STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA

By

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DECLARATION

I do hereby declare that this research thesis entitled "**STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA"** is my own work. To the best of my knowledge, the thesis does not contain material which has been written by someone else except where due references are made. All sources are properly cited and documented. I further declare that this thesis, or any part of it, has not been submitted in the past or will be in the future, for degree purposes to any other institution. I declare that I submitted this thesis to originality checking software and that it falls within the accepted requirements for originality.

Pricilla Mudzana. S 27/01/2023

Date

DEDICATION

To God, the giver of life. I glorify you. Without you, where would I be? To my husband, Naison Gundidza, and my children, Shingie and Paidamoyo, you were my strength and reason to persevere.

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STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA

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ABSTRACT

The purpose of the study was to develop strategies to promote responsible sexual behaviour among school-going adolescents in the Mpumalanga Province of South Africa utilising a sequential explanatory mixed-method design.

The study was conducted in two phases. Phase I (quantitative) included 252 school-going adolescents from two high schools aged 15 to 19 years. A pre-tested self-administered questionnaire was utilised to collect data. The study explored the school-going adolescents' sexual behaviour patterns, sexual and reproductive health knowledge and information, attitudes towards responsible sexual behaviour, and utilisation of sexual and reproductive health services. Quantitative data were analysed using Statistical Package for Social Sciences (SSPS) version 20 software. According to Chi-square test results, the p-value of 0.562 suggested no statistically significant relationship between adolescents' gender and attitudes towards responsible sexual behaviours. However, there was a statistically significant association between adolescents' age and attitudes, and level of schooling and attitudes towards responsible sexual behaviours at a 5% significant ratio and a p-value of 0.000. There was another association between drinking alcohol and attitudes towards responsible behaviour (p-value 0.003 at a 5% significant level). The Chi-square test suggested acceptance of the existence of an association between getting drunk, getting drugged and casual sex and employing pregnancy prevention measures.

In Phase II, a nested sample of 14 school-going adolescents participated in two qualitative focus group discussions, and 30 key stakeholders participated in face-to-face interviews using interview schedules as data collecting tools. The phase explored the challenges adolescents face in maintaining responsible sexual behaviour and key stakeholders' views on adolescent sexual behaviours. Creswell's thematic data analysis approach was used to analyse the qualitative data. The findings revealed that though adolescents showed an excellent understanding of sexual responsibility, there was a high inclination to engage in risky sexual behaviours. Gaps in adolescents' knowledge of SRH and lack of open communication between adolescents' parents and partners put them at risk of sexual malpractice. Identified sources of information for SRH, such as religion, media, peers and significant others like teachers, health professionals and non-governmental organisations, played an important role in moulding adolescents' sexual behaviour, both positively and negatively.

The integrated results of Phase I and Phase II, together with literature control, were used to develop the proposed strategies to promote responsible sexual behaviour among school-going adolescents. These were validated by field experts.

The study supported evidence that there are challenges adolescents meet in their effort to maintain responsible sexual behaviours. Hence the proposed twelve strategies to promote responsible sexual behaviour among school-going adolescents.

KEYWORDS: Adolescence, high school-going adolescents; promotion, responsible sexual behaviour; risky sexual behaviour, sexual and reproductive health; sexual knowledge; stakeholders; strategies

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ABBREVIATIONS

CAPS	Curriculum and Assessment Policy Statement
CTOP	Choice of termination of pregnancy
CVI	Content Validity Index
HIV	Human Immunodeficiency Virus
MCH	Maternal and Child Health
NDP	National Development Plan
NGOs	Non-Governmental Organisations
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STATS SA	Statistics South Africa
STIs	Sexually Transmitted Illnesses
TPB	Theory of Planned Behaviour
WHO	World Health Organisation

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Adolescent development is a remarkable journey toward becoming an adult. As adolescents grow into adults, they may start to engage in sexual activities though some choose to abstain (Larsson, Bowers-Sword, Narvaez & Ugarte 2021:2). Unfortunately, a reliance on abstinence alone has proven ineffective as adolescents ultimately engage in sexual intercourse without being properly oriented to the reality of what this entails (WHO 2018:7; Obare & Kabiru 2018:1; Haberland & Rogow 2015: S20).

Sexual behaviour is a behaviour practised by a person to fulfil a sexual need. Adolescents engage in different sexual behaviours that are either risky (also known as high-risk sexual behaviour) or responsible (Machimana 2012:4). Responsible sexual behaviour is a safer way of practising sex, and anyone can practice safe sex regardless of whether the person was sexually active before. Responsible sexual behaviours include taking steps to prevent unwanted or unplanned pregnancies and contracting sexually transmitted illnesses (STIs) (Nkosi & Pretorius 2019:110).

Responsible sexual behaviour includes absolute abstinence, being well-informed about reproductive health, maintaining healthy relationships through good communication, supporting each other, maintaining equality and fairness, trust, honesty, mutual respect and spending quality time in a relationship, and consistent contraceptive use (Nkosi & Pretorious 2019:10; Odigwebu, Amoo & DeWet 2018:7; Nkhwashu & Mafukata 2015:1082; Machiyama, Casterline, Mumah, Huda, Obare, Odwe, Kabiru, Yeasmin, Cleland 2017: 4). Conversely, Chawla and Sarkar (2019:29) define high-risk sexual behaviour as:

> *"…a behaviour of initiation of sexual activity under different circumstances. This include but not limited to early age sexual debut and engaging in unprotected sex or unnatural (anal/oral sexual intercourse). Furthermore, inconsistent*

condom use; having sex with multiple partners whether protected or not; practicing irregular or transactional sex; or engaging in sex under and/ or with a drug user or a person under the influence of drugs (psychoactive substances) and alcohol. The risky sexual behaviour often results in STIs (including HIV/AIDS), unintended pregnancies or abortions, or interpersonal or legal conflicts".

Risky sexual behaviours are practised by some adolescents, since most engage in unprepared and unprotected experimental sex, often driven by sexual desire (Michielsen, Remes, Rugabo, Van Rossem & Tammerman 2014:54; Lam & Lefkowitz 2013:526). In a recent study of young people aged 15-24 in KwaZulu-Natal, Nkani and Bhana (2016:1) revealed that adolescents acknowledged the consequences of risky sexual behaviour but still reported engaging in dangerous sexual practices. Risky sexual behaviour exposes adolescents to unplanned pregnancies (sometimes accompanied by illegal abortions), STIs (including HIV coupled with poor adherence to antiretroviral therapy), dropping out of school, and long-term infertility and poverty (Marcell, Morgan, Sanders, Lunardi, Pilgrim, Jennings, Page, Loosier & Dittus 2017:404; Mpumalanga Provincial Aids Council 2017:24). These consequences may be overwhelming for an adolescent, leading to mental distress, depression and, at extremes, early death (Ngidi, Moyo, Zulu, Adam & Krishna 2016:99).

Risky sexual behaviours involve unprotected sex, multiple partners, reckless use of alcohol leading to bad decisions while intoxicated, non-use of contraceptives with irregular partners, and transactional sex (Nkosi & Pretorius 2019:110; Odigwebu et al. 2018:7; Nkani & Bhana 2016:1). SABC news online (2018) revealed that Mpumalanga Province's healthcare facilities recorded 5 609 pregnancies among adolescents in all three districts under its jurisdiction. This translated to a 78% increase in pregnancies in only one year, which was significantly higher among Blacks followed by Coloureds, while Indians and Whites had lower teenage pregnancy rates. Older adolescents aged 17-19 accounted for most adolescent fertility (SABC news online 2016; Statistics South Africa 2016: online).

In 2018, an estimated 12.2% HIV prevalence was reported among young South Africans. Currently, HIV infections are eight times higher among women in their

adolescent years than among men of the same age. Moreover, Mpumalanga Province has the highest rate of new HIV infections (WHO 2018:7; Mpumalanga Provincial Aids Council 2017:24; SALDRU 2016:4; Machiyama et al. 2017:5). There is thus a significant threat to the efforts by different stakeholders in South Africa in ensuring healthy, productive, economically active, socially sound and highly educated adolescents. Adolescents ultimately have to contribute to the fight for a decreased disease burden, which is extremely threatened by this population engaging in irresponsible sexual behaviour (Obare & Kabiru 2018:2; Nkani & Bhana 2016:4; Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Davids, Ramlagan, Mbelle, Van Zyl, Wabiri & Onoya 2014:42).

An adolescent's association with peers involved in deviant behaviour results in peer pressure and reliance on peers as sources of information related to sexual matters. This support system often drives adolescents to irresponsible sexual behaviours (Mpondo, Ruiter, Schaafsma, Van den Bourne & Reddy 2018:.45) Disrupted family structure or a lack of parental or family support further exposes adolescents to inadequate family relationships and poor socioeconomic status, influencing the early onset of adolescents' sexual activities. Inequitable access to education and healthcare services further contribute to irresponsible sexual behaviour (Mpondo et al. 2018:45).

However, different programmes meant to empower adolescents in South African schools and communities are in place. The issues covered include sexual and reproductive health (SRH), contraception and family planning, yet the programmes report a lack active participation from most adolescents (Hebert, Ramirez, Lee, North, Askari, West & Summer 2017:363; Nkani & Bhana 2016:4; Haberland & Rogow 2015:4). A concerted effort at individual, family and community level is thus needed to devise strategies that parents, teachers, school-going adolescents, and health personnel could collaboratively use to ensure that responsible sexual behaviours are promoted to end teen pregnancies and STIs (Pugh 2019:1).

