EXPLORING FACTORS THAT INFLUENCE CONDOM USE AMONG HIGH SCHOOL TEENAGERS AGED BETWEEN 16 AND 18 YEARS IN DUTYWA DISTRICT, EASTERN CAPE, SOUTH AFRICA

by

NOMANDLA MNYIPIKA

Submitted in partial fulfilment of the Master of Arts degree in the Department of Sociology with specialisation in Social Behaviour Studies in HIV and AIDS

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR. Sinenhlanhla S. Chisale

JUNE 2014

Student No: 41346645

DECLARATION

I declare that the study on **EXPLORING FACTORS THAT INFLUENCE CONDOM USE AMONG HIGH SCHOOL TEENAGERS IN DUTYWA DISTRICT AGED BETWEEN 16 and 18** is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

…….. …….. .....

SIGNATURE

Ms Nomandla Mnyipika Date

ABSTRACT

The Department of Education nationwide introduced HIV and AIDS care and support for learning and teaching programmes as intervention strategies for supporting vulnerable learners. Despite these interventions, teenagers continue to fall pregnant and this increases their vulnerability to HIV infection. HIV and STIs are rife among teenagers owing to ignorance and peer pressure, among other factors. The aim of this exploratory qualitative study was to explore factors that influence condom use among high school teenagers aged between 16 and 18 in Dutywa District. Focus group discussions and in-depth face-to-face interviews with 12 high school teenagers from one high school (High School X) were used to collect data. Thematic analysis was used to analyse data. The findings of this study revealed that high school teenagers are not using condoms to any significant degree. In their opinion, condoms limit sexual pleasure; they indicate a lack of trust and unfaithfulness between partners and are associated with sexually transmitted diseases. The findings of this study are significant for the policy implementation of schools.

Key Terms

Condom use, unsafe/unprotected sex, factors, high school teenagers, HIV and AIDS, teenage pregnancy, STIs, Health Belief Model, Department of Education, Department of Basic Education

Acknowledgements

I wish to thank God Almighty for providing me with the good health, strength and perseverance to complete this study.

I want to thank the following persons for their contributions to this dissertation:

- Special thanks to my supervisor, Mrs Sinenhlanhla Chisale, for her guidance, support and encouragement
- The teenagers from one selected high school in Dutywa District for their willingness to participate in the study
- The Department of Education Dutywa District, Eastern Cape for granting me permission to conduct the study
- I also thank the Department of Education for financial support throughout my studies
- My colleagues, George and Duma Mamba, for support throughout the study
- Ms Maki Cenge for assistance and support
- Ms Busisiwe Ntsholo for her assistance and support
- Mr Leon Roets, programme convener, for his support and encouragement.

Dedication

I dedicate this study to my children Kamva, Mivuyo and Mlibo for their unwavering support throughout the study.

Acronyms

AIDS: Acquired Immune Deficiency Syndrome

DoE: Department of Education

DBE: Department Of Basic Education

HBM: Health Belief Model

HIV: Human Immune Virus

HSRC: Human Science Research Council

LO: Life Orientation

NSP: National Strategic Plan

SASHA: South African Sexual Health Association

STIs: Sexual Transmitted Infections

SCT: Social Cognitive Theory

UNAIDS: Joint United Nations Programmes on HIV/AIDS

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization

Table of Contents

Contents **Page**

Chapter 1

Introducing the Study

1. Introduction

This exploratory qualitative study sought to explore factors that influenced condom use among high school teenagers in Dutywa District, Eastern Cape. Various strategies have been put in place to curb the prevalence of HIV/AIDS worldwide, yet HIV and AIDS continue to spread at an alarming rate. Education is as an important tool in reaching out to vulnerable groups especially the sexually active and those inexperienced in the realm of sexual activity such as secondary school pupils.

Teenagers continue to be vulnerable to HIV and AIDS despite all the efforts made by the education sector to prevent the spread of HIV among school pupils. The Department of Education (DoE) in the Eastern Cape implemented the Life Orientation Programme, and the HIV and AIDS Directorate has implemented Care and Support for Teaching and Learning and Youth Affairs programmes since 2007. Despite all these interventions, teenage girls continue to fall pregnant and this is a concern because pregnancy indicates that protection (condom usage) and prevention strategies against HIV, STIs and pregnancy are ineffective.

As a result, this study aimed to examine factors that influence condom use among high school teenagers in Dutywa District, Eastern Cape. The key question of the study was: What are the key factors that influence condom use among teenagers? The study used an exploratory qualitative research design to examine teenagers' perceptions, beliefs and attitudes on condom use. Data was collected through focus group interviews and in-depth face-to-face interviews. Data analysis was done through thematic analysis. The theoretical framework underpinning this study was a Health Belief Model (HBM).

1.1 Background of the Study

I noticed with concern that Dutywa District has a high prevalence of teenage pregnancies despite the HIV and AIDS care and support programmes offered by the Department of

Education in Dutywa District of the Eastern Cape. Dutywa District is surrounded by numerous rural villages, situated about 80 km south of Mthatha which was the former capital city of the former Transkei. Dutywa district's primary claim to fame is as the birthplace former president, Thabo Mbeki. It has a population of approximately 254,909 (City Population, 2013:1). Dutywa falls under Mbhashe Municipality of Amathole District in the Eastern Cape. The majority of the population lives in the surrounding rural neighbourhood and in poverty. This area is characterised by poverty, unemployment, poor infrastructure as a result of having no access to basic needs such as water, sanitation and electricity.

The DoE realized that learners were vulnerable to a wide range of challenges and it decided to include in its curriculum a subject which would address issues such as HIV and AIDS. It is for that reason that the DoE, nationally, decided to include compulsory subjects that addressed the question of health issues, societal issues, life skills, HIV and AIDS, STIs and teenage pregnancy. Bridges and Alford (2010:483) claim that life skills provide adolescents with the information and skills they need regarding health risk behaviours. Despite high levels of awareness in connection with the modes of transmission and prevention among teenage learners in all categories, teenage girls continue to fall pregnant.

1.2 Research Problem

The DoE nationwide introduced HIV and AIDS programme called Care and Support for Learning and Teaching (CSTL) as intervention strategies towards supporting vulnerable learners (MacPhail and Campbell, 2001:13). Despite these prevention interventions, teenagers continue to fall pregnant and this increases their vulnerability to HIV infection. This may be because teenagers lack the ability to use condoms because of lack of knowledge; the myths they believe about condoms; circumcision mythology among boys; social economic factors; or the inability of the department to communicate these interventions effectively to learners. Though literature addresses the problem of teenage pregnancies, little is said about the reasons for teenagers' use or non-use of condoms. I am a psycho-social services coordinator for all schools in Dutywa District. I deal with many teenage pregnancies per year; for example, this year alone (2013) I dealt with five teenage pregnancies from High

School X.[1] This is a health concern because it shows that as teenagers do not use condoms, they are vulnerable to HIV. This study sought to investigate factors that influenced condom use among teenagers.

1.3 Purpose of the study

The aim of this study was to investigate the factors that influenced condom use among high school teenagers in Dutywa District, Eastern Cape, South Africa. The study contributed to existing literature on teenagers' perspectives, beliefs and attitudes concerning condom use. The study was considered significant for the following reasons:

- The literature reviewed has not revealed any previous study on factors that influence condom use among high school teenagers in Dutywa District.
- Consistent condom use among teenagers could help to reduce teenage pregnancy, STIs and HIV infection.
- The findings of the study could help the Department of Basic Education (DBE) review and improve the existing HIV and AIDS programmes designed to prevent new infections.
- The study aimed to provide information to health care providers and the prevention programmes coordinators of the DBE, information that could be used to improve the already existing peer education programme.

1.4 Research Questions

1.4.1 What beliefs and attitudes do teenagers regard towards condom use?

1.4.2 What factors contribute to risky sexual behaviour among teenagers?

1.4.3 What are adolescents' views of condoms as an HIV prevention strategy?

[1] I have withheld the name of the school used for data collection for ethical reasons. In my study I will refer to the school as High School X.

1.5 Objectives of the Study

1.5.1. To explore teenagers' beliefs, and attitudes concerning condom use

1.5.2. To examine factors that contribute to condom use

1.5.3. To investigate adolescents' views on condoms as a prevention strategy

1.6 Definition of Key Terms and Variables

Teenagers: Teenagers are young people aged between 13 and 19 years. They are between childhood and adulthood

Condom: A barrier device commonly used during sexual intercourse to reduce the probability of pregnancy and spreading of sexually transmitted diseases such as HIV and AIDS (WHO, 2013:6)

Attitudes: An attitude is a settled way of thinking or feeling, typically reflected in a person's behaviour (Whitely, 2010:2).

Beliefs: the ideas, viewpoints and attitudes of a particular group of society. They consist of fables, proverbs, myths, folklore, tradition, superstition and education that influence the ideas, values, emotions, perceptions and attitudes of the members of society (Beuno, 2010).

Sexual risky behaviour: sexual activities that may expose an individual to the risk of infections such as HIV and other STIs. These include unprotected sex, early sexual debut, taking drugs or alcohol before sexual intercourse, multiple sexual partners, forced or coerced sexual intercourse for reward etc.

Epidemic: a disease that is infectious and spread over the world such as HIV/AIDS.

Sexuality/Sexuality education: sexuality is a socialising process formal or informal. It includes instruction and training in all aspects which may help to form normal and wholesome attitudes, values and ideals in relation to sex.

Sexuality education includes the nature of love, personal relationships and family. It means education related to the reproductive system, contraception and STIs.

1.7 Research Methodology and Design

A qualitative, explorative design was employed in the study. I conducted focus group interviews and face-to-face in-depth interviews with the participants in their setting. The study collected data from two focus groups with six members in each group. The target population were high school teenagers aged between 16 and 18 years. Data collected from in-depth interviews and focus group interviews was analysed qualitatively through thematic content analysis. A detailed description of research methodology and design used by the study will be done in chapter 3.

1.8 Chapter Outline

This dissertation is divided into five chapters that are arranged as follows:

Chapter 1

This chapter deals with the introduction and background to the study. Also included in this chapter is the problem statement, the purpose of the study, the significance of the study, terminologies used in the study and research questions. An introduction to the methodology of the study, ethical considerations, scope and limitations are also part of this chapter.

Chapter 2

This chapter is the literature review of the current academic debates on condom use among high school teenagers. The theoretical framework guiding the study is also described in this chapter.

Chapter 3

The chapter presents the research methodology and design used by the study. The study population and sampling methods used by the study are also provided. Furthermore, this chapter describes the data collection methods and the ethical consideration of the study. Finally, the chapter also presents the data analysis tool used by this study.

Chapter 4

This chapter presents and discusses the research findings of the study. Thematic analysis is used to analyse the data. Codes and themes that emerged from focus groups and in-depth interviews are presented and discussed.

Chapter 5

This chapter forms the conclusion of the study. The chapter presents the key findings and outlines the study's limitations. The chapter concludes with the recommendations of the study.

CHAPTER 2

Literature Review

2.1 Introduction

Chapter 1 introduced the study by describing the background of the study and outlining the research questions and objectives of the study. This chapter describes what previous literature has to say about factors that influence condom use among teenagers. In this chapter, I reviewed related research studies, books, journals and internet sources about factors influencing condom use among high school teenagers.

2.2 HIV Prevalence among Adolescents in South Africa

HIV and AIDS represent one of the biggest challenges to the health and wellbeing of young people in South Africa. The HIV and AIDS and STI National Strategic Plan 2007-2011 identifies young people as a priority group for preventive interventions (DBE, 2007b). HIV prevalence among children aged 2 to 14 years is 2.5% while prevalence among 15 to 24 year olds is 8.6% (Shisana, Rehle, Parker, Joosete, and Pillay-van Wyk, et al, 2009:6). Despite the recent downturn in HIV prevalence rates among young people aged between 15 and 24 years, the HIV incidence rate in this group is still the highest of all the age groups (Shisana et al., 2009:6; Dorrington, Johnson, and Bradshaw, 2006).

Non-condom use can lead to the spread of HIV and AIDS as well as unwanted teenage pregnancy (Mestad, Secura, Allsworth, Madden, Zhao and Pelpert 2011:493). Panday, Makiwane, Ranchod and Letsoalo (2009:11) argue that older adolescents aged 17 to 19 account for the bulk of teenage pregnancy in South Africa. Rates are significantly high among blacks with 71% per 1000; coloureds 60%; Indians 22% and whites 14%. This may be because teenagers lack the ability to use condoms through lack of knowledge, the myths they believe about condoms, social economic factors and the inability of the department to communicate these interventions effectively to the learners (WHO, 2013:16). The 2008 analysis of the Education Management Information System (EMIS) data on teenage pregnancies shows an increase in learner pregnancies (DBE, 2011; cf Panday et al, 2009). The DBE (2011:16) further states that the provinces with the highest prevalence rates of

teenage pregnancy are Eastern Cape, Limpopo and KwaZulu Natal in areas that are deep rural and poverty stricken.

In South Africa, HIV prevalence among youth aged between 12 and 24 years is higher than in other age groups. The female youth have a higher rate (16,9%) than male adolescents (4,4 %). According to the DBE (2011:6), the huge campaign that was introduced was set to reduce the incidence of HIV infection among learners through condom promotion, STIs, treatment programmes, the HIV/AIDS life skills intervention and through mass media communications (UNAIDS, 2011:16). Nevertheless, adolescents in South Africa continue to engage in risky sexual behavioural practices (Kanku and Mash, 2010:568). The UNAIDS report (2011:28) supports this notion and argues that South Africa has the largest HIV epidemic in the world. In addition, the UNAIDS report (2011:28) says, despite high prevalence and risk behaviours in South Africa and other sub-Saharan African countries, adolescents in these countries perceive themselves as being at low risk of HIV infections. An explanation for this is that teenagers have feelings of invulnerability (Bombereau and Allen, 2008:24).

2.3 Education in a context of HIV and AIDS in South Africa

The DoE states that several HIV and AIDS prevention programmes have been implemented in all South African public schools (DoE, 2007a :6). Flisher, Mukoma and Lottar (2007:22) explain that despite the implementation of several prevention programmes, very few have been evaluated with sufficient rigour to conclude they have had desired effect. Adolescents continue to report high sexual behaviour despite the sound knowledge about sexual health risks (Shisana et al., 2009:12). In addition, UNAIDS (2004) states that governmental and non-governmental responses to HIV and AIDS gather pace across sub-Saharan Africa. Access to HIV prevention messages has increased dramatically and HIV prevention messages have taken a wide range of different mediums and have targeted many different sub-groups, but the most trusted source for young people to learn about HIV is through schools and teachers.

