 3.1 to 3.5 (pages 76 to 83)

4.3.3 Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy life style behaviours?

- Items 4.1 to 4.14 (pages 85 to 108)

Item 1.1: Age of the adolescent in years

Figure 4.1

Age of the adolescent in years ($N = 87$)

Figure 4.1 shows that 43 (49.4%) of the respondents were aged between 18 and 19 years, with 11 (12.6%) respondents were between 14 and 15 years, and 33 (38.0%) of the respondents fell between the ages of 16 and 17 years. These findings appear to indicate that sexual activity among adolescents increases with age.
The findings are consistent with the statistics on STD's from Zone 7 clinic and the statistics on teenage pregnancy in the Sebokeng Maternity Delivery Register 1995. According to these statistics, most of the teenagers who delivered at this hospital and those with STD's were between the ages of 16 and 19 years (tables 1.1, 1.2, 1.3 and 1.4).

**Item 1.2: Gender of the adolescent**

![Pie chart showing gender distribution of the adolescent respondents.](image)

*Figure 4.2*

*Gender of the adolescent (n = 89)*

Of the respondents, 66 (74.2%) were females, and only 23 (25.8%) were males. The outcome of these findings was unexpected as males are usually seen as the main users of the sexually transmitted disease service. However, the results appear to confirm the report of the Department of Health (1997b:13) which stated that below the age of 20 years, more females present with sexually transmitted diseases than males. The reason for this is that the lining of the female genital tract is immature, thus making females more susceptible to sexually transmitted diseases.
Figure 4.3 shows that 42 (47.7%) of the respondents were in Standard 7 to 8 (now Grade 9 and 10), 34 (38.6%) were in Standard 9 to 10 (Grade 11 to 12), and only 12 (13.7%) were in Standard 5 to 6 (Grade 7 to 8). When cross-tabulation was done between age and standard of education, it was found that those in Standard 7 to 8 (Grade 9 to 10) were in the age group 16 to 17 years whilst 26 (76.5%) of those in Standard 9 to 10 (Grade 11 to 12) were between 18 and 19 years. This is a satisfactory finding, also showing age appropriateness to schooling level.
The majority of the respondents, 81 (92.0%) were still at school. Though no follow-up question was asked to determine reasons for non-school attendance, it is a concern that of the sample 7 (8.0%) were no longer attending school. Academic aspirations have been indicated as a factor that influences the delay of sexual involvement and makes health education messages more meaningful (Rice 1992:372).

*Figure 4.4*

*Number of adolescents attending school (N = 88)*
Figure 4.5

Living arrangements of the adolescent (N = 87)

Figure 4.5 shows clearly that 53 (60,9%) of the respondents live with both parents; 2 (2,3%) live with their fathers; 20 (23,0%) live with their mothers and other siblings; 7 (8,1%) live with their grandparents; 1 (1,1%) lives with friends and 3 (3,5%) live with relatives. Only 1 (1,1%) respondents indicated "others" but did not specify what this meant. The findings show that whilst most of the respondents are living with their parents, women more than men appear to be in the majority in terms of single parenting. This is an expected outcome as most women today appear to be more independent and maintaining their own homes than was the case in the past.

The findings also appear to link up with earlier research findings that family factors such as divorce, separation are on the increase and may also influence moral behaviour among children (Mayekiso & Twaise 1992:23; Sapire 1986:419).
Item 1.6: Educational level of the father of the adolescent

![Bar chart showing educational levels of fathers]

Figure 4.6

Educational level of the father of the adolescent (N = 84)

Not all the respondents answered this question, presumably because they did not know. Figure 4.6 shows that 30 (35.7%) of the respondents' fathers' educational level was between Standard 6 and 8 (Grade 8 and 9). Very few, 2 (2.4%) indicated that their fathers had a degree; 6 (7.1%) indicated that their fathers had diplomas; 8 (9.5%) indicated that their fathers had no education and 5 (6.0%) indicated their fathers' qualifications as priest, electrician and police officer. Of the remaining respondents, 8 (9.5%) indicated that their fathers had reached an educational level between Standard 1 and 2 (Grade 3 and 4); 10 (11.9%) indicated a level between Standard 3 and 5 (Grade 5 and 7) and 15 (17.9%) between Standard 9 and 10 (Grade 11 and 12). The educational level of parents is of significance in terms of receptivity to information and imparting knowledge to their children.
Item 1.7: Educational level of the mother of the adolescent

As with the father's educational level, not all respondents answered this question (N = 85), possibly because they did not know or were not sure about the educational level of their parents. The statistics for both the father's and mother's educational levels were very similar, with only slight differences. Of the respondents, 35 (41.2%) indicated that their mothers' education level was between Standard 6 and 8 (Grade 8 and 10); 1 (1.2%) mother had a degree; 7 (8.2%) indicated that their mothers had no education; 5 (5.9%) indicated that their mothers had Standard 1 to 2 (Grade 3 to 4); 15 (17.6%) indicated Standard 3 to 5 (Grade 5 to 7); 14 (16.5%) indicated Standard 9 to 10 (Grade 11 to 12) and 5 (5.9%) indicated diploma level. Three (3.5%) respondents indicated that their mothers had other unspecified educational levels.
A chi-square test was done, to determine whether there was a relationship between the educational level of the mother and the occurrence of sexually transmitted diseases. From the chi-square test ($p = 0.372$), it would appear that there is no significant relationship between the educational level of the mother and the extent of sexually transmitted disease among adolescents.

> **Item 1.8: Type of housing in which the adolescents live**

![Type of housing in which the adolescents live](image)

*Figure 4.8*

_Type of housing in which the adolescents live ($N = 87$)*

Figure 4.8 shows that 55 (63.3%) of the respondents lived in a standard four to five-roomed house; 16 (18.4%) live in standard six-roomed homes whilst 14 (16.1%) stay in a shack and only 1 (1.1%) respondents indicated that they live in a two-roomed unit and in a hostel, respectively. These findings appear to indicate the socio-economic status of parents and
appear to link with the educational level of parents. These findings are to be expected as the majority of homes in the townships are the standard four- to five-roomed homes.

Item 1.9: Social clubs attended by adolescents

Table 4.1: Social clubs attended by adolescents (N = 84)

<table>
<thead>
<tr>
<th>TYPE OF CLUB</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social club</td>
<td>10</td>
</tr>
<tr>
<td>Sporting club</td>
<td>30</td>
</tr>
<tr>
<td>Church youth club</td>
<td>31</td>
</tr>
<tr>
<td>No club</td>
<td>13</td>
</tr>
</tbody>
</table>

Not all the respondents answered this question. More than one response was possible for this question. Most respondents (30) indicated that they belong to a sporting club or a church youth club, and 10 indicated that they belong to a social club. Thirteen indicated that they do not belong to any club. With the lack of other recreational facilities and the number of “taverns” (houses used as drinking places) and the night clubs available in the area, most respondents were expected to indicate belonging to a social club. On the whole, the findings were satisfactory as most respondents said they either belonged to a sporting or a church club, which are socially acceptable meeting places.
Figure 4.9 indicated that the majority, 40 (45.5%) of the respondents were between the ages of 14 and 16 years when they had sexual intercourse for the first time, whilst 19 (21.5%) were in the age group 17 to 19 years. It is of great concern to note that 11 (12.5%) of the respondents were in the age group 11 to 13 years and that 5 (5.7%) were less than 10 years old when they had sexual intercourse for the first time. A mean age for the commencement of sexual contact was found to be 13.5 years. It is not known why one respondent did not answer this question.

These findings appear to confirm studies by Magwentshu (1990:123), Preston-Whyte and Zondi (1991:1389) and Zabin and Hayward (1993:27), who report that adolescents today tend to engage in sexual intercourse at a much younger age. In their study among adolescents in KwaZulu, Preston-Whyte and Zondi (1991:1389) found that, by the time the adolescents were 13 years old, many of them had already been sexually active. Kau
(1989:77) studies 22 male adolescents in the Molopo Region of Bophuthatswana and found that the critical age at which adolescents commenced sexual intercourse was 12 years. She reported a trimodial distribution as 12, 14 and 16 years.

It was also interesting to find that 13 (14.8%) of the respondents indicated that they never had sex, and yet were visiting a sexually transmitted disease clinic. The researcher has found that adolescents are not always willing to disclose their sexual activities, as occasionally adolescents will present with genital ulcers and urethral discharges and still claim never to have been engaged in sexual intercourse. For example, in item 2.3 respondents were asked about places where they usually had sexual intercourse and four of those who indicated never having had sex responded that they usually had sex in their homes.

> **Item 2.2: Frequency of sexual activity of the adolescent in a month**

![Graph showing the frequency of sexual activity of the adolescent in a month.](image)

_Figure 4.10

Frequency of sexual activity of the adolescent in a month (N = 82)_
Not all the respondents answered this question, perhaps because they found it difficult to remember or were not willing to disclose the extent of their sexual activity. Most of the respondents indicated that they had sexual intercourse weekly: 39 (47.6%) indicated that they had sexual intercourse one to two times weekly, 7 (8.5%) said three and more times weekly and 14 (17.1%) indicated three or five times per month. Only 1 (1.2%) respondent indicated six or more times per month; 6 (7.3%) stated that they have sex sometimes and 15 (18.3%) indicated that they had never had sex.

These findings are not consistent with earlier studies by Zabin and Hayward (1993:55) and Kau (1989:88), who reported that the frequency of sexual intercourse among adolescents in their studies was episodic. Kau (1989:88) reported that the majority of the 200 (51.0%) of the adolescents in her sample indicated a monthly frequency of sexual intercourse. A chi-square test was done to determine the relationship between frequency of sexual intercourse and age at first sexual intercourse. The results showed a significant difference (0.000) in the frequency of sexual intercourse between those who started early in their teenage years and those who started late. This indicates that those who start engaging in sex at a much younger age tend to have sexual intercourse more frequently. The findings appear to concur with Rice (1992:368) and Zabin and Hayward (1993:277) who assert that adolescents who start sexual intercourse early tend to be sexually permissive.
Item 2.3: Location where the adolescent had sex

Not all the adolescents responded to this question. More than one response was possible. Of the 79 who responded, 46 indicated that they usually had sexual intercourse in the partner's home; 15 indicated that they had sex in their own homes; 6 mentioned a public place; 9 indicated a relative's house and 3 indicated unspecified "other" places. When gender of respondent and location for sexual activity was cross-tabulated, it was found that the boy's home was most commonly used for engaging in sexual intercourse. The results appear to concur with the views of Gullotta et al (1993:65), who state "that common places for sexual intercourse among adolescents were one's own home or the partner's home". It is interesting to find that the male's home was mostly used as location for sexual relations. The findings appear to confirm the views of Louw (1991:394), Setiloane (1990:45) and Smailes and Cunningham (1992:16) that rigid sexual norms and values are changing. In the researcher's experience in the African culture, it is considered taboo for a girl to visit the
boy's home before marriage.

Item 2.4: Number of sexual partners of the adolescent

![Pie chart of sexual partner distribution](image)

**Figure 4.12**

*Number of sexual partners of the adolescent (N = 87)*

Not all the respondents answered this question. Of the respondents, 60 (69.0%) had only one partner; 13 (15.0%) had two to three partners, and 3 (3.4%) indicated four or more partners. Eleven (12.6%) respondents indicated that they had no partner, which is a surprising response. When cross-tabulation was done for gender and multiple partners, more males, than females were found to have more than one partner. Though small, these numbers agree with the findings of Gullota et al (1993:69) and Kimane and Joseph (1996:46) on differences in the number of partners for males and females. In a study carried out in Alexandra township, Gauteng Province, Kimane and Joseph (1996:46) reported that in their sample 43.0% of the males as compared to 90.0% of the females had only one sexual partner, which shows that the majority of males had more sexual partners.
Item 2.5: Type of sexual partners

Table 4.2: Type of sexual partners (N = 86)

<table>
<thead>
<tr>
<th>TYPE OF PARTNER</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>62</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td>Both (male and female)</td>
<td>17</td>
</tr>
</tbody>
</table>

All the respondents did not answer all the questions. It would appear that the respondents did not fully understand the question. The respondents were expected to indicate whether their sexual partners were male or female. Seventeen (19.8%) respondents indicated that they had both male and female sexual partners, 62 (72.1%) stated that they had male partners and only 7 (8.1%) mentioned that they had female partners.
Item 2.6: Strongest feeling experienced by the adolescent during sexual intercourse

Figure 4.13

Strongest feeling experienced by the adolescent during sexual intercourse (N = 81)

Not all the respondents answered the question (N = 81). The reason for this could be that it is not always easy to describe feelings. However, from figure 4.13, it is clear that less than 32 (39.6%) of the respondents indicated experiencing a pleasurable feeling during the act of intercourse; 18 (22.2%) indicated that they experience no feelings, 17 (21.0%) respondents experienced feelings of shame and 13 (16.0%) experienced feelings of guilt. One (1.2%) respondent indicated that she had been raped. It was expected that more cases of rape would be identified, as currently the media frequently report cases of child and adolescent sexual abuse (Sowetan 1997a:4; Sunday Times 1977b:1).
The results on pleasurable feelings could be linked to the frequency of sexual intercourse (Item 2.2), where the majority of respondents, 39 (47.6%) indicated having sexual intercourse once or twice weekly.

**Item 2.7: Reasons given for the first act of sexual intercourse**

Table 4.3: Reasons given for the first act of sexual intercourse ($N = 77$)

<table>
<thead>
<tr>
<th>INDICATIONS OF HOW THE FIRST ACT OF INTERCOURSE OCCURRED</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt like doing it</td>
<td>13</td>
<td>16.8</td>
</tr>
<tr>
<td>You and your partner planned it</td>
<td>27</td>
<td>35.1</td>
</tr>
<tr>
<td>You were forced by your partner</td>
<td>17</td>
<td>22.1</td>
</tr>
<tr>
<td>You were forced by a person other than your partner</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>It just happened</td>
<td>18</td>
<td>23.4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

**TOTAL** 77 100.0

Only 77 respondents answered this question. Table 4.3 shows that 27 (35.1%) of the respondents planned the act of sexual intercourse; 17 (22.1%) indicated that they were forced by partners; 18 (23.4%) said that it just happened and 13 (16.8%) indicated that they felt like doing it. The one (1.3%) who indicated that she was forced by a person other than the partner stated clearly that she was raped. Only 1 (1.3%) respondent indicated “other unspecified reason”. Of the 17 (22.1%) respondents who indicated being forced by partners, 16 were females and only one was a male. It is not known whether males are truly forceful initiators of the sexual act, or whether females are too ashamed to admit willingness.
Item 3.1: The adolescent's perception on sexual behaviour

In this questions respondents were asked to respond on a three-point scale: agree, disagree and not sure to the statements given.

Table 4.4: The adolescent’s perception on sexual behaviour (n = 89)

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>N</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There is nothing wrong in having sex as long as you are in love.</td>
<td>78</td>
<td>46</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>• Teenagers can engage in sex, irrespective of age.</td>
<td>66</td>
<td>20</td>
<td>31</td>
<td>15</td>
</tr>
<tr>
<td>• Teenager can have sex with as many partners as they like.</td>
<td>70</td>
<td>12</td>
<td>45</td>
<td>13</td>
</tr>
<tr>
<td>• Sex before marriage is wrong.</td>
<td>75</td>
<td>41</td>
<td>22</td>
<td>12</td>
</tr>
</tbody>
</table>

Not all the respondents responded to all the statements given. It would appear from the findings in table 4.4 that the majority of the respondents disagreed with all the statements except the statement “there is nothing wrong in having sex as long as you are in love”.

Forty-six (59,0%) of the respondents agreed with the statement that “there is nothing wrong in having sex as long as you are in love”; 17 (21,8%) disagreed and 15 (19,2%) were not sure. The results were consistent by Kunene’s (1988:107) findings. Kunene looked at the views on teenage pregnancy at Umlazi in Natal and found that teenagers approved of sexual intercourse during the adolescence period. It would appear that there is consistency on this statement and the feelings experienced during sexual intercourse (Item 2.6), where 32 (39,6%) of the respondents seemed to enjoy the act and 27 (35,1%) had planned the act (Item 2.7).
A total of 31 (47,0%) respondents disagreed with the statement that teenagers can engage in sex, irrespective of age; 20 (30,3%) respondents agreed and 15 (22,7%) were not sure. A chi-square test was done to test the extent to which males and females disagreed with the statement and no significant difference ($p = 0.828$) was found.

Most of the respondents, 45 (64,3%) disagreed with the statement that teenagers can have sex with as many partners as they liked. Only 12 (17,1%) respondents agreed whilst 13 (18,6%) were not sure. The response to this statement appears to be consistent with the response in Item 2.4 where the adolescents were asked how many partners they had. The majority of respondents 60 (69,0%) indicated having only one partner. This is a satisfactory finding and could indicate that information on sexual related matters is having an impact.