1.2 STATEMENT OF THE RESEARCH PROBLEM

The promotion of responsible sexual behaviour in adolescence creates a bright future for adolescents. However, increased irresponsible behaviour among adolescents is a

significant problem in townships, especially in Mpumalanga Province. This province had one of the highest school pregnancy rates in 2014 (National Population unit 2014:32). Moreover, in 2015, an estimated 12.7% of the South African population was living with HIV; one-fifth were South African women in their reproductive years (15-45 years). Many orphaned adolescents are also HIV positive because of maternal infections, and not as a consequence of their own risky sexual behaviour. However, these individuals pose a risk to their partners if they decide to engage in sex without protection (Kidman & Anglewicz 2017:4).

An estimated three million girls aged 15-19 undergo unsafe abortions every year (Lokubal, Corcuera, Balil, Frischer, Kayemba, Kurinczuk, Opondo & Nair 2022:1). In low and middle-income countries, complications from pregnancy and childbirth are a leading cause of death among girls aged 15-19. Complications are also 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years. Infants of adolescent mothers are also more likely to have low birth weights (Sedgh, Finer, Bankole, Eilers & Singh 2015:227; Statistics South Africa 2018:14; WHO 2014a:1).

In addition, school dropouts are increasing, especially among pregnant girls, due to a lack of support from parents and teachers. Pregnant adolescents are unable to balance pregnancy, motherhood, and school, and while some may not drop out of school, their pregnancy can delay the completion of their schooling. Adolescent pregnancy also results in emotional stress for girls when divulging the situation to parents, and boys divulging they impregnated a girl (Nkosi & Pretorius 2019:110).

Moreover, despite widespread freely available contraceptives, dissemination of reproductive health education, progressive reproductive laws in South Africa, documentation of the devastating effects of teen pregnancy and STIs, and awareness campaigns run by public health and non-governmental organisations (NGOs), most adolescents still do not adhere to responsible sexual behaviours (Shisana et al. 2014:36; Nkani & Bhana 2016:1; Kembo 2013:151; Yager, Decker, Campa & Brindis 2017:398). It therefore continues to be a great concern for schools, families, healthcare facilities and communities on how to promote responsible sexual behaviour

among school-going adolescents. Hence, this study sought to develop strategies to effectively promote responsible sexual behaviours among school-going adolescents.

1.3 RESEARCH PURPOSE

The purpose of the study was to develop strategies to promote responsible sexual behaviours among school-going adolescents in Mpumalanga Province, South Africa.

1.4 RESEARCH OBJECTIVES

The study's objectives were:

- To explore and describe school-going adolescents' patterns of sexual behaviour.
- To determine school-going adolescents' knowledge and attitude towards responsible sexual behaviour.
- To explore the challenges school-going adolescents face in achieving responsible sexual behaviour.
- To explore and describe community members' viewpoints with regard to school-going adolescents' responsible sexual behaviour.
- To develop effective strategies to promote responsible sexual behaviour among school-going adolescents.

1.5 RESEARCH QUESTIONS

- What are school-going adolescents' patterns of sexual behaviour in Mpumalanga Province, South Africa?
- To what extent do school-going adolescents understand the concept of responsible sexual behaviour?
- To what extent do school-going adolescents practice responsible sexual behaviour?
- What are the challenges school-going adolescents encounter in achieving responsible sexual behaviour?

- What are community members' opinions regarding responsible sexual behaviour among school-going adolescents?
- What are the most effective strategies to promote responsible sexual behaviour among school-going adolescents?

1.6 THEORETICAL FOUNDATION OF THE STUDY

1.6.1 Research paradigm

A paradigm is a worldview and epistemological stance; it is a shared belief in a community of researchers, and a model example of research. The researcher used the pragmatic worldview as a paradigm for this study. Both the quantitative and qualitative research approaches were used to answer the research questions. Pragmatism is not confined to any one philosophy but promotes a pluralistic approach and reality; hence, the researcher chose the pragmatism worldview (Brink, van der Walt & van Rensburg 2018:19; Creswell 2014:9).

1.6.2 Theoretical framework

The theory of planned behaviour (TPB) guided the study by giving a frame of reference on which to base the study by linking beliefs to behaviour . The TPB suggests that a person makes a logical decision to engage in specific behaviours by evaluating the information available to them. The theory states that attitude, subjective norms, and perceived behavioural control – in combination – shape an individual's behavioural intention (Ajzen 1991:180). Figure 1.1 shows the constructs of the theory.

The theory was deemed fit to be applicable in this study to predict and explain the degree of school-going adolescents' intention to perform responsible sexual practices. The theory was also utilised to investigate these adolescents' beliefs towards responsible sexual behaviour. Behavioural attitude evaluated how favourable or unfavourable attitudes influenced responsible sexual behaviours to prevent unwanted pregnancies, HIV, and other sexually transmitted diseases (Hensel & O'Sullivan 2022:74). The subjective norms investigated the involvement of important or significant people responsible for adolescents' sexual behaviour. Subjective norms enlightened the researcher of the effects of a combination of social pressures or

expectations and actions enforced by important persons on adolescents' sexual responsibility and justified why school-going adolescents complied with these pressures and expectations imposed on them (Wilson, Jensen, Ballard & Taylor 2022:19)

An exploration of the school-going adolescents' attitudes towards certain sexual behaviours allowed the researcher to understand these adolescents' appraisal or interpretation of sexual behaviours in comparison to actual sexual practices.

Perceived behavioural control beliefs are the degree of control the adolescent has over the actual practice of sexual responsibility. It also includes adolescents' confidence that the consistent practice of sexual responsibility can be achieved (Wilson et al 2022:19).

The perceived behavioural control construct assisted the researcher in evaluating the school-going adolescents' willingness to practice responsible sexual behaviours, exploring the challenges they face in an effort to perform those sexual behaviours, and their self-confidence that they can perform the appropriate practices successfully; whether with ease or difficulty (Ajzen 2012:18). Chapter 2 explains the TPB in detail.

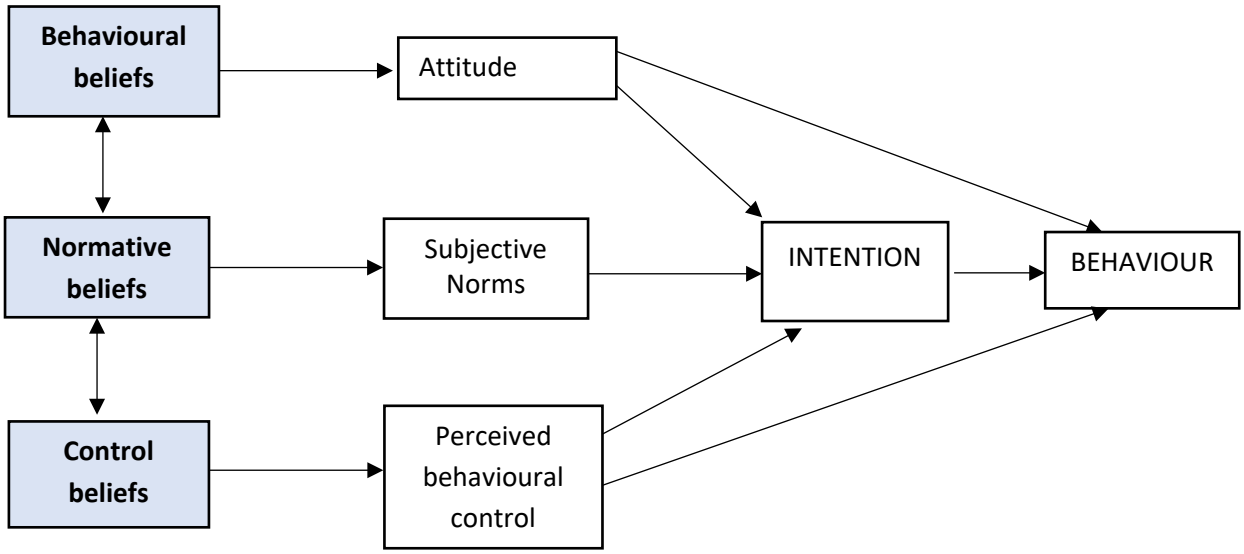

Figure 1.1: Theory of Planned Behaviour

Adapted from Ajzen (1991:182)

1.7 DEFINITION OF CONCEPTS

1.7.1 Adolescence

This is the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. Adolescence can be categorised as early adolescence from 10 to 13 years, middle adolescence from 14 to 16 years, and late adolescence from 17 to 19 years (WHO 2016:2). In this study's context, adolescence will mean middle and late adolescence.

1.7.2 Adolescents

Adolescents are individuals between the ages of 10 and 19; this covers the term 'child' adopted by the Convention on the Rights of the Child as a person under the age of 18 years (WHO 2014a:2). In this study, adolescents are boys and girls aged 15 to 19 attending high school in one of the townships of the Mpumalanga Province.

1.7.3 Behaviour

Behaviour is anything an individual does in response to internal or external events (Kwasnicka, Dombrowski, White & Sniehotta 2016:279). In this study, behaviour means the way an adolescent sexually conducts themselves.