Teenagers are exposed to the risk of unintended pregnancy, STIs as well as HIV at an alarming rate although the consistent and correct use of condoms can reduce the likelihood of unwanted pregnancies and HIV infections. As a result, in developing countries, public health policies and programmes have focused on the sexual and reproductive health needs of

adolescents in recent years (DBE, 2011:15). These factors emphasise dropping out from school without achieving an academic qualification. It is along that background that the DoE, nationally, deemed it fit that in its curriculum it would include compulsory subjects which would among other things address the question of health issues, societal issues, life skills, HIV/AIDS, STIs and teenage pregnancy (DoE, 2007a :9). In agreement, Tomlinson (2013:2) argues that in South Africa programmes on HIV and AIDS are blooming especially those targeting the youth. I also support this notion, for example, the involvement of high school teenagers in peer education programmes to bring about knowledge of HIV and AIDS has been explored and implemented by countries like South Africa since 2007. According to Tomlinson (2013:4), this programme teaches learners assertiveness, techniques, decision making, survival techniques and negotiating skills. Issues of HIV and AIDS, gender and sexuality are discussed in these programmes. Though literature addresses the problem of teenage pregnancies, little is said about the reasons for teenagers using or not using condoms.

2.4 Factors that Influence Condom Use

Demographic, attitudinal and educational factors have all been associated with increased condom use by teenagers; although studies on each of these factors are far from clear (Kanku and Mash, 2010:28). Changes that include societal norms regarding practising sex before marriage, having sex and several partners at an early age, influence condom use (Cobb, 2010:79). As a result of changes, female teenagers are at a higher risk of experiencing unwanted pregnancies and both female and male teenagers are at high risk of contracting sexually transmitted infections including HIV (Cobb, 2010:86). Teenage pregnancy is an important public health issue for communities in South Africa.

Alarming figures released by the Eastern Cape Province education department indicate that teenage pregnancies doubled in 2010 despite a decade of dedicating resources to sex education (DBE, 2007a :9). According to David Harrison, Chief Executive Officer of loveLife, South Africa has a huge teen pregnancy problem. One in three girls has had a baby by the age of 20 (IRIN, 2007:4). In South Africa, Free State, Gauteng and North West have lower proportions of teenage pregnancies while Mpumalanga, Northern Cape, Limpopo and Eastern Cape have high levels (DBE, 2007b:7). This is a true reflection of inconsistency in the prevention strategies including condom usage. Teenagers are exposed to the risk of unwanted pregnancy, STIs as well as HIV at an alarming rate although the consistent and

correct use of condoms could reduce the likelihood of unwanted pregnancies and HIV infections. As a result, in developing countries, public health policies and programmes have focused on the sexual and reproductive health needs of adolescents in recent years (DBE, 2011:9).

2.5 Efforts Aimed at Increasing Condom Use among Adolescents

Despite noted improvement in condom use by adolescents, significant problems still exist. Efforts aimed at increasing condom use by adolescents have taken place in communities, schools and school settings, for example, HIV and AIDS and Life Skills/Orientation programmes in South African schools were initiated in 2000 and implemented in public schools with a focus on learners in grades R to 12 (DBE, 2011:57). The aim of this programme is to integrate HIV and AIDS into the curriculum as a strategy to mitigate the spread of HIV and AIDS. The 2012 UNAIDS report (2011:2) states that age-appropriate sexual education increases knowledge of HIV among learners. I support the notion that, for example, Life Orientation/Life Skills in South African schools be taught from grade R to 12 as this subject addresses HIV and AIDS issues. The DBE (2011:29) states that the education system reaches over 12 million children and those schools are permanent institutions that can help to sustain support services in the long term such life skills/orientation that focuses on sexual health. In community settings, youth development programmes incorporate condom use into messages being transmitted to high-risk adolescents but there have been no specific studies of the significant but generally small effects. Condom use is considered one of the most effective preventative measures against HIV and sexually transmitted infections, if used correctly and consistently (UNAIDS, 2011).

Various studies have been conducted to establish the extent of condom use in South Africa. Findings Abdulraheem and Fawole (2009) report that 38.1% of adolescents in their study always used condoms while the rest did not. Another study by Hartell (2005) reveals that more than 50% of the sexually active learners never used a condom. Condom use declined among all groups in South Africa, according to the latest household survey released by the Human Sciences Research Council (Van der Linde, 2013). This same trend of decline in condom use has been reported by UNAIDS (2011).

According to Silva (2007), one of the reasons for adolescent pregnancies, with regard to the provision of services, includes lack of access to family planning services (including access to male and female condoms). Some adolescents are sexually active and indulge in unsafe sex, most of which has to do with individual attitudes and perceptions. South Africa's Children's Act 38 of 2005 (as amended by Act 41 of 2007) gives adolescents 12 years and older the right to access reproductive health services. Section 134 of the Act states that no person may refuse to sell condoms to a child over the age of 12 years; or sell condoms that are provided free of charge (AfroAidsInfo 2013:2). According to AfroAidsInfo (2013:2), a person who disregards these provisions is guilty of an offence and can be fined or imprisoned for 10 years, or be given both a fine and a term of imprisonment. AfroAidsInfo further states that a child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality. Empowering the youth and their parents with information, education and counselling can contribute to reduced unsafe sexual practices. It has been suggested that a comprehensive approach emphasising both abstinence and safer sex practices should be adopted in sex education and that the programme should be adjusted according to the development stages of learners (Panday et al., 2009:12).

2.6 Mass Media

According to the DBE (2011:9), mass media campaigns in South Africa have played a seminal role in improving knowledge of sexual behaviour and, in particular, HIV. The DBE (2007b) further states that three multi-media campaigns: namely, loveLife, Soul City and Khomanani have reached high levels of coverage among young people – the former two above the 80% mark required for high intensity and high frequency coverage. Evidence for the cumulative effect of a range of mass media programmes suggests that they have been effective in shifting a number of health behaviours including condom use, self-efficacy in the use of condoms, communication with partners and peers about HIV testing and faithfulness to partners. While there is support for the increased coverage and intensity of media programmes, a distinct focus on teenage pregnancy is required. In addition, because of the threshold effect of exposure to media programmes, such interventions need to form part of a comprehensive strategy regarding teenage pregnancy.

2.7 Possible Factors that Influence Condom Use among Teenagers

Teenagers are at the stage in their lives that is characterised by exploring, adventuring and experimenting, including sexual experimentation. Adolescents contribute substantively to the quadruple burden of the disease profile in South Africa (DBE, 2011:6). While deaths from HIV and injuries peak in the youthful years, the risk factors for death from non-communicable disease are also initiated during adolescence and early adulthood. In fact, unsafe sex/sexually transmitted infections (31.5%), interpersonal violence (8.4%), alcohol use (7%) and tobacco use (4%) - the vast majority of which are initiated during adolescence - are the leading risk factors for the burden of disease profile in SA (DBE, 2007b:7). HIV is the most critical threat to the health and overall wellbeing of youth in SA. This is a clear indication that teenagers are engaging in unsafe sexual intercourse which places them at high risk of contracting STIs, including HIV and AIDS and of unwanted pregnancies. (Ochieng, Kakai and Abok, 2011:32-38).

Various studies such as those by WHO (2013: 9), UNAIDS (2008:7) and the DBE (2011:12) show that several factors influence condom use among teenagers. A number of key factors associated with high risk sexual behaviour (e.g. non-use of condom) increase teenagers' vulnerability to HIV infections (WHO, 2013:5). UNAIDS (2009:18) identifies a combination of socio-economic factors such as poverty and unstable economy, poor infrastructure and rapid socio-cultural and economic change. In addition, Lebese, Maputle, Ramathuba, & Khosa (2013:2) state that condom use by teenagers has been perceived to be influenced by various factors including socio-economic status, knowledge of condom use, attitudes, cultural values and beliefs and norms and educational status. The DBE (2011:12) also argues that factors such as peer pressure, cultural barriers, gender inequalities, government policies, parent-adolescent communication, rape, sexual abuse are contributory factors to non-condom use. In the literature reviewed above it can be seen that certain factors do influence condom use among teenagers.

South Africa is characterised by a number of high-risk practices, such as sexual intercourse at an early age; low contraceptive use; multiple partners and sexual networks; weak sexual negotiation skills between males and females; political instability; and barriers to both abstinence, (such as peer pressure and the social and cultural value placed on sexual intercourse) and condom use (Varga, 2000:67-69). The non-use of condoms and the cultural

values related to fertility make up what Preston-Whyte (1999:141) calls the "condom dilemma".

Various studies, journals, global reports cited above indicate that non-condom use is a problem among teenagers. According to WHO (2013: 9), various studies agree that teenagers are aware of condom use but practically engage in unprotected sex for various reasons that have been mentioned such as not having a condom at the time of sexual intercourse, misconception about condom use and lack of skills to negotiate protected sex. On that note, it is clear that multiple possible factors influence condom use among teenagers.

2.7.1 Gender

Gender stereotyping plays a role in determining social expectations and behaviours (Kanku and Mash, 2010:1). The UNAIDS Global AIDS Report (2013:8) explains that gender inequality damages the physical and mental health of millions of girls across the world and young men through resources, power, authority and control.

Because of differences in exposure and vulnerability, the problems of males and females vary in magnitude across different health conditions. Cultural barriers are major obstacles in sexual reproductive health issues with regard to adolescents (Cobb, 2010:83). In addition, Cobb (2010:83) maintains that in many cultures, young girls are expected to submit to the desires of their boyfriends on sexual matters. They, therefore, lack the ability to negotiate safe sex (Panday et al., 2009:12). Sarkar (2008:119) supports this notion and argues that perceptions and experiences of condom use among adolescents may also influence their decisions on whether or not to use condoms. They further provide reasons that include a decrease in pleasurable feelings during the sexual act in males, and allergies in females. Similarly, Kanku and Mash (2010:10) explain that adolescent boys believe that sex would not feel as good when they use condoms. They want to experience the raw feeling. The UNAIDS Global Report (2013:7) states that gender inequality and harmful gender norms continue to increase HIV-related vulnerability. Ochieng et al. (2011:34) argue that male adolescents have more access to information on condom use than female adolescents. The most explanatory factor for this may be gender power differences in condom use. A study conducted by Exavery, Lutambi, Mubyazi, Kweka, Mbaruku and Masanja (2011:2) in Tanzania, links gender inequality to a variation of social, cultural and gender norms as well as lack of skill in

condom use. According to the UNAIDS Global Report (UNAIDS, 2013:7), gender imbalances have been identified and, as a result, all countries (92%) that conducted mid-term reviews of their national AIDS response, acknowledged the central importance of addressing this problem. Leclerc-Madlala (2008) states that various studies in South Africa suggest that negotiations within relationships are complex. An entrenched male advantage often compels females to comply with the desires of their partners and thus restricts their control of their sexual health.

2.7.2 Economic factors and transactional sex and condom use

According to UNAIDS (2009:6), transactional sex is the term used to describe sexual interaction that involves the exchange of sex for money and material things. Financial and material exchange as the motivating force underlying sexual relationships is a well-recognised dynamic in the HIV pandemic, particularly in sub-Saharan Africa (Dunkle, Jewkes, Nduna, James, Levin, Sikweyiya & Koss, and 2007:12,35). Transactional sex among teenagers is often motivated by substantial needs, access to resources, advance in education and the achievement of higher status in youth programmes. WHO (2013:6) reports that teenagers are vulnerable to HIV due to poverty, as a result it likely for teenage girls to drop out of school and engage themselves in transactional sex or to be sold for labour or sex work. The DBE (2010:16) states that economic factors may play a role in teenage pregnancies and HIV infections because poverty forces girls to submit to men's desires for sex without a condom. Dunkle et al. (2007:1236) argue that, owing to poverty, young girls fail to negotiate safe sex practices. Dunkle et al. (2007:1236) further argue that transactional sex has been noted as a potential source of teenagers' vulnerability to gender-based violence and sexual exploitation as they have sex in situations in which they might otherwise refrain. Bombereau and Allen (2008:24) explain that the social development department contributes to non-condom use by giving social grants to children whose mothers are not working and this motivates young girls to fall pregnant intentionally.

2.7.3 Social and behavioural factors and condom use

According to Welling, Collubein, Slaymaker, Signh, Hodges, Petal and Bojos (2006), some factors such as religion, socio-economic and socio-cultural factors prohibit condom use. Some religions prohibit condom use based on their religious beliefs. Some cultures also

forbid condom use based on their cultural beliefs. WHO (2013) reports that this also leads to early sexual debut. Lack of social support for condom use from peers, parents, religious leaders and health workers is associated with lower odds for condom use (Sanders, Yarber, Kaufman, Crosby, Graham, and Milhausen 2012:31). According to Han and Bennish (2009:28), social expectations hamper communication about sex. Han and Bennish (2009:28) continue that, for example, some societies in the rural areas of KwaZulu Natal and Eastern Cape, do not allow children to openly acknowledge their sexual desires in their relationships. As a result, teenagers usually avoid talking about their sex lives.

The other reason hindering condom use among adolescents is substance abuse (Flisher et al., 2007:158). In agreement, Kanku and Mash (2012:1) maintain that substance abuse, particularly alcohol abuse among teenagers, is a critical influence. According to WHO (2013:7), the heavier the consumption of substances, the greater the likelihood of non-condom use. Despite knowledge of preventive measures, condom use is limited. People who abuse alcohol are more likely to engage in behaviours that place them at risk of contracting HIV. NIAAA (2003:8) adds that a history of heavy alcohol use has been correlated with a lifetime tendency toward high-risk sexual behaviours including multiple sex partners, unprotected intercourse, sex with high-risk partners and the exchange of sex for money or drugs. For example, alcohol can act directly on the brain to reduce inhibitions and diminish risk perception (NIAAA, 2003). People who abuse alcohol are more likely to engage in behaviours that place them at risk of contracting HIV. Dhar and MacManus (2008) claim that the use of drugs and alcohol before sex is one of the behavioural risks that lead to non-use of condoms. There is a growing role of alcohol use in the spread of HIV in South Africa. The number of shebeens and taverns in poor rural and semi-urban areas in South Africa has grown and with the growth has come the associated lifestyle. Such places are often located near schools.