The findings on the responses to the statement “sex before marriage is wrong” showed that 41 (54,7%) of the respondents agreed with the statement, 22 (29,3%) disagreed and 12 (16,0%) were not sure. It is interesting to note that although half of the respondents’ agree with the statement “sex before marriage is wrong”, many admitted to being engaged in sexual activities on a weekly basis.

These findings appear to concur with the views of Becker (1988:9), Jacobson (1994:10), Montessoro and Blixen (1996:34), Mogan and Corley (1991:858), Santelli and Beilenson (1992:275), Sapire (1988:21) and Smailes and Curringham (1992:16), who presume that though adolescents may have knowledge about correct sexual behaviour, this does not seem to deter them from engaging in wrongful sexual practices.

A chi-square test was done to determine the perceptions of males and females on sex before marriage, and no significant difference ($p = 0.468$) was found. The results on perceptions on sex before marriage are not consistent with Kau’s (1991:39) findings in a sample of 200 male adolescents, where 64,0% were of the view that sex before marriage is all right.
Item 3.2: Influencing factors that promote sexual behaviour among adolescents

Table 4.5: Influencing factors that promote sexual behaviour among adolescents (n = 89)

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>N</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>• Sex is considered a way of life by teenagers.</td>
<td>74</td>
<td>37</td>
<td>50,0</td>
<td>20</td>
</tr>
<tr>
<td>• Teenagers do what friend of the same age do.</td>
<td>75</td>
<td>40</td>
<td>53,3</td>
<td>20</td>
</tr>
<tr>
<td>• Teenagers want to experiment with sex.</td>
<td>67</td>
<td>32</td>
<td>47,8</td>
<td>14</td>
</tr>
<tr>
<td>• Teenagers are influenced by television.</td>
<td>71</td>
<td>36</td>
<td>50,7</td>
<td>23</td>
</tr>
<tr>
<td>• Teenagers are influenced by movies.</td>
<td>71</td>
<td>41</td>
<td>57,7</td>
<td>19</td>
</tr>
<tr>
<td>• Teenagers are influenced by what they read in magazines.</td>
<td>72</td>
<td>38</td>
<td>52,8</td>
<td>21</td>
</tr>
<tr>
<td>• Teenagers do not know about the dangers of early sex.</td>
<td>76</td>
<td>47</td>
<td>60,8</td>
<td>13</td>
</tr>
<tr>
<td>• Teenagers are influenced by alcohol.</td>
<td>71</td>
<td>27</td>
<td>38,0</td>
<td>22</td>
</tr>
<tr>
<td>• Teenagers are influenced by use of dagga.</td>
<td>72</td>
<td>25</td>
<td>34,7</td>
<td>23</td>
</tr>
<tr>
<td>• Teenagers are influenced by use of other drugs.</td>
<td>70</td>
<td>31</td>
<td>44,3</td>
<td>19</td>
</tr>
</tbody>
</table>

Not all the respondents answered each question. From the findings in table 4.5, it would appear that adolescents in the Vaal Region feel that all the abovementioned factors have to a certain extent, had an influence on the sexual activities of adolescents in the region.
A total of 37 (50,0%) respondents agreed with the statement that “sex is a way of life”, 20 (27,0%) disagreed and 17 (23,0%) were not sure. There appeared to be consistency with the statement that “there is nothing wrong with engaging in sex as long as you are in love” (Item 3.1) where 46 (59,0%) of the respondents agreed with this statement, 17 (21,8%) disagreed and 15 (19,2%) were not sure.

Peer pressure is apparently regarded as an influential factor in sexual involvement as 40 (53,3%) respondents agreed with the statement that “teenagers do what others of the same age do”, 20 (26,7%) disagreed and 15 (20,0%) were not sure.

These findings appear to be consistent with Louw’s (1991:422) findings that peer group pressure plays a vital role in influencing adolescents’ behaviour, including sexual activities. The findings in table 4.5 are not conclusive in terms of the media. In respect of television, 36 (50,7%) of the respondents and in respect of magazines, 38 (52,8%) indicated that these sources did have an influence on adolescents’ sexual behaviour. This appears to support the findings of Brown and Newcomer (1991:87), Greenburg et al (1993:66) and Kunene (1988:36) that the media provide the most social pressure for adolescents to become sexually active. In this context 23 (32,4%) respondents disagreed with the statement that what is viewed on television influences adolescents’ sexual practices and 12 (16,9%) were not sure. Of the 71 respondents who responded to the statement on the influence of the movies, 19 (26,8%) disagreed movies influence sexual activity of adolescents in the Vaal Region and 11 (15,5%) were not sure.

“Teenagers do not know about the dangers of early sex” rated very high, with 48 (60,8%) respondents indicating that these factors did have an influence on adolescents’ sexual involvement. This could be significant in terms of the knowledge gained through the health education programme, namely, that it was not, in fact, effective in empowering adolescents with knowledge. The respondents also viewed the use of alcohol and other drugs as having an influence on adolescents’ sexual activities. Twenty-seven (38,0%) of the respondents agreed that the use of alcohol has influence on adolescents’ sexual involvement, and 31 (44,3%) also viewed the use of other drugs as influencing adolescents’ sexual behaviours.
This appears to support Disler (1991:47), Flanigan et al (1990:205), Jacobson (1994:11), Lowry et al (1994:1116), who share the view that alcohol and drug use is common among adolescents and that the use of these substances appears to influence adolescents’ sexual activities. Though 31 (44.3%) respondents regarded the use of drugs among the adolescents as of significant influence on their sexual activities, 19 (27.1%) disagreed and 20 (28.6%) were not sure.

Whilst 27 (38.0%) respondents viewed alcohol as influencing adolescents’ sexual activities, 22 (31.0%) disagreed and 22 (31.0%) were not sure. Twenty-five (34.7%) of the respondents agreed with the view that the use of dagga influenced adolescents’ sexual behaviours, 23 (32.0%) disagreed and 24 (33.3%) were not sure. Experimentation with sex was also indicated by 32 (47.8%) respondents as having an influence on adolescents’ involvement in sexual activities.

Item 3.3: The extent to which respondents used alcohol, dagga and other drugs before having sexual intercourse

The respondents were required to give responses on a three-point scale: never, sometimes and often, to determine the extent to which dagga, alcohol, benzine, glue and other drugs were used before engaging in sexual intercourse.
To what extent have you ever used the following before having sex?

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>N</th>
<th>NEVER</th>
<th></th>
<th>SOMETIMES</th>
<th></th>
<th>OFTEN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Dagga use</td>
<td>71</td>
<td>64</td>
<td>90,1</td>
<td>4</td>
<td>5,7</td>
<td>3</td>
<td>4,2</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>71</td>
<td>50</td>
<td>70,4</td>
<td>17</td>
<td>24,0</td>
<td>4</td>
<td>5,6</td>
</tr>
<tr>
<td>Benzine use</td>
<td>70</td>
<td>68</td>
<td>97,1</td>
<td>2</td>
<td>2,9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Glue sniffing</td>
<td>69</td>
<td>65</td>
<td>94,2</td>
<td>2</td>
<td>2,9</td>
<td>2</td>
<td>2,9</td>
</tr>
<tr>
<td>Use of other</td>
<td>68</td>
<td>63</td>
<td>92,7</td>
<td>3</td>
<td>4,4</td>
<td>2</td>
<td>2,9</td>
</tr>
</tbody>
</table>

Not all the respondents answered all the questions asked. Although the majority of respondents indicated that they never used the harmful substances listed, the findings from table 4.6 show that 17 (24.0%) of the respondents indicated that they sometimes used alcohol before having sex, 4 (5.6%) admitted that they often used alcohol before engaging in sexual intercourse and 50 (70.4%) indicated that they never used alcohol. The findings are surprising and do not appear to be consistent with Disler’s (1991:41) finding on health related life style behaviours of adolescents that 76.6% of the sample among high school pupils in Cape Town were using alcohol.

Four (5.7%) respondents indicated that they sometimes used dagga before sex and 3 (4.2%) admitted using dagga often, whilst 64 (90.1%) said they never used dagga. The use of other drugs, though names of drugs were not indicated, did not appear to be significant. Three (4.4%) of the respondents indicated sometimes using drugs other than dagga and 2 (2.9%) said they used other drugs often. It would appear that the number of adolescents involved in the use of drugs and other related substances before sex was minimal. It is of concern that adolescents are involved in these acts as the use of these substances prior to engagement in a sexual act may decrease inhibitions thus promoting unsafe sexual practices.
The alarming reports by the media on drug trafficking in South Africa increase the concern. For example, the *Sunday Times* (1997a:7) reported on drug trafficking and the involvement of young girls and sex selling in order to get drugs. Young girls in the group 12 to 14 years were mentioned in sex selling and drug trafficking.

Benzine was also found to be insignificantly used. Only 2 (2.9%) respondents indicated that they sometimes used benzine, 68 (97.1%) said they never used benzine. With regard to glue sniffing, 2 (2.9%) respondents indicated that they sometimes sniffed glue, 2 (2.9%) indicated that they did so often and 65 (94.2%) indicated that they never sniffed glue.

> **Item 3.4: The use of alcohol and other drugs by partners before sexual act**

The respondents were asked to give responses on a three point scale: *never*, *sometimes* and *often* to the use of alcohol and other drugs by partners before having sex.

**Table 4.7: The use of alcohol and other drugs by partners before sexual act (n = 89)**

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>N</th>
<th>NOT KNOWN</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent has your partner used any of the following before having sex?</td>
<td></td>
<td>F  %</td>
<td>F  %</td>
<td>F  %</td>
</tr>
<tr>
<td>• Dagga</td>
<td>71</td>
<td>63 88,7</td>
<td>6  8,5</td>
<td>2  2,8</td>
</tr>
<tr>
<td>• Alcohol</td>
<td>73</td>
<td>54 74,0</td>
<td>17 23,3</td>
<td>2  2,7</td>
</tr>
<tr>
<td>• Benzine</td>
<td>67</td>
<td>63 94,0</td>
<td>2  3,0</td>
<td>2  3,0</td>
</tr>
<tr>
<td>• Glue</td>
<td>68</td>
<td>63 92,6</td>
<td>3  4,4</td>
<td>2  3,0</td>
</tr>
<tr>
<td>• Other drugs (specify)</td>
<td>48</td>
<td>44 91,7</td>
<td>1  2,0</td>
<td>3  6,3</td>
</tr>
</tbody>
</table>
Not all the respondents answered all the statements given. It is apparent from the findings in table 4.7 that there were similar patterns between self-use of alcohol and other drugs before the sexual act and those of the partner. The same low levels of dagga use, benzine use and glue sniffing were indicated for self and for partners.

Seventeen (23.3%) of the respondents indicated that their partners sometimes used alcohol before engaging in sexual intercourse, 2 (2.7%) said their partners often used alcohol and 54 (74.0%) indicated that they did not know. Generally, the other harmful substances were reported to be insignificantly used by their partners. Sixty-three (88.7%) respondents indicated that they do not know if their partners used dagga, 6 (8.5%) said their partners sometimes used dagga and only 2 (2.8%) reported frequent use of dagga by their partners. Though the names of other drugs were not mentioned, 3 (6.3%) respondents reported frequent use of drugs by their partners, 1 (2.0%) said sometimes and 44 (91.7%) indicated that they did not know whether their partners used drugs.

➤ Item 3.5: Life style behaviour patterns of other adolescents in the Vaal Region
Table 4.8: Life style behaviour patterns of other adolescents in the Vaal Region (n = 89)

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>N</th>
<th>DEGREE OF INVOLVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More than one response could be given for this question. Not all the respondents gave responses to these statements, perhaps because the respondents found it difficult to give a view on others. On the whole, the findings in table 4.8 show that there is a general view that adolescents are using alcohol and other drugs to an increasing extent. It was also interesting to note that respondents viewed others as using alcohol and other drugs to a greater extent than they, themselves, or their partners did. Whereas 17 (24,0%) reported self-use of alcohol (item 3.3) and 17 (23,3%) reported for partner use (item 3.4), 47 (61,0%) respondents felt that many adolescents in the area were using alcohol. Of the respondents, 26 (35,6%) reported dagga smoking as the most frequent.

These findings would also support the survey findings of the Bridges Community Project in Cape Town and the South African National Council for Alcoholics (SANCA) (Sunday Times 1997c:10). According to the Bridges Programme Survey, it was found that on the average 70,0% of the Standard 6 pupils had tried alcohol and about 50,0% had been drunk, and by the time they reached Standard 9, 70,0% had been drunk.
Though no follow-up questions were asked to obtain more information on alcohol and drug use, it is apparent that adolescents in the Vaal Region use alcohol and other related substances, to some extent. Benzine sniffing viewed as minimally used by other adolescents in the area. Six (8.3%) respondents indicated that many adolescents in the Vaal Region sniff benzine, 19 (26.4%) said only a few sniff benzine, 47 (65.3%) did not know the extent to which benzine was used by the adolescents in the area. Eight (11.1%) respondents felt that many adolescents in the Vaal Region sniff glue, 21 (29.2%) said only a few are sniffing glue and 43 (59.7%) mentioned that they did not know the extent to which adolescents used glue. As in the case of alcohol, 38 (50.0%) indicated that many adolescents in the area smoke cigarettes, 18 (23.7%) said only a few smoke cigarettes and 20 (26.3%) did not know the extent to which cigarettes were used by the adolescents in the area.

Item 4.1: Reasons given by adolescents for visiting the STD clinic

Figure 4.14

Reasons given by adolescents for visiting the STD clinic (N = 78)
Not all the respondents answered this question. This was an open-ended question. Though respondents gave reasons expressed in different ways, four main categories were identified, namely:

- Forty-one respondents indicated that they were sick or suffered from sexually transmitted diseases.
- Eleven respondents needed pregnancy prevention methods.
- Nineteen respondents came as the contact person of an individual with confirmed STD for assessment.
- Seven respondents were in need of health education.

From figure 4.14 it is clear that 41 respondents were sick or suffered from sexually transmitted diseases. Statements given for this response were for example:

- I am sick.
- I have a sexually transmitted disease.
- I have sores on my penis.
- I have a discharge.
- I have a problem.

Although this was an alarming finding, these were satisfactory responses, showing that respondents had insight into their condition, for example, that they had a sexually transmitted disease and knew that they must come for advice and treatment.

Eleven respondents indicated the need for a contraceptive method. Phrases used were:

- I do not want to get a baby.
- I need a prevention method.
- I want protection against rape.
- I am not ready to have a baby.
- I need condoms.
The 11 respondents who indicated the need for a contraceptive method could have been referred for treatment of a sexually transmitted disease after examination and the realisation by the clinic nurse that the individual had a sexually transmitted disease which the respondent was not aware of (asymptomatic condition). According to research and literature (Ballard 1997:7; Department of Health 1997b:13), it is common to have a sexually transmitted disease without the patient knowing until diagnosed by a clinical medical person. In this context Ballard (1997:7) states that “a wide range of presentations of STD’s diseases present with mixed infection and may involve more than one site, and some of them are asymptomatic, especially in women”.

In the researcher’s experience, females being examined for the purpose of family planning screening are often discovered to have erosions of the cervix, ulcers in the genital organs and vaginal discharges without being aware of the condition. It is in this context that the National Health Plan Policy (Department of Health 1996c:7) has adopted the implementation of comprehensive primary health care within district health systems to overcome the previously fragmented and uncoordinated health services.

The 19 respondents who indicated having been in contact with persons suffering from STD gave statements such as:

- My partner is sick.
- Came for a check up.
- My partner asked me to come.
- I received a message that I must visit the clinic.

It was encouraging to realise that those in contact with STD partners were actually encouraged by partners to attend for treatment. In the researcher’s experience, it is difficult to get both partners treated as STD patients appear to be reluctant to disclose any problem they may have to their parents. Ten respondents indicated the reason for visiting the clinic as seeking information. Examples of statements given were
• need for health education
• need for advice
• nurses educate us more than parents
• need to know more about sexually transmitted diseases.

Often clinics are visited whenever an individual is sick or needs health screening or contraceptive measures. That respondents would visit a health centre for information was encouraging, as it indicates that they will, in fact, come to a clinic when they have health-related problems.