1.7.4 Community

A community is a group of people with diverse characteristics linked by social ties. They share common perspectives and engage in joint actions in geographical locations or settings (Merriam-Webster Dictionary 2023:online). In this study, a community is a group of parents, teachers, and health professionals who deal with adolescents every day and play a vital role in the promotion of adolescents' responsible behaviour.

1.7.5 High school-going adolescents

It is defined as secondary school children or children attending an educational institution for the final grades of senior secondary school, which are grades 10, 11 and 12 (World Education Network: online). The term ‘school-going adolescents’ will be used in the study to mean children in grades 10, 11 and 12 aged 15 to 19. In this study, the term ‘adolescents’ will also refer to ‘school-going adolescents’, and both will be used interchangeably.

1.7.6 Promotion

Promotion is an activity that supports or actively encourages a cause, venture or aim. This is the process of enabling people to increase control over and improve their health (World Health Organization 2017:30). In this study, promotion means encouraging and enabling adolescents to practice control of their health through responsible sexual behaviours, and by means of social and environmental interventions, treatments and cures.

1.7.7 Responsible sexual behaviour

In this study, responsible sexual behaviour is understood as making informed decisions and safer sex choices, including abstinence, respecting one’s partner, having open communication about all forms of sexual activity, and taking precautions against unplanned pregnancy, and STIs, including HIV (Nkani & Bhana 2016:1).

1.7.8 Sexual behaviour

Sexual behaviour entails sexual activities/practices (Tagwirei 2014:11). In this study, sexual behaviour pertains to behavioural patterns that show the moral aspect of sexual involvement. It includes the number of sexual partners a person has at a point in time, the frequency of sexual intercourse, the rate at which sexual partners are changed, and the age at which an adolescent starts engaging in sexual activities in the townships of Mpumalanga Province.

1.7.9 Risky sexual behaviours

Entails behaviours that increase one's risk of contracting STIs like HIV and experiencing unintended pregnancies that are detrimental to adolescents' health (Vhembo 2013:7). In this study, risky sexual behaviour means sexual practices that adolescents engage in which expose them to STIs, falling pregnant and other consequences as a result of these.

1.7.10 Strategies

These are high-level plans to achieve one or more goals under conditions of uncertainty. It typically involves setting goals, determining actions to achieve the goals, and mobilising resources to execute the action (Cagney 2016:18). In this study, strategies mean plans and actions developed to achieve responsible sexual behaviour among adolescents.

1.8 OPERATIONAL DEFINITIONS

In this study's context, school-going adolescents' sexual behaviour pattern was the dependent variable. Key concepts involved the adolescence stage, sexuality, sexual responsibility, SRH experiences, attitudes towards responsible behaviour, and perceptions of the use of health services. The population were school-going adolescents who, in this study, were females and males aged 15-19 years attending high schools in the townships of Mpumalanga Province. Key stakeholders in the community were parents, teachers, and healthcare and NGO professionals. Sexual responsibility among school-going adolescents was the independent variable.

1.9 RESEARCH DESIGN AND METHODS

The researcher used the sequential explanatory mixed-method design to answer the research questions, considering each phase's requirements.

1.9.1 Research approach

Mixed-method research was used to answer the research questions of this study. Rubin and Babbie (2017:70) and Creswell and Plano Clark (2018:2) cited mixed-method research as “an inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks to understand a research problem more completely”.

1.9.2 Research design

A research design is defined as the overall approach to or outline of the research that shows all parts of the process; it is a blueprint that must be followed during the course of the study. These are procedures for collecting, interpreting and reporting data in research studies (Fouche, Strydom & Roestenburg 2021:157; Creswell & Plano Clark 2018:51; Houser 2015:14). Creswell and Plano Clark (2018:2) define mixed-method designs as “those that involve at least one quantitative method meant to collect numerical data and one qualitative method meant to collect words, with neither type of method inherently linked to any particular inquiry paradigm”.

The most fitting design for this study was the sequential explanatory mixed-method, which has two phases, as depicted in Figure 1.2. The researcher used the sequential explanatory mixed method to collect, analyse and combine quantitative and qualitative data during the research process. This design facilitated a better understanding of the research problem and promoted the development of appropriate strategies to promote school-going adolescents’ responsible sexual behaviour (Durand & Chantler 2014:163; Creswell 2014:2). A diagrammatic representation of the sequential explanatory mixed-method design follows in Figure 1.2. Chapter 3 also provides more information about this approach.

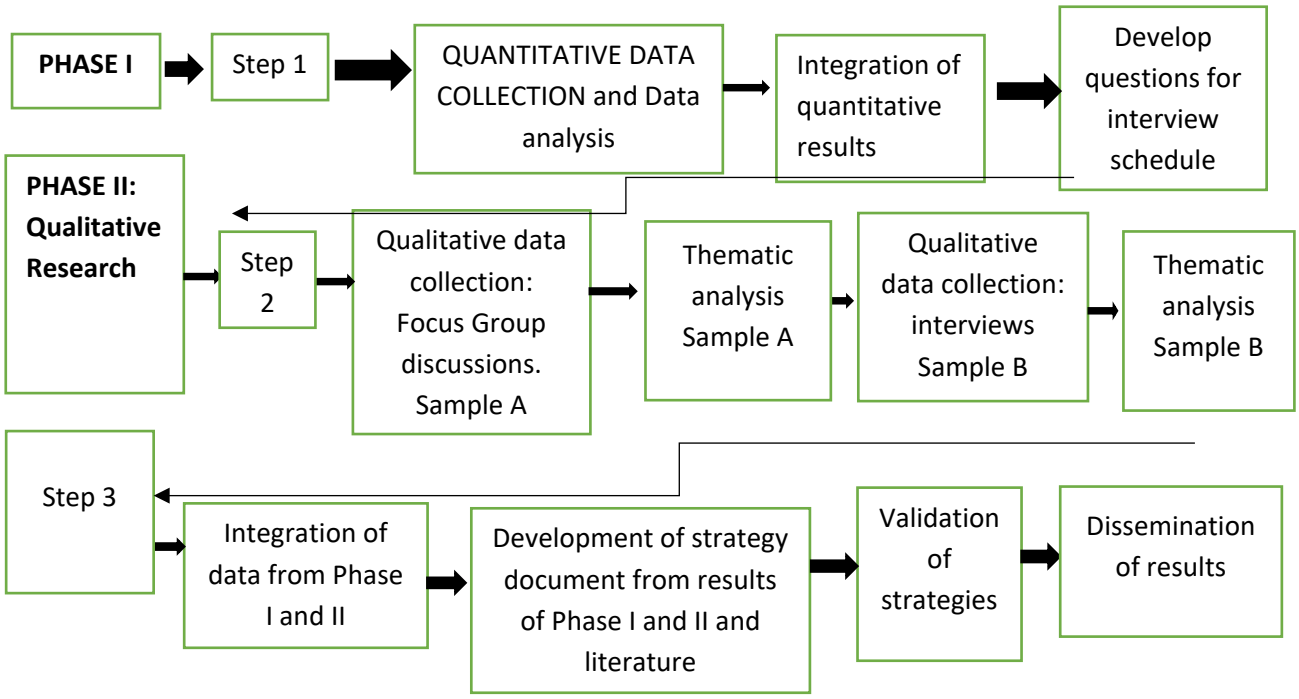

Figure 1.2: The sequential explanatory mixed-method study (adapted from Creswell and Plano Clark 2018:79)

1.9.2.1 Phase I

The researcher explored a few concepts in terms of patterns of sexual behaviours among school-going adolescents. This included current behaviours, sexual practices, and the experiences of school-going adolescents who were sexually active and those who had not engaged in sexual intercourse. Sources of SRH information and an evaluation of school-going adolescents' knowledge of SRH and certain attitudes towards sexual behaviours were explored. Graphs, Likert scales, and tables were used to depict the sexual behaviour patterns among school-going adolescents. Finally, the effects of adolescents' biographical profiles and behaviour patterns were explored.

1.9.2.2 Phase II

A qualitative study followed up on the quantitative findings obtained in Phase I, and this happened over two steps. The first step in Phase II involved interviews with a few adolescents who participated in the first phase and secondary key community members, namely parents, teachers, NGO and health professionals. The second

phase dug deeper into school-going adolescents' challenges in achieving responsible sexual behaviour by qualitatively exploring adolescents' and community members' views. The researcher performed a thematic analysis of the data gathered, and different themes emerged, as discussed in Chapter 4.

After the first step in Phase II, the second step focused on formulating a strategy document for use in promoting responsible sexual behaviour among school-going adolescents. The document was created when the researcher merged information from Phases I and II during a discussion of the results. Different experts validated the strategy document.

1.9.3 Data quality control

The researcher maintained the quality of data in various ways. The questionnaire was reliable and valid to maintain data quality. The researcher's approaches to maintaining validity, reliability and trustworthiness are explained in Chapter 3.

1.9.3.1 Validity in Phase I

A data collection instrument is used as a means for producing quantitative and qualitative data for analysis and interpretation (Fouche et al. 2021:207; Creswell & Plano Clark 2018:195). Phase I utilised a questionnaire to collect data, and the researcher had to ensure it was valid and reliable in order to measure the adequacy and accuracy of the concepts being measured in a consistent manner (Fouche et al. 2021:200-2010)

Construct validity refers to the extent to which a measure adequately represents the underlying construct it is supposed to measure (Fouche et al. 2021:203; Creswell & Poth 2018:256). The questionnaire effectively measured the patterns of sexual responsibility among adolescents. **Conclusion validity** is the degree to which the conclusions reached in the study are reasonable. This was the most important type of validity because it was relevant in helping the researcher decide if there was a relationship in the observations (Creswell & Poth 2018:256).