According to WHO (2002:16), males generally have more social liberties than females with respect to alcohol use as well as sexual activities. Furthermore, WHO emphasises that alcohol is commonly used as a sex facilitator, is a symbol of masculinity and a means of relaxation, socialising and improving communication skills. Alcohol beverages are also used as a facilitator in approaching the opposite sex.

It is certain that alcohol use and sexual risk behaviours increase during the festive season when celebrations occur across the country. I corroborated this view as the *Daily Dispatch* dated 7th January 2014 reported that chemists recorded alarming rates of morning pill use among teenagers during December 2013. This shows that high risk factors increase during festive seasons. Alcohol use and promiscuity among teenagers during the festive season put them in high risk of HIV infections, unwanted pregnancies and STIs.

2.7.4 Peer pressure

Adolescents are more likely to listen to and openly discuss sensitive issues such as sexual matters with their peers than with adults (DBE, 2007a:9). Campbell and MacPhail (2002:6) argue that behaviour is socially influenced and that behavioural norms that influence behaviour are developed through interaction with adolescents' peer groups. Campbell and MacPhail (2002:6) continue that adolescent behaviour is influenced by what adolescents see as a norm or what they think people believe about behaviour. As a result, Reddy et al, (2010) explain that people do not only change with information, but they change when others around them change (peer pressure). According to Han and Bennish (2009:31), adolescents are familiar with the cultural context that their peers live in and are aware of the factors that influence their behaviour. Han and Bennish (2009:31) add that adolescents identify with one another and influence one another through the development of group norms. The research findings of Hammer and Banegas (2010:290) are similar to the findings of Nwanko and Nwoke (2009:140) that indicate that adolescents' behaviour is influenced by peer groups. These authors state that a commonly cited reason for initiating sexual relations among adolescents is pressure from media and their peers. HIV research indicates that peer pressure among both boys and girls undermines healthy social norms and HIV prevention messages to abstain, use condoms and delay sexual debut (Sasha, 2013). Sasha (2013) further states that, as girls enter adolescence, they begin to grow into womanhood and become sexualised objects. Within the media, images of sexuality and overly thin body images can socialise girls into seeing themselves as sexual objects. On the other hand, boys are pressured to exhibit their manhood through sexual conquest.

2.7.5 Early sexual debut

According to WHO (2013:3), early sexual debut can place adolescents at increased risk of unintended pregnancies, STIs and HIV infections. Teenagers who begin sexual activities early appear more likely to have sex with high-risk partners and less likely to use condoms (WHO, 2013:3). Biddlecom, Gregory, Lloyd and Mensch (2006:4) support the WHO report and state that the age of sexual debut affects the risk of pregnancy as well as risk of transmitting HIV infections. Biddlecom et al. (2006) further maintain that early entry into sexual life and the context within which intercourse begins are key indicators of adolescents' potential risk for unplanned pregnancies, STIs and HIV infections. Most previous study results indicate that a significant proportion of South African youth experience sexual debut between the ages of 14 and 17 years. A school-based study on young teenagers aged 13 years in South Africa and Tanzania indicates that approximately one in five teenagers experience sexual debut at this young age (WHO, 2002:33). These studies indicate that a significant proportion of South African adolescents are sexually active before the legal age of consent.

2.7.6 Parent-adolescent communication

According to WHO (2002:26), sex education has rarely been a comfortable topic in parent-child communication. Many parents are unwilling to talk about sex as they may lack the knowledge themselves. Many barriers may prevent open communication between parents and children about sexual issues. For example, adults fear that talking and teaching about sex will make young adolescents sexually active.

As the primary socialising agents of children, parents are a trusted source of information about sexuality for young people (DBE, 2007a:9). Yet this represents a missed opportunity because most parents lack both knowledge and skill to talk openly about sex and feel disempowered about parenting their children in an environment that emphasises a rights-based culture for children (DBE, 2007a:10). In addition, Han and Bennish (2009:31) state that the generational knowledge gap, fuelled by the educational gap between parents and children, also contributes to their sense of disempowerment. However, family-level interventions trialed in SA have shown that programmes can promote open communication between parents and children about sensitive subjects and foster strong parent-child bonds, as well as teach parents how to set and enforce rules.

Parents play a passive role in providing information to their children, yet they are expected to be key players in this role (Panday et al., 2009:12). Panday et al. (2009:12) adds that this is because sex in most African societies is a taboo subject between parents and children. According to WHO (2002:26; cf UNICEF 2002), in urban areas most parents work and spend little time with their children. Children, therefore, spend their time with grandparents or other persons entrusted with their care and communication about sex and sexuality is silent (UNICEF, 2002:11). The global prevalence of HIV and AIDS increases from year to year (WHO, 2013:9). In assessing the core of the HIV/AIDS problem, Taffel (2005:1) claims that parents do not know how to communicate with their children. He expresses the opinion that parents and children live in two different parallel worlds. In agreement Nwanko and Nwoke (2009: 140) explain that:

> [W]hile parents are perceived to be the logical source of information; they often do not discuss sexuality issues with their children because they are embarrassed by the subject. As a result, the family is no longer the prime reference group in reproductive health related decisions, since teenagers tend to value the opinions of their friends more highly.

2.7.7 Accessibility, stigmatisation and discrimination

Despite the high incidence of HIV in adolescents and the efficacy of condoms in preventing HIV transmission, condom use among adolescents remains low owing to limited access (DBE, 2010:19). Especially in rural areas, schools are a few of the sites accessible to large numbers of youths, yet condom distribution is rarely undertaken in schools. A critical challenge for prevention efforts in adolescents is to ensure that the newly guaranteed reproductive health rights are realised. For high school teenagers in South Africa, access to condoms is limited. Barriers to access include sustained travel time and the cost of travel to sites closed when students are out of school, the judgmental and often hostile attitude of providers and the cost of condoms in shops.

According to UNAIDS Global Overview Report (2013):

> [D]despite the youth friendly clinic initiated in South Africa, teenagers are still confronted with negative HIV and sexual and reproductive health services and stigmatizing attitudes of health staff ... Persistent challenges to effective HIV prevention for adolescents and young people include inadequate access to high-quality and youth friendly [health service providers] ... Some teenagers are hindered in their ability to obtain essential services ...[due to] lack of confidentiality amongst healthcare workers …

This result in young girls rather not using contraceptives. UNAIDS (2011:19) argues that societies believe that the availability of contraception encourages sexual activities.

2.7.8 Political and religious factors

According to WHO (2013:27), some political leaders denied the link between HIV and AIDS and favoured alternative theories. AIDS denialists had a significant political impact in South Africa under the former president, Thabo Mbeki. As far as the religion factor is concerned, pressure from both Christian and religious leaders resulted in the banning of safe sex campaigns including condom advertisements, for example, Catholic churches banned condoms in 2009 and again in 2013 (WHO, 2013:28). Some religious sectors viewed HIV and AIDS as a disease of promiscuous people; they believed that those who were infected by HIV were reaping what they sowed (Chitando, 2007:19). Both the former minister of health, the late Manto Tshabalala-Msimang and the previous president, Thabo Mbeki, voiced doubts about the causation and treatment of HIV and AIDS. This was the worst AIDS policy that hindered public understanding of the disease.

2.7.9 Government policies

South Africa's recently adopted Children's Act provides children with the right to access reproductive health services as a way of addressing the HIV pandemic but there remains confusion about how socially divisive rights provided by the Act, such as condom access for youth, will be achieved (DBE, 2007a:16). The Children's Act, together with South African government policies, allows individual schools to decide whether to distribute condoms, but

most schools and school staff are unaware of this South African policy and the regulations governing condom use provision in schools (Han and Bennish, 2009:28).

Han and Bennish (2009:29) argue that, because of confusing and contradictory policies and public pronouncements regarding provision of condoms in public schools, few schools have undertaken to provide condoms, leaving students, especially those in rural areas, with few options for obtaining them. The current South African government has left the decision of whether to distribute condoms in schools to the school governing bodies of individual schools, rather than enacting a clear national policy (Han and Bennish, 2009:28). Reflecting these tensions, South African government policy is unclear and school staff members are often unsure whether condom distribution in schools is permissible. As a result, most schools hesitate to distribute condoms and those few that do distribute condoms do so discreetly.

For example, the recent finding on discussions that were held in rural schools in KwaZulu Natal on condom distribution in schools indicate that attitudes about condoms in schools at community level vary widely (Han and Bennish, 2009:28). Cultural and moral concerns remain strong among both parents and learners including the preservation of such traditional values as abstinence until marriage (Han and Bennish, 2009:28). The DBE (2011:11) explains that many parents and some students and a few school staff members feel that condom availability promotes sexual activity and undermines traditional values. Han and Bennish articulate that this ambiguity created by unclear policies and contradictory public statements has characterised South Africa's approach to other HIV-related issues as well (Han and Bennish, 2009:28).

2.8 Knowledge, Belief and Awareness about Condoms and HIV

Adolescents might hold different ideas about condoms than adults, influencing their attitudes towards condom usage (Tarkang, 2009:176). Lionel Nicholas, a psychologist, conducted a study among black South African university students and his findings are that black students perceive condoms as being too expensive to buy, as making sex less pleasurable, and that too many condoms will be required for all their sexual encounters. Respondents also argued that condoms made partners feel distrusted. Nicholas further says participants maintained that real men do not use condoms (Nicholas, 1998:893).

In a study that was done with learners from Limpopo Province, South Africa, learners admitted to not using condoms, as they were not HIV positive and regarded themselves as being safe from contracting STDs including HIV (Peltzer, 2001:55). According to the WHO report (2013:6), teenagers of South Africa are highly aware of or knowledgeable about HIV and AIDS. The report further says teenagers' attitudes regarding condom use to prevent infection are also high but their actual behaviour regarding condom use is very low (WHO, 2013:7). WHO (2013) also advocates that, although teenagers seem to have the basic facts concerning condom use, the quality of their knowledge and understanding and the level of awareness vary considerably and some misconceptions still abound. There are misconceptions about condom use when boys are circumcision. Maughan-Brown and Voenkataramani (2013:122) in their findings explain that the majority of people are aware about the benefits of male circumcision for men in reducing chances of HIV infection. Therefore, they argue that such findings could have important implications for prevention programs because such beliefs reduce the perceived need for safe sex behaviours.

The report by WHO (2013:19) supports this notion by stating that even though HIV prevalence has declined among teenagers in most of the regions, knowledge of AIDS is still surprisingly low. This means that teenagers are aware of HIV and their attitudes towards condom use are positive, but they are split on the actual use because most of them believe in condom use but some are still negative (WHO 2013:4). Namis (2010:17) argues that teenagers should be as knowers as opposed to innocent in relation to sex. As a result of this, the DBE (2011:16) explains: "You know that there are people out there who are abstaining and you can do the same thing. There is positive pressure to abstain now ..." (DBE, 2011:16). According to Wellings, Colluben, slaymaker, Singh, Hodges, Patel, and Bojos (2006:89), adolescent boys believe that sex would not feel as nice if they used condoms. They want to experience flesh-to-flesh contact and condoms are perceived as a prevention of intimacy.

2.8.1 Media

Maluleke (2007:11)'s findings indicate that the media is one of the factors that influence adolescent sexuality, negatively or positively, due to the tendency of young people to believe that any behaviour and attitudes that are portrayed by media are normal. Maluleke (2007:11) also argues that adolescents ignore programmes that teach good things and want to watch programmes that destroy them such as pornographic films. Some movies have been found to pressure sexual exploration. The scenes screened are tempting to teenagers. First, they teach

them sex and those who watch these scenes go into real action (Sasha, 2013:3). They arouse the curiosity of children and increase the propensity for sexual exploration that often leads to wrong and irrational decisions among adolescents. The internet has made hard core images very accessible to young people. Victor and Starsbuger (2010:3) argue that pornography is mainstream sex now. In addition to this, the authors articulate that media now throws sex at kids even when they are not looking for it, and hits them at a very much younger age (Victor and Starsburger, 2010:3). Social networking websites and home pages enable teenagers to present themselves publicly in sexually suggestive ways.

2.8.2 Condom and Male ego

According to Selikow, Ahmed, Flisher, Matthews & Mukoma (2009:28), boys have a lack of confidence which is caused by misinformation about condom use. They want to be accepted or to fit in the clan. Selikow et al. further maintain that part of being accepted is to avoid being ridiculed and eating sweets in plastic, eating bananas in the skin and other condom-related analogies are used to mock teenagers who intend to use condoms (2009:28). Tarkang (2009:127) argues that using condoms is associated with stupidity. These factors undermine the probability of using condoms (Selikow et al., 2009:29).

2.9 Theoretical Framework

The study adopts the Health Belief Model (HBM) as a theoretical framework.

2.9.1 Health Belief Model

The HBM was developed by Rosenstock in the 1960s and Becker in the 1970s. This is a psychological model that attempts to explain and predict health behaviours (Glanz, Lewis and Rimer, 2002:25). This is done by focusing on the attitudes and beliefs of individuals. It is applicable to this study as the key aim of the study is to understand teenagers' attitudes, beliefs and perceptions about condom use (Glanz et al., 2002:25). Therefore, the HBM guides this study in exploring related factors that influence condom use among teenagers. Initially, "the health belief model was designed to describe a model of disease prevention not a model of disease treatment" (Glanz et al., 2002: 52)

The HBM consists of six concepts:

- **Perceived susceptibility**: a person's belief about the chances of contracting conditions (HIV, STIs and unplanned pregnancies in this research study). This also defines the population at risk and their levels (teenagers in this research study)
- **Perceived severity**: One's beliefs on the seriousness of a condition and its consequences – non-use of condoms, teenage pregnancy, HIV and AIDS and STI infections in this study
- **Perceived benefits**: One's beliefs on the effectiveness of advice to reduce risk or serious impact
- **Perceived barriers**: One's beliefs on the tangible and psychological cost of the advised behaviour (socio-psychological factors, for example, peer pressure, parent-adolescent communication). Perceived barriers are important factors in decision making. Its application is based on the ability to identify and reduce barriers, that is, encouraging condom use as it is an effective prevention of HIV, STIs and unplanned pregnancies
- **Perceived efficacy** or benefits of preventive measures and cues to action. The person has to be self-efficacious, that is, have the ability to perform intended behaviour; this means cues to action which are defined as evidence of strategies that motivate a person to action. It refers to personal and environmental events motivating teenagers to use condoms such as peer education, social support and health services. It also refers to advocacy and awareness campaigns and condom distribution at schools (Champion and Skinner, 2008:21).
- **Cues to action** include the evidence of strategies that motivate a person to action. (peer education, social support and health services)

2.10 Conclusion

This chapter discussed the debates on condom use among teenagers. The main thread that cuts across literature is that condom use among teenagers is influenced by demographic, attitudinal and educational factors. As a result of this, the study was guided by the HBM because of its assumption that people's beliefs about health problems, perceived benefits of action, barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behaviour. The next chapter describes the research methodology and design that was used by the study.