Item 4.2: Adolescents' satisfaction with the STD clinic services

![Figure 4.15: Adolescents' satisfaction with the STD clinic services (N = 82)](image)

Adolescents' satisfaction with the STD clinic services (N = 82)
Not all the respondents answered this question. It would appear from figure 4.15 that 77 (94.0%) of the respondents were satisfied with the service, and only 5 (6.0%) indicated that they were dissatisfied with the service. These findings are not consistent with the general view that health services are often perceived as displaying negative attitude towards users, and that a judgemental attitude is usually displayed toward adolescents and those suffering from sexually transmitted diseases (Schoeman 1990:4; Sekeito, Padayachee, Schoub, Ballard & De Beer 1993:83).

Item 4.3: Reasons given by the adolescent for satisfaction with the STD clinic services

A follow-up question was asked to determine the reasons why STD services were considered satisfactory or unsatisfactory. This was an open-ended question in order to get the views of respondents. Unfortunately, many did not respond. Table 4.9 below gives examples of some of the reasons given for satisfaction/dissatisfaction with the services offered.

Table 4.9: Reasons given by the adolescent for satisfaction with the STD clinic services
(N = 64)

<table>
<thead>
<tr>
<th>REASONS GIVEN</th>
<th>NUMBER OF Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive health information</td>
<td>8</td>
</tr>
<tr>
<td>Sickness gets cured/better</td>
<td>25</td>
</tr>
<tr>
<td>Pregnancy prevention is ensured</td>
<td>5</td>
</tr>
<tr>
<td>Nurses are helpful</td>
<td>7</td>
</tr>
<tr>
<td>Receive good treatment</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REASON FOR UNSATISFACTORY SERVICE</th>
<th>NUMBER OF Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting period too long</td>
<td>6</td>
</tr>
<tr>
<td>Feel neglected/ignored</td>
<td>4</td>
</tr>
</tbody>
</table>

TOTAL: 64
There were a lot of missing frequencies on this question. The reason could be that respondents did not want to commit themselves or give their true feelings on the service. It would appear that reasons given for satisfactory service were mostly based on reasons for visiting the service, for example, respondents were sick. Waiting periods at clinics and personnel attitude appeared to be the two common factors causing dissatisfaction concerning the service. Public health services have a reputation of unfavourable attitudes and treatment to patients. Shortage of staff, lack of privacy and overcrowding at clinics could account for the prolonged waiting period and feeling of being neglected as stated by the respondents.

Items 4.4 and 4.5: Contraceptive use by adolescents

![Figure 4.16](image)

Contraceptive use by adolescents (N = 78)

Forty-nine (63.0%) respondents indicated that they used pregnancy prevention methods whenever they engaged in the sexual act, and 29 (37.0%) stated that they never used pregnancy prevention methods. The results appear to show an increase in the use of
contraceptives among adolescents in comparison to previous studies done in South Africa (Mogotlane 1993:13; Preston-Whyte & Zondi 1991:1394). Mayekiso and Twaise (1992:22) report that only 12.3% of the adolescents used some form of contraception, although 55.2% were found to be sexually active. The common contraceptive methods used by the adolescents are presented in table 4.10 below.

When a chi-square test was done to compare male and female use of contraceptive methods, a significant difference ($p = 0.027$) was found, which showed that more female than male adolescents were using contraceptives. Nine (39.1%) males as compared to 40 (60.6%) of the female adolescents were found to be using contraceptives.

It would appear that the use of contraceptives among male adolescents is still poor, which indicated that condom use, as a method commonly used by males (10), is still unfrequent.

Table 4.10: Contraceptive methods used by adolescents (N = 52)

<table>
<thead>
<tr>
<th>CONTRACEPTIVE METHODS</th>
<th>NUMBER OF RESPONDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not using any method</td>
<td>7</td>
</tr>
<tr>
<td>Injectables</td>
<td>25</td>
</tr>
<tr>
<td>Condoms</td>
<td>19</td>
</tr>
<tr>
<td>Pill (Triphasil)</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

More than one response was possible. Not all the respondents answered this question. This was an open-ended question to determine whether adolescents knew the contraceptive methods available. Many left the space open and seven did indicate that they are not using any method. Of those who responded, 25 indicated that they were using injections. Of the injections mentioned, four stated Nur-Estrate and another four mentioned Depo Provera, whilst the rest just said injection. Nineteen respondents indicated using condoms and only 1 respondent reported using Triphasil pills. Not all the respondents could mention the contraceptive methods they were using. This could be an indication of a lack of knowledge
of contraceptives, as well as the doubts and misconceptions the respondents had about contraceptive use or that the contraceptives were not used regularly.

The findings on the poor use of condoms concur with previous studies in South Africa (Sekeito et al 1993:82; Varga 1996:15). In their study among sexually transmitted disease patients in Johannesburg, Sekeito et al (1993:82) report that in a sample of 180 STD clinic attendees, only 30% of the respondents indicated that they had used condoms in the past. This is of great concern, as condom use is considered very important in the prevention of STD/HIV (Department of Health 1997a:115).

Item 4.5 (b): Reasons given by adolescents for the non-use of contraceptives

A follow-up question to determine the reasons for the non-use of contraceptives was asked. This was an open-ended question in order to get the views of the adolescents. The reasons for the non-use of contraceptives are presented in table 4.11 below.

Table 4.11: Reasons given by adolescents for the non-use of contraceptives (N = 27)

<table>
<thead>
<tr>
<th>REASONS GIVEN FOR NON-USE OF CONTRACEPTIVES</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not in love</td>
<td>2</td>
</tr>
<tr>
<td>Planning a baby</td>
<td>1</td>
</tr>
<tr>
<td>Partner is using condom</td>
<td>1</td>
</tr>
<tr>
<td>Do not like prevention method</td>
<td>3</td>
</tr>
<tr>
<td>Did not know about contraceptives</td>
<td>4</td>
</tr>
<tr>
<td>Scared of injection</td>
<td>3</td>
</tr>
<tr>
<td>Want to be honest with my partner</td>
<td>2</td>
</tr>
<tr>
<td>School teacher says should not prevent</td>
<td>2</td>
</tr>
<tr>
<td>Do not enjoy sex with condom</td>
<td>3</td>
</tr>
<tr>
<td>Boyfriend does not want me to use</td>
<td>2</td>
</tr>
<tr>
<td>Difficult to get condoms</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>27</strong></td>
</tr>
</tbody>
</table>
The respondents could give more than one answer. The various reasons given by the 27 respondents who answered this question show that there is still a lot of misconception and lack of knowledge about the use of contraceptives. It was surprising to find that one respondent, 18-years old, was actually planning pregnancy. This is a concern as the rate of teenage pregnancy is reported to be increasing. The Department of Health (1995:114) reported that 392 per every 1,000 deliveries in South Africa constitute teenage pregnancy. That many did not respond to this question could indicate doubts, irregular use of contraceptives or a lack of knowledge of the methods available.

Kau (1989:103), Mayekiso and Twaise (1992:22) and Syden (1992:57) report poor and erratic use of contraceptives among adolescents. The findings in this study are therefore of significance in terms of knowledge on safe sex that should have been gained through the health education programme. This indicates the need to broaden and intensify the adolescent health education programme, especially in terms of the contraceptive measures available.

Item 4.6: Adolescents who knew that they were suffering from sexually transmitted diseases

Figure 4.17
Adolescents who knew that they were suffering from sexually transmitted diseases (N = 79)
Not all the respondents answered this question. Only 36 (46,0%) respondents admitted suffering from a sexually transmitted condition and 43 (54,0%) indicated that they were not suffering from any STD condition. Though it was expected that not all would have clear knowledge about their condition, 43 (54,0%) of those respondents indicated they did not suffer from a sexually transmitted disease and in fact was a much higher rate than expected. This may indicate ignorance, lack of knowledge about their condition or denial. The findings could be attributed to the following factors:

- Generally, patients suffering from sexually transmitted diseases are not always willing to disclose their condition. In the researcher’s experience, patients often relate their conditions to some other factor, such as bumping against an object, or environmental factors of a place they recently visited, rather than the act of intercourse.

- The wide range of ways in which sexually transmitted disease present, some of which may be detected through laboratory blood tests while others affect parts of the body other than the sex organs. Due to this and often the lack of symptoms patients usually find it difficult to accept that they have contracted an STD. Laboratory results on blood tests indicating an STD infection are usually not readily accepted by patients until later when signs and symptoms which affect the genital organs start to show (Ballard 1997:7; Coetzee et al 1994:104).

- Subclinical infections, which are symptoms which are usually ignored by patients and are often detected by nurses or doctors during an examination. Such infections are common among females (Ballard 1997:7) and are usually discovered during family planning examination procedures.

Several respondents in this study indicated that they had visited the clinic for the purpose of obtaining contraceptive methods and were subsequently treated for a sexually transmitted condition (item 4.1).
Respondents who indicated that their sexual partners had a sexually transmitted condition and were thus visiting the clinic for check up. Often partners of affected persons are also found to have the disease.

These findings are significant in terms of health education and creating awareness regarding the spread of sexually transmitted diseases and the resultant complications. Broadening health education strategies, more especially for the purpose of educating children and the youth, is imperative as sexually transmitted diseases are found to be commonest in the 15 to 24 years age group (Department of Health 1997b:13).

Item 4.7: Sexual activity and pregnancy among the adolescents attending the STD clinics

![Figure 4.18](image_url)

*Sexual activity and pregnancy among the adolescents attending the STD clinics (N = 81)*
Not all the respondents answered the questions. Both males and females responded to the question. Although 61 (75.0%) respondents indicated that no pregnancy occurred as a result of their sexual activity, 20 (25.0%) stated that they had fallen pregnant or made somebody pregnant. Most previous studies on teenage pregnancy were conducted only among females.

When a chi-square test was done between gender and pregnancy ($p = 0.486$), it revealed that there was no significant difference between the male involvement and the female pregnancy rate. Four (17.4%) of the males and 16 (24.3%) of the female adolescents were found respectively to have made somebody pregnant or fallen pregnant at some stage. These findings appear to be consistent with previous studies that teenage pregnancy is still a problem (Mohamed & Masona 1991:316; Mogotlane 1993:11; Schoeman 1990:14).

Of the 20 respondents who indicated pregnancy as a result of their sexual activity, several were still at school. This indicates that the responsibility of caring for the baby is shifted to somebody else, either parents, grandparents, relatives or the state and has major implications for the teenagers' future prospects.

> **Item 4.8: Health education given to adolescents in the Vaal Region on topics related to sexuality and life style behaviours**
Table 4.12: Health education given to adolescents in the Vaal Region on topics related to sexuality and life style behaviour (n = 89)

<table>
<thead>
<tr>
<th>HEALTH EDUCATION TOPIC</th>
<th>N</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Sex organs and how they function</td>
<td>77</td>
<td>54</td>
<td>70,1</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>76</td>
<td>55</td>
<td>72,4</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>77</td>
<td>51</td>
<td>66,2</td>
</tr>
<tr>
<td>Abortion</td>
<td>77</td>
<td>38</td>
<td>49,4</td>
</tr>
<tr>
<td>HIV and AIDS</td>
<td>77</td>
<td>54</td>
<td>70,1</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>74</td>
<td>47</td>
<td>63,5</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>75</td>
<td>18</td>
<td>24,0</td>
</tr>
<tr>
<td>Masturbation</td>
<td>72</td>
<td>17</td>
<td>23,6</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>73</td>
<td>45</td>
<td>61,6</td>
</tr>
<tr>
<td>How to say no to sex</td>
<td>77</td>
<td>42</td>
<td>54,5</td>
</tr>
<tr>
<td>Dangers of drug use</td>
<td>71</td>
<td>40</td>
<td>56,3</td>
</tr>
</tbody>
</table>

Not all the respondents answered all the questions. Table 4.12 indicates that the respondents had some form of exposure to information on most of the topics. The results could be attributed to the fact that no probing questions were asked on the content of the topics. Only a general assessment was done to determine if respondents had had some form of information on the specific topics. Depth of knowledge was not determined. According to the results as shown in table 4.12, topics which the respondents were most familiar with in order of frequencies were:

1. Sex organs

Fifty-four (70,1%) respondents indicated having received some form of information while 23 (29,9%) were not exposed to any form of education.
Sexually transmitted diseases

Fifty-five (72.4%) respondents indicated that they had received some STD information and 21 (27.6%) had received no information at all. The high response to this topic could be attributed to the fact that respondents had attended a sexually transmitted disease clinic, and the information received could be on their condition. However, it is worrying that 21 (27.6%) respondents indicated that they had no knowledge of STD's, considering the extent of HIV/AIDS and the classical sexually transmitted diseases. It is in this context that the White Paper for the Transformation of the Health System in South Africa (Department of Health 1997a:113) sees the HIV/AIDS life skills programme for the youth as crucial in addressing the sexuality issues as well as preventing the spread of the HIV/AIDS/STD infection.

Teenage pregnancy

Fifty-one (66.2%) respondents mentioned that they received some information on teenage pregnancy. Though the depth of knowledge was not measured, this is an encouraging response. However, 26 (33.8%) indicated that they had no education on teenage pregnancy.

Abortion

Thirty-eight (49.4%) of the respondents indicated having been exposed to information on abortion, whilst 39 (50.6%) were not. Since the legalisation on abortion promulgated in South Africa in 1997, research is needed to measure the rate of abortions performed illegally, legalised Termination of Pregnancy (TOP), and the use of contraceptives by adolescents. Opponents against the legalisation of abortion argue that this will reduce the use of contraceptives by the women including adolescents. It is also necessary to measure the extent to which TOP has decreased illegal abortion. According to the statistics from Sebokeng Hospital, an average of eight adolescents below the age of 20 years were admitted to this hospital monthly for abortions (Sebokeng Gynaecology Admission Record 1992-
1996) (see chapter 1). Many challenges face the health workers if awareness is to be created on contraceptives, the implication of illegal abortion and TOP.

**HIV/AIDS**

Fifty-four (70.1%) respondents indicated having received some form of information on HIV/AIDS and 23 (29.9%) did not. This was an expected outcome as the media is frequently giving information on this topic and health departments at all levels are engaged in awareness campaigns on HIV/AIDS. It is alarming, however, that as many as 23 respondents were unaware of the implications.

**Sexual abuse**

The findings revealed that 47 (63.5%) respondents had received some form of education on sexual abuse, though 27 (36.5%) had not. These findings are expected, as the media frequently report on the extent of sexual abuse among women and children in the country. The *Sowetan* (1997a:4) released an alarming report by the South African Law Commission on the rate at which children abuse, including sexual abuse, is increasing in the country. According to this report child abuse is increasing by about 30.0% a year. The *Sowetan* (1997b:1) also gave a shocking report of 15 children aged between 9 and 15 years were allegedly being raped by a farmer in Tzaneen. This shows the need to broaden and intensify the sexuality/life skills education programme to provide sexuality education including child sexual abuse to children at a much younger age.

**Contraceptives**

Forty-five (61.6%) respondents indicated that they had received some form of information on the use of contraceptives and 28 (38.4%) had no information. These findings show that there is still a lack of information on contraceptives among adolescents. This is a matter of concern and an area that needs urgent attention.
How to say no to sex

Table 4.12 shows that 42 (54.5%) of the respondents had received some form of education/advice on "how to say no to sex". This is a concept used by the Department of National Health and Population Development (Annexure A) as an approach to teach adolescents how to resist coercion into undesired sexual contact. It is encouraging to find that half of the respondents had exposed to this technique but the findings are still alarming in terms of the remaining respondents who had not been exposed.

Drug use

Of the respondents, 40 (56.3%) indicated that they had received some information on drug use and their dangers while 31 (43.7%) had received no information on this aspect.

Homosexuality and masturbation

These were the two least known topics. Eighteen (24.0%) of the respondents indicated having been exposed to some form of information on homosexuality, and 57 (76.0%) had not been exposed. Only 17 (23.6%) respondents indicated having received some information on masturbation while 55 (76.4%) had not.

Item 4.9: Sources where information was obtained by adolescents in the Vaal Region on topics related to sexuality and life style behaviour patterns

More than one response was possible for this question. The respondents were expected to match the topics with the main source where the information was obtained.