1.9.3.2 Reliability in Phase I

Reliability is the degree to which the measure of a construct is consistent or dependable, and it is a method free from measurement error (Fouché et al. 2021:200; Creswell & Poth 2018:264; Gray, Grove & Sutherland 2017:371). The modified questionnaire that was used extracted and modified questions from a known tool designed and tested by the World Health Organisation (WHO) for interviewing adolescents. The questionnaire underwent a test-retest reliability check before the study commenced, and the WHO questionnaire, where the questions for the study were extracted, is extensively used in other studies; this increased the study's reliability. During the study, the results from the first phase were further scrutinised in the second phase using a qualitative approach to better understand the concept of 'sexual responsibility among adolescents.

1.9.3.3 Trustworthiness

This was a concern in Phase II, where qualitative research took place. The researcher took steps to ensure transferability, credibility, dependability, and confirmability (Fouché et al. 2021:393; Singh 2013:2010). The researcher prepared an open interview guide based on the findings from Phase I and information extracted from an extensive literature review. The researcher pre-tested the interview guide with participants with the same experiences and interests. The findings from the pre-test enriched the interview guide to ensure in-depth key informant interviews were conducted.

Prolonged engagement also assisted in ensuring trustworthiness. The researcher was immensely engaged in the interview guide's preparation, data collection, analysis and write-up. Member checking was also conducted to evaluate the credibility of the research findings. This was accomplished by sending the transcribed data to the participants for them to check if the transcribed data were accurate, and if it had the same meaning participants intended. The researcher incorporated participants' input by making corrections to the document (Gray et al. 2017:370).

1.9.3.4 Data management and analysis

Data analysis involved analysing quantitative data using SSPS version 20 software, and analysing the qualitative data using thematic analysis (Fouché et al. 2021:434).

During Phase I, the researcher checked the collected data for consistency and completeness, thus cleaning the data before feeding it into the system. Descriptive analysis allowed the researcher to present the results in the form of tables, frequencies, means and standard deviations.

Phase II of the study consisted of a transcription of the interview data. The researcher immersed herself in the data by listening to the audio recordings, reading and re-reading the transcript to clean the data, and identifying codes' characteristics. The researcher effectively reduced the data by sorting codes into themes and patterns. The qualitative research findings in Phase II were thus presented using different themes, categories and sub-categories.

The integration or mixing of the analysed data resulted in an interpretation of findings where inferences were made based on the collected quantitative and qualitative data from Phase I and Phase II. Both deductive and inductive reasoning were applied to draw conclusions. Common findings from both phases were interpreted and supported by relevant literature.

The final step involved the development of a final strategy document based on the inputs from the first and second phases of the study, and the strategies were validated by different stakeholders (Fouche et al. 2021:431; Creswell & Plano Clark 2018:83).

1.10 ETHICAL CONSIDERATIONS

Research ethics involves planning, conducting, and reporting research and protecting human and animal subjects. The researcher applied for ethical approval from the Research Ethics Committee of the University of South Africa, Department of Health Studies (Annexure D). The researcher also received a support letter from the Mpumalanga Department of Health (Annexure C) before data collection commenced.

Completed questionnaires and scripts are kept in a locked cupboard to maintain confidentiality. In addition, participants were identified through numerical codes instead of using their actual names, thereby protecting them from disclosure to unauthorised persons to maintain anonymity and confidentiality. Confidentiality was ensured throughout their participation, and informed consent was used to reflect participants' willingness to participate in the study. Each participant willingly signed the consent form before data collection began. Participants were assured they could withdraw their participation despite consenting at any time (Gray et al. 2017:161-184).

1.11 SIGNIFICANCE OF THE STUDY

Policymakers and various stakeholders may incorporate the developed strategies in preventive and health promotion programmes for adolescent health. They can thereby promote healthy sexual behaviours among adolescents and equip parents and guardians with information on preventive care and health promotion to ensure adolescents' sexual health.

1.12 SCOPE OF THE STUDY

The researcher conducted the study with school-going adolescents aged 15-19 years, parents, teachers, healthcare and NGO professionals in one of the townships of Mpumalanga Province. Middle and late adolescents participated in the study because this period is when most adolescents start to engage in sex, and they are mature enough to give useful information. This research established strategies to promote responsible sexual behaviour. Evaluating the effectiveness of these strategies is not the aim of this study, and follow-up research to evaluate the strategies is encouraged. It is the researcher's hope that the outcome of this study will increase awareness of how to promote adolescents' responsible sexual behaviour.

1.13 STRUCTURE OF THE THESIS

The study has eight chapters:

Chapter 1: Orientation to the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Data analysis, presentation and discussion of findings for Phase I

Chapter 5: Data analysis, presentation, discussion and literature control of Phase II's findings

Chapter 6: Discussion of the integrated data from Phases I and II

Chapter 7: The development and validation of strategies to promote responsible sexual behaviour among school-going adolescents

Chapter 8: Conclusions, recommendations and limitations

1.14 SUMMARY

Chapter 1 presented the background of the research problem, the purpose, objectives, the research questions, the research methodology and theory that guided the researcher, and definitions of terms. This is the blueprint of the thesis. Chapter 2 discusses the literature review in detail.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a systematic process of identifying, scrutinising and summarising written information about a specific research problem often prepared to put a research problem into context (Fouché et al. 2021:94; Polit & Beck 2017:733). The literature review is not a mere explanation of what other authors have said, but a thorough discussion that highlights insight and awareness of different arguments, approaches and theories related to the topic. This chapter focuses on an assessment and review of available literature on adolescents' sexual responsibility.

The researcher used Google Scholar, PubMed Central, Elsevier and Unisa library e-journals and repository databases. Information sources such as Statistics South Africa, conference reports on adolescents, and institutional websites (such as WHO websites) provided important literature for this study. The researcher thus consulted various sources of information, such as hardcopies and e-books, mid-year statistical releases, online journals, media news, and international and government policies and guidelines.

Data search strategies employed different key concepts related to the study to review available literature on adolescence, sexuality, adolescents' sexual behaviour and sexual behaviour patterns. Key concepts assisted the researcher in understanding what others were saying about this topic, which led to the minimisation of duplication on the topic. The literature review increased the chances of the researcher coming up with additional information on the topic (Polit & Beck 2017:88; du Plooy-Cilliers, Davis & Bezuidenhout 2014:101; Antonius 2013:36).

2.2 ADOLESCENCE

Adolescence is the period between childhood and adulthood when girls and boys aged 10 to 19 go through physical, emotional and social development (Larsson et al. 2021:2:

Beksinska, Pillay, Milford & Smit 2014:676). Adolescence is characterised by rapid growth and changes, and has three different phases classified according to age group, namely early adolescence starting from 10-13 years, middle adolescence from 14-16 years, and late adolescence from 17-19 years (Fasakin 2017:1; WHO 2016:2; Statistics South Africa (STATS SA) 2018:xiii).

According to UNICEF data from April 2022, there were 1.3 billion adolescents worldwide, making up 16% of the world's population. However, the Convention on the Rights of Children claims adolescents remain vulnerable in many respects, including sexual health.

According to STATS SA (2018:x), adolescents constituted 18.5% of the population in South Africa in 2018. Most adolescents are among the Black African (19.3%) and Coloured (18%) population groups. The Indian/Asian and White (12%) population groups constituted the lowest proportion of adolescents in the country. The population of adolescents aged 15-19 years in Mpumalanga Province in 2019 was estimated at 386 635. Males constituted 193 457 of the total adolescent population, while females amounted to 386 635 (STATS SA 2019:16; Mpumalanga Provincial Aids Council 2017:24).

The sexual needs of adolescents are frequently neglected and unaddressed at all stages of adolescence, leading to sexual irresponsibility among this group (UNICEF 2022: online). According to UNICEF (2021: online), 17% of the total population are adolescents, and many adolescents have planned pregnancies resulting in high birth rates among this group, especially in sub-Saharan Africa and South Africa. The United Nations (2020:15-18) suggested that falling pregnant and giving birth during adolescence is related to higher total fertility in adulthood, leading to higher annual population growth in the country.

The WHO (2014:1) proposed, "Adolescence as a time or opportunity during which different performances prepare a healthy adulthood". However, for many adolescents, irresponsible sexual behaviours predispose them to negative socioeconomic and health outcomes such as HIV/AIDS and infertility due to complications of untreated

STIs, illegal abortions, and early childbirth (Todhunter, Hogan-Roy & Pressman 2022:98)

2.2.1 Statistics of adolescents

The total population of school-going adolescents in grades 10, 11, and 12 in the township where this research was conducted was 1 997. A biographical profile of the adolescents in 2016 revealed that 74.4% had both parents alive, 8.7% had one parent alive, and 4% of adolescents were orphans. Overall, 52.3% of adolescents stayed with both parents, with the father as the head of the house, 28.2% stayed with one parent with the mother as head of the household, and 19% of adolescents stayed with guardians as the head of the household (Mpumalanga Provincial Aids Council. 2017.5).