CHAPTER 3

Research Methodology and Research Design

3.1 Introduction

Chapter 2 reviewed previous and current literature on the debates on condom use among teenagers. This chapter describes the research methodology and research design employed by the study. In addition, this chapter describes the research tools used by the study to gather data, the sampling procedures and the data analysis tool used by the study. +The focus of the study is to explore factors that influence condom use among high school teenagers.

3.2 Research Methodology and Design

A qualitative approach, which this research adopted, has its roots in social science, is holistic in form and focuses on research participants as creators of their reality. Babbie and Mouton (2011) argue that researchers who use this paradigm see reality through the eyes of those who are living it, as they generally believe that there is no single reality. Qualitative research is interested in how people differ in relation to a particular experience as much as it is in what they have in common (King and Harrocks, 2010:27). Thus the aim of qualitative research is not to measure but to understand and analyse the knowledge, experience and perceptions of the research participants.

It aims at finding and unveiling the hidden answers to meanings which people employ to make sense of their lives and experience. Its departure point is doing research with real people in mind (Janesick, 1994:210). As a result, in qualitative research the research participants become co-researchers. Acknowledging the research participants as co-researchers is important on the issues of ethical considerations and informed consent especially when it comes to children and adolescents. I employed a qualitative methodology in anticipation of gaining an in-depth understanding of adolescents' knowledge, perceptions of and attitudes to condom use. Denzin and Lincoln (1994:3) explain that qualitative research does not privilege a single methodology over another nor does it have a distinct set of methods that are entirely its own. Thus they explain:

> Qualitative researchers use semiotics, narrative, content, discourse, archival and phonemic analysis even statistics. They also draw upon and utilize the approaches, methods and techniques of ethno methodology, hermeneutics, feminism, rhizomatics, deconstructionism, ethnographies, interviews, psychoanalysis, cultural studies, survey research and participant observation among others.

Hence, this qualitative study follows an exploratory research design. An exploratory research design leads to insight and comprehension (Terre Blanche, Durrheim, and Painter, 2006). The goal of an exploratory study is to understand a situation but not come up with final answers or decisions. The aim is to discover ideas and insights from the participants in an effort to create new knowledge. Polit and Beck (2004:20) describe an exploratory design as an instrument of research in which participants' responses can be explored to reveal new meaning, the manner in which it is revealed and other factors relating to it. It bears relevance to the purpose of the study as it will yield new knowledge on future research and inform HIV and AIDS policies on curbing the epidemic particularly among adolescents in South Africa. Another advantage of this design is that it employs an open and flexible research strategy, thus leading to richer responses from participants (Babbie and Mouton, 2011:80). The common methods of collecting data in exploratory designs are in-depth interviews, literature search, case studies and focus groups. With regard to this study, exploring factors that influence condom use among high school teenagers aged between 16 and 18 years in Dutywa District, Eastern Cape, data will be collected through focus groups and in-depth interviews.

3.3 Data Sources

My data sources were high school teenagers that were drawn from one high school in Dutywa District. Information was sourced through focus group interviews and in-depth face-to-face interviews with the participants. I used material such as notes pads and a digital voice recorder to record interviews and focus group interviews.

3.4 Data Collection Techniques

3.4.1 Focus group interviews

Focus group interviews as a qualitative research method are small structured groups with selected participants, normally led by a moderator (Litoselliti, 2003:1). Focus groups are much cheaper than other kinds of interviews in the sense that a group of people can be interviewed at one time. They give a researcher a greater range of responses in a shorter

period of time. Different opinions may be debated, as a result strengthening the rapport between members of the focus group with one another and with me. The study considered six members in each focus group. This decision was taken because "smaller groups offer more opportunity for people to talk and are more practical to set up and manage, as they can easily take place in less formal settings ..." (Litoselliti, 2003:3). The main purpose of the focus group research was to draw upon the respondents' attitudes, feelings, beliefs, experiences and reactions regarding condom use among teenagers. A tool for focus group questions was developed as a guide. Furthermore, the focus groups unveiled to me how serious and emotional the topic was to the research participants. This was done by my monitoring their emotions and body language as they spoke or as someone else spoke (Litoselliti, 2003:8-9).

At the beginning of each focus group, I introduced the note-taker and myself. I explained my role and that of the note-taker to the participants. The note taker further explained that an audio recorder would be used to ensure that discussions were recorded accurately. After the introductions, I allowed the participants an opportunity to state their expectations. Then ground rules were set. After that I explained that during the session, there were no right or wrong answers but rather differing points of view and that the sessions would be audio recorded because she did not want to miss any of the responses. I assured the participants of complete confidentiality. It is difficult to ensure confidentiality in focus groups but the participants were assured that if they felt that what they wanted to say was sensitive they could keep the thought and share it with me in a one-on-one in-depth interview. Streubert and Carpenter (2008:163) and Harrell and Bradley (2009:82) argue that in focus group interviews participants may tend to withhold sensitive information or behaviour they may think is socially unacceptable.

Two focus groups were scheduled and organised according to gender because girls might be shy to speak about intimacy and condoms in front of boys. As an educator with experience of working with teenagers, I was aware that in mixed groups, boys tended to dominate the discussion, thus silencing the voice of the girls. A maximum of 12 and a minimum of six learners per session were selected. The study's participants were in grades 10 and 11. An objective of collecting information about the teenagers' knowledge, beliefs, attitudes and behaviour on condom use was to allow the focus group to speak in both collective and individual voices. Conducting interviews with focus groups of teenagers was an advantage since teenagers feel more relaxed when they share their feelings with their peers than with adults. Interviews involve sensitive questions that may cause harm or victimisation. This could be the case in this research as these participants were among the vulnerable groups. As

the issue of condom use may be sensitive and some people may withhold information, follow-up interviews were held through in-depth face-to-face interviews with individual participants. This methodology allowed for research participants to provide answers to open-ended questions that generated insight into the subject. The information was summarised. Of the 12 participants invited, 12 adolescents attended the interviewing sessions. Six participants were female and six male. Participants ranged between the ages of 16 and 18 years. The sample was regarded as adequate because a focus group interview requires about 5 to 15 people whose opinions and experiences are requested simultaneously (Brink, 1999:159).

3.4.2 In-depth face-to-face interviews

In-depth interviews as a qualitative research technique involves conducting intensive individual interviews with small groups of respondents to explore their perspectives of a particular situation (Merriam, 2009:97) The reason for the in-depth interviews was to explore in a sensitive and confidential way factors that influence condom use among high school teenagers. At the interviews, the letter of invitation was read aloud, the participants were informed that participation in the study was not mandatory, and that they had the right not to participate. Participants were assured that they would not be coerced into answering questions. All the participants met the criteria set. They were assured that no harm would come to them as a result of participation in the study because anonymity and confidentiality would be maintained (Brink, 1999:40-43).

All the participants who participated in the focus groups also participated in the in-depth interviews. This helped with issues of validity and reliability of data as interviews enhance and enrich focus group data by adding new data. Similar questions that were asked in focus groups were also asked in in-depth interviews. Both in-depth and focus group interviews were facilitated in Xhosa to allow participants freedom to express themselves freely.

Giving them freedom to use their home language enriched the data because their concealed perspectives about the factors that influence condom use among them clearly emerged. Interviews were audio recorded with the consent of the participants.

During the in-depth interviews session, I asked open-ended questions that yielded powerful information.

3.5 Issues of Reliability and Validity

To ensure and increase reliability and validity, this study employed triangulation which entails collecting material in different ways and from different sources. Data triangulation helped the study to understand the phenomenon of condom use among adolescents by approaching it from different angles (Babbie and Mouton 2011: 275). Multiple methods from different sources such as interviewing, field observation and a review of documentary sources on condom use among adolescents were used.

3.6 Target Population and Sampling Techniques

The study's intention was not to cover all the schools in the district and, therefore, I used a purposive sampling technique. Purposive sampling was appropriate for the study because the target population was grade 10 and 11 adolescents from one high school in Dutywa District (School X). This is one of the high schools in Dutywa District that has a high rate of teenage pregnancies. Only one high school was selected because the study was of a limited scope owing to time constraints. High School X is among the piloted schools that participated in the HIV and AIDS care and support for teaching and learning programme. This programme is a learner-centred intervention programme with the purpose of reducing HIV new infections among the learners. The youth programme consisting of peer education and soul buddyz, was implemented at this school in 2008. But despite these intervention strategies, the school has a high rate of teenage pregnancy and drop outs.

A sample of 12 focus group participants was recruited from the school. Learners from grades 10 and 11 were sampled for the study. The ages of the teenagers in the study ranged from 16 to 18 years. The sample consisted of six boys and six girls. This method allowed each individual an equal chance of being selected for the sample. Information was sourced through interviews with the research participants.

3.7 Ethical considerations

3.7.1 Informed consent

Informed consent written in plain language that was understandable to everyone was obtained. Permission to conduct the study from the selected site was obtained from the

relevant authorities of the Department of Education (DoE), the school principal, school governing body (SGB), parents/guardians and children. The paper presented by Professor Cooper at the Psychological Society of South Africa Conference that was held on 24-27 September 2013 emphasised that the Children's Act is of a higher order than any other order when it comes to children's interest.

He further maintained that, according to the Children's Act, the golden number for child maturity was 12 years. So the child at 12 was mature enough to give consent. On that note final consent was obtained from the children in compliance with the Children's Act, South African Children's Rights Council and the United Nations Convention of the Rights of the Child (UNCRC). According to Fombad (2005) children are the group most vulnerable to HIV and as they see themselves as experimenting adults, they deserve special concern. The informed consent form explained the basic nature of the study (Neuman, 1997:250). The agreement was obtained from participants before commencement of the study and after explanation concerning the study.

3.7.2 Confidentiality

Confidentiality and anonymity were maintained throughout the study; code names were used instead of real names. Clear boundaries were set at the outset and carefully maintained by all people involved in the study. I was obliged to safeguard the confidential information obtained during the course of research study. Participants' names were not identified. Codes name were used instead of names (Creswell and Ebersohn, 2010). However, as it was difficult to maintain confidentiality in the focus groups I, as the facilitator of the groups, had to make sure that I did not probe sensitive questions. Potential participants were informed of the voluntary nature of their participation. Since many participants were still minors, approval was obtained from their parents/care givers but with the children's assent. No unauthorised person would have access to the data.

3.8 Data Analysis

Data was analysed qualitatively. I read through all the responses a number of times and then analysed each response individually. The verbal interviews were audio recoded with the consent of the participants. Because of the qualitative and explorative nature of the study,

thematic content analysis was used as a method of analysing the data. A thematic analysis of the scripts of interviews was done and raw data was broken into sentences to identify common themes and patterns. The five stages of thematic analysis were followed in identifying and coding emergent themes within the data and interpreting the themes (Guest, MacQueen and Namey, 2012:11). Thematic analysis emphasises pinpointing and examining patterns within the data. Thematic analysis was performed through the process of five stages according to the suggestions of (Terre Blanch et al, 2006).

1. **Familiarisation**: This means becoming familiar with the data. At the initial stage I familiarised myself with the data, (Gibbs. 2007:5)
After data collection, researcher immediately transcribed the data into written form from the audio recorded data (Guest et al., 2012:11).
2. **Inducing themes**: This refers to generating initial codes through inductive analysis. This is the systematic way of organising and gaining meaningful parts of the data called coding and relating it to the research questions (Terre Blanch et al, 2006).
3. **Coding**: During this stage, the researcher read the data carefully. It simple meant that whenever the researcher found a meaningful segment of the text in a transcript, the researcher assigned a code (Creswell and Ebersohn, 2010:105)
4. **Elaboration**: At this stage, existing themes were defined and refined so that they could be presented in the final analysis (Terre Blanch et al, 2006).
5. **Interpretation**: Themes and data interpretation will be presented in the next chapter (chapter four). I conducted detailed analysis and produced a written report. After the final themes had been reviewed, I started the process of writing the final report (Terre Blanch et al, 2006).

3.9 Conclusion

This chapter described the methodology and the design that were employed by the study. The study used a qualitative research methodology and followed an exploratory research design. The chapter also described the data collection tools and the process of the data collection. In addition, the chapter described the ethical considerations employed by the study as well as the data analysis process that was employed by the study. The following chapter is a presentation and discussion of the research findings.

CHAPTER 4

Research Findings and Discussions

4. 1 Introduction

Chapter 3 described the methodology and design employed by the study. It further articulated the data analysis procedure. This chapter follows a thematic analysis process to describe and discuss themes that emerged from the in-depth interviews and focus group discussions. This chapter answers the research questions. The objectives of this study are as follows:

a) To explore teenagers' beliefs in and attitudes to condom use
b) To examine factors that contribute to condom use
c) To investigate adolescents' views on condoms as a prevention strategy

4.2 Profile of the participants

Name/code name	Gender	Age	Grade	Race
Boy 1	**Male**	**16**	**10**	
Boy 2	**Male**	**17**	**10**	
Boy 3	**Male**	**16**	**10**	
Boy 4	**Male**	**17**	**11**	
Boy 5	**Male**	**17**	**11**	
Boy 6	**Male**	**18**	**11**	
Girl 1	**Female**	**16**	**10**	
Girl 2	**Female**	**17**	**10**	
Girl 3	**Female**	**16**	**10**	
Girl 4	**Female**	**16**	**11**	
Girl 5	**Female**	**17**	**11**	
Girl 6	**Female**	**18**	**11**	

4.3 Objective 1: Exploring teenagers' beliefs and attitudes about condom use

4.3.1 Emerging Themes: Beliefs and attitudes about condom use

Participants, both girls and boys, indicated that people protect themselves from HIV and other STIs by using condoms. This was an indication that teenagers had general knowledge about HIV. Nevertheless, there was a common belief by teenagers that not using condoms was a sign that someone was in a serious relationship. Girls indicated that, non-condom use proved that they trusted their sexual partner. According to some participants, the length and intensity of a love relationship influenced condom use. The longer a relationship lasted, the greater the chance of discontinuing condom use.