Table 4.13 presents the topics related to sexuality and life style behaviour and the main sources where adolescents received the information.
Table 4.13: Sources where information was obtained by adolescents in the Vaal Region on topics related to sexuality and life style behaviour (n = 89)

<table>
<thead>
<tr>
<th>HEALTH EDUCATION TOPICS</th>
<th>N</th>
<th>10</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
<td>F %</td>
</tr>
<tr>
<td>Sex organs</td>
<td>53</td>
<td>4</td>
<td>7,5</td>
<td>16</td>
<td>30,2</td>
<td>24</td>
<td>45,3</td>
<td>1</td>
<td>1,9</td>
<td>2</td>
<td>3,7</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>51</td>
<td>4</td>
<td>7,8</td>
<td>13</td>
<td>25,6</td>
<td>11</td>
<td>21,6</td>
<td>12</td>
<td>23,5</td>
<td>4</td>
<td>7,8</td>
</tr>
<tr>
<td>Abortion</td>
<td>49</td>
<td>5</td>
<td>10,2</td>
<td>10</td>
<td>20,4</td>
<td>2</td>
<td>4,1</td>
<td>9</td>
<td>18,4</td>
<td>14</td>
<td>28,5</td>
</tr>
<tr>
<td>Pregnancy prevention methods</td>
<td>50</td>
<td>4</td>
<td>8,0</td>
<td>33</td>
<td>66,0</td>
<td>1</td>
<td>2,0</td>
<td>1</td>
<td>2,0</td>
<td>2</td>
<td>4,0</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>54</td>
<td>3</td>
<td>5,5</td>
<td>9</td>
<td>16,7</td>
<td>10</td>
<td>18,5</td>
<td>14</td>
<td>25,9</td>
<td>6</td>
<td>11,1</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>51</td>
<td>5</td>
<td>9,8</td>
<td>5</td>
<td>9,8</td>
<td>7</td>
<td>13,8</td>
<td>19</td>
<td>37,3</td>
<td>5</td>
<td>9,8</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>41</td>
<td>9</td>
<td>22,0</td>
<td>1</td>
<td>2,4</td>
<td>4</td>
<td>9,8</td>
<td>9</td>
<td>22,0</td>
<td>4</td>
<td>9,7</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>56</td>
<td>5</td>
<td>8,9</td>
<td>23</td>
<td>41,1</td>
<td>5</td>
<td>8,9</td>
<td>8</td>
<td>14,3</td>
<td>4</td>
<td>7,1</td>
</tr>
<tr>
<td>Drugs</td>
<td>48</td>
<td>8</td>
<td>16,7</td>
<td>4</td>
<td>8,3</td>
<td>10</td>
<td>20,8</td>
<td>10</td>
<td>20,8</td>
<td>3</td>
<td>6,3</td>
</tr>
</tbody>
</table>
The findings in table 4.13 show clearly that the clinic, the school and television were the three main sources where information was obtained. This is an expected finding as, the sexuality and life style behaviour programme is mainly provided in the clinics, schools and through television. The radio, magazines, brothers and sisters (siblings) were used minimally as sources of information, whilst parents, friends, doctors and the church appeared to have played the least role as sources of information.

The clinic provided the most information on pregnancy prevention methods, 33 (66,0%), teenage pregnancy, 13 (25,6%), sex organs, 16 (30,2%) and sexually transmitted diseases, 23 (41,1%). This was an expected outcome as the clinics, apart from providing health education, they also provide service for contraceptives and sexually transmitted diseases.

Television appeared to have been the main source of information on sexual abuse, 19 (37,3%), HIV/AIDS, 14 (25,9%) and teenage pregnancy, 12 (23,5%). Other significant topics heard of on television were drugs, 10 (20,8%), sexually transmitted diseases, 8 (14,3%) and abortion, 9 (18,4%). Only 1 (1,9%) respondent indicated having received information on sex organs from television and again on pregnancy prevention methods.

The school appears to have played a significant role in providing information on sex organs: 24 (45,3%) of the respondents indicated the school was their main source of information on sex organs, 11 (21,6%) obtained information from school on teenage pregnancy, 10 (20,8%) on drugs and another 10 (18,5%) on HIV and AIDS.

The school appears to have played a minimal role as source of information for sexually transmitted diseases, 5 (8,9%), homosexuality, 4 (9,8%), abortion, 2 (4,1%) and pregnancy prevention methods, 1 (2,0%). It is worrying that, with the extent of sexual abuse reported through the media in the country, the school appears to play an insignificant role in informing children about sexual abuse. Only 7 (13,8%) respondents indicated that the school was a source of information on sexual abuse.
The radio appears to be a significant source of information on abortion: 14 (28.5%) of the respondents indicated that they obtained information on abortion from the radio, 6 (11.1%) of the respondents indicated the radio as a source of information for HIV/AIDS, and 4 (7.1%) obtained information from the radio on sexually transmitted diseases, 5 (9.8%) on sexual abuse, 3 (6.3%) on drugs, 4 (7.8%) on teenage pregnancy and only 2 (3.7%) on sex organs.

Magazines and siblings appear to have played an insignificant role as sources of information on sexuality and life style behaviour topics. According to the findings doctors, the church and parents appeared to have been indicated as the least used sources of information.

It is disturbing that no respondents indicated doctors as sources of information on topics such as teenage pregnancy, sex organs and drugs. The findings could be attributed to the fact that adolescents could be consulting doctors very rarely or that doctors pay little attention to prevention and promotion of health services. The results show the need for a multisectoral approach in the health education programme of adolescents.

Parents were also found to be among the sources least used for health information. No respondents indicated parents as source of information on HIV, sexually transmitted diseases and abortion; 3 (5.7%) indicated having received information from parents on sex organs, 4 (7.8%) on teenage pregnancy, 2 (4.0%) on pregnancy prevention methods, 3 (5.8%) on sexual abuse, 1 (2.4%) on homosexuality and 1 (2.1%) on drugs. This is an expected finding and a cause for concern as parents appear to be less informed on health-related issues. The results are significant in terms of the need to design programmes for parents so that parents can know what health information to impart health information to their children and how to do so.
Friends were also indicated as the least source of information on the sexuality topics. In almost all the topics, very few indicated friends as sources of information. Only 1 (1.9%) respondent indicated friends as a source of information on sex organs, none on teenage pregnancy, 2 (4.1%) on abortion, 2 (4.0%) on pregnancy prevention methods, 1 (1.9%) on HIV/AIDS, 1 (2.0%) on sexual abuse, 1 (1.9%) on sexually transmitted diseases, 8 (19.5%) on homosexuality a further 5 (10.4%) respondents indicating friends as source of information on drugs.

The findings contrast with those of Disler (1991:88), Mayekiso and Twaise (1992:21) and Rice (1992:389). Mayekiso and Twaise (1992:21) found that the highest percentage in the sample (45.5%) gained information from friends and peers. On the whole, the results in this study reveal that the clinic, followed by the school, television and radio are the main sources of information for the adolescents in the Vaal Region. Little information was received from magazines, brothers and sisters, friends and parents. The least information was received from doctors and the church.

The findings in this study appear to be consistent with those of Magwensthu (1990:4) where 43.0% of the sample indicated that they had never been given information on masturbation and homosexuality.

Items 4.10 and 4.11: The extent to which information received was useful in decision making about the adolescents' sexual life

Although 61 (85.9%) respondents indicated that the information received helped them in making decisions about their sexual life, they did not give support to their responses (item 4.11).
Item 4.12: Categories of persons considered appropriate by adolescents to give information on sex education and life style behaviour skills

Table 4.14: Categories of persons considered appropriate by adolescents to give information on sex education and healthy life style behaviour skills (n = 89)

<table>
<thead>
<tr>
<th>PREFERRED EDUCATORS</th>
<th>N</th>
<th>YES</th>
<th></th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>Health professionals</td>
<td>77</td>
<td>68</td>
<td>88,3</td>
<td>9</td>
</tr>
<tr>
<td>School teacher</td>
<td>69</td>
<td>57</td>
<td>82,6</td>
<td>12</td>
</tr>
<tr>
<td>The church</td>
<td>65</td>
<td>37</td>
<td>56,9</td>
<td>28</td>
</tr>
<tr>
<td>Parents</td>
<td>71</td>
<td>58</td>
<td>81,7</td>
<td>13</td>
</tr>
<tr>
<td>Youth clubs</td>
<td>63</td>
<td>44</td>
<td>69,8</td>
<td>19</td>
</tr>
</tbody>
</table>

Not all the respondents answered all the questions. From table 4.14, it is clear that 68 (88,3%) of the respondents considered health professionals as appropriate educators on sexuality; 57 (82,6%) considered school teachers and 58 (81,7%) considered parents. However, 9 (11,7%), 12 (17,4%) and 13 (18,3%) respondents, respectively, indicated that health professionals, school teachers and parents were not appropriate sex educators. Though parents were rated the least appropriate source of information on sex education (item 4.9), it is apparent that respondents regard parents as important and appropriate educators on sexuality issues. The results concur with Mayekiso and Twaise's (1992:28) as well as Kau's (1989:104) findings. In both these studies it was found that adolescents wish to discuss issues related to sex with their parents. Kau (1989:104) reports that 61,5% of the 200 male adolescents in her sample wanted to discuss contraceptives with their parents. These findings are of significance in terms of the healthy life skills education programme. According to the Department of National Health (Life Skill Policy) (Annexure C), the programme should be school-based and also involve parents, non-governmental organisations and peer groups. Thirty-seven (56,9%) respondents mentioned that the church should be involved and 28(43,1%) did not see the church as an appropriate institution to provide
sexuality information. Youth clubs were also regarded as relevant participants in the healthy life style programme: 44 (69.8%) respondents said yes while 19 (30.2%) said no.

However, 9 (11.7%) respondents indicated that health professionals should not be role players in sex education and healthy life skills; 12 (17.4%) said school teachers should not take part and 13 (18.3%) indicated that it is not necessary for parents to take part in educating children and adolescents on sexuality issues.

The results also show that 44 (69.8%) respondents regard peers (youth clubs) as necessary participants in the sexuality and healthy life skills education programme, though 19 (30.2%) felt that peer groups are not important. Of the respondents, 37 (56.9%) indicated the church as being important in imparting knowledge on sexuality and healthy life skills. However, 28 (43.1%) respondents, said that it is not necessary for the church to be involved. Although there were respondents who felt that some of the role players mentioned in table 4.14 were not important in taking part in the sexuality education programme, it is apparent from table 4.14 that a multisectoral approach to the provision of the healthy life skills/sexuality programme is necessary. These findings appear to support the approach adopted by the Department of Health (1997a:110-113) that “in order to prevent the spread of HIV/AIDS/STD epidemic, which is rooted in society’s fabric, and to empower the youth with knowledge and skills in sexuality, the involvement of all sectors of the society is necessary”.

Item 4.13: Educational level considered appropriate by the adolescents for information on selected topics related to sexual behaviour

Not all the respondents answered all the questions. Respondents were given topics related to sexuality, and were asked to indicate the level at which the topics should be taught.
Table 4.15: Educational level considered appropriate by the adolescents for information on selected topics related to sexual behaviour (n = 89)

<table>
<thead>
<tr>
<th>HEALTH EDUCATION TOPICS</th>
<th>N</th>
<th>Preschool</th>
<th>Grade 1 to 2</th>
<th>Std 2 to 5 (Grade 3 to 7)</th>
<th>Std 6 to 8 (Grade 8 to 10)</th>
<th>Std 9 - 10 (Grade 11 to 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
<td>F</td>
</tr>
<tr>
<td>Sex organs</td>
<td>78</td>
<td>9</td>
<td>11,5</td>
<td>9</td>
<td>11,6</td>
<td>26</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>74</td>
<td>1</td>
<td>1,4</td>
<td>2</td>
<td>2,7</td>
<td>32</td>
</tr>
<tr>
<td>Abortion</td>
<td>73</td>
<td>1</td>
<td>1,4</td>
<td>-</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Sexually transmitted</td>
<td>75</td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>9,3</td>
<td>33</td>
</tr>
<tr>
<td>diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>69</td>
<td>8</td>
<td>11,6</td>
<td>8</td>
<td>11,7</td>
<td>27</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>70</td>
<td>15</td>
<td>21,4</td>
<td>10</td>
<td>14,3</td>
<td>21</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>63</td>
<td>4</td>
<td>6,3</td>
<td>5</td>
<td>7,9</td>
<td>15</td>
</tr>
<tr>
<td>Masturbation</td>
<td>69</td>
<td>4</td>
<td>5,8</td>
<td>4</td>
<td>5,8</td>
<td>19</td>
</tr>
<tr>
<td>Drugs</td>
<td>72</td>
<td>6</td>
<td>8,3</td>
<td>11</td>
<td>15,3</td>
<td>30</td>
</tr>
<tr>
<td>Prevention methods</td>
<td>64</td>
<td>2</td>
<td>3,1</td>
<td>-</td>
<td>-</td>
<td>28</td>
</tr>
</tbody>
</table>
The findings in table 4.15 show clearly that adolescents in the Vaal Region felt that from preschool level through to Standard 9 to 10 (Grade 11 to 12), health information on sex and sexuality should be given to children depending on the relevancy of the topic. It would appear though that Standard 2 to 5 (Grade 4 to 7) level was considered the most appropriate schooling level for children to start receiving education on almost all sex and sexuality-related topics. Standard 2 (Grade 4) was considered the appropriate level to commence education in the topics mentioned as follows: education on sex organs 26 (33,3%), teenage pregnancy 32 (43,2%), sexually transmitted diseases 33 (44,0%) drugs 30 (41,7%) and contraceptive methods 28 (43,8%).

It is interesting to note that the respondents considered some topics, namely sex organs 9 (11,5%), HIV/AIDS 8 (11,6%), sexual abuse 15 (21,4%) and drugs 6 (8,3%), appropriate health education topics to start at preschool level. The responents who answered this question appeared to have a general view that information is necessary on all the topics throughout the child’s development and at all school education levels.

The findings in this study appear to support the approach of the Department of Health (Annexure B) that health education programmes should be age related and offered at all levels of a person’s development.

Item 4.14: The extent to which adolescents still needed information on topics related to sexuality in the adolescent sexuality programme outlined in Annexure A

The respondents were expected to indicate on a four-point scale the degree to which they still needed information or knowledge on the topics listed in table 4.16.
Table 4.16: The extent to which adolescents still needed information on topics related to sexuality in the adolescent sexuality programme outlined in Annexure A (n = 89)

<table>
<thead>
<tr>
<th>SEXUALITY PROGRAMME TOPICS</th>
<th>N</th>
<th>A NEED A LOT</th>
<th>B NEED SOME</th>
<th>C NEED JUST A LITTLE</th>
<th>D HAVE ENOUGH INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F</td>
<td>%</td>
<td>F</td>
<td>%</td>
</tr>
<tr>
<td>Sex organs</td>
<td>70</td>
<td>31</td>
<td>44,3</td>
<td>19</td>
<td>27,1</td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td>72</td>
<td>35</td>
<td>48,6</td>
<td>14</td>
<td>19,4</td>
</tr>
<tr>
<td>Abortion</td>
<td>69</td>
<td>40</td>
<td>58,0</td>
<td>11</td>
<td>15,9</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>75</td>
<td>42</td>
<td>56,0</td>
<td>17</td>
<td>22,7</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>70</td>
<td>38</td>
<td>54,3</td>
<td>11</td>
<td>15,7</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>74</td>
<td>50</td>
<td>67,6</td>
<td>14</td>
<td>18,9</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>72</td>
<td>37</td>
<td>51,4</td>
<td>12</td>
<td>16,7</td>
</tr>
<tr>
<td>Drugs</td>
<td>72</td>
<td>38</td>
<td>52,8</td>
<td>12</td>
<td>16,7</td>
</tr>
<tr>
<td>Masturbation</td>
<td>70</td>
<td>35</td>
<td>50,0</td>
<td>12</td>
<td>17,2</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>73</td>
<td>38</td>
<td>52,1</td>
<td>18</td>
<td>24,6</td>
</tr>
</tbody>
</table>
Not all the respondents answered all the questions. The findings in table 4.16 show clearly that respondents still need considerable information/education on all the topics mentioned. The findings correlate with those in item 4.8 where the respondents were asked whether they had received some information on these topics. It was clear that though respondents had received some information, further knowledge and education were still needed.

Though respondents appeared to have had some information on sexually transmitted diseases, 50 (67,6%) indicated that they still needed a lot of information, 14 (18,9%) indicated a need for some information, 6 (8,1%) said they needed just a little and only 4 (5,4%) said they had enough information.

Forty-two (56,0%) of the respondents reported the need for more information on HIV/AIDS, 17 (22,7%) indicated a need for some information on HIV/AIDS, 7 (9,3%) said they need just a little more information and only 9 (12,0%) reported that they had enough information. These findings show the need for in-depth information on these topics, and are significant in terms of continuous education from early childhood through to adulthood.

Of the respondents, 40 (58,0%) showed that they needed a lot of information on abortion, 11 (15,9%) said that they still needed some information, 8 (11,6%) indicated a need for just a little information, while 10 (14,5%) respondents said they had enough information.

Thirty eight (54,3%) of the respondents indicated that they still need a lot of information on sexual abuse with only 13 (18,6%) mentioning that they have enough information. On the whole more than half the respondents indicated that they still need a lot of information on all the topics indicated in table 4.14.