The Statistics South Africa (2018:20), suggested that in 2016 adolescents made up 18.5% of the total population in South Africa. The majority of adolescents were from Black African (19.3%) and Coloured (18%) population groups. The Indian/Asian group was represented by 14% of adolescents, and 12% were Whites, constituting a minority group. Adolescents were also more likely to reside in rural areas (22.5%) than in urban areas (16.2%) (STATS SA 2018:20).

2.2.2 Sexuality characteristics during adolescence

The transition into adolescence contributes to behaviour changes, specifically in terms of decisions to engage in irresponsible sexual behaviours. Adolescents start to explore and experience sexual-related feelings, increased sexual interests, and place greater importance on matters of sexuality (Muanda et al. 2018:7).

2.2.2.1 Early adolescence

Globally, when early adolescents start to see changes in their bodies, attraction to the opposite or same sex ensues. At this stage, adolescents fantasise about dating and sex. Kissing, flirting, masturbation, or having sex characterise adolescents' sexual development at this stage (Netshikweta, Olaniyi & Tshitangano 2018:323).

Early adolescence is when boys and girls reach puberty, grow aware of their bodies, their own sexuality, and their sexual behaviour changes because they go through interrelated physical, psychological, and sociological development processes. However, many adolescents at this stage randomly engage in unplanned sexual intercourse, characterised by the consequences of irresponsible sexual behaviours, such as unplanned pregnancies, HIV infection and other STIs (Beksinska, Closson, Smit, Dietrich, Hornschuh, Smith, Nduna, Brockman, Ndung'u, Gray & Kaida 2021:6; Netshikweta et al. 2018:323).

2.2.2.2 Middle adolescence

According to Michielsen et al. (2014:57), most adolescents have their first sexual experience between the ages 14-16 years. At this stage, some adolescents start to make decisions regarding sex as their reasoning capacities increase, while others who had already initialised sex in early adolescence continue the behaviour (Netshikweta et al. 2018:323). Planning for the future starts at this stage, and adolescents experience further holistic growth; that is, physically, mentally and socially.

While boys and girls mature, a further exploration of their sexual identity happens, and they start to form friendships and relationships. Middle adolescents spend less time with their parents and more time with friends. Moreover, adolescents have a strong urge to belong to a social group. During middle adolescence, what the social group says about sexual issues is more important than what their parents say. This contributes to adolescents sharing incorrect information and fatal omissions regarding sexual behaviours (Fasakin 2017:126).

Unfortunately, many adolescents not taking cognisance of their sexual responsibility and practising safer sex suffer negative consequences. New attitudes and trends experienced in middle adolescent's sexual life potentially shape some sexual patterns and behaviours that follow adolescents into adulthood. These patterns and behaviours often continue throughout the person's life, either positively or negatively. In simpler terms, behaviours adopted in middle adolescence are likely to continue into adulthood (Fasakin 2017:126).

It is also noteworthy that when adolescents have sexual intercourse for the first time and consecutively, the experience is rooted in individual, relational and societal aspects. Individual aspects, such as an underlying succession of hormones and life changes, contribute to whether adolescents participate in responsible or irresponsible sexual behaviours. As a result, some adolescents engage in deliberate and planned sexual acts while others are affected by attributes such as sexual coercion (Taukeni & Feirreira 2016:1; Ajzen 2012:18).

2.2.2.3 Late adolescence

Larsson et al. (2022:3) say adolescents have generally completed physical development and have grown to a full adult height by late adolescence. Self-perception drives a late adolescent into a specific pattern of sexual behaviour. For instance, adolescents who engage in responsible sexual behaviour fear destroying their own future, which accelerates the acquisition of knowledge and use of protective measures. Late adolescents have the capability to make independent decisions, have stable interests, greater emotional abilities, can think things through and express ideas in words (University of Minnesota SAHRC 2021:1-2).

2.3 SEXUALITY AMONG ADOLESCENTS

According to the WHO fact sheet of the 15 September (WHO, 2022), as of 2019, adolescents in low-and middle income countries had estimated 21 million pregnancies each year, of which approximately 50% were unintended and resulted in 12 million births. An estimated three million girls undergo unsafe abortions every year globally and South Africa is not spared either. Complications related to pregnancy and childbirth are a leading cause of death among 15-19-year-olds. Stillbirths, new-born deaths, and low birth weights are characteristics of adolescent pregnancies (WHO 2022; Baron, Subedar, Letsoko, Makua & Pillay 2022:253).

Moreover, there is a widespread lack of constructive sex education globally and in South Africa (Ngabaza & Shefer 2019:422). The fact sheet (WHO 2022) emphasised sexuality education disparities in low and middle-income countries in terms of comprehensive and correct knowledge on how to behave sexually responsible.

2.3.1 Types of sexual experiences

A person can engage in sex alone or with other people. Sexual intercourse is an example of sexual behaviours involving penetration between partners, such as vaginal-penile, oral and anal sexual intercourse.

2.3.2 Sexual behaviours during adolescence

Sexual behaviours are the manners or conduct through which individuals experience and express their sexuality. Sexual intercourse is an example of sexual behaviours involving penetration between partners, such as vaginal-penile, oral and anal sexual intercourse (Polit & Beck 2017:88).

Sexual behaviour among adolescents can be responsible or risky (Chawlar & Sakar 2019:30). Sexual responsibility has long been the cornerstone for a healthy sexual and reproductive adolescent. Sexual responsibility involves safer sex practices, such as engaging in healthy relationships, using condoms, contraceptives or practising abstinence, and knowing one's HIV status. Unfortunately, negative sexual experiences during adolescence in most circumstances come with undesirable consequences, such as unwanted pregnancies and STIs, including HIV/AIDS. (Chawlar & Sakar 2019:30) Cognitive immaturity during adolescence is the leading cause for adolescents not practising responsible sexual behaviours because they lack self-control, have delayed gratification, and have no experience in assessing certain risks associated with their sexuality. As a result, adolescents fail to make sound decisions related to the different sexual behaviours in which they engage.

2.3.3 Types of sexual relationships during adolescence

According to Larsson et al. (2021:3), adolescents engage in different types of relationships, irrespective of their stage of adolescence. Experimental and transactional relationships are more common among adolescents, and result in sexual behaviours that are responsible or risky (Bogner, Hadley,Franz, Barker, Houck 2023:516; Vhembo 2013:4). According to Lubinga, Maes and Jansen (2016:77), a person who has a supportive and knowledgeable partner who can read and

understand sexual messages are better off than a person with a partner who does not comprehend sexual messages.

- **Experimental sexual relationship**

An experimental sexual relationship involves adolescents' entering into sexual relationships out of curiosity and the need to experiment and learn about sex (Jansen 2021:43). Male adolescents are often more curious and have a greater desire to have sexual intercourse than female adolescents. Moreover, the effects of high hormonal levels and the desire for love often contribute to the initiation of sex among adolescents (Larsson et al. 2021:3). Some adolescents plan sexual engagement while, for others, sex comes randomly. However, a study conducted in Rwanda among adolescents refuted whether planned sex occurred responsibly or irresponsibly. The study instead revealed that during adolescence, adolescents engage in experimental sex, which takes place unprepared between two young people driven by sexual desire (Ali, Merdad & Bellizzi 2021:5).

- **Transactional sexual relationship**

Esan and Bayajidda (2021:4) revealed that some adolescents initiate sex because they want to get money to take care of their needs, which their parents fail to do. In many underprivileged communities, especially townships, many parents and adolescents have accepted their poor socioeconomic status influences the early onset of transactional sexual activity among adolescents. Hence, there is insufficient efforts to stop this toxic normalisation. Transactional sex is now a norm in most countries, including South Africa, where persons can engage in sex after paying for the service in monetary terms or with gifts. Many people are involved in this act without even noticing that it is transactional sex. This behaviour has a negative impact on the sexual responsibility of an adolescent.

- **Coerced sex**

There is evidence that in certain situations, adolescents may be unable to refuse sex (WHO 2014:2). In South Africa, gender-based violence against women and girls is rife in different provinces. Hence, most first sexual encounters are forced in these areas. This has a negative impact on the adolescents' ensuing sexual behaviours, such as

engaging in unprotected sexual intercourse with other men (Smith, Jacob, Lopez-Sanchez, Grabovac, Yang, Pizzol, Sigman, McDermott & Koyanagi 2022:1285).

- **Casual sexual relationships**

According to Dube, Lavoie, Blais and Hebert (2017:1066), many adolescents engage in casual sex at an early age and this has negative psychological impact on some of them such as depression if they are dumped or betrayed by a casual partner.

2.4 FACTORS AFFECTING ADOLESCENT SEXUAL BEHAVIOUR

Certain factors impact whether adolescents practice responsible or irresponsible sexual behaviour. The likelihood of adolescent engaging in responsible sexual behaviour in a relationship is dependent on many factors, namely the strength of the intention to engage in responsible sexual behaviour, their understanding of sexual health information, and their needs (Lubinga et al. 2016:77).

The perception among adolescents and the community towards responsible sexual behaviour can be positive or negative, resulting in the inhibition or promotion of responsible sexual behaviour. Good attitudes towards life can also influence the practice of responsible sexual behaviours by an adolescent. Positive attitudes allow adolescents to focus on a successful future and their ultimate well-being (Borneskog, Haggstrom-Nordin, Stenhammar, Tyden & Iliadis 2021:5; Mokwena & Morabe 2016:83).