4.3.1.1 Theme 1: Barrier to pleasure

The opinion that condoms reduce sexual pleasure emerged from both focus groups and in-depth interviews. Boy 3 believed that using a condom was like eating a sweet wrapped in paper. He said: "What is the use of eating a sweet still wrapped in paper, while the taste is in the sweet itself? You can't enjoy sex with plastic inside and there is importance of flesh-to-flesh for full satisfaction." Another participant, Boy 1, agreed with Boy 3 that using a condom was like eating an unpeeled banana and according to him a condom decreased sexual pleasure and prevented intimacy. Teenagers understand condoms as a hindrance to sexual satisfaction. This misconception about condom use is mainly common to the ignorant and adventurous communities particularly teenagers who like experimenting. This finding is parallel with the conclusions of WHO (2013) that misconception about condoms is one of the problems that affect mainly teenagers. Belief in a condom as a barrier is also perpetuated by peer pressure among teenagers. This finding was identified by Campbell and MacPhail (2002:6) who explain that behaviour is socially influenced and that behavioural norms that influence behaviour are developed through interaction with peer groups.

4.3.1.2 Theme 2 Belief that condom use implies distrust of one's partner

a) Teenagers' views about condom use

The Health Belief Model (HBM) explains the role of beliefs in decision making. The study participants were knowledgeable about how HIV is spread and they were also knowledgeable about condoms as a method of preventing HIV transmission. They viewed condom use as the

most effective strategy to prevent the spread of HIV and AIDS. Being knowledgeable did not necessarily lead to action and it was clear that decision to use was complex. The use of condoms was also perceived to be associated with casual sex. Where there was true love condoms were no longer used. Condoms should be used, they said, especially when a relationship was new and you were not sure about your new partner's HIV status

Girl 3 explained that "when a boyfriend negotiates condom use the first thing to come into my mind is that he thinks I am dirty or I show signs of HIV and AIDS." Some girls said they knew that condoms minimised chances of infection by HIV; however, they were ashamed to carry condoms around because people might think that they were sleeping around and were prostitutes. The study performed by WHO in 2013 (2013:19) discovered that teenagers were highly aware of and knowledgeable about condom use but there was a split regarding actual use. This was caused by fear of being labelled and a belief that it could give the impression that a girl was sexually advanced. In South Africa, adolescents commonly believed condom use was synonymous with promiscuity and infidelity.

Boy 5 said :

> I also agree on that it is a good thing to use a condom but places where condoms are sold or supplied are not acceptable because of lack of privacy and confidentiality. So when you buy/take a condom (abantu bakufakela umjojo banjoge kuwe) this means people make you feel embarrassed/ashamed when they look at you as if you are doing a very strange thing.

Although the teenagers in the study were aware of the reliability of condom use for contraception and prevention of HIV infection, they demonstrated some mixed feelings about condom use. They had the perception that condom use put a strain on a relationship. A condom was also associated with lack of trust, as some of participants argued that they thought a condom was for people who were not sure about their partner especially when the relationship was new. This parallels the argument of Panday et al. (2009:12) that the issue of condom use is vital, since requesting condoms may provoke suspicion. Panday et al. further explain that condoms are steadily increasing in acceptance in casual relationships. The boys said that condoms should be used; however, they argued that condoms should not be used by teenagers because they were young and they wanted to experiment with sex. The study

participants revealed that they were ignorant about the fact that they were susceptible to health threats because of non-condom use. However, their understanding of condom usage was influenced by ignorance to taking action.

4.4 Objective 2: Examining factors that contribute to condom use

4.4.1 Emerging Themes: Theme 1: Factors that contribute to condom use

a) Access to condoms

Places where condoms could be obtained were well known. Although some high school teenagers knew that condoms were available free of charge in hospitals and chemists they argued that the clinics and hospitals were "too far" and that money was needed for the taxi fare. It was widely known that supermarkets and pharmacies sold condoms, but the learners considered these sources to be "too expensive". Boy 5 articulated:

> We spend most of our time here in school till late because we attend afternoon classes when we go home it is already late and clinics close at 4:30. Then ma'am you take your girlfriend to your place and there is no condom and you ended up having sex without it.

Teenagers also indicated that there were no clinics near their home areas so if someone wanted a condom he or she had to go to town and sometimes they did not have money for taxi fare and a condom. This according to the HBM is the perceived barrier, and it refers to a belief in the tangible and psychological costs to oneself from engaging in the action. The barriers to accessing condoms are described by the BDE in its 2010 report (2011:19) that condom use among teenagers is low owing to limited access. Parallel to this is the UNAIDS Global Overview Report (2013) as it states that teenagers are still confronted with negative and stigmatising attitudes by health staff when they try to access condoms.

Teenagers suggested that if schools provided free condoms it would increase condom use because buying limited them in their sexual practices. The South African schools policy prohibits condom distribution in schools; therefore teenagers or school pupils rely on condoms that they get from clinics or other public places. South African schools have introduced HIV and AIDS Life Skills / Orientation in all public schools and the focus is on

Grades R-12 (DBE, 2011:57). However, despite this effort, condoms are not readily accessible in schools for learners. The HBM refers to this as a perceived barrier to accessing condoms.

Evidence suggests that teenagers need to have access to condoms that are either free or at a relatively low cost so that they are encouraged to use them for their own protection. This implies that there is a need to go beyond health facilities and find other avenues where condoms may be accessed. The BDE (2011:19) states that condom distribution is rarely undertaken especially in rural areas. Barriers to access condoms include sustained travel time; the cost of travel to the nearest town; the judgemental attitude of health service providers; and the cost of condoms in shops. A critical challenge for prevention efforts in adolescents is to ensure that the newly guaranteed reproductive health rights of children are realised. That means that condom distribution to high schools is imperative and might motivate teenagers to use condoms.

i) Unavailability of condoms when needed

The learners commented that opportunities to have sex might present themselves at an unexpected time when no condom was available. It was not considered possible or reasonable to resist sex because a condom was not available. Furthermore, those learners who knew that condoms should only be used once felt that this limited the number of "rounds you can go in a night" unless many condoms were available.

Girl 4 commented that chances to have sex might present themselves at an unexpected time when no condom was available. It was considered impossible and unreasonable to resist sex because a condom was not available. Boy 3 stated:

> Sometimes you visit your girlfriend and spend time with her then things get hot only to find out you don't have condoms. Both of you talk about condoms as if you will not have sex but while you are still together it happens that you end up having sex.

In agreement, Boy 5 said: "When partners are sitting together for a long time they end up touching and kissing and that leads to sex without using a condom." Boy 4 also stated that

they only thought about condoms when they were about to penetrate so "if your girlfriend allows you to penetrate without a condom you carry on."

ii) Health workers' attitudes

Participants suggested that access to condoms was not a problem but health services, distances to health centres and shops, cost and stigma could be a problem. Cost and distance were not the only factors that limited access; the embarrassment caused by going to the family planning clinics and the reportedly antagonistic attitudes of some clinic staff and supermarket cashiers, particularly to teenagers, discouraged the learners. Both boys and girls perceived the health services to be adult-centred because of the negative reception from clinic staff.

According to the participants, nurses at the clinics did not uphold their professional code of conduct by treating them with dignity and respect with the right to privacy and confidentiality. Scott (2009: 87) explains that negative attitudes towards condoms tend to be reinforced by healthcare workers, such as nurses, who object to handing out condoms to young girls at healthcare facilities. Teenagers complained about their dissatisfaction about the type of services provided by health care workers as they were not friendly. Most participants reported that unless the attitudes of health care workers changed positively and the manner in which they dealt with learners improved, High School X would continue to experience high rates of teenage pregnancies. This means that despite significant advancements in policy and programmatic levels to improve the availability and accessibility of health services to young people, usage and implementation were compromised by the lack of acceptability of service providers. This meant that teenagers were still confronted with the negative and stigmatised attitudes of health care workers and this hampered condom use. Judgemental attitudes by the nurses at the clinics were perceived as the main barrier preventing learners from seeking help and hampering condom use.

iii)Embarrassment and shame

Adolescents were primarily concerned with social acceptability and the opinion of their peers, so they did not want to be associated with negative connotations regarding condoms.

Teenagers felt embarrassed about every stage of condom use so the act of buying condoms, carrying condoms and asking for instructions were difficult.

Both female and male participants indicated that they felt embarrassed while talking about sexual matters with friends of the opposite sex, even with their sexual partners. They found it difficult to initiate discussion about condom use with their sexual partners. Boys and girls argued that it was difficult to keep condoms as they felt embarrassed when caught by family or friends. The findings of this study indicated that both girls and boys felt shy and uncomfortable while buying condoms and other contraceptives from the local stores and pharmacies. There was a clear indication that social factors such as the stigma attached to carrying and buying condoms and seeking help from health institutions were associated with perceived lack of efficacy. These perceived barriers were roadblocks that outweighed the perceived benefits.

b) Media and technology influence

i) Access to TV and cell phones

During interviews, the media emerged as the main source of information on sexual health, especially during the new era of democracy in South Africa when there is freedom of expression and easy access to television, magazines and even pornographic films or videos. The participants reported learning about sexual health from the media in (1) television drama series and films which they claimed elicited and enhanced their sexual desires and were very informative. (2) Teenagers indicated that other media – cell phones and phonographs – were also leading sources of information about sex and sexuality. These films were sometimes discussed with same-sex peers at school, who would add more information based on their different experiences, or participants would even try to implement what they had seen with their partners. Teenagers reported that some films on television contained too many sex scenes, especially those that were screened late at night. This finding is parallel with that of Victor and Starsburger (2010) that social networking websites and home pages enable teenagers to view sexually suggestive scenes publicly. Teenagers explained that they learnt a lot about sex from television; in some of the TV programmes the films showed sexual intercourse. They claimed that they watched films at night when the adults were asleep. In these programmes they could see how women were handled when having sexual intercourse

and this prepared them for their own sexual encounters. They argued that television films showed step-by-step how this was done.

Sometimes they felt it was too much as when they were watching they were aroused. They normally played these programmes late at night. Boy 4 said: "I am telling you, you can't watch it with somebody older than you. It is too explicit." This reveals that technology has a great influence on adolescents. As a result of this, the DoE, in partnership with other stakeholders such as loveLife, Soul City and Khomanani, have introduced mass media campaigns to reach this population. This shows that the government is aware that technology plays a significant role in shaping the behaviour of teenagers.

Boys 2, 3, 4 and 5 stated that during break time at school they spent time downloading porn pictures and videos on their cell phones; they then practised what they saw with girls. People on the porn pictures did not use condoms. Girls on the other side confirmed that they sat up watching late movies that contained sex scenes. They switched off the volume so that their parents would not be suspicious. Adolescents explained that most of the time they liked to be alone and away from parents. Using their cell phones they downloaded sex pictures and they met with boyfriends. The boyfriend would ask the girl to try what they had seen on TV or on the cell phone download. Most participants explained that owing to curiosity they wanted to experience what they had seen on TV or cell phone. The Sasha (2013) study argues that some video shows have been found to be agents of sexual exploration for teenagers, arouse their curiosity and increase their propensity for sexual exploration.

Exposure of children to sex in TV is increasing day by day. Such exposure has been found to affect adolescents' moral judgement and is said to have contributed to the high level of pregnancy among teenagers. In a study on the youth's perceptions of sexuality in Limpopo, South Africa, television was found to influence teenagers' sexuality because of their perception that whatever was portrayed on television was normal or correct (Maluleke 2007:11).

In this study, the results showed that teenagers had the liberty to watch any kind of programme. They obtained information about sex from television and film and this information was sometimes positive and sometimes negative. This means that parents should be aware of the type of information that their teenage children come into contact with, so that

they can guide them. It is also important for them to keep the lines of communication open, as this would enable teenagers to discuss with them sexuality issues

c) Use of alcohol

i) Influence of alcohol

Barriers predicted by the HBM such as alcohol abuse emerged in the study when participants described the connection between alcohol abuse and high risk sexual behaviour. Most participants explained that alcohol abuse affected their sexual behaviour and might lead to poor decision making. They explained that when one was drunk one could not even remember to use a condom. Participants said it was worse for girls because alcohol blinded them and influenced them to throw themselves at sex partners. Both boys and girls attended weekend parties and pubs/taverns/clubs where alcohol was used extensively. Prior studies such as those by NIAAA (2005) indicate that heavy alcohol abuse has been linked to high-risk sexual behaviours, including multiple sex partners, unprotected sexual intercourse, and sex with high-risk partners.

In addition, teenagers explained that being in love and using alcohol blinded them to the risk of unprotected sex even when they knew the possibilities of contracting HIV. Boys explained that girls tended to have unprotected sex with older partners in exchange for alcohol. Girls enjoyed riding in beautiful cars driven by older men and being given free drinks. All these were a motivation to sleep with a man without a condom. Alcohol also impairs a human's reasoning ability. When teenagers are under the influence of alcohol, condoms are not a priority. This corresponds with the findings of Dhar and MacManus (2008) that the use of drugs and alcohol before sex is one of the behavioral risks that lead to non-condom use. According to girls, parties and other occasions where young people consume alcohol were also settings for older men. Girl 3 said: "Like ma'am older man took the advantage of the situation where decision making is impaired."

Alcohol consumption puts young girls at risk because they get so drunk that they are not able to reason appropriately. Teenagers explained that some girls went to parties in the evening and the next morning they found themselves in bed with strange men they had hooked up with during the party. After realizing this, the next stop for young girls was the chemist to purchase morning-after pills.