These findings are significant in terms of intensifying the health education programme and making the target group active participants of the programme.
4.4 CONCLUSION

This chapter presented the findings and analysis of the data. The next chapter will discuss conclusions, recommendations and limitations of the study.
CHAPTER 5

Conclusions, recommendations and limitations of the study

5.1 INTRODUCTION

The purpose of this study was to explore adolescents' sexual behaviours and to determine whether the adolescent health education programme offered in the clinics and schools had had an effect in increasing knowledge on sexuality and motivating safe sexual practices among adolescents.

This chapter presents the conclusions, recommendations and limitations of the study. The conclusions are drawn from the findings as presented and analysed in chapter 4 and will be based on the research questions that provided the conceptual framework for the study, as follows:
• Who is the sexually active adolescent in the Vaal Region?
• What factors contribute to the sexual behaviours of adolescents in the Vaal Region?
• Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy lifestyle behaviours?

5.2 CONCLUSIONS

5.2.1. Who is the sexually active adolescent in the Vaal Region? (items 1.1 to 1.5, 2.1 to 2.5)

Based on the analysis of the data the conclusions are that:

○ Gender and age of the adolescent

Both male and female adolescents in the Vaal Region attending the STD clinic are sexually active. Of the sexually active adolescents, 43 (49.4%) fall in the age group 18 to 19 years although 5 (5.7%) indicated having been engaged in sexual contact as early as the age of 10 years and under. Sixty-six (74.2%) of the adolescents attending the STD clinic are females. The findings substantiate the report given by the Department of Health (1997b:13) which stated that under the age of 20 years, more females present with STD's than males. According to Ballard (1997:7), in comparison to males, females are most frequently found to have (asymptomatic) STD without the individual being aware of the condition.

○ Educational standard and school attendance of the adolescents

Of the adolescents attending the STD clinic, 81 (92.0%) were still at school, with 12 (13.7%) indicating that they were still in Standard 5 or 6 (Grade 7 or 8). These findings are significant in terms of implementing effective health education programmes at a much younger age at school.
Living arrangements of the adolescent

The data show 53 (60.9%) of the adolescents live with both parents, 20 (23.0%) live with their mothers as single parents, and 7 (8.1%) are living with their grandparents. These findings are not surprising and reflect the living patterns in urban areas and show that the traditional extended family, which existed in the past, more especially among Black communities, is declining.

Age of the adolescent at first sexual intercourse

Although the mean age for commencement of sexual contact was found to be 13.5 years, 40 (45.5%) of the respondents were between the ages of 14 and 16 years when they had sex for the first time. It is also significant to note that 16 (18.2%) of the respondents commenced sexual intercourse when they were as young as 10, 11, 12 and 13 years. Commencement of sexual intercourse at an early age is considered a risk factor in terms of unsafe sexual practices and may lead to unintended pregnancy and STD's. For this reason it is important that healthy life style programmes are introduced early in the school programme.

Frequency of sexual activity of the adolescent in a month

More than half of the respondents indicated that they engage in sexual intercourse on a weekly basis, with 7 (8.5%) stating that they have sex two to three times a week. Though no probing question was asked to determine whether this took place with the same or different partners, these findings are alarming and carry a risk of occurrence of sexually transmitted diseases, particularly with respect to females. According to the Department of Health (1997b:13), under the age of 20 years, the lining of the female genital tract, which is still immature, makes girls more susceptible to STD's than males. That the majority of the respondents engaged in sexual intercourse on a weekly basis, was an unexpected finding. According to previous research, sexual activity among adolescents has been found to be infrequent and sporadic (Kau 1989:88; Zabin & Hayward 1993:55). The findings on the frequency of sexual intercourse among adolescents are significant in terms of parents'
involvement in the education of children on sex and sexuality. Sex education should be continuous throughout the child’s development.

**Number of sexual partners the adolescents have**

The findings indicate that 60 (69,0%) of the respondents have only one sexual partner, while 16 (18,4%) of the respondents have two or more partners. Multiple partners or frequent change of partners is regarded as a risk factor for the occurrence of STD’s (Ballard 1997:5). Although the majority of the respondents indicated that they only have one partner, it is not known how often the adolescents change one sexual partner for another.

**Type of sexual partners**

The majority of the adolescents attending the STD clinic in the Vaal Region are heterosexual. It would seem that this question was not fully understood by the 17 adolescents who said that they had both male and female partners.

5.2.2 What factors contribute to sexual behaviour among the adolescents in the Vaal Region? (items 1.6 to 1.9, 2.6 to 2.7 and 3.1 to 3.5)

**Educational level of the parents of the adolescents**

The educational level of both the mothers and fathers of the adolescents attending the STD clinic ranged from no formal education to parents with diplomas and degrees. The educational level of 39 (35,7%) fathers and 35 (41,2%) mothers was found to be between Standard 6 and 8 (Grade 8 and 10), 6 (7,1%) fathers and 5 (5,9%) mothers had diplomas, while 2 (2,4%) fathers and 1 (1,2%) mother had a degree. Parents’ education is considered important in terms of being receptive to health information and subsequently imparting such information to their children (Brooks-Gunn & Furnstenbergh 1989:251; Gullotta et al 1993:110). In this study, the educational level of parents did not appear to have a significant impact on the sexual behaviour patterns of the adolescents. A chi-square test was done
(p = 0.372), which showed that there was no significant relationship between the educational level of the mothers and the extent of sexually transmitted diseases among the adolescents.

- The type of houses in which the adolescents live

More than half of the respondents lived in a standard four- or five-roomed house, while 16 (18.4%) lived in a standard six-roomed home. It is also important to note that less than a quarter of the respondents lived in a shack. The findings on the living arrangements show that the majority of the respondents belonged to a low to middle income group, which clearly indicates the living patterns and socioeconomic status within a township. In this context, Morris (1993:68-69) states that the lower income groups rather than the higher income groups show greater levels of overall risks, including risks associated with sexual behaviour practices.

- Social clubs attended by adolescents

Of the respondents, three belonged to a sports club, 31 belonged to a church youth club and 10 indicated that they belonged to a social club. Social clubs are often associated with the use of alcohol and other drugs, which may result in adolescents’ engaging in unplanned sexual intercourse. The findings of this study were satisfactory as sports and church clubs are considered acceptable gathering places for the adolescent.

- Strongest feeling experienced by the adolescents during sexual intercourse

Although a quarter of the respondents indicated that they experienced no specific feeling during the act of sexual intercourse, 32 (39.6%) indicated that they experienced a pleasurable feeling, 17 (21.0%) experienced feelings of shame and 13 (16.0%) felt guilty after the sexual act. No test was done to determine if there was a correlation between the feelings experienced with the sexual act and the frequency of sexual intercourse.
Reasons given for the first act of sexual intercourse

Although 27 (35.1%) of the respondents indicated that they planned the first act of sexual intercourse, most gave other reasons, such as forced by a partner, 17 (22.1%), it just happened, 18 (23.4%), and felt like doing it, 13 (16.8%). It is apparent that the majority of the respondents did not have prior planning of the sexual act. If there were prior planning, precautionary measures, such as the use of condoms or other contraceptive measures, would be taken, which would help prevent STD's/HIV and unplanned pregnancy.

The adolescents’ perceptions of sexual behaviour

From the study, it would appear that the adolescents attending the sexually transmitted disease clinic are aware of what is expected in terms of safe sexual behaviours although this did not deter them from engaging in sexual intercourse. Forty-five (64.3%) of the respondents disagreed with the statement that teenagers can have as many partners as they like and 31 (47.0%) indicated that age is an important factor to be considered before engaging in sexual intercourse. However, 40 (59.0%) respondents felt that there is nothing wrong in having sex as long as one is in love. This substantiates the finding in item 2.2, where the majority stated that they engage in sexual intercourse on a weekly basis.

Influencing factors that promote sexual behaviour among adolescents

From this study, it is concluded that the adolescents attending the STD clinic consider the following to be important factors that promote sexual activity among adolescents:

- lack of knowledge about the dangers of early sex
- media influence, particularly films (movies) and television
- peer pressure

Half of the respondents considered sex as a way of life. These findings substantiate the responses given in item 2.2 that most have sexual intercourse on a weekly basis.
The extent to which alcohol, dagga and other drugs are used by adolescents in the Vaal Region

The respondents indicated that before engaging in sexual intercourse, 64 (90.0%) never smoke dagga, 68 (97.1%) never drink benzine, 65 (94.2%) never sniff glue, 63 (92.7%) never take other drugs, while 17 (24.0%) indicated that they sometimes drink alcohol and 4 (5.0%) indicated that they often drink alcohol.

It would appear that the use of alcohol, dagga and other drugs among adolescents attending the STD clinic does not pose a serious problem. This is a satisfactory finding as the use of drugs and alcohol would decrease inhibitions and could lead to unplanned sexual intercourse. However, when asked to give their views on the use of these substances by other adolescents in the same age group in their area, 47 (61.0%) indicated that many adolescents in the Vaal Region use alcohol.

5.2.3 Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy life style behaviours? (items 4.1 to 4.14)

Reasons for visiting the clinic

Reasons for visiting the clinic were asked in order to determine whether the respondents were aware of their disease or not. Although 41 adolescents indicated that they visited the clinic because they are sick, only 36 (46.0%) admitted that they were suffering from a sexually transmitted disease. These findings are significant in terms of educating the public, and in particular the youth, about sexually transmitted diseases. Removing the stigma attached to these diseases would help promote an understanding of these diseases and, in turn, help to prevent the spread of sexually transmitted diseases.

Contraceptive use by adolescents

Of the adolescents who answered this question, 49 (63.0%) indicated that they are using
contraceptives: 25 use injections, 19 use condoms and only 1 is on the pill. It is worrying that condom use among adolescents is still poor, as condoms are considered useful in the prevention of STD’s and HIV infections, in particular among adolescents who may not have stable partners.

○ **Teenage pregnancy among the adolescents attending the STD clinic**

Despite the apparent use of contraceptive measures, 20 (25,0%) adolescents indicated that, as a result of their sexual activity, teenage pregnancy had occurred. Although this is not a big number, it is of major concern as most of these adolescents were still at school. Teenage pregnancy is a well-documented problem as it has long-term socioeconomic implications for the teenager, the family and the community as a whole. The fact that teenage pregnancy occurred appears to indicate that preventive measures are not fully understood or used correctly.

○ **Health education given to adolescents in the Vaal Region on topics related to sexuality and life style behaviours**

Most of the adolescents indicated that they have received information on most of the topics related to sexuality and life style behaviours. More than half of the adolescents stated that they have had information on sex organs, STD’s, teenage pregnancy, HIV/AIDS, sexual abuse, contraceptives and drugs. Poorly known topics are abortion, homosexuality and masturbation. The findings showed that adolescents were familiar with most of the topics, even though the depth of the knowledge was not determined.

○ **Sources where information was obtained by adolescents in the Vaal Region on topics related to sexuality and healthy life style behaviour patterns**

In terms of the findings, information on topics related to sex and sexuality was received mainly from health professionals in the clinic, the school, television and the radio. Friends, siblings, parents, the church and doctors were not indicated as major sources of sexual
information. It was surprising to find that friends were not identified as an important source of information although many indicated peer pressure as one of the main factors that influence adolescents to engage in sexual intercourse (item 3.2). Disler (1991:88), Magwentshu (1990:116), Mayekiso and Twaise (1992:21) and Syden (1992:70) found that peer groups had an influence on information relating to sex and sexuality.

Most of the adolescents indicated that the information they received from the above sources did assist them in making decisions about their sexual activities. However, it would appear that the information received was not effective in terms of implementing safe sexual practices. These findings are consistent with earlier findings (Becker 1988:9; Jacobson 1994:10; Montessoro & Blixen 1996:34; Moran & Corley 1991:858; Santelli & Beilenson 1992:275; Sapire 1988:21; Smailes & Cunningham 1992:16).

Categories of persons considered appropriate by the adolescent to give information on sex education and life style behaviour skills

The individuals identified by the adolescents as most appropriate to give information on sex education and life style behaviour skills were health professionals, 68 (88,3%), school teachers, 57 (82,6%) and parents, 58 (81,7%). The fact that parents were listed as an important source of information indicates the need to design multisectoral sexuality education programmes in future which include not only all the major role players but parents in particular.

Educational level considered appropriate by the adolescent for teaching selected topics related to sexual behaviour

The adolescents in the Vaal Region felt that, depending on the relevancy of the topic, health education on sex and sexuality should be given to children from preschool level through to Standard 9 and 10 (Grade 11 and 12). Standard 2 to 5 (Grade 3 to 7) was considered the most appropriate level for schoolchildren to commence education on almost all the sex and sexuality-related topics. The findings appear to support the recommendation of the
Department of Health (Annexure B) that the HIV/STD life skills programme should be age-related and offered at all levels of a person's development.

The extent to which adolescents still needed information on topics related to sexuality in the adolescent sexuality programme outlined in Annexure A

Most of the adolescents who answered the questions felt that the current programme on sexuality offered in the Vaal Region should be improved with more than half of the adolescents indicating that they needed further information on all the topics listed and particularly, on sexually transmitted diseases. These findings show that the adolescents attending the STD lack knowledge and understanding of the information given in relation to sex and sexuality.

5.3 RECOMMENDATIONS ARISING FROM THE RESEARCH

According to the White Paper on the Transformation of Health Systems in South Africa, the Department of Health (1997a:113), the youth have been identified as the most vulnerable group for the development of HIV/AIDS/STD. In this context, Ballard (1997:5) contends that the behavioural risk factors of acquiring STD's are those that place the young, single, alcohol abusers or habit forming drug abusers at risk for HIV/AIDS infections. This study shows that adolescents are at risk for STD's and HIV infection and the findings are potentially useful for the development, implementation and evaluation of the sexuality/life skills programme for adolescents. The recommendations are outlined according to the conclusions based on the research questions that provided the conceptual framework for the study.

5.3.1 Who is the sexually active adolescent in the Vaal Region?

Based on the analysis of the data, the conclusions are that both male and female adolescents attending the sexually transmitted disease clinics are sexually active and start to engage in sexual contact as early as the age of 10 years and under. It is therefore recommended that:
• Sexuality/life skills education programmes should be given throughout the child’s development and in particular from preschool to high school level.

• Programmes should be age-related and also include those already out of school.

• Healthy life style programmes should form an integral part of the school education programme.

• Parents should form important partners in the healthy life style programmes of children and adolescents, as support and guidance throughout the child’s life is important.

• The healthy life style programme should take into consideration the physical, emotional, psychological and social development of the target group.

• Sexually transmitted disease and HIV/AIDS education programmes should be integrated.

• Sexually transmitted disease services should be made available as part of comprehensive health services.

• All health workers providing reproductive health services should be trained in counselling and management of sexually transmitted diseases to ensure a quality STD service.

• Counselling and education should form the basis of the STD service.

5.3.2 What factors contribute to sexual behaviour of the adolescents in the Vaal Region?

According to the findings of the study, various factors contribute to adolescents’ involvement
in sexual activity, especially the influence of the media, peer pressure, socio-economic factors as well as lack of knowledge about dangers of early sex.

It is therefore recommended that:

- The media be used to popularise key prevention strategies of STD’s and HIV/AIDS.
- Peer group teaching programmes should be designed that will reflect the cultural beliefs and values of the target group.
- Establishing youth centres where an environment based on respect and trust free of criticism and judgment can be created for the adolescents to feel safe and free to express feelings without fear.
- A multisectoral approach be adopted in the planning and implementation of the healthy lifestyle education programmes.
- The health department, education department, nongovernmental organisations, churches and parents should work together in a concerted effort to plan and implement the health education programmes.
- Programmes should be designed for parents to equip them with knowledge and skill in educating their children on issues relating to sex and sexuality.
- Recreational facilities for the youth, more especially in townships, should be improved.
- Condoms be made available and accessible in various public places other than health centres.
- Socioeconomic factors that underlie the spread of HIV/AIDS and STD’s should be
addressed.

5.3.3 Is the adolescent in the Vaal Region knowledgeable about safe sexual practices and the importance of healthy life style behaviours?

The results of the study showed that the adolescents lack in-depth knowledge and understanding of the information relating to sex and sexuality and that the life style education programme offered at schools and clinics was not effective in motivating safe sexual practices among adolescents.

It is thus recommended that:

- Methods and strategies for implementing the programmes should be revised.

- Active participation of the learner in planning and implementing the programme should be emphasised.

- The knowledge, attitudes, concerns and behavioural needs of the youth should be assessed in the planning and implementation of the programmes.

- There should be proper selection and training of people who will present the programme, for meaningful communication and interaction between learner and teacher to take place.

- Programmes for training teachers should be developed in order to achieve effective teaching and learning.

- Methods for continuous monitoring and evaluation of the programmes should be developed.