- **Peer pressure**

Most sexual experiences in adolescents a result of peer influence and boys are more influenced by per pressure. However, not all adolescents are equally vulnerable to peer pressure (Widman, Chouka-Bradley, Helms & Prinstein 2016:323). A study in Nigeria concurred, and parents acknowledged that peers encouraged adolescents' early sexual debut. These peers may also be playing the role of an absent parent (Esan & Bayajidda 2021:3). Parents were of the opinion that most peers influence each other to misbehave sexually for the wrong reasons. Some adolescents also engage in promiscuous behaviour in exchange for money. This money is used for

adolescents' upkeep, such as buying expensive clothes and jewellery, which their parents cannot afford to buy them. However, not all adolescents engage in sex for the sake of money; some do so for fun (Adegboyega, Ayola & Muhammed 2019:55; Widman et al. 2016:323).

According to Jansen (2021:43), adolescents often try new things due to peer pressure. This sometimes leads to a loss of contact with parents, which could also contribute to poor decision-making. However, with proper peer support, adolescents are buffered from the risk of substance abuse such as alcohol, drugs and marijuana, which predispose them to high-risk sexual behaviours.

- **Incomprehensible sexuality messages on the media**

According to Lubinga et al. (2016:77), sometimes an adolescent can come across an important message, for example, on a poster. The person may read and think that they comprehend the message when they are actually confused. This happens with health education messages on sexuality that adolescents come across in the media or other sources. Sometimes, adolescents do not fully understand the intended message, leaving them with knowledge gaps or wrong ideas, predisposing them to risky sexual behaviours. Lubinga et al. (2016:78) noted that it is particularly risky when both partners are not knowledgeable and misinterpret health information messages. Misinterpretations of the message may also reinforce negative beliefs, which may be harmful to the acceptance and practice of responsible sexual behaviour.

- **Relational factors**

According to Michielsen et al. (2014:57), at the relational level, family experiences affect adolescents' sexual responsibility at any level of their development. Parents and immediate family members play a significant role in raising a sexually responsible child. Adolescents need to learn from credible SRH sources like parents who provide credible or expert information on appropriate sexual behaviours (Esan & Bayajidda 2021:3).

In return, adolescents must listen to their parents and respect their teachings to equip themselves with knowledge regarding responsible sexual behaviours. Information

from a parent often gives adolescents confidence in engaging in responsible sexual behaviour (Nkosi & Pretorius 2019:109; Marcell et al. 2017:408).

In Fasakin's (2017:126) study, adolescents confirmed the most trusted sources of SRH information were immediate family because they have the best interests of the adolescent in mind.

- **Parent as educator, guide, information disseminator**

Adolescents regard parents (specifically mothers) as a major source of knowledge dissemination, leading to healthy SRH behaviours (Fasakin 2017:114). According to Duby, Verwoerd, Isaksen, Jonas, Maruping, Dietrich, Lovette, Kuo and Mathews (2022:12) parents have a significant role in adolescents' sexual health. They are a cornerstone in the performance of responsible sexual behaviour by adolescents, from their first sexual encounter and thereafter. Adolescents regard their parents (mothers, in particular) as a major influence of knowledge dissemination, leading to healthy SRH behaviours. Parents are particularly responsible for initial sexual education. Mothers are deemed fundamental sources of information, more than friends, religious leaders, teachers, sex educators, or the media and internet. These sources are good sources of information as they engage in personal interactions with adolescents, which normally yields in-depth understanding (Esan & Bayajidda 2021:3).

However, there is a need for programmes to strengthen parenting skills in this area (Embelton, Nyandat, Ayuku, Sang, Kamanda, Ayaya, Nyandiko, Gisore, Vreeman, Atwoli, Galarraga, Ott & Braitstein 2017:423; Marcell et al. 2017:408). According to Esan and Bayajidda (2021:3), many parents understand their adolescents' sexual and reproductive health needs. They also possess knowledge of the factors that influence adolescents' early initiation of sex because they were adolescents themselves. However, few consider sex education as one of the most critical sources of information on sexual responsibility available to adolescents.

- **Parents as supporters of adolescent sexual behaviour**

Ideally, parents should support adolescents in realising the importance of responsible sexual behaviour. According to Marcell et al. (2017:405), mothers usually book

appointments with healthcare providers in connection with the adolescent's sexual and reproductive health needs. However, a majority of parents still disapprove of some responsible sexual practices like contraceptive use by adolescents. Without parental support and involvement, adolescents engage in risky sexual behaviour unknowingly, and this may lead to their reliance on peers as sources of information and support (Hebert, Ramirez, Lee, North, Askari, West & Summer 2017:363; Nkani & Bhana 2016:4).

- **Parent as communicator**

Past studies revealed poor communication between mothers and adolescent daughters, with regard to responsible sexual education, despite sharing a good relationship (Agdeve, Fiaveh & Ocrah 2022:559; Duby et al. 2022:11).

For instance, most mothers who participated in a prior study had no idea whether their daughters were sexually active. Instead, they expressed the hope that their daughters were still virgins. On the other hand, 68.5% of adolescent participants felt communication with their mothers with regard to issues of reproductive health and responsible sexual behaviour was poor. Most parents therefore merely 'hoped' for adolescents' purity without playing an active role in their child's sex life. However, a study by Born, Wolvaardt and McIntosh (2015:509) revealed that 62% of adolescents felt comfortable discussing sex-related issues with their parents.

Wilson, Jensen, Ballard and Taylor (2022:34) concluded that positive and clear communication between adolescents and parents about sexuality lowers sexual risk-taking. Parents' teachings also promote adolescents' healthy communication patterns with intimate partners, thereby promoting sex satisfaction.

- **Parents as counsellors**

Parents are adolescents' first line of counselling about sex and its risks. Hence, there is a need to sit down with adolescents and discuss sexual issues in a non-threatening environment; otherwise, adolescents will leave the conversation (Esan & Bayajidda 2021:4).

- **Hindrances to parent-adolescent communication**

Gaps between adolescent and parent relationships may hinder parent-adolescent SRH communication and influence openness, trust, cordiality, and rapport. The relationship quality between parent and adolescent may determine how the adolescent conducts themselves sexually and their level of secrecy regarding any form of risky sexual behaviour (Agbeve et al 2022: 562: Fasakin 2017:126).

Parents' inability to develop a close relationship with their adolescents leads to secrets regarding sex-related matters. Most parents know this, and some relationships fail when adolescents choose to keep quiet even though they are suffering the consequences of irresponsible sexual behaviour caused by alcohol and drug use, as well as smoking (Jansen 2021:43; Esan & Bayajidda 2012:5).

Evidence shows that it is difficult for parents to discuss sex-related matters for different reasons: norms and religious doctrines hinder many parents' discussions on sexual issues with their children, despite parents knowing their adolescents are initiating sex at an early age. Most parents also do not involve themselves in their children's sexual education for cultural reasons, as it is taboo for some to discuss sexuality with children (Agbeve et al. 2022:562; Duby et al. 2022:12).

However, other parents and adolescents feel that early childbearing has been a norm historically and they do not think it is a significant topic and these parents got pregnant when they were young. This explains the high incidences of risky sexual behaviours among adolescents in the study area, resulting in teen pregnancy, STIs, and illegal abortions, among others (Duby et al 2022:12). The challenges emanate from a lack of parental involvement and ignorance, especially among mothers on issues of their daughters' and sons' sexuality (Begun, Barman-Adhikari, Greenblatt, Sahajpal, Campbell, Cooke & Rice 2023:541; Marcell et al. 2017).

Gillespie, Balen, Allen, Soma-Pillay and Anuma (2022:1018) pointed out that parents tend to blame the government for disseminating sex education through Life Orientation in formal schools, exposing children to too much information, which is undesirable. Some parents believe sexual education in schools may promote immorality in children

because children will learn ‘adult things’ before it is appropriate. Hence, they are resistant or hesitant to discuss sex-related issues with children.

Though these parents want to teach their children, they want to do it when they feel the child is ready. However, the question is, how soon is too soon? Evidence indicates that it is often too late for parents to teach their adolescents about responsible sexual behaviours in their own time because the child is ahead of them from lessons learnt at school or already engaging in sexual intercourse. Hence, there is evidence of mixed feelings on sexual education in schools among parents (Pulerwitz, Blum, Cislaghi, Costenbader, Harper, Heise, Kohli & Lundgren 2019: 8). This view is in contrast with Nigerian parents’ beliefs, where parents acknowledge that their children initiate sex at an early stage, hence the need to take action early, prompting adolescents to speak openly about sex as it does not corrupt them or undermine traditional practices; rather, it promotes sexual responsibility (Esan & Bayajidda 2021:3).

Adolescents may also fear punishment from parents if they speak about sex, while parents fear discussing sex with adolescents because they fear directing their adolescents into sexual experimentation (Fasakin 2017:117). The other challenge is that most parents are absent in their adolescent’s sex life. A lack of proper parental guidance results in adolescents involving themselves in and performing adverse social acts, such as using drugs and engaging in unprotected sex with the non-use of contraceptives and illegal termination of pregnancies (Esan & Bayajidda 2021:3).

The absence of parents in an adolescent’s sexuality has been an issue for decades in most South African, and African countries, like Nigeria. This absence of a parent may predispose adolescents to irresponsible sexual behaviours, such as immature involvement in sexual relationships, substance and alcohol abuse, and absenteeism from school that affect their reasoning capacity (Fasakin 2017:117; Esan & Bayajidda 2021:3).