This study's findings indicated that most of the learners used alcohol so that they could be seen as "cool" by their fellow peers. Since there were no recreational facilities in the schools and within the community, taverns were the only places where they could have fun and relax. Age restriction laws in the taverns within the community were not enforced because some of the participants in this study who frequented pubs and taverns mostly during weekends were under the age of 18. Tavern owners did not ask for identity documents. Most studies show that the escalating rates of alcohol abuse and HIV are closely related (WHO 2013:9; UNAIDS, 2008:7; DBE, 2011:12) Alcohol use increases the risk of exposure to HIV through its association with high risk sexual and substance abuse behaviour. Teenagers use alcohol out of curiosity, boredom, peer pressure and the search for excitement. This perceived barrier is correlated with gender and age.

d) Reputation

i) Social expectations and gender norms

Girls were expected to be submissive to boys and this often led to expectations of sex on the part of boys. Girls explained that as young girls were not expected to talk about sex, they pretended not to know anything to avoid being embarrassed in social circumstances. Girls explained that society's expectations and gender norms influenced adolescent sexual behaviour. They also agreed that girls were expected to behave in socially acceptable ways. They were unable to speak freely about sex and if they were involved in several relationships with the opposite sex, they were regarded as sluts, cheap and easy targets to obtain sexual favours. Male participants agreed that boys were allowed to have more than one partner and were expected to have sex. Another important aspect was that of fidelity which was emphasised by the boy participants. They believed that if a gir1 asked a boy to use a condom, it meant that she did not trust him or that she had been unfaithful and promiscuous. Male participants also viewed it as a universal belief that if a man slept with a woman prior to marriage his status was elevated in society. However, if a girl indulged in a similar sexual behaviour she was seen as "cheap".

The majority of the young girls requested a youth friendly clinic or special programmes during the school holidays and/or a knowledgeable accessible person to advise them concerning the realities of relationships with the opposite sex. This corresponds with the cues

to action construct of the HBM which refers to the evidence of strategies that motivate a person to action. The HBM cues to action apply to personal and environmental events that motivate teenagers to use condoms. Interestingly, none of the teenagers suggested talking to or improving their relationships with their parents. From the perspective of the teenage boys, it did appear that being in a sexual relationship with a girl was considered extremely important. No mention was made of the boy initiating a safer sex practice or taking responsibility for preventing pregnancy or the transmission of a sexually transmitted infection. In some instances, boys actively prevented the teenage girls from taking contraception. Even if the girl managed to make the decision and obtained contraception, the contraception had to be taken secretly. In addition, the boys made promises they never seriously considered keeping.

Social constructs rewarded boys but punished girls for being in sexual relationships. Furthermore, it seemed, as far as boys were concerned, the focus of a sexual relationship was to impregnate teenage girls and abandon them during their pregnancy. There was no vision for the future or even any perception of risk of passing on HIV infections. There was no apparent sense of responsibility for acts performed or consideration of their consequences. Just experiencing a sexual relationship was sufficient and if that did not happen, the relationship was ended and another initiated with the same end in mind. Responsibility was not yet part of the teenagers' actions because they knew that HIV was incurable, and was the consequence of practising unprotected sex but the girls continued to engage in unprotected sexual intercourse in this area and fall pregnant. This perceived barrier is connected to social constructions of gender in sexual relationships.

e) Condom use and male ego

i) Insecurities

The use of condoms seemed incompatible with the notion of manliness held by the learners. Some boys felt that real men did not use condoms. The condom seemed to challenge the male ego particularly when its use was suggested by a female. The erect penis seemed to be associated with manhood. Putting a cover over it was seen as covering up and hiding away that manhood and this was seen as an indication of weakness. Male sexual insecurities might explain that in part as fear of losing an erection, fear that condom could not fit the penis size, that is "too big"

Boys explained that they also wanted to prove their manhood. When a girl was around, a boy could not control himself because when a girl saw a boy she expected sex. Failing to comply lowered their self-esteem. The boys further explained that if a boy did not want to be involved in sexual activities others would start doubting his sexuality. They would call him names like "uyi sisi" which means "you are gay". They felt the pressure of proving their manhood to their social groups. Corroborating this view, Selikow et al. (2009) state that male teenagers believe that becoming a real man only involves having sex with girls. Selikow et al. further maintain that male teenagers believe they should have a female partner if they want their name to "go on". Clearly, the male participants in the study believed that having sex with girls was an important facet of becoming a real man and distinguished real men from "sissies". The above argument showed that boys' beliefs about what it was to be a real man influenced and created negative stereotypes of condom use. This perceived barrier is linked to social constructions of manhood and peer pressure.

f) Transactional and economic factors

Male participants maintained that sometimes girls were involved in relationships with older partners for financial benefits. They mentioned that girls received gifts, money, went out especially during festive seasons, enjoyed free rides to beaches and so on with older men. Most of the boys stated that they sometimes lost girlfriends who were materialistic to older men because they could not provide material things. Most of the times these older men were players; they were able to sleep with many girls by virtue of being financially stable. Most of the boys claimed that transactional sex was very common among high school female teenagers. But they did not mention that boys at high school were also playing for sex. This study indicated that economic factors were viewed as a potential factor that exposed teenagers to the vulnerability of HIV transmission. Despite the HBM construct of cues to action such as peer education and life orientation lessons, teenagers were reluctant to use condoms because of the expense (economic needs). Their social circumstances limited their ability to express themselves positively and to enforce decision making strongly. This situation lowered their self-esteem. Low self-esteem has been noted to be a predictor of reduced condom use (Panday et al., 2009:12).

One female participant stated that if an older partner financially provided for the girl, it was a possibility that the girl would allow that man to control everything because she feared rejection. This perceived barrier of economic benefits is connected to the age, social and economic status of a girl. This study identified the practice of age mixing or transactional sex as a major factor in the spread of HIV.

4.4.2 Theme 2: **Social and behavioural factors and condom use**

Adolescents mentioned factors that contributed to risky behaviours. The following sub-themes were identified:

a) Peer pressure

Friends or peers can strongly influence one's behaviour regarding unprotected sex. Girl 3 stated that girls sat in groups discussing sex and boyfriends. It was in these groups that females got to hear about new terms and relationship activities and that led to curiosity and wanting to experiment with and experience those activities. In agreement, Girl 5 said:

> You are five in a group and two are having sex with their boyfriends. You decide not to have sex till you get married. They say to you that you are foolish and because of that pressure you may change your mind.

That statement indicated that girls risk sex because of fear of being excluded from friendship circles. On the other hand, most of the boys argued that they did not want to be a misfit in a group. They said if boys were perceived as not being sexually active, they were at risk of being excluded from their peer group. Seemingly teenagers engaged in unprotected sex because they wanted to be part of a clan. They were avoiding being given names such as "isishumane" (not having a girlfriend). This is parallel with the views of Campbell and MacPhail (2006:6) who maintain that behavioural norms that influence behaviour are developed through interaction with peers.

Both boys and girls shared similar sentiments regarding peer pressure. The perceived barrier of peer pressure in both male and female participants was correlated with a very strong level of fear of peer disapproval which resulted in non-condom use. Peer pressure reduced levels of

condom use and increased levels of sexual activity. Fear of rejection by peers was an issue raised in focus group discussions. Teenage boys feared that if they did not do the same as their friends they would be scorned and rejected. Some were associated with "aboSenzo" (a gay character in the drama soapy *Generations*) or even called a sissy. They then engaged in unplanned and unprotected sex to prove their manhood. Male participants explained that they talked as males about sex, that is, how to do it, when and where and how it felt with and without a condom. Boy 1 explained that his friends influenced him because they forced him to kiss girls and do other things. He tried not to give in but peer pressure was something very hard to refuse, he added.

The research findings of Hammer and Banegas (2010:290) are similar to those of this study. They state that a commonly cited reason for initiating sexual relations among adolescents is pressure from society and their peers. In their quest for a sense of belonging and to avoid rejection by their group, adolescents succumb to this pressure. According to Boy 2, his friends influenced him to engage in sex without condoms. They told him that he could not trust condoms and that they spoilt pleasure.

Lyon and D'angelo (2006:149) report that when adolescents perceive that their friends of similar age are engaging in risky sex, this perception is likely to foster the same behaviour in them. Conversely, perceived peer norms that are supportive of sexual protective behaviours may influence adolescents to adopt and maintain safer sex practices (Lyon and D'angelo 2006:149).

The statement above shows that peer pressure can be a perceived benefit as well as a perceived barrier according to the HBM. It was clear that very few teenagers discussed constructive topics as only one participant explained that his friends had influenced him positively and told him to be careful because of the possible diseases (HIV, AIDS and STIs). Both male and female participants emphasised that their peers played a major role in influencing their beliefs and behaviour in respect of their sexuality. They turned to their peers for guidance and approval regarding their sexuality rather than to their parents. All participants emphasised that peer pressure influenced them to engage in high-risk sexual behaviour so as to gain recognition among their peers. This study's findings showed that peer groups are significant because they satisfy the learners' basic human needs to develop optimally. Those needs encompass the need to belong to a group, to interact socially and the

need to develop a sense of self. Belonging to a peer group enables learners to interact socially with other learners and to have experiences independent of teachers and parents. This is parallel with Nwanko and Nwoke (2009) research findings that teenagers tend to imitate their peers' behaviour in an effort to match the group behaviour and to show others that they are able to do what their peers do.

The most identified factor in adolescent sexuality is the perceived behaviour of peer groups. There is a need to prove oneself: not being a sissy, to be seen as cool and to be involved in unprotected sex. Generally, adolescents do not want to be different from their peer group. It was mentioned in the literature review that the adolescent period is characterised as adventurous and explorative, especially the exploration of sexuality (DBE, 2007a:16). In focus group discussions, the participants admitted that even though they knew about condom use they also wanted to experiment without condoms because of their inclination to experiment sexually.

b) Pleasing boyfriend

Participants argued that teenagers engage in sex for fear of being rejected by a partner, wanting to satisfy the partner and wanting to experience what friends and peers were talking about so as not to be a misfit in the group. Also satisfying a male partner was based on the fact that male partners threatened to abandon their partners for other girlfriends. According to Girl 1, she feared that she would lose her boyfriend because he told her that there were many queens out there so if she did not want to satisfy him he would leave her or cheat. In addition, Girl 6 remarked:

> Insisting on using condoms put a strain on the relationship because of when a boy wanted to have sexual intercourse with a girl and a girl don't want to, he threaten to leave the girl and because you love him you end up surrendering and you have unplanned and unprotected sex with him because you don't want him to leave you.

This is a clear indication that male partners irrespective of their age are alleged to bully their female partners as they force them into unprotected sex. It is clear that teenage girls have a low sense of self-efficacy and find it difficult to say "NO" possibly because they want to please their boyfriends and fear rejection (Panday et al., 2009:12).

4.4.3 Theme 3: Poor communication and negotiation skills

a) Poor parent -child communication

Both boys and girls shared the same view/information about their parents and their partners. The research findings indicated that parental involvement in adolescent sexuality was limited. Children, particularly learners, acquired sex information mostly from their peers and from school curricula. Life Orientation, for instance, was identified as the most prominent source of HIV and AIDS information. Parents did not communicate with their children about sex. They apparently still thought that it was a topic to be discussed by adults. They did not want to believe or accept that their children were sexually active. They believed that by talking about sex with their children they were giving them permission to have boy/girlfriends and sex (Han and Bennish, 2009:31). Both male and female participants agreed that sex and sexual health matters were taboo within their immediate family circles. Parents ignored the fact that adolescents have sexual needs and become angry and refuse to offer sex education to young people. In the African community it is not culturally appropriate to discuss sexual health with parents as it is a sign of disrespect. Both male and female participants demonstrated that teachers played an effective role in influencing young people's beliefs, expectations and behaviour with regard to their sexuality, HIV and AIDS and risk-reducing behaviour. The general focus of HBM is on knowledge and individual socio-demographic and cultural factors such as the influence of family, peers and institutions that include education and religion.

Most female participants argued that they could not talk to their parents about sex because they feared that they would be angry. Girl 2 stated:

> It can be easy to talk to parents only if they started the topic and if they approach them and talk about sex but they can't just talk about this problem about sex unless the parents ask them.

Boys explained that mothers communicated better with girls especially when girls just started to menstruate. They added that mothers were over protective of girls. Girl 5 said:

> I live with my grandparents they never talked to me with anything related to sexuality. Our grandparents do not talk about sexual issues. And ma'am the truth is that we are very secretive when it comes to sexual activities.

Most of the participants indicated that their parents expected them to live their religious beliefs. Girl 5 further said:

> [F]or example if you are raised by saved "born again Christians" they don't talk about sex before marriage. So they expect girls to abstain till marriage. But they forget that we have our own needs and values.

The whole group supported her. She went on to say that parents even went to the extent of criticising the Department of Education for introducing Life Orientation. According to Kaplan (1998:296), adolescents become more emotionally autonomous and idealise their parents less. They depend somewhat less on their parents and more on their peers, which is accompanied by increased susceptibility to peer pressure. This perceived barrier is linked to religion and the idea that parents do not discuss puberty and sexual matters with their children.

b) Poor partner communication

Most participants agreed that adolescents, especially girls, had poor negotiation and decision-making skills which sometimes led to unsafe sex. Girls further reported that it was not easy to talk about sexual matters with their boyfriends. They concluded that there was less chance of refusing sex if boys asked explicitly. Fear of rejection was a dominant factor in this aspect. Girl 4 said:

> Ma'am we don't communicate sexual matters with our boyfriends. Once we start a relation the next step is sexual intercourse without discussing how we shall protect ourselves. The boys don't bother by checking girls' readiness and willingness.

In agreement, Girl 2 said: "Ma'am we feel shy to talk or to negotiate condom use with our partners." Girl 4 also said: "Ma'am it is not easy to talk about sex with a person of your opposite sex. We feel shy." The gender-power relationship was identified as a major

contributor to both poor communication and non-condom use. There was a clear indication that girls had less choice than boys about when to initiate sexual activity and condom use. The fear of a partner's reaction often kept a girl from suggesting condom use. In parallel, a study conducted by Leclerc-Madlala (2008) states that various studies in South Africa suggest that negotiations regarding relationships are complex. An entrenched male-made advantage often compels females to comply with the desires of their partners and restrict their control to their sexual health. Teenagers, especially females, stated that open discussion about the topic was not simple and was made difficult by social taboos and secrecy surrounding it. Consequently, WHO (2013) advises that intimate discussions are necessary to obtain information about sexuality and to negotiate safer sex but may be particularly difficult for teenagers especially those who have relatively little experience with such discussions. The presumption or construction that teenagers "should" feel shy and fear being judged by their partners and partners is a perceived barrier to condom use. In this study the perceived barrier of infrequent communication was related to social constructions and gender roles that gave boys absolute power over girls in sexual relationships.