- Each phase/module of the programme should be evaluated after implementation.
• There should be a consistent policy and coordination of efforts by educators, parents and health professionals.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

It is recommended that further research studies be done to

• explore in detail the extent to which sexually transmitted diseases affect adolescents

• extend the research project to wider areas in Gauteng Province and other provinces in South Africa

• evaluate the appropriateness and effectiveness of the healthy life skills programme and how these are implemented in practice

• explore the impact of the media on the sexual behaviour of adolescents

• determine the impact drug and alcohol use has on the sexual behaviour of adolescents

5.5 LIMITATIONS OF THE STUDY

Certain limitations were identified during the study, namely:

• It was difficult to obtain the desired sample size initially planned. Decentralisation of the sexually transmitted disease services took place at the time of the study, thus decreasing the number of attendances at the selected clinics.

• An exploration description research study was done using mostly closed questions thus in-depth information could not be obtained. Structured interviews to explore the answers in greater depth could have clarified the situation more effectively.
• The questionnaire was written in English. This could have had an impact on the understanding, the response rate and the answers given as English was a second language to most of the respondents.

• The study was limited to the Western district of the Vaal Region. The results of the study could therefore not be generalised.

5.6 ASSUMPTIONS

Assumption 1: Adolescents in the Vaal Region are sexually active.

This assumption was found to be true as indicated by the early age at which the adolescents commence sexual activity, the frequency of sexual intercourse, the constant location the adolescents use for sexual contact and that the adolescents regarded sexual intercourse as a way of life. According to the findings, most of the respondents had sex on a weekly basis, enjoyed the act of sexual intercourse and used a home as a constant place for the sexual contact.

Assumption 2: Adolescents engage in unsafe sexual activities.

This assumption was substantiated by the following:

• the prevalence of sexually transmitted diseases
• the poor use of condoms
• the early commencement of sexual intercourse

Assumption 3: Peer groups play a role in promoting sexual activity among adolescents.

This was found to be true. More than half of the respondents indicated that adolescents do what others of the same age do.
Assumption 4: Knowledge and understanding of safe sexual practices is poor.

This assumption was found to be true. Though respondents indicated that they have received information on most of the topics related to sex and sexuality, most stated that they still needed a lot of information on all the topics related to sex and sexuality. More than half, 47 (60.8%) of the respondents indicated that a lack of knowledge on the dangers of early sex was a contributory factor to adolescents' sexual activities and the majority of the respondents indicated that they still needed a lot of information in all of the topics related to sex and sexuality.

Assumption 5: The current healthy lifestyle behaviour programme offered in schools and clinics does not promote safe sexual practices among adolescents in the Vaal Region.

This was also found to be true and is substantiated by the lack of understanding of the topics related to sex and sexuality and the fact that the adolescent attended STD clinics. The respondents indicated that the programme should be age-related and offered as early as preschool level.

5.7 CONCLUSION

In the wake of the HIV/AIDS epidemic, the occurrence of STD's, especially among the youth, is of great concern. The literature review and the findings of the study show that many and complex factors contribute to adolescents’ sexual activity. In the Vaal Region these appear to be compounded by social, economic and political conditions.

The active involvement of the youth and schoolchildren in politics, especially in the Black townships, seemed to have turned the schools into battlefields for liberation. This resulted in violence, lawlessness and disruption in school attendance, which led to children indulging in risky behaviours, such as the use of harmful drugs and alcohol (Everatt & Sisulu 1992:4, 6).
To date, the culture of learning, teaching and discipline has been severely disrupted with both learners and teachers taking turns in strikes. The extent to which discipline at school is affected today is frequently depicted in media reports, where intimate relationships such as sexual relationships between teachers and schoolchildren are often reported (Sowetan 1997c:4; Sunday Times 1997a:1). These factors contribute to a state of normlessness and indirectly influence the sexual activities of the adolescents.

In this context, the RDP outlines the restructuring and restoration of the education system, sport and recreation and youth development, in general, among its priorities (African National Congress 1994:64, 73). If full attention is given to implementing the recommendations and approaches as suggested in the RDP document (African National Congress 1994:73), the youth could be enabled to realise their full potential, enhance self-respect and discipline and their energy could be channelled in a constructive manner.

A major strength in the transformation of health services in South Africa in terms of sexuality and health services for the youth is the design of the life skills education programme for the youth (Department of Health 1997a:113). According to the Department of Health (1997a:113), it is envisaged that the life skills programme will be a component of a broader education programme, which will include other aspects of health and family life education that will equip them with the skills to enable them to develop self-esteem, self-confidence and respond appropriately to the challenges and hurdles they face.

A multisectoral effort should be made to implement the recommendations in the RDP document as well as the recommendations made in this study on the restructuring of education and training, and youth development and a concerted effort to implement the life skills programme. Societal values and norms could then be restored, which would improve adolescents’ sexual behaviour.
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DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

ADOLESCENTS SEXUALITY EDUCATION PROGRAMME

1. OBJECTIVES - ADOLESCENT SERVICE

1.1. PROMOTES FAMILY HEALTH

- Promotes communication between parents and their children
- Lowers the incidence of unplanned, unwanted pregnancies
- Emphasises the importance of delaying the first pregnancy and its related health and social consequences
- Promotes a better quality of life through knowledge and understanding

1.2. PROVIDES ACCEPTABLE, ACCESSIBLE SERVICE

- Youth Health Centres
  - Counselling: Individual
  - Groups
- Involves the male in sharing responsibility for reproduction

1.3. CONTRIBUTES TO DEMOGRAPHIC OBJECTIVES OF POPULATION DEVELOPMENT PROGRAMME

- Decreasing the incidence of mother and child mortality rates.

2. DEPARTMENTAL APPROACH

Throughout the world, pregnancy and childbearing are occurring at younger ages than in the past, resulting in adverse health, demographic and social consequences. Postponing first births until age 20 or later would significantly reduce maternal and infant mortality and morbidity, slow population growth, and contribute to improvements in the quality of life for people everywhere.

2.1. PROVISION OF QUALITY SERVICES

The aim of the Department is to provide a two-faceted service for adolescents:

2.1.1. The provision of quality contraceptive services to sexually active teenagers, male and female, where the need for such services exists, but

2.1.2. Emphasis being laid on reaching adolescents, male and female, before their first sexual experiences.

Rationale:

Research shows that traditional "sex education" and availability of contraceptives, as in USA and Britain for example, has had little effect on lowering teenage pregnancy rates.

Although it is imperative that information on human sexuality, and training in decision-making and interpersonal communication, must be provided, data indicates that information and skills can only be valuable if they are applied by the teenager.
For this reason more comprehensive effort must be put into this area. Opposition to meaningful education programs for adolescents must be overcome. The problem of teenage pregnancy will not be solved by simplistic approaches - a more heightened awareness and commitment is needed.

In addition, provision of information services and development of decision-making and interpersonal communication skills has to be integrated into the specific culture concerned - based on the common denominator of all teenage cultures - viz. that emotions play a much greater role than intellectual abstractions, and that "here" and "now" are pressing elements in the decision-making process.

2.2. **YOUTH ADVISORY CENTRES AND FAMILY PLANNING CLINICS**

In order to achieve successful services as outlined in 2.1, centres away from adult family planning services, should be established within specific socio-cultural milieus.

These centres must be staffed by trained, skilled personnel capable of building up trusting relationships between themselves and teenagers. Only in this way will problems be revealed spontaneously by teenagers.

Contraceptive services will not be offered at these education centres, but the nurse working at the centre will be in the position to provide contraceptives to those sexually active teenagers who request such services. Although linked to family planning services, the term "family planning" should not feature in services for adolescents as it is not a meaningful concept for youth.

2.3. **PEER-GROUP COUNSELLING**

Selected teenagers should be trained to provide information and decision-making skills, thereby acting as counsellors and educators for their fellow teens in the community.

**Rationale:**

Research confirms that young people gain most of their information about sexuality from other young people. Utilising teenagers themselves to disseminate information will greatly increase the number of young people reached.

2.4. **PARENT-INVOLVEMENT**

Parent-training must run concomitantly with providing information and education services to youth. In this way obstacles, such as parental fears of promoting promiscuity, can be clearly defined and approached.

One of the most difficult tasks of the project will be to surmount the cultural fear that exposing adolescents to sexual information and contraception encourages sexual activity.

Parents need reminding of their powerful focal role in each child's psycho sexual development and their daily contribution to teaching their children about sexuality. They should be offered assistance in understanding their own sexual feelings and concerns and in developing comfort with their children's emerging sexuality.

Families should be assisted in creating a home environment (within the socio-cultural milieu) where information, values and feelings are shared in a caring and consistent manner.
COMMUNITY PROFILES

Profiles must be done to:

- establish existing adolescent programmes, activities and services
- establish felt needs and real needs
- establish socio-cultural factors which will influence the provision of an adolescent service.

Step 2: Establishment of advisory Committees

As teenage pregnancy is not only a health problem, but a social, educational and economic problem, it is logical that the approach to its solution also must multifaceted and should involve all sectors of the community.

The most appropriate way to create community interaction is at the local level which holds the greatest potential for success. Persons such as clergy, parents, politicians, youth-serving professionals and teenagers themselves must be co-opted.

Step 3: Planning of training programmes for adolescents and parents

(at local level)

Broadly subject matter should include:

For teenagers specifically -

- self-awareness and personal values
- decision-making and problem solving
- reproductive anatomy and physiology
- reproductive health care
- conception, pregnancy and childbirth
- contraception
- sexually transmitted diseases
- population issues

For parents specifically -

This will depend on socio-cultural milieu, but should be directed to include common parental concerns about childhood and adolescent sexuality from birth to 18 + years.

Step 1 will be carried out under the guidance of the Liaison Officer (community development)

Steps 2 and 3 will be carried out under the training, guidance and supervision of the 3 regional office personnel specifically appointed for the adolescent project.
3. POLICY ON FAMILY PLANNING CONTRACEPTIVES FOR ADOLESCENTS

3.1. INTRODUCTION

Young people are being encouraged to marry late, or at least to delay the first child by several years, then they must be offered contraceptive services if they cannot be persuaded to delay sexual activity. There are three patterns of sexual behaviour among adolescents: abstinence, pre-marital sex or sex at an early age within marriage.

Since abstinence is not universal among young adolescents, contraception is perhaps the most obvious service they are likely to need although they are often as ignorant about the possibility of regulating their fertility as they are about how to regulate it. For adolescents who want contraception, a careful assessment of their circumstances is even more important than for older men and women. Their age, parity and way of life must be weighed along with the regularity of the sexual relationship in which they are likely to be engaged. One thing is clear: whatever the disadvantages of the various modern methods of contraception, using them is reckoned to carry far fewer health risks than a pregnancy or abortion would for a young adolescent.

4. FAMILY PLANNING PROGRAMME: CONTRACEPTIVE METHODS FOR ADOLESCENTS

It is well documented that no contraceptive carries as great a risk of death as an adolescent term pregnancy or abortion (mortality risk 11.1 deaths per 100,000 births). However certain aspects must be regarded when prescribing contraceptives for adolescents. These are in addition to the usual method contra-indications considered for adult clients.

The policy of this Department with regard to the choice of contraceptives for adolescent clients requesting contraception is outlined below.

4.1. ABSTINENCE

Abstinence remains the method of choice for adolescents and should always be considered as a possibility when discussing contraceptive methods with adolescents.

4.2. ORAL CONTRACEPTIVES

4.2.1. Oral contraceptives must contain the lowest effective dosage of oestrogen and progestogen when prescribed for adolescents.

4.2.2. Motivation, maturity and level of sexual activity are important considerations when considering oral contraception for adolescents.

4.2.3. Pap smears, particularly for oral contraceptive users, must be taken at regular intervals.

4.2.4. Oral contraceptives should be avoided in the first two years following menarche. However girls should experience at least three spontaneous menstrual periods before oral contraception.

4.2.5. The disadvantages of the progestogen-only pill are the same as those for adult women, and use of this pill is therefore limited.
4.3. **INJECTABLE CONTRACEPTIVES**

4.3.1. The policy of this Department remains in accordance with the statement by WHO on the technical and safety aspects of using injectable contraceptives among adolescents, viz., "if sexually active adolescents are not able to use other methods, an injectable hormonal method may be prescribed since the social, medical and psychological consequences of unwanted pregnancy and abortion outweigh any physiological reservations that currently exist. Until further knowledge is gained...... hormonal contraceptives should be avoided within the first 2 years of the menarche".

4.3.2. Norethisterone enanthate 200mg is recommended in preference to Medroxyprogesterone acetate 150mg because of the shorter delay in return to fertility, lesser weight gain and lower incidence of amenorrhea.

4.4. **INTRA-UTERINE DEVICES (IUD's)**

IUD's are not recommended for use among adolescent women.

All adverse event rates are higher for adolescent nulliparous women than for older, parous women.

4.5. **BARRIER METHODS AND "NATURAL METHODS"**

These methods carry the same risk/benefit associations as for older women.

4.6. **POST-COITAL CONTRACEPTION**

Please refer to A10/1/1/B of 4 April 1985, with due regard to the use of hormones by adolescents.

4.7. **STERILISATION**

May sometimes be considered in cases of mental retardation, and must be dealt with in accordance with the Abortion and Sterilisation Act.

An attempt must always be made to involve the parents/guardians in the counselling process when a minor adolescent attends a clinic for contraception. If this attempt is rejected by the adolescent, confidentiality must be respected. Complete and accurate documentation is essential.

4.8. **ADOLESCENTS AND CONTRACEPTION**

That there has been a revolution in sexual attitudes is undeniable. This revolution is often erroneously attributed to the advent of the birth control pill and its easy availability. This view ignores the various factors which underlay the use of effective birth control methods. Such factors are discontent with the traditional forms of family life and the isolated nuclear family, dislike of sex-role stereotyping, and the unacceptability of a high divorce rate. This dissatisfaction has led to experimentation with alternative life styles such as communes and "open" relationships.

A second consideration with regard to the argument that contraception encourages promiscuity is that most studies show that by the time people seek contraception they have already had sexual intercourse. It appears that only a minority of people abstain from coitus for fear of pregnancy. Inaccurate speculation and fact, although contraception may slightly increase the frequency of coitus, it does not affect the decision to have intercourse or to increase the number of partners.
4.9. RESPONSIBILITY AND BIRTH CONTROL

Unfortunately, the majority of both men and women seem to assume that the burdens of birth control should fall on women. One reason for this is that the female is most directly involved in the possible consequence of pregnancy. Ideally, the decision as to the method of contraception should be a shared responsibility. The male's attitude counts - two people prevent pregnancy better than one. A concerted education/communication process on individual and non-individual levels, is needed to make men (and women) aware that men also have a share in the responsibility of birth control.

4.10. THE ADOLESCENT AND BIRTH CONTROL

The two main reasons why sexually active teenagers do not use contraceptive methods are their confusion about the morality of birth control and their ignorance about reproduction and contraception.

Psychological studies carried out in several countries to compare sexually active adolescent girls who do not use contraceptives have found that girls not using contraceptives:

- Tend to hold fatalistic attitudes - they are more likely to feel powerless to control the events of their lives;
- have a low sense of personal competence;
- have a passive, dependant approach to male-female relationships;
- are generally more inclined to take risks, and to cope with anxiety by attempting to deny possible dangers rather than by facing up to them;
- tend to fear that taking contraceptives is a sign of planning for sex and sex can only be justified if it is "accidental" or "spontaneous".

It was also found that girls who accept their sexuality frankly are more likely to use contraceptives than those who deny it - whether to themselves or to others.

Among adolescents either seeking, or not objecting to pregnancy, a common theme is that of emotional deprivation - the need to love and be loved, to seek attention, to be seen as "adult", to escape school or to change a dull life.
Annexure B

Gauteng Provincial Department

Life Skills and HIV/AIDS Education Programme
GAUTENG PROVINCIAL HEALTH DEPARTMENT
LIFE SKILLS AND HIV/AIDS EDUCATION PROGRAMME

1. BACKGROUND AND INTRODUCTION

In South Africa 392 of every 1000 births are to teenage mothers. The rate of HIV prevalence is highest amongst the 15-29 year old with young women being particularly at risk. The rate of infection for 15-19 year old is 6.47%.

Many young people become sexually active from an early age. There is enormous pressure from peers and the media to become sexually active. Media bombard teenagers with contradictory messages about sexuality. Parents, communities and religious groups are promoting abstinence before marriage.

Teenagers are expected to make decisions about being sexually active or not without being given information and skills to help them make responsible and health choices.