Parents (especially mothers) also often face challenges in discussing sexual responsibility with adolescents for personal reasons, such as considerations of age (feeling that the child is too young to understand such issues of sexuality). In the same vein, adolescents have constrained relationships with parents because of the age

difference, where adolescents feel their parents think that they are still too young to have sex-related discussions. Furthermore, evidence points out that parents and adolescents have conflicting ideas based on modern or traditional norms, thus constraining their relationship (Duby et al. 2022:12).

However, not all parents support late initiation of sex-related discussions; some are of the opinion that discussions among parents, adolescents and schools should start early to prevent sexual risks (Fasakin 2017:119). Parents must also act as a buffer against the risk of substance use, which puts adolescents at risk for high-risk sexual behaviour in low socioeconomic environments (Jansen 2021:43).

According to Duby et al. (2022:12), the tone and communication strategy that the parent uses when having a sex-related discussion with an adolescent determine the fruitfulness of the discussion. Moreover, the role of extended family members in promoting responsible sexual behaviour is very significant. Gender differences ultimately determine the quality of discussions about sex-related matters, where females prefer receiving sexual information from female figures like mothers, sisters and aunts, while males prefer male figures like fathers and uncles (Fasakin 2017:118; Gillespie et al. 2022:1019).

- **Social factors**

Certain social factors guide adolescents in their sexual adventures. Perceived control measures dictate whether an adolescent will perform sexual acts responsibly or in a risky way. Sexual double standards are a set of rules holding adolescent boys and girls to different standards. These norms restrain sexual autonomy and expose adolescents (especially girls) to high-risk behaviours (Ali, Merdad & Bellizi 2021:5).

Community environments and the world influence adolescents' sexual behaviour. Socio-cultural determinants, such as changes in social support and experience, perceptions among peers, and social constructs also affect the adolescent's decision whether to practice responsible or risky sexual behaviour (Jansen 2021:43; Larsson et al. 2022:3).

In the same vein, there is ongoing confusion in the social and public health arena in South Africa concerning irresponsible sexual behaviours among adolescents attributed to social causes. Socially, adolescents receive controversial information about sexual responsibility from schools, homes, churches, clinics and other platforms like the internet and media. Despite efforts by different stakeholders to bring information to adolescents' disposal, some adolescents find it controversial, and they still engage in irresponsible, risky sexual behaviours that have dire consequences (Gillespie et al. 2022:1019).

Conversely, Jansen (2021:43) pointed out that social support from communities, teachers, and peers might prevent adolescents from engaging in substance use, such as alcohol and drugs. Unfortunately, for many adolescents, the social fabric has been eroded and no longer holds value to them. Hence, adolescents continue to practice irresponsible sexual behaviour despite being surrounded by social groups meant to help them.

- **Community factors**

Communities are an important tool and potentially powerful factor in promoting responsible adolescents. Adolescents' behaviour has become a societal issue (Jansen 2021:43), though some African communities have drifted from their cultural and traditional orientations (especially with the emergence of colonialism) and its subsequent anti-African identity, sentiments promoted by religious orientation, political systems and ideological postulations, such as superiority in terms of race and colour. There have also been some social changes in traditional gender roles and social structures in South Africa (Duby et al. 2022:120). Nigeria similarly acknowledged that parents and communities reported on these changes, and parents are forced to adapt and be there for their children (Esan & Bayajidda 2021:4).

African parentage helps shape adolescents' sexual behaviours. Ultimately, cultures, values and philosophies regarding child development and growth are deeply rooted in the power of sexual and reproductive education. Ritualistic practices and initiation ceremonies tutor and induce pro-social behaviour in an African child by African indigenous people. These African practices prepare the child for responsible adulthood, demonstrated by, for example, the child's readiness for healthy and

culturally acceptable behaviour in terms of sexuality in society (Nkhwashu & Mafukata 2015:1084). However, there is evidence that most adolescents no longer participate in traditional activities, or that culture alone prevent adolescents from utilising sexual and reproductive health services which could help adolescents responsibly shape their sexual practices (Gillespie et al. 2022:1021; Khumalo, Taylor, Makusha & Mabaso 2020:6).

- **Political factors' impact on adolescents' sexual behaviour**

Reproduction and sexual health, behaviour and education is politically motivated and has been categorised as a global priority. For instance, questions are asked whether condoms should be provided in schools. (Tuyisenge, Hategeka & Aguilera 2018:1). Reproductive health was politicised in the early 1970s when the issue of teenage pregnancy among Black adolescents made people more vocal against apartheid, and effects of Covid lockdown on SRH (Solomons & Gihwala 2021:3). In South Africa, critics also blame the government for providing the child support grant, saying it promotes reckless sexual behaviour among adolescents, not upholding sexual and reproductive health rights have dire consequences on individuals and the country at large (Pugh 2019:1).

Some community members also believe that the government is not doing a great job disseminating information; instead, it is destroying the social fibre of society by providing sexual information to young children (United Nations Population fund (NFPA) 2015:7). Still, not all parents blame the government. Some appreciate that times have changed along with adolescents' sexual behaviours; hence, there is a need for information that is reliable and current to promote good sexual health and well-being (Esan & Bayajidda 2021:4).

These traditional structures provide adolescents with an African education entrenched in preparatory SRH education when they transition from childhood into adulthood. However, in the last two decades, there has been an erasure of South African communities' cultural norms. It is thus critical to provide integrative sexual education to adolescents in the home, school and community environments, and parents

(especially mothers) must be at the focal point of this education (Nkosi & Pretorious 2019:110; Powell, Weeks, Illangasakare, Rice, Wilson, Hickman & Blum 2017:169).

In addition, some cultures are still entrenched in risky lines of thought. For instance, the issue of male masculinity, where males regard themselves as true men by sleeping with women from an early age. This cultural belief does not promote responsible sexual behaviour among adolescents (Larsson 2022:4).

- **School curriculum factors**

Risky sexual behaviours disproportionately affect school-going adolescents despite different measures being in place at schools to promote responsible sexual behaviours and combat the negative effects of risky sexual behaviour (Gillespie et al. 2022:1019).

According to Powell et al. (2017:169), the government of South Africa introduced Life Orientation as a subject in schools. The curriculum aims to teach and equip school-going adolescents with social skills, like maintaining responsible sexual behaviours and promoting access to accurate information on SRH. This reduces the incidence of pregnancy and HIV infections among school-going adolescents (UNFPA 2015:6). Life Orientation lessons also provide information to school-going adolescents on where they can access contraceptives and reproductive healthcare services. It creates an understanding and offers support to reduce adolescent pregnancy by promoting the use of contraceptives (Powell et al. 2017:169).

Educators are the motivators and enablers of schooling and promoters of responsible sexual behaviours among adolescents. They play an educative and supportive role to adolescents in schools, teaching sexual assertiveness and diversity in a frank, trustworthy way (Mokwena & Morabe 2016:83-83). A study carried out on educators' views on the growing rate of teenage pregnancy revealed that adolescents' early exposure to sexual health information is beneficial; for instance, if adolescents listen to elders' and teachers' teachings. However, sexual education could itself be troublesome as adolescents become too inquisitive and start to experiment to get a feel of what they are told not to do (Nkosi & Pretorius 2019:110; Mokwena & Morabe 2016:84). In addition, adolescents may misinterpret messages intended to promote responsible sexual behaviour, thereby reinforcing the negative beliefs they might

initially have. Unfortunately, adolescents who do not attend school also have knowledge gaps regarding sexual behaviours and teachings on sexual responsibility (Gillespie et al 2022:1019).

In 2015, the Department of Education introduced condom distribution in schools for learners in disadvantaged communities and schools with a high prevalence of teenage pregnancies. However, some stakeholders felt this strategy failed to yield the expected dividends because parents and churches felt children were too young to talk about sexual intercourse, so they did not encourage the initiative (Nkosi & Pretorius 2019:110).

A 2022 study in South Africa revealed that adolescent mothers in relationships characterised by intimate partner violence, reflect low relation power and offer no communication about HIV prevention (Bhushan, Stoner, Groves, Kahn & Pettifor 2022:67). Pregnant adolescents ultimately need someone trained, and this role is often left to teachers who are ill-equipped and do not have the necessary skills to support the learner emotionally. Educators thus use their caring and nurturing skills (gained as mothers) to counsel and support pregnant adolescents. Hence, the study suggested the need for a well-planned curriculum imparted by a professional person with expertise in the sexual and reproductive health (SRH) subject (Nkosi & Pretorius 2019:113). Sexuality education teaches adolescents to protect themselves against sexual coercion, intimidation, abuse, and respect for all sexual preferences (Nkosi & Pretorius 2019:113).

Despite the intended benefits of SRH education in schools, there are also problems. According to Nkosi and Pretorius (2019:113), “adolescents misinterpret children’s rights taught because they lack awareness and insight regarding the impact of their own behaviour resulting from the application of children’s rights out of context. Most adolescents know their rights and not the responsibilities that go with them.” Teachers are of the opinion that it is very difficult to reprimand adolescents who misinterpret their ‘rights’ and engage in risky sexual behaviours despite their vulnerability because adolescents say that they have rights to their bodies and to do what they want with them (Wakjira & Habedi 2022:72; Nkosi & Pretorius 2019:113).