4.5. Objective 3: Investigating adolescents' views on condoms as a prevention strategy

4.5.1. Emerging themes: adolescents' views on condoms as a prevention strategy

The majority of the study participants both boys and girls acknowledged that condom use was an efficient means of preventing HIV infections, STIs and teenage pregnancy. But although they had awareness they perceived themselves as a group that was at low risk of contracting HIV. The findings by UNAIDS (2011:28) are that despite the high prevalence and risk behaviours in South Africa, adolescents still perceive themselves as being at low risk of HIV infections. This corresponds with the perceived susceptibility construct of the HBM that refers to a person's belief in the chances of acquiring a condition. According to this study, teenagers were aware that people should use condoms to protect themselves from contracting HIV infection, preventing transmission and re-infecting one another. Girl 3 explained that "when condoms are used consistently and correctly they are indeed highly effective in preventing sexual transmission of HIV." Most participants agreed that condoms were the most effective prevention strategy because of their multipurpose use such as prevention against STIs, pregnancy and HIV infection. When used consistently and correctly, condoms were referred to as the most efficient prevention strategy. But at the same time, teenagers'

beliefs and myths about condom use greatly influenced the actual use. They believed that condoms caused STIs. The HBM explains this construct as the perceived barrier.

i) Causes of STIs

During interviews girls indicated that latex condoms caused STIs and related symptoms such as allergies, vaginal itching and abdomen pains. Similar opinions were expressed by male participants who said that the lack of lubrication made sex painful for both partners and that they were not able to use condoms for "quick rounds". Both boys and girls complained about irritation and discomfort. This was a clear indication that teenagers did not use condoms because they feared getting allergies. Their fear and perception that condoms caused STIs reduced their chances of practising safe sex. Tarkang (2009) in his study believes that side effects could act as barriers deterring teenagers from using condoms consistently during sexual intercourse.

Condoms were also associated with mistrust, multiple sexual partners and having casual sex by the study participants. Prior studies like that of Tarkang (2009:178) emphasise the finding, that perceived benefits and perceived barriers of the threat of HIV infections influence the effectiveness of condom usage. Teenagers had low self-efficacy regarding condom use because of personal beliefs about condoms. These beliefs seemed to retard their ability to take action and use a condom each time they engaged in sexual intercourse. Beliefs and misconceptions about condom use were identified as a perceived barrier to the effectiveness of condoms to protect teenagers from contracting disease.

ii) Circumcision replaces condoms

Only two boys in the focus group discussion had been circumcised. The legal age for going to initiation school is 18. These participants explained that they did not use condoms because they had been circumcised so they had a low risk of being infected with HIV and STIs. This is the perceived susceptibility that exposes circumcised teenagers to HIV infection, STIs and unplanned pregnancies and other reproductive health problems (perceived severity). This shows that circumcision retarded the intention to use condoms. This is parallel with the research findings by Maughan-Brown and Voenkataramani (2013) that boys who heard that

male circumcision partially protected men against HIV were likely to perceive themselves as being at no risk of contracting HIV themselves.

According to Maughan-Brown and Voenkataramani (2013:123), the potential HIV-protective effects of male circumcision were associated with a lower perceived risk of contracting HIV and with reduced condom use among women in South Africa and Kenya. They argue that when women in Kenya and South Africa heard about the protective benefits of circumcision's perceived reduced personal HIV risk they engaged in riskier sexual behaviour. This is parallel with the findings of this study because two of the male participants who had been circumcised had the misconception about circumcision as a prevention strategy. Boys who have been circumcised have a perception that they are free from the risk of contracting HIV infections and may engage in more high-risk sexual behaviour. Circumcision has been identified as a perceived barrier to condom use.

It was clear that the misconception about circumcision as a prevention strategy arose from simple ignorance and misunderstanding about circumcision and HIV transmission. The teenage boys lacked knowledge that circumcision did not offer total protection from HIV and AIDS. This could increase their reluctance to follow other HIV prevention behaviours such as using condoms correctly every time they had sexual intercourse, being faithful to one partner, and abstinence.

Some studies such as that by WHO (2013:2) show that circumcision has an effect on the transmission of other sexually transmitted diseases and is a cost-effective public health intervention against the spread of HIV and AIDS, although not necessarily more cost-effective than condoms. The joint WHO (2013) recommendation also notes that circumcision only provides partial protection from HIV and should not replace known methods of HIV prevention.

4.6 Conclusion

This chapter presented and discussed the research findings of the study. The findings revealed that peer pressure and lack of knowledge of the importance of using condoms were the perceived barriers to condom use among teenagers. For example, teenagers believed that condom use was an indication of lack of trust in a partner's faithfulness. It also challenged

male ego, limited sexual pleasure and was associated with sexually transmitted diseases. There were a few perceived benefits of condom use according to the study findings. Though teenagers were aware of condom use, but perceived barriers hindered them from using condoms. Participants in this study also perceived themselves as a group which was at low risk of HIV infection; therefore, they did not see the urgency of condom use.

Chapter 5

Key Findings and Recommendations

5.1 Key Findings

The study revealed that the barriers to condom use perceived by the teenagers of the selected high school were the most vital factors that influence condom use. These factors hindered the intention of teenagers to use condoms. When beliefs and attitudes about condoms were examined, it was found that lack of self-efficacy in buying and carrying condoms and communicating about sexuality with both partners and parents hindered condom use. During the interviews it was clear that the most contributory factors to non-condom use were issues of intimacy and trust and the fact that condoms were associated with casual sex. In long love relationships, after trust had been established, condoms were no longer perceived as needed.

The study also discovered that adolescents had high levels of knowledge about the transmission of the HIV virus and were fully cognizant of the value of barrier contraception such as condoms in preventing HIV transmission. However, most of them did not personalise the threat of AIDS. Despite the high profile given to HIV, few adolescents were able to transfer their knowledge to adopting safe sex behaviour. For example, there was an indication that boys were being pressured by society generally. Many parents were very concerned about the boys' masculinity. Boys felt the pressure to prove their masculinity and refute any claims of homosexuality; they were real "men", not gays. They tried to prove their masculinity by having sex as often as possible and with as many girls as possible. Within Dutywa District, a number of meaningful issues regarding adolescent sexuality were identified, although a full investigation was not possible.

Peer pressure for both girls and boys was the most identified factor. Peer pressure proved to be both a perceived barrier and a perceived benefit. For boys the influence of their peers appeared crucial in acquiring information and knowledge about sex and satisfying sexual curiosity. Seemingly, boys had sex to follow the crowd, for fun, to experience pleasure and because they believed that the majority of their peers had sex. This was a clear indication that sexual activities were the norm. On the other hand, girls achieved a reputation among their friends by boasting about sexual encounters. Then out of curiosity others just followed the

crowd because they wanted to fit in the group. Boys mentioned that they felt rejected by sexual partners who favoured older men who took the girls to pubs and taverns. Peer pressure was a perceived benefit when responsible adolescents guided and informed others about the risks of not using a condom during sex. Adolescents educated one another about HIV and some even advocated abstinence.

It was clear that, among teenagers, factors that could influence condom use included some of the following issues: peer pressure, cultural beliefs; myths and attitudes; lack of knowledge about condom use; unplanned sex; poor negotiation and communication skills; poor parent-child communication; and unhelpful attitudes of health services staff. There was a belief that condom negotiation put a strain on relationships as it gave rise to suspicion and distrust on the part of the girls. The issue of trust was vital since the negotiating of condom use provoked suspicion. Other issues that hindered consistent condom use included the importance of flesh-to-flesh contact with condoms being perceived as a barrier to sexual pleasure. It appeared that condoms were steadily increasing in acceptance within casual relationships but had made little progression in longer relationships. The perception was that long-term relationships and serious partners were risk-free and did not need protection. This was a clear indication of immaturity and lack of knowledge about the facts of condom use. The findings revealed that teenagers considered discussion about condom use unnecessary.

5.2 Recommendations

Adolescents are an especially vulnerable group to HIV but they are also our greatest hope for changing the spread of this pandemic. Therefore, the following recommendations are made according to national level, policy, education and a local level which includes practise and lastly research.

National level (DOE) (HIV directorate and other governmental departments)

POLICY

- Curriculum should reform, inclusion of beliefs and attitudes and revise peer education caution programmes to address the social drivers of the epidemic.
- Skills development; self-awareness, negotiation skills, assertiveness
- Capacity building educators

- Collaborative development of indicators to measure success

LOCAL LEVEL

- More involvement with parents and the parent teacher association at school level
- More involvement with communities
- HIV prevention programmes also need to be geared towards targeting people who have a strong influence on adolescents such as parents, by encouraging them to talk about sexuality and HIV. Parents have to be empowered with skills and knowledge with regard to both HIV and AIDS as they need to address the vulnerability of girls to HIV and AIDS through open communication about sex. Quality Learning and Teaching Campaigns (QLTC) were launched in 2010 by President Jacob Zuma and the Minister of Basic Education, Mrs Motsega, in Qamata location at Cofimvaba, Eastern Cape. The main emphasis was that the education and learning of a child should be a three-legged pot which included the DoE, learners and the community at large. This programme was launched in in 2012 in all schools of Dutywa District and pledges were signed by all the relevant stakeholders in the community including parents.
- Curriculum reform on more holistic approach including social factors which fuel the epidemic for example alcohol, substance abuse
- HIV/AIDS and Youth affairs coordinators to enhance awareness on circumcision

RESEARCH

- Monitor and Evaluate programmes at schools
- Further research to be conducted in high schools in order to explore factors that influence condom use among high school teenagers.

5.3 Limitation of the study

The study results were limited to one high school in Dutywa District and cannot be generalised to the entire district and other areas.

List of Sources

Abdulraheem, I.S. & Fawele, O.I. (2009). "Young people's sexual risk behaviours in Nigeria" in *Journal of Adolescent Research,* 24(4):525-527.

AfroAidsInfo (2013). *An HIV/AIDS information portal for South Africa*: *unsafe sex, condom and adolescents*. Cape Town: Medical Research Council.

Babbie, E. & Mouton J. (2011). *The practice of social research*. Cape Town: Oxford University Press.

Becker, M. H., ed. (1974). "The Health Belief Model and Personal Health Behavior" in *Health Education Monographs* 2:324–473.

Beuno, C.F. (2010). *Education and science. The concept of beliefs in sociology and anthropology*. [O] Available at: http://Savior.hubpages.co/.hub/Area Department of sociology. (Accessed on 22.02.2012).

Biddlecom, A., R. Gregory, C.B. Lloyd, & B. Mensch. (2006). "Premarital sex and schooling transitions in four sub-Saharan African countries," Paper for *IUSSP Seminar on Sexual and Reproductive Transitions of Adolescents in Developing Countries,* 6–9 November, Cholula, Mexico.

Bombereau, G. & Allen, C, (2008*). Social and cultural factor driving the HIV epidemic in the Carrabbean.* Carabbean: Health Research Council.

Bridges, E., & Alford, S. (2010). "Comprehensive sex education and person-oriented approach" in *Journal of School of Psychology*, 48(6):483-510.

Brink, H.I. (1999). *Fundamentals for research methodology for health professionals*. Cape Town: Juta.

Campbell, C. & MacPhail, C. (2002). "Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth" in *Social*

Science and Medicine, 55 (2):331- 345. [O] Available at: http:// eprints Isc. ac.uk/ archives 0000038

Champion, V.L. & Skinner, C.S(2008). "The health belief Model" in Glanz K, Rimer B.K, Viswaneth K, Eds,(4th ed). Health behaviour and Health education: Theory Research and Practices, San Francisco, Jossey-Bass. Pp 45-65

Children's Act 38 of 2005 (as amended by the Children's Amendment Act no 41 of 2005). [O] Available at: http:// www. Info.gov.za/gazette/acts/2005/a 38-05 pdf (Accessed 9/12/2008). South Africa (Republic). Government Gazette (2006). Children's Act 38 of 2005 Vol 492. No 28944 http://www.government.gazzette.co.za (Accessed 2/10/2013.

Chitando, E. (2007). *Living in hope*: *African churches and HIV/AIDS 2*. Geneva: WCC Publications.

City Population. (2013) Population.DE. Available www.City (Accessed on 10/102013).

Cobb, T.G. (2010*).* "Strategies providing cultural competent and health care amongst Americans" *Journal of Cultural Diversity*, 17(3):79-86.

Cooper, S. (2013). Universal Declaration of Ethical Principles for Psychologists, a paper presented in the *PsySSA Ethics workshop* in Johannesburg 23-25 June 2013.

Creswell, J.W. & Ebersohn, L. (2010) *First steps in research*. Pietermaritzburg, South Africa:

Daily Dispatch, January 7th 2014. Daily Dispatch. East London.

Denzin, N.K. & Lincoln, Y.S. (1994). "The fifth moment" in Denzin N.K. & Lincoln Y.S. (eds). *Handbook of qualitative research* edited. Thousand Oaks, CA: Sage.

Dhar, L., & MacManus, A. (2008). *Study of knowledge, perception and attitudes of adolescent girls towards STIs/HIV*. [O] Available at http//creative commons.org/lice=ses/by2.0 (Accessed 14/03/2013).

Dorrington, R.E., Johnson, J.F., Bradshaw, D. & Daniel, T. (2006). *The demographic impact of HIV/AIDS in South Africa. National and provincial for 2006*. Cape Town: Centre for Actuarial Research: SA Medical Research Council and Actuarial Society of South Africa.

Dunkle, K.L, Jewkes, R., Nduna, M., Jama, N., Levin, J., Sikweyiya,Y., & Koss, M.P. (2007) "Transactional Sex with Casual and Main Partners among South African Men in the Rural Eastern Cape: Prevalence, Predictitors and Associations with Gender-Based Violence" in *Social Science and Medicine*, 65 (6):1235-1248

Exavery, A., Lutambi, A., Mubyazi, G.M., Kweka, K., Mbaruku, G. & Masanja, H. (2011). "Multiple sexual partners and condom use amongst adolescents 10-19 years old in Tanzania" in *BMC Public Health* 11:482-490.