There is an urgent need to develop intersectoral programmes which address sexuality and lifeskills education. This programme should be introduced from an early age. The programme should help students understand their own physical and emotional development in order to gain insight into their own sexuality. The programme should further aim to develop a positive self-esteem, effective communication skills, interpersonal relationship skills etc. Once teenagers are clear about their own values and who they are, they'll be able to make responsible decisions that will reduce the risk of unwanted pregnancies, abuse, sexually transmitted diseases and AIDS.

2. AIMS AND GOALS OF LIFESKILLS EDUCATION

The Gauteng Provincial Health Department aims to promote an effective and age appropriate lifeskills programme inclusive of emotional, social and physical needs for all children, adolescents and young adults.

IN ORDER TO ACHIEVE THIS GOAL, THE FOLLOWING SHOULD BE CONSIDERED IN ASSESSMENT, PLANNING, IMPLEMENTATION AND EVALUATION OF THE LIFESKILLS EDUCATION PROGRAMME:

- There must be consultation and communication with parents and communities around the lifeskills programme.
- The content and approach of teaching must be non-judgmental.
- Both directive and experiential learning approach should be used.
- There should be compulsory lifeskills training for school going youth.
- The lifeskills education should be taught through and official curriculum throughout school years.
- The curriculum must be introduced at pre-primary level.
- The lifeskills programme must be age appropriate.
The process of curriculum development and lifeskills implementation should be developed through inter-departmental workshops and consultation.

The programme must be assessed, co-ordinated and evaluated continuously.

The criteria for facilitators who will present the programme must be taken into account when selecting persons to present the education after they have been trained in lifeskills presentation.

3. CONTENT

The development of the lifeskills programme should allow for knowledge and skills that are age appropriate to be introduced at various phases of development.

PHYSICAL NEEDS

a) Knowledge on:
   - Basic anatomy (knowing your body)
   - Growth and development stages including nutrition
   - Sexual growth and development
   - Reproductive health including STD’s, AIDS and pregnancy
   - Hygiene

b) Emotional:
   - Clarification of values and establishing a value system
   - Communication skills
   - Inter-personal relationships
   - Emotions during puberty (self-development)
   - Self-assertiveness and saying no (negotiation skills)
   - Building self-esteem
   - Decision making and problem solving skills
   - Goal setting
   - Stress management
   - Conflict management

c) Social:
   - Gender roles and cultural roles
   - Gender and cultural stereotyping
   - Relationships skills (establishing and maintaining meaningful relationships)
   - Understanding and coping with peer pressure
   - Physical, sexual and emotional abuse
   - Eating disorders
   - Teenage pregnancy and parenting skills
   - Substance abuse
   - Domestic violence

d) Resources:
   - Awareness of appropriate resources and support groups and systems within each community
e) The content should include knowledge of:
- Physical development
- Gender roles and cultural roles
- Gender and cultural stereotyping
- Reproductive health care and pregnancy
- Sexually transmitted diseases and AIDS
- Substance abuse
- Domestic violence

f) Skills that are most needed include:
- Self-development
- Positive self-esteem
- Self assertiveness and negotiating skills
- Problem solving, decision making and goal setting
- Communication skills
- Relationship skills
- Establishing a value system and clarifying values
- Understanding and coping with peer pressure
- Stress management
- Conflict management

5. METHODOLOGY

The lifeskills programme should address factual knowledge in a didactic way to ensure that, new knowledge is integrated with existing understandings and experiences. The approach taken in teaching lifeskills must be learner-centred which allows for students to perceive issues from their own point of view and enhances participative learning. Facilitators must present basic information and skills in an experimental manner. These methods include working in small groups using techniques such as brain-storming problem solving, role-plays, games, group discussions, questioning and workshops. Where facilitators do not have access to resource material, innovative teaching methods should be used.

6. CRITERIA FOR PRESENTERS

Relevant persons involved in facilitating lifeskills education should be trained in lifeskills presentation to ensure that they present an effective lifeskills programme. The presenters must be acceptable role models within the community and they must have access to youth so that the programme is sustainable. Specialised pre and in-service training courses must be established to ensure that facilitators are equipped to present the programme.

7. RESOURCE MATERIAL

Facilitators must have access to resource material including printed and audio-visual material. Where appropriate resources are not available, the development of appropriate literature and material to support the implementation of this programme is necessary.
8. COMMUNITY AND PARENT INVOLVEMENT

Communities and parents should be involved in the development and implementation of a lifeskills programme. Community involvement is needed to ensure the sustainability of the programme.

The following organisations/structures could be involved:

Youth organisations
Parents, student or teacher organisations
Women’s organisations
Health care workers
Private sector
Cultural and church organisations.

9. OUT OF SCHOOL YOUTH

Non-school going youth should be targeted through existing organisations such as NGO’s and CBO’s and initiated through appropriate programmes.

10. MONITORING AND EVALUATION

The programme must constantly be assessed, co-ordinated and evaluated to ensure to efficiency of the lifeskills programme and to serve as a basis for further planning and refinement. Lifeskills programmes must include an appropriate methodology for evaluating the impact and success of the programme.
GAUTENG PROVINCIAL HEALTH DEPARTMENT
LIFE SKILLS AND HIV/AIDS EDUCATION PROGRAMME

SUBCOMMITTEE : CURRICULUM DEVELOPMENT

1. RATIONALE

The rapid increase of HIV/AIDS epidemic and other STD's internationally and especially South Africa, necessitate that the spread of these diseases be curbed, through, inter alia:

- Enabling learners to apply preventative strategies; and

- encouraging them to actively demonstrate positive, responsible attitudes and care towards persons with HIV/AIDS and STD's.

2. UNDERLYING PRINCIPLES

2.1. Principles underlying an HIV/AIDS/STD education programme include the following: It should -

- Follow a holistic, co-operative and inclusive approach (multi-disciplinary, inter-sectoral and community-based);

- be practical and sustainable;

- be affordable;

- be acceptable to learners and the community;

- be cultural sensitive;

- be educational acceptable

- be learner centred/participatory;

- be factual correct; and

- increase knowledge, develop skills, promote positive and responsible attitudes and provide motivational supports.
2.2. Underlying philosophy

The philosophy underlying and HIV/AIDS/STD education programme is:

➢ To provide learners with voice and context to express their concerns and feelings about sexuality, HIV/AIDS and STD's;

➢ to encourage and resource the development and implementation of practical, sustainable programmes in school communities;

➢ to support and evaluate these programmes, and to translate them into practical suggestions for schools, curriculum planners, teachers and learners;

➢ to promote an holistic, co-operative and inclusive approach (multi-disciplinary, inter-sectoral and community-based) as essential to advancing an effective HIV/AIDS and STD's prevention strategy in school communities.

2.3. A programme should increase knowledge, develop skills, promote positive and responsible attitudes and provide motivational supports.

2.2.1. Knowledge

Information that will help learners decide what behaviours are healthy and responsible includes:

➢ Ways HIV/STD's are transmitted and not transmitted;

➢ the long asymptomatic period of HIV;

➢ personal vulnerability to HIV/STD's;

➢ means of protection from HIV/STD's;

➢ sources of help if needed; and

➢ how to care for people in the family who have AIDS.
2.2.2. **Skills development**

The skills relevant to HIV/AIDS and STD's preventative and coping behaviours are:

- Self-awareness;
- decision-making;
- assertiveness to resist peer pressure;
- negotiation skills to ensure abstinence and safer sex;
- practical skills for preventative measures;
- coping with loss.

These skills are best taught through participatory methodologies.

2.2.3. **Attitudes**

Attitudes derive from beliefs, feelings and values. HIV/AIDS/STD education should promote:

- Positive attitudes towards delaying sex;
- personal responsibility;
- safer sexual practices as means of protection;
- confronting prejudice;
- being supportive, tolerant and compassionate towards persons with HIV/AIDS;
- living positively with one's own HIV status;
- respecting the rights of persons infected with HIV;
- being sensitive towards the implication of multiple partners, violent and abusive relationships, alcohol, drug and substance use.
2.2.4. **Motivational supports**

Even a well informed and skilled person needs to be motivated to initiate and maintain preventative practices. A realistic perception of the learner's own risk and of the benefits of adopting preventative behaviour is closely related to motivation. Peer reinforcement and support for healthy actions is crucial, as peer norms are powerful motivators of behaviour.

3. **PROGRAMME OUTCOMES**

In view of the fact that responsible behaviour is the key to prevention, the following outcomes are considered as minimal requirements for an effective HIV/AIDS/STD education programme.

At the end of the programme, learners will be able to:

3.1. Demonstrate a clear and accurate understanding of sex, sexuality, gender and sexually transmitted diseases:

- Definitions of sex, sexuality, gender and STD's:

- sexual identity ➔ sexual orientation
  ➔ gender roles
  ➔ self concept
  ➔ body image;

- elements/domain of sexuality (mental, physical, etc.);

- development of the above-mentioned elements from 0 - 18 (life-cycle development);

- sex response cycle;

- differentiate between HIV, AIDS and STD's and their relatedness;

- clarify values, morals and beliefs;

- HIV/STD ➔ origins
  ➔ history
  ➔ prevalence
  ➔ stages (links with other diseases)
  ➔ immune system
  ➔ different kinds of STD's
  ➔ links between STD's
3.2. Critically identify ways in which HIV/STD's can be transmitted:

- Infectious bodily fluids (blood, sex, mother to child);
- entry and exit points;
- activities that transmit HIV/STD's (blood/sex/mother to child),
  \textit{Percentages vs. reality}
- activities and situations that increase the risk of transmission (physical/home environment);
- recognition on own vulnerability - "not who you are, but what you do".

3.3. Critically identify ways in which HIV/STD's cannot be transmitted:

- Bodily fluids;
- entry and exit points;
- identify myths and beliefs (participatory);
- facts about transmission (over reaction).

3.4. Identify and evaluate the effectiveness of HIV/STD's prevention methods:

- Clarify prevention (caring, yourself, workplace, schools);
- prevent exchange of bodily fluid;
- identify the methods (blood to blood, sex, mother to child);
- evaluate effectiveness;
- value clarification around choice of options.

3.5. Identify, access and mobilise sources of assistance within a community:

- Need for support;
- identify sources (e.g. project) and list them (clubs/individual/printed media);
3.6. Critically evaluate reasons for delaying sexual intercourse or practising abstinence:

- Benefits of delaying (pro's and cons);
- pro's and cons of abstinence;
- pregnancy - options;
- problem solving;
- decision making;
- values, pressures and morality;
- responsibility (own);
- goal setting (visioning);
- critically evaluating media information and role models;
- differentiate between love, lust and infatuation;
- relationships and commitments.

3.7. Negotiate assertively when pressured for sexual intercourse:

- What is assertiveness?

Theory and practice
what is negotiation?

*Theory and practice*

what is pressure?

role play;

situations to be identified;

- gender oppression
- abuse (sexual & substance - school parties)
- rape - what a pressure situation is, your reaction and how you handle this unexpected situation
- peer pressures
- "cultural" pressures

right to resist violation of personal space and your body;

assistance.

3.8. Critically evaluate reasons and methods for having protected sex when/if sexually active:

- Pro's and cons for protected sex;
- problem solving;
- decision making;
- values, pressures and morality;
- responsibility of male and female;
- goal setting (visioning);
- critically evaluating media information and role models;
- differentiate between love, lust and infatuation;
- relationships and commitments.
methods to apply - total spectrum (illustrate and demonstrate);

contraception vs. protection.

what is assertiveness?
Theory and practice

what is negotiation?
Theory and practice

what is pressure?

role play;

situations to be identified;

gender oppression
abuse (sexual & substance)
rape - what a pressure situation is, your reaction and how you handle this unexpected situation
peer pressures
"cultural" pressures

right to resist violation of personal space and your body;

assistance;

relationships → begin
→ sustain
→ maintain
→ end;

what is unprotected sex? (Refer back);

legal issues → rape
→ marriage
→ abortion;

Link to other areas
3.10. Accept, cope and live positively with the knowledge of being HIV positive:

- Testing
  - practical issues
  - emotional side
  - a worried well
  - disclose/confidentiality - choices

- rights, responsibilities and choices;

- spiritual;

- support systems;

- counselling;

- diet;

- medical;

- emotional;

- dealing with unwanted pregnancies;

- support.

3.11. Show compassion, empathy and solidarity towards persons with HIV/AIDS or those affected:

- Rights and responsibilities of a person with HIV/AIDS;

- define concepts of compassion, empathy and solidarity;

- stigmatisation and discrimination;

- concrete things to be done (schools, family, community, personal relations);

- life skills (Rooth);

- support to others who are affected.

- support.
3.12. Recognise the need to care/be able to provide basic care for people with AIDS in the family and community and those affected:

- Sociological impact - society, family, hospital;
- need to care for people in home;
- referral out for home-based care;
- basic information on care;
- link up with sources;
- psychological and emotional support (link up with 3.11);
- support to others affected;
- crisis and stress management;
- problem solving.

3.13. Understand and cope with loss and the grieving process:

- Stages of loss;
- stages of grieving;
- self;
- significant others;
- identify situations where loss may occur;
- coping skills
  - emotionally
  - psychologically;
- healing process;
- crisis and stress management.
Annexure C

Department of National Health and Population Development

Adolescent Contraceptive Clinic Card
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</tbody>
</table>

| DEPARTEMENT VAN NASIONAL GESONDHEID EN BEVOLKINGSONTWIKKELING |
| DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT |

| ADOLESCENTEKAART - ADOLESCENT CARD |

<table>
<thead>
<tr>
<th>SENTERUM</th>
<th>DATUM</th>
<th>GEBORTE DATUM</th>
<th>BEVOLKINGS GROEP</th>
<th>OUDERDOM</th>
<th>KLIENT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CENTRE</td>
<td>DATE</td>
<td>DATE OF BIRTH</td>
<td>POPULATION GROUP</td>
<td>AGE</td>
<td>1</td>
</tr>
</tbody>
</table>

| GESKIEDENIS: EERSTE BESOEK - HISTORY: FIRST VISIT |

<table>
<thead>
<tr>
<th>FISIESE/EMOSIONELE VOORKOMS</th>
<th>PHYSICAL/EMOTIONAL APPEARANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FISIESE GESKIEDENIS</td>
<td>PHYSICAL HISTORY</td>
</tr>
<tr>
<td>TUBERKULOSE</td>
<td>TUBERCULOSIS</td>
</tr>
<tr>
<td>DIABETES MELLITUS</td>
<td>DIABETES EPILEPSY</td>
</tr>
<tr>
<td>ASMA</td>
<td>ASTHMA</td>
</tr>
<tr>
<td>VELPROBLEME</td>
<td>SKIN DISORDERS</td>
</tr>
<tr>
<td>ANDER</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REPRODUKTIEWE GESKIEDENIS</th>
<th>REPRODUCTIVE HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANLIK-SPERMAGENESI</td>
<td>MALE-SPERMAGENESIS</td>
</tr>
<tr>
<td>VROULIK-MENSTRUASIE MENARC</td>
<td>FEMALE-MENSTRUATION MENARCHE</td>
</tr>
<tr>
<td>SWANGERSKAP</td>
<td>PREGNANCY</td>
</tr>
<tr>
<td>HUIDIGE MEDIKASIE</td>
<td>CURRENT MEDICATION</td>
</tr>
<tr>
<td>ROOKGEWOONTES</td>
<td>SMOKING HABITS</td>
</tr>
<tr>
<td>ALKOHOLINNAME</td>
<td>ALCOHOL INTAKE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATUM</th>
<th>HOOFPYN/MIGRAINE</th>
<th>HEADACHES/MIGRAINE</th>
<th>ASEMHALING STELSEL</th>
<th>RESPIRATORY SYSTEM</th>
<th>KARDIOVASKULARE STELSEL</th>
<th>CARDIA VASCULAR SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>HOOFPYN/MIGRAINE</td>
<td>HEADACHES/MIGRAINE</td>
<td>ASEMHALING STELSEL</td>
<td>RESPIRATORY SYSTEM</td>
<td>KARDIOVASKULARE STELSEL</td>
<td>CARDIA VASCULAR SYSTEM</td>
</tr>
</tbody>
</table>
### Seksuele Geskiedenis

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HET SY/HY AL KOITUS GEHAD?</td>
<td>HAS SHE/HE HAD SEXUAL INTERCOURSE?</td>
</tr>
<tr>
<td>EERSTE KOITUS: MELD OUDERDOM</td>
<td>FIRST SEXUAL INTERCOURSE: STATE AGE</td>
</tr>
<tr>
<td>REDES VIR BOGENOMSDE</td>
<td>REASONS FOR ABOVEMENTIONED</td>
</tr>
<tr>
<td>HUIDIGE SEKSUELE VERHOUING</td>
<td>PRESENT SEXUAL RELATIONSHIP</td>
</tr>
<tr>
<td>AANTAL SEKSMAATS</td>
<td>NUMBER OF SEX PARTNERS</td>
</tr>
<tr>
<td>LENGTE VAN VERHOUING/S</td>
<td>LENGTH OF RELATIONSHIP/S</td>
</tr>
<tr>
<td>HOE DIKWELS HET SY/HY KOITUS?</td>
<td>HOW OFTEN DOES SHE/HE HAVE SEXUAL INTERCOURSE?</td>
</tr>
<tr>
<td>TOTALE AANTAL SEKSMAATS</td>
<td>TOTAL NUMBER OF SEX PARTNERS</td>
</tr>
<tr>
<td>WAAR IS SEKSUELE KENNIS OPGEDOEN?</td>
<td>WHERE WAS SEXUAL KNOWLEDGE GAINED?</td>
</tr>
</tbody>
</table>

### Kontraceptive Geskiedenis

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HET SY/HY AL OOR KONTRACEPTIEWE MIDDELS GEBRUIK</td>
<td>METHOD/S</td>
</tr>
<tr>
<td>GEBRUIK SY/HY TANS 'N KONTRACEPTIEWE MIDDEL?</td>
<td>METODE</td>
</tr>
<tr>
<td>DOES SHE/HE USE A CONTRACEPTIVE AT PRESENT?</td>
<td>METHOD</td>
</tr>
<tr>
<td>HET SY/HY Dit MET DIE SEKSMAAT BESPREK?</td>
<td>METODE</td>
</tr>
<tr>
<td>DID SHE/HE DISCUSS IT WITH THE SEX PARTNER?</td>
<td></td>
</tr>
<tr>
<td>HET SY/HY Dit MET DIE OEURS BESPREK?</td>
<td>METODE</td>
</tr>
<tr>
<td>DID SHE/HE DISCUSS IT WITH THE PARENTS?</td>
<td></td>
</tr>
<tr>
<td>HOE BETROKKE IS DIE OEURS?</td>
<td>METODE</td>
</tr>
<tr>
<td>HOW INVOLVED ARE THE PARENTS?</td>
<td></td>
</tr>
</tbody>
</table>

### Sosiale-Familie Geskiedenis

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEHALTE VAN KOMMUNIKASIE MET OEURS</td>
<td>QUALITY OF COMMUNICATION WITH PARENTS</td>
</tr>
<tr>
<td>GESINSINTERAKSIE</td>
<td>FAMILY INTERACTION</td>
</tr>
<tr>
<td>VADER/KLIENT</td>
<td>FATHER/CLIENT</td>
</tr>
<tr>
<td>MOEDER/KLIENT</td>
<td>MOTHER/CLIENT</td>
</tr>
<tr>
<td>BROERS/KLIENT</td>
<td>BROTHER/S/CLIENT</td>
</tr>
<tr>
<td>Systers/KLIENT</td>
<td>SISTERS/CLIENT</td>
</tr>
<tr>
<td>ANDER</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

### Algemeen

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KEN SY/HY DIE WETLIKE ASPEKTE VAN SEKS?</td>
<td>DOES SHE/HE KNOW THE LEGAL ASPECTS OF SEX?</td>
</tr>
<tr>
<td>KEN SY/HY DIE GEVARE VAN VROESE SEKS?</td>
<td>DOES SHE/HE KNOW THE DANGERS OF EARLY SEX?</td>
</tr>
<tr>
<td>KEN SY/HY DIE GEVARE VAN VEELVULDIGE SEKSMAATS?</td>
<td>DOES SHE/HE KNOW THE DANGERS OF MULTIPLE SEX PARTNERS?</td>
</tr>
</tbody>
</table>

### Opsomming van Probleme en Plan van Aksie

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Datum</td>
<td>DATE</td>
</tr>
<tr>
<td>Handtekening</td>
<td>SIGNATURE</td>
</tr>
</tbody>
</table>
Annexure D

Questionnaire given to the adolescent
1.1. Mark your age in years in the given space with an X.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>14 - 15 Yrs</th>
<th>16 - 17 Yrs</th>
<th>18 - 19 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1.2. Gender.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1.3. Educational standard.

<table>
<thead>
<tr>
<th>Standard</th>
<th>5 - 6</th>
<th>7 - 8</th>
<th>9 - 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1.4. Are you still attending school?

<table>
<thead>
<tr>
<th>Status</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

1.5. With whom do you live?

- * Both parents together with brothers and sisters
- * Father together with brothers and sisters
- * Mother together with brothers and sisters
- * Grandparents
- * Friends
- * Relatives
- * Other (Specify ........................................)
### 1.6. What is your father’s highest qualification?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>1.</td>
</tr>
<tr>
<td>Less than or equal to Standard 2</td>
<td>2.</td>
</tr>
<tr>
<td>Standard 3 - 5</td>
<td>3.</td>
</tr>
<tr>
<td>Standard 6 - 8</td>
<td>4.</td>
</tr>
<tr>
<td>Standard 9 - 10</td>
<td>5.</td>
</tr>
<tr>
<td>Diploma</td>
<td>6.</td>
</tr>
<tr>
<td>Degree</td>
<td>7.</td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td>8.</td>
</tr>
</tbody>
</table>

### 1.7. What is your mother’s highest qualification?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>1.</td>
</tr>
<tr>
<td>Less than or equal to Standard 2</td>
<td>2.</td>
</tr>
<tr>
<td>Standard 3 - 5</td>
<td>3.</td>
</tr>
<tr>
<td>Standard 6 - 8</td>
<td>4.</td>
</tr>
<tr>
<td>Standard 9 - 10</td>
<td>5.</td>
</tr>
<tr>
<td>Diploma</td>
<td>6.</td>
</tr>
<tr>
<td>Degree</td>
<td>7.</td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td>8.</td>
</tr>
</tbody>
</table>

### 1.8. In what type of house do you live?

<table>
<thead>
<tr>
<th>Option</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard house (eg. 6 Rooms or more)</td>
<td>1.</td>
</tr>
<tr>
<td>4 - 5 Roomed house</td>
<td>2.</td>
</tr>
<tr>
<td>Shack</td>
<td>3.</td>
</tr>
<tr>
<td>Hostel</td>
<td>4.</td>
</tr>
<tr>
<td>Other (Please specify)</td>
<td>5.</td>
</tr>
</tbody>
</table>
3.

1.9. Do you belong to any of the following groups? (Tick all appropriate spaces if you belong to more than one)

* Social Club
* Sports Club
* Church Youth Group
* Other (Please specify ...........................................)

2.1. What was your age when you had sex for the first time

* Never had sex
* 10 years and below
* 11 - 13 years old
* 14 - 16 years old
* 17 - 19 years old

2.2. How often do you have sex in a month?

* Never had sex
* 1 - 2 times a week
* More than 3 time a week
* 3 - 5 times a month
* More than 6 times a month
* Other (Please specify...........................................)

2.3. Where do you usually have sex?

* In your home
* In your partner’s home
* In your relative’s house
* In a public place (eg. School)
* Other (Please specify.................................)
2.4. How many sexual partners do you have?

* No sexual partner
* One
* 2 - 3
* 4 and more

2.5. Are your sexual partners?

* Males
* Females

2.6. What is your strongest feeling when you have sex?

* Pleasure
* Guilt
* Shame
* No specific feeling
* Other (Please specify ..........................................)

2.7. The first time you had sex, how did it happen? Mark the most relevant answer?

* You felt like doing it
* You and your partner planned it
* You were forced by your partner
* You were forced by another person other than your partners
* It just happened
* Other (Please specify ..........................................)
3.1. To what extent do you agree with each one of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>* There is nothing wrong in having sex as long as you are in love</td>
<td></td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>* Teenagers can engage in sex irrespective of age</td>
<td></td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>* Teenagers can have sex with as many partners as they have</td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>* Sex before marriage is wrong</td>
<td></td>
<td></td>
<td>31</td>
</tr>
</tbody>
</table>

3.2. In your opinion, what do you think are the reasons why teenagers have sex early in life?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Sex is considered a way of life by teenagers</td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>* Teenagers do what friends do</td>
<td></td>
<td></td>
<td>33</td>
</tr>
<tr>
<td>* Teenagers want to experiment with sex</td>
<td></td>
<td></td>
<td>34</td>
</tr>
<tr>
<td>* Influence by television</td>
<td></td>
<td></td>
<td>35</td>
</tr>
<tr>
<td>* Influence by movies</td>
<td></td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>* Influence by what they read in magazines and books</td>
<td></td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>* Teenagers do not know much about the dangers of early sex</td>
<td></td>
<td></td>
<td>38</td>
</tr>
<tr>
<td>* Influence by alcohol</td>
<td></td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>* Influence by use of dagga</td>
<td></td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>* Influence by use of other drugs</td>
<td></td>
<td></td>
<td>41</td>
</tr>
</tbody>
</table>
3.3. To what extend have you ever used any of the following before having sex?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dagga</td>
<td></td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td>43</td>
</tr>
<tr>
<td>Benzine</td>
<td></td>
<td></td>
<td>44</td>
</tr>
<tr>
<td>Glue</td>
<td></td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Other drugs</td>
<td></td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.4. To what extend has your partner used any of the following before having sex?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Not Known</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dagga</td>
<td></td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Benzine</td>
<td></td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>Glue</td>
<td></td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>Other drugs</td>
<td></td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>(specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.5. In your opinion, to what extend do you think the youth (teenagers) in your area are involved in the following practices?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Not Known</th>
<th>A few</th>
<th>Many</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette smoking</td>
<td></td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>Dagga smoking</td>
<td></td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Benzine sniffing</td>
<td></td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Glue sniffing</td>
<td></td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Use of other drugs</td>
<td></td>
<td></td>
<td>57</td>
</tr>
</tbody>
</table>
7.

4.1. Give your reasons for visiting the Clinic?


4.2. Did the service you received at the Clinic meet your needs?

1  

2  

Yes  

No

4.3. Give reasons for your answer


4.4. When you have sex, do you usually use a pregnancy prevention method?

1  

2  

Yes  

No

4.5. If Yes, which method do you use?


If No, give reasons for not using a prevention method?


4.6. Have you ever suffered sexually transmitted diseases (STD/VD)?

1  

2  

Yes  

No
4.7. Has pregnancy resulted from your sexual activity?

<table>
<thead>
<tr>
<th></th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.8. Have you ever received education/information on the following topics? (Tick Yes or No).

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Sex organs and how they function</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>* Sexually transmitted diseases</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>* Teenage pregnancy</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>* Abortion</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>* HIV and Aids</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>* Sexual abuse</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>* Homosexuality</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>* Masturbation</td>
<td>69</td>
<td></td>
</tr>
<tr>
<td>* Contraceptives (Prevention methods)</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>* How to say No to sex</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>* Dangers of drug use</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>
4.9. If you ticked Yes for any of the above topics in 4.8, please also indicate next to the topic, the main source from (Column B) where the information was gained. Eg. If you ticked Yes for abortion, and you gained the information mostly through the radio, put 4 next to abortion as follows:

* Abortion

<table>
<thead>
<tr>
<th>Column A Topic</th>
<th>Main Source</th>
<th>Column B Main Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex organs</td>
<td></td>
<td>1. Clinic</td>
</tr>
<tr>
<td>Teenage Pregnancy</td>
<td></td>
<td>2. School</td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td>3. Television</td>
</tr>
<tr>
<td>Sexually Transmitted deseases</td>
<td></td>
<td>4. Radio</td>
</tr>
<tr>
<td>Prevention Methods</td>
<td></td>
<td>5. Magazines</td>
</tr>
<tr>
<td>HIV and Aids</td>
<td></td>
<td>6. Doctor</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td></td>
<td>7. Church</td>
</tr>
<tr>
<td>Homosexuality</td>
<td></td>
<td>8. Parents</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td>9. Friends</td>
</tr>
<tr>
<td>Masturbation</td>
<td></td>
<td>10. Brothers &amp; Sisters</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Other</td>
</tr>
</tbody>
</table>

4.10. Has the information you received helped you make decisions regarding your sex life?

<table>
<thead>
<tr>
<th>1</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>No</td>
</tr>
</tbody>
</table>

4.11. Give reasons for your answer
4.12. In your opinion, who should be involved in giving education on sex education or life skills.

<table>
<thead>
<tr>
<th>* Health professionals</th>
<th>1 Yes</th>
<th>2 No</th>
</tr>
</thead>
<tbody>
<tr>
<td>* School teachers</td>
<td>1</td>
<td>85</td>
</tr>
<tr>
<td>* The Church</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>* Parents</td>
<td>1</td>
<td>87</td>
</tr>
<tr>
<td>* Youth Clubs</td>
<td>1</td>
<td>88</td>
</tr>
<tr>
<td>* Other (Specify...)</td>
<td>1</td>
<td>89</td>
</tr>
</tbody>
</table>

4.13. For each of the following topics, what do you think would be the right time to give information?

<table>
<thead>
<tr>
<th>Pre-school</th>
<th>Gr 1 to Std 1</th>
<th>Std 2 to Std 5</th>
<th>Std 6 to Std 8</th>
<th>Std 9 to Std 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Sex Organs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Teenage pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Sexually Transmitted diseases</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* HIV and Aids</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Sexual Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Homosexuality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Masturbation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Prevention Methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.14. To what extend do you need information on each of the following topics? (Please tick to show whether you still need a lot of information, some information, just a little information or you have enough information.

<table>
<thead>
<tr>
<th>Topic</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex organs and their functions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teenage pregnancy</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HIV and Aids</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
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<td></td>
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<tr>
<td>Sexual transmitted deseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homosexuality</td>
<td></td>
<td></td>
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<tr>
<td>Dangers of drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Masturbation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy prevention methods</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Other</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

100 101 102 103 104 105 106 107 108 109 110
Annexure E

Obtaining permission to conduct the study
RE: REQUEST FOR DATA COLLECTION

Sir/Madam

I hereby request for permission to check records on adolescent health from hospital records starting 1990 - 1995.

I have registered for a Master's degree in Nursing Science with UNISA.

The title for my dissertation is: "The adolescent, perception on selected health related life style behaviours in the Vaal Triangle."

At present I am with the Western Vaal Metro Substructure (health).

If permission is granted the following will be observed:

- Research will not hamper the hospital routine.
- I will collect the data single handed.
- The data will be regarded confidential and will not be published.

Dates suggested for the collection of data:

95-12-18 - 95-12-22.

Yours faithfully

M.D. MAGAGULA

M.D. MAGAGULA
ENQUIRIES: Dr. A. van der Spuy
(016) 88 1100 X300
FAX: 88 2804 (016)

M. D. Magagula
P.O. Box 3939
VEREENIGING
1930

15 December 1995

E: PROPOSED STUDY FOR MASTERS DEGREE

Permission granted to do the study.
Please contact Mrs. E. Mtembu to make arrangements.

SNR. SUPERINTENDENT
/er
8 October 1996

The Medical Officer of Health
Western Vaal Metropolitan Substructure
P O Box 3
VANDERBIJLPARK
1900

Sir/Madam

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

In support of the application made earlier this year, re: request to register for a Master's degree with UNISA, I hereby request permission to collect data from the adolescents attending sexually transmitted disease clinic in the area. The data collection process will not interfere with the work schedule as the subjects will be responding to the questionnaire whilst they wait.

The research endeavors to highlight important areas of teenage sexual activity, influencing factors and the extent to which the adolescent sexuality program has been effective.

The findings will help with the planning of programs appropriate for the adolescents in line with the Life Skill Program outlined in the new Policy.

Your support in this regard will be greatly appreciated.

Yours faithfully

[Signature]

MRS MD MAGAGULA

PROJECT DOC
TO: MRS MD MAGAGULA
FROM: MEDICAL OFFICER OF HEATH

24 OCTOBER 1996

PERMISSION TO CONDUCT RESEARCH STUDY


Since the topic of your research is a general issue of concern within our service for quite some time, it will be interesting, and valuable to have some information on the topic.

Your are given permission to conduct your research, provided that you will forward us with the necessary protocol, in order to evaluate the impact it will have on service rendering in general, and that a copy of your final results will be made available to our office.

Wishing you good luck!

Yours sincerely

DR JWG VAN DER WALT

PROJECT DOC
Annexure F

Covering letter to the adolescent explaining
the purpose of the study
Dear Teenager

You are kindly asked to answer a few questions which will take about 15 minutes of your time.

The information will help identify important issues of teenage sexual activity, that will help in planning appropriate health programmes for the teenagers.

Please answer all questions. There is no right or wrong answer, but your truthful and sincere views will be highly appreciated.

Your name will not appear anywhere on the form. All information given will be strictly confidential.

After completing the form, kindly drop it in the box provided.

Thank you for your time and willingness to complete the form.

Yours sincerely

MRS MD MAGAGULA