Flisher, A.J, Mukoma, W. & Lottar, F. (2007). "Evaluating adolescent sexual and reproductive health interventions in Southern and Eastern Africa" in Klepp, K.I., Flisher A.J & Kaaya S (eds). *Promoting adolescent sexual and reproductive health in East and Southern Africa* Cape Town: ASRC Press 249-265.

Fombad, C.M (2005) *Children and Informed Consent to HIV/AIDS Testing in Botswana.* University of Botswana Law Journal 2 (33):33-72.

Gibbs, G. R. (2007). *Analysing qualitative data, part of the qualitative research*. University Surrey, Guilford.

Glanz, K., Lewis, F.M. & Rimer, B.K. (2002). *Health behaviour and health education. theory, research and practice*. San Francisco: Health Education Research.

Global Round Table Working Group on Youth. (2004). *Youth and the state of culture*. [O] Available at: outreach@youth coalition.org (Accessed 14/04/2013).

Guest, G., MacQueen, K.M. & Namey, E.E. (2012). *Applied thematic analysis*. Thousand Oaks, CA Sage.

Hammer J.& Banegas M.P.(2010) "Knowledge and Information seeking behaviour of Spanish – Speaking Immigrant Adolescents in Curacau.Netherland Antilles – family and community health" in *Journal of Health Promotion and Maintenance* 33(4): 285–300.

Han, J. & Bennish, M.L. (2009). *Condom access in South African schools*: *law, policy and practices.* PLos Med: DOI.

Harrel, M.C. & Bradley, M.A, (2009). *Data collection methods. Semi-structured interviews and focus group discussions.* Rand National Research Institute: USA.

Hartel, C.G. (2005). *HIV/AIDS in South Africa*: *a review of sexual behaviours among adolescents.* South Africa: PLos Med: DOI.

IRIN 06 March (2007). South Africa: Teenage pregnancy figures cause alarms: Johannesburg. [O] Available at: http//www.irrnne/ Report = 70538 (Accessed on 27/08/2009).

Janesick, V.J. (1994). "The dance of qualitative research design. metaphor, methodology, and meaning" in Denzin, N.K and Lincoln Y.S. (eds). *Handbook of qualitative research* Thousand Oaks: Sage:209-219.

Kanku, T. & Mash, R. (2010). "Attitudes, perception and understanding amongst adolescents regarding teenage pregnancy, sexuality and contraception" in *South Africa Family Practice.* Vol (62)52(6):563-572.

Kaplan, P.S. (1998). *The human odyssey life-span development.* USA, Pacific Grove: Brook/Cole Publishing Company.

King, N. and Harrocks, C. 2010. *Interviews in Qualitative Research.* London ECIY ISP: SAGE Publications.

Lebese, R.T., Maputle, S.M., Ramathuba, D.U. & Khosa, L.B. (2013). *Factors influence uptake of contraceptive services by Vhotsonga adolescents of Limpopo.* South Africa: health SA Gesondheid.

Leclerc-Madlala, S., Simba, I. & Cloete, A. (2009*).* The sociocultural aspects of HIV/AIDS in South Africa in *Springer Science* + Bussiness Media: New York

Leclerc-Madlala, S. (2008). "Age-disparate and intergrational sex in South Africa: the dynamics of hypervulnerability" in *AIDS* 22 Suppl- SI 7- S25.

Litoselitti, I. (2003). *Using focus groups in research*. New York: Continuum.

Lyon, M.E. & D'angelo, L.J. (2006). *Teenagers HIV and AIDS insights from youth living with the virus,* Westport, Conn: Praeger Publishers

Maluleke, T.X. (2007), "The youths' perceptions of sexuality in the Limpopo Province of South Africa" in *Health SA Gesondheid* 12(3): 3–16.

Maughan-Brown, B. & Venkataramani, A. S. 2013. "Incorrect Beliefs About Male Circumcision and Male-to-Female HIV Transmission Risk in South Africa: Implications for Prevention" in *AIDS Journal of Acquired Immune Deficiency Syndromes* 62 (4):121-123.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. Jossey-Bass : San Francisco.

Mestad, R., Secura, G., Allsworth, J.E., Madden, T., Zhao, Q. & Pelpert, J.E. (2011). "Acceptance of long-acting reversible contraceptives methods by adolescents" in *Contraceptive Choice Project* 84(5):493-498. [O] Available at: http://dx.dol.org (Accessed 22/10/2012).

Mitchell, C. & Pithouse, K. (2009). *Teaching and HIV&AIDS*. Johannesburg: Macmillan.

Namisi, F.S. (2010). *Communication on sexuality within Kenya family setting in the context of HIV and AIDS*: *the perception of parents and 14-19 year old adolescents.* Bergen: University of Bergen.

NIAAA. (2003). *Alcohol abuse and HIV/AIDS in resource-poor societies*. National Institute of Health: Maryland. Available at: http://www.niaaa.nih.gov (Accessed 22/10/2012).

Nicholas, L. 1998. "Black South African students' beliefs and attitudes about condoms" in *Psychological Reports,* 83:891-894.

Nwankwo, B.O & Nwoke E.A. (2009). "Risky sexual behaviours among adolescents in Owerri Municipal: predictors of unmet family health needs" in *African Journal of Reproductive Health* 13:135–145.

Ochieng, M.A., Kakai, R., & Abok, K. (2011). "Knowledge, attitude, and practice of condom among secondary schools in Kisumu district, Nyanze Province, Kenya" in *Asian Journal of Medical Science,* 01(2011):3:32-36.

Panday, S., Makiwane, M., Rarchod, C. & Letsoalo, L. (2009) *Teenage pregnancy in South Africa.* Pretoria: Department of Basic Education.

Peltzer, K., Promtussananon, S. & Mashego, T. (2006). Youth sexuality in the context of HIV/AIDS in South Africa in Lipshitz, M. (ed). *Domestic violence and its reverberations* (113- 179). New York: Nova Science Publishers..

Polit, D.F. & Beck, C.T. 2004. *Nursing research*: *principles and methods;* 7th edition. Philadelphia: Lippincott.

Preston-Whyte, E. (1999). *Reproductive health and condom dilemma*: *identifying situational barriers to HIV protection in South Africa*. (139-155). Caribbean, The Australian National University.

Sasha, C. 2013. Copy of untitled Prezi; Juvenile Delinquency and Drug use. [O] Available at: http://prezi.com/f_rkhwdx9ygf/copy-of-untitled-prezi/ (Accessed 22/03/2014).

Sanders, S., Yarber, W., Kaufman, E., Crosby, R., Graham, C., and Milhausen, R. (2012). "Condom use errors and problems: a global view" in *Sexual Health*, 9(1):81-95.

Sarkar, N.N. (2008). Barriers to condom use. *The European Journal Centre and Reproductive Health Care* June 2008, 13(2):114-122.

Scott, S. (2009). *HIV/AIDS:* Understanding social-cultural factors and their influence on sexual behaviour and decision making in Africa. *Journal of the Montiba Anthropology students Association,* 28:89.

Selikow, T.A., Ahmed, N., Flisher, J., Matthews, C. & Mukoma, W. (2009). *A qualitative study of peer pressure and sexual risk behaviours amongst adolescents*. Cape Town: Medical Research Council.

Shisana, O., Rehle, T., Simba, L., Parker, L., Joosete, L., Pillay-van Wyk, V. et al, (2009). *South African National Survey.* Cape Town: HSRC Press

Silva, M. (2007). *Female adolescents' knowledge regarding implications of pregnancy in Bengo area - Angola.* Unpublished MA Health Studies dissertation. UNISA: Pretoria.

South Africa (Republic). Department of Basic Education. (2011). *Guidelines for the implementation of peer education programmes for learners in South Africa*. Pretoria: Department of Basic Education.

South Africa (Republic). Department of Education. (2007a). *Measures for prevention and management of learner pregnancy*. Pretoria: Department of Education.

South Africa (Republic). Department of Education. (2007b). *The HIV&AIDS and STI National Strategic Plan 2007*. Pretoria: Department of Education.

South Africa National AIDS Council (2006) *HIV & AIDS and STI Strategic Plan 2007-2011*. Pretoria: SANAC.

Struebert, H.J. & Carpenter, D.R. (2008). *Qualitative research in nursing*: *advancing the humanistic imperative*. 2nd ed. Lippincott: Philadelphia.

Taffel, R. (2005). *Breaking through to teens*. New York: Guilford Press.

Tarkang, E.E. (2009). Knowledge, attitudes and perceptions regarding HIV/AIDS and sexual behaviours Among senior secondary school learners in Kumba, Cameroon. Unpublished PhD Thesis: Pretoria:UNISA.

Terre Blanche, M., Durrheim, K and Painter, D. (2006). "Why Qualitative Research?" in Terre Terre Blanche, M, Durrheim, K and Painter, D (eds) *Research in Practice: Applied Methods for the Social Sciences,* 2nd edition. Cape Town: UCT Press: 272-284.

Tomlinson, C. (2013). The truth about the youth sexual behaviour and risks in South African youth. NSP Review. [O] Available at: Wwwnspreview.org/2013/06/11/the- truth-about – youth (Accessed on …)

UNAIDS Global AIDS Report, (2013). *UNAIDS report on the global AIDS epidemic 2013. Joint United Nations Programme on HIV/AIDS (UNAIDS*) [O] Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/unaids_global_report_2013_en.pdf (Accessed 14/04/2013).

UNAIDS. (2011). *World AIDS Day Report* [O] Available at http:// www.unaids.org/.../unaids/..../20121120_unaids_global_-_report_2012_wit. Accessed January 2012

UNAIDS,(2009).*UNAIDS guidance* n*ote on HIV and sex work*. www.unaids.org/../unaidspublication/2009/JC2306-unaids. (Accessed 12 September 2011).

UNAIDS (2008). Report on the global AIDS Epidemic 2008.Geneva.

UNAIDS .(2005). Factsheet: Africa. [O] Available at http://www.unaids.org (Accessed 2111/2005).

UNAIDS (2004). *Joint United Nation programme on HIV and AIDS 2004, report on the global AIDS epidemic*. Geneva: UNAIDS.

UNICEF. (2003). HIV/AIDS and young people; world youth report.http://www.unicef. org/aids/publications.htm. Accessed July29,211

UNICEF. (2002). *LifeSkills girls, HIV/AIDS and education*. Nairobi: UNICEF.

Van der Linder, I. (2013). *Plenary session – HIV/AIDS in South Africa*: *Unsafe sex, condom and Adolescents*. www.hsrc.ac. Za/… hiv- aids /Plenary-session3-20-june 2013. Accessed on 17 September 2013

Varga, C.A. (2000). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning*, 34(3):16-172.

Victor, C. & Starsbuger, M.D. (2010). Health effects of media on children and adolescents. *Paediatrics*, 125:756-75.

Welling, K., Collubein, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D. & Bojos, N. (2006) Sexual behaviour in context: a global perspective, in *Lancet* 368(9548):1706-28.

Whitely, B.E. (2010). The psychology of prejudice & discrimination. United States: Wadsworth Engages Learning.

WHO. (2002). *Adolescent friendly health services. An agenda for change*. Geneva: World Health Organization.

WHO. (2013). *Global health strategy of HIV/AIDS* 2011-2015: *Let us do what is right for everyone*. Geneva: World Health Organization.

APPENDICES

APPENDIX A

LETTER TO SCHOOL ADMINISTRATOR

Iris Street
Butterworth
4960
February2013

The Principal
XXX Senior Secondary School
DUTYWA
5000

Dear Sir

REQUEST TO CONDUCT A RESEARCH STUDY IN YOUR SCHOOL

I request your permission to conduct focus group interviews with a maximum of 12 selected learners in grades 10 and 11 in your school. I am currently registered with the University of South Africa for a Master's Degree of Art in Behavioural studies in HIV/AIDS. The title of the research is: **Exploring factors that influence condom use among high school teenagers aged between 16 and 18 years in Dutywa District, Eastern Cape, South Africa**

In order for me to complete the study I request authorisation from School Management Team. The study seeks to investigate factors that influence condom use among high school teenagers. My supervisor is Mrs Sinenhlanhla Ngwenya and the programme coordinator is Mr Leon Roets in the department of Sociology.

The name of the school will be kept confidential as codes will be assigned to a particular school e.g. High School X. Learners' names will not be used. Confidentiality and anonymity

will be maintained. The findings will assist in the improvement of existing prevention programmes and life orientation courses.

The data collectors have been trained in how to deal with issues that may cause psychological harm to the participants during the data collection.

Kind regards

Nomandla Mnyipika

Cell: +27 8209 10 527
Email: mnyips@webmail.co.za

APPENDIX B

Informed Consent Form for Participants to be signed by parents/guardians

I Mr/Ms (full name and surname in capital letters)

……accept participation in the research process with Nomandla Mnyipika an MA student in Social Behavioural studies in HIV and AIDS at UNISA.

I am aware that my participation in this project is entirely voluntary.

I am aware that I am free to withdraw from the project at any time without any problem;

I understand that my personal information including recordings and narratives will be kept confidential.

I understand that my true identity will not be divulged in the final project to ensure anonymity.

I understand that I will receive no payment or compensation from the study

Signature of applicant……

Signature of witness……

Date……

APPENDIX C

PARTICIPANTS' CONSENT FORM TEMPLATE

I agree to take part in the research study: Exploring Factors that Influence Condom Use among High School Teenagers in Dutywa District.

I have read and understand the study purpose as described. I understand that agreeing to take part means that:

I agree to be involved in a focus group.
I agree to allow the focus group discussion to be audio recorded
I understand that my participation is voluntary and that I can withdraw at any stage of the study without being penalised.
I understand that the research extracts from the focus group for use in reports or publishing findings will not under any circumstances identify names.

Signature :

Participant's name:

Date :

APPENDIX D

Research questions

Question 1

What are teenagers' **beliefs**, **attitudes**, and **perceptions** about condom use?

Sub-topics

1.What do you think about people using condoms?

2.How do you feel about using condoms?

3.Whose responsibility is it to get/buy condoms? (Why?)

Question 2

In your opinion, what could be the factors that contribute to risky sexual behaviour among teenagers in this area?

Question 3

What is your view of condoms as an HIV prevention strategy?