- **Church's influence on sexual behaviour**

According to Mokwena and Morabe (2016:84), some religious parents, adolescents, and communities in South Africa prefer the church as the primary messenger of sexual health programmes for adolescents. In this way, they assume that the permissive sexual messages adolescents receive from other sources, like peers, are counteracted.

It has also been reported that some messages from the church hinder sexual responsibility. Therefore, though the church is a conducive place for adolescents to receive constructive education about sexual responsibility, resistance is always present from some church leaders, congregants, and adolescents themselves. Straight-forward SRH education coming from clergymen causes discomfort among churchgoers. Lack of financial resources and competing SRH messages from home, friends, the media and community members further render indoctrinated SRH education from churches ineffective (Powell et al. 2017:169).

In Baltimore City in the United States, research with religious parents of Black American adolescents, religious leaders, pastors and youth aged 13-19 years offered a widespread endorsement of church-based adolescent sexual health education through scriptures that cover relevant topics such as sex, sexual expectations and relationships. The religious parents identified the church as a positive place for adolescents to learn about sex, thus promoting the dissemination of information about sexual responsibility among adolescents (Powell et al. 2017:173).

In addition, adults believed adolescents learn through familiar and respected community stakeholders and congregation members' experiences of SRH. That can help adolescents to understand the possible consequences of their sexual actions and encourage better decision-making. For example, familiar and respected congregants can share messages of redemption on how they were saved from bad sexual behaviours and the consequences thereof by the church (Sunarsih, Astuti, Shanti & Ambbarwati 2020:5).

Some adolescents have a big impact on other adolescents by leading an exemplary lifestyle. Consequently, other youth may want to follow in their footsteps. However,

adolescents may feel uncomfortable discussing issues of sex at church because the church is just not the right place (Powell et al. 2017:173).

Though there are indications of benefits towards church-based programmes in promoting responsible sexual behaviour, the intervention often faces resistance from other church followers. Some claim the information is excessive or do not accept changes in church doctrine to accommodate adolescents' sexual behaviour. The church may also experience financial constraints in offering certain programmes that uplift adolescents' responsible sexual behaviour, leading to such programmes' failure (Nkosi & Pretorius 2019:111; Powell et al. 2017:173).

Studies found that some adolescents who place less importance on religion are more likely to engage in transactional sex than adolescents who are religious. As a result, adolescents who engage in transactional sex often engage in irresponsible sexual acts because they are not in a position to negotiate for safer sex. A significant relationship between religious upbringing and a high level of sexual guilt was also found, and this translates to communication from religious leaders about sexually being threatening (Wilson, Jensen, Ballard & Taylor 2022:28). Worse still, immaturity among adolescents results in the high possibility of these youngsters engaging in sex without any consideration (Embeton, Nyandat, Ayuku, Sang, Kamanda, Ayaya, Nyandiko, Gisore, Vreeman, Atwoli, Galawaga & Braitstein 2017:423).

- **Modern norms versus traditional norms' influence on sexual behaviour**

In Mpumalanga Province of South Africa and in other African countries, adolescents, especially girls, rely on friends, religious leaders, teachers, sex educators, or the media and the internet for sexual health education (Esan & Bayajidda 2021:4). However, even though adolescents benefit from the above sources, outside the home it will not be of much help because there are competing messages (Gillespie et al. 2022:1019).

Home and school are where adolescents spend most of their time. Adolescents learn traditional beliefs and taboos enshrined in the community related to sexual behaviours at home and many adolescents learn modern beliefs away from home (Khumalo et al 2020:4). However, after receiving SRH teachings at home, adolescents still like to

learn new things and experiment with sex outside the home. Adolescents also experiment sexually in an irresponsible way, which is not allowed at home (Adegboyega et al. 2019:55). For instance, adolescent boys and girls (to a lesser extent) typically start to watch pornography at early ages (10-14). As a result, adolescents with permissive behaviours tend to engage in irresponsible sexual behaviour because they do not have experience dealing with the after-effects of that behaviour (Yu, Kagesten, De Meyer, Moreau, van Reeuwijk & Lou 2021:S33).

It has also been reported that adolescent contraceptive use is taboo for many parents. Despite the high prevalence of teen pregnancies in Black communities, most parents still disapprove of responsible sexual practices such as contraceptive use by adolescents. Without parental support, adolescents would be unable to practice responsible sexual behaviour (Powell et al. 2017:173; Nkani & Bhana 2016:4).

Traditional and gender norms are shared beliefs about sexual behaviours and related roles and responsibilities. Many young people grow up in communities where gender norms reinforce beliefs regarding male strength and control, female vulnerability and the need for protection from men. These gender norms sometimes dictate the SRH decisions among families, adolescents and communities (Yu et al. 2021:S36). For instance, men believe it is women's responsibility to use contraceptives to prevent pregnancy and STIs. Conversely, some modern parents and adolescents may regard traditional methods of promoting sexual responsibility as ancient (Pulerwitz 2019a: S7).

These days the incidences of irresponsible sexual behaviours are indeed higher than in older days when morals and values played a big role in an adolescent's sexual health (Pulerwitz et al. 2019a: S7). Morals and values instilled by family in an adolescent contribute significantly to a sexually responsible adolescent. Hence, family plays a significant role in instilling good sexual morals and values in adolescents.

- **Healthcare services and providers' influence on adolescents' sexual behaviour**

The best place for adolescents to receive help in promoting responsible sexual behaviour is the local clinics, hospitals, pharmacies or doctors. Access to and

utilisation of friendly health services is vital in promoting responsible sexual behaviour among adolescents. Most parents globally thus agree with the introduction of youth-friendly services. Adolescents can then choose a healthcare provider they can relate to and are comfortable with. Different initiatives are devised and published for health facilities to provide the best possible SRH services to adolescents, aiming to increase demand for these services among adolescents and promote their responsible sexual behaviour (Denno, Hoopes & Chandra-Mouli 2015:S23).

- **Training healthcare providers/clinic staff, implementation and supervision**

Baltag et al. (2022:11) and Sunarsih et al. (2020:5) revealed that adolescents want compassionate, respectful and empathetic healthcare providers who offer confidential interactions, are not biased and able to give information and seek consent before any procedure. Healthcare providers' interpersonal communication style can thus facilitate or deter adolescents from engaging with those who should be supporting responsible sexual behaviour among adolescents. In a study conducted in Uganda and Mozambique, there was an increase in the uptake of SRH services such as family planning and STI services after training and establishing youth-friendly health workers, district capacity building and supervision. These initiatives apply in South Africa, but most adolescents lack participation (Marcell et al 2017:405; Lubinga et al. 2016:101; Denno et al. 2015: S26).

Adolescents still feel uncomfortable visiting healthcare services despite multiple interventions available for them at health facilities because of lack of knowledge (Baltag et al. 2022:5). Healthcare providers perform physical examinations, and this creates discomfort. In men, touching might lead to erections, causing anxiety. Moreover, a lack of proper explanation of procedures and lengthy discussions discourage adolescents from seeking help related to sexual and reproductive issues (Marcell et al. 2017:405).

Adolescents want to choose topics of discussion and actively participate in their own care. They therefore need confidence in asking and answering questions when interacting with healthcare providers. Greater self-confidence would thus help adolescents improve their health and develop into healthy and successful adults (Baltag et.al 2022:11; Marcell et al. 2017:405).

In Nigeria, China, and South Africa, multiple strategies, including information distribution and awareness targeting adolescents and the provision of free condoms and contraceptives, resulted in 14-fold increased odds of contraceptive and condom use (Esan & Bayajida 2012:3). Madagascar franchised clinics for adolescent networking and subsidised sexual and reproductive services, extensive community outreach, social marketing and mass media communication to increase clinic attendance. Moreover, improvements in youth/adolescent-friendly services are linked to multimedia HIV-prevention campaigns and clinic attendance, which improved HIV testing. This is of significant benefit to the promotion of responsible behaviour (Esan & Bayajidda 2021:3; Denno et al. 2015: S26).

- **Out-of-facility SRH services**

Community health services bring the services to where adolescents reside and spend their time. Potential locations include schools, workplaces, streets, malls, homes, youth centres, pharmacies, storefronts, and public toilets. A study in Kenya revealed that services provided in schools carrying messages of abstinence, faithfulness and condom use, combined with HIV testing, motivated adolescents to use reproductive and sexual health services. Youth centres proved to be costly to run, and few adolescents attend them; rather, older youths are the ones who frequent youth centres in most countries (Denno et al. 2015:S36).

Community programmes and awareness campaigns run by NGOs in partnership with the government assist in disseminating SRH messages and promoting the accessibility and availability of appropriate adolescent health services. It facilitates a physical environment that is conducive to the provision of adolescent-friendly services. These programmes require an adequate drug supply, training and staff development to provide effective adolescent SRH care, and ensure individualised continuity of care (James, Pisa, Imrie, Beery, Martin, Skosana & Delany-Moretlwe 2018:3).

Active non-governmental organisations in Mpumalanga Province aim to promote responsible sexual behaviour among adolescents. However, these entities have reported a lack of active participation by most township adolescents (Lubinga et al. 2016:84) and thus warn against a reliance on educative messages since the intended

audience may fail to comprehend these, though there may be a potential uptake in SRH services and significant changes in sexual behaviour.

2.5 RESPONSIBLE SEXUAL BEHAVIOUR APPROACHES

Intentional sexual responsibility among adolescents means engaging in sexual health practices that promote sexual health and development, known as safer sex. Some adolescents engage in responsible sexual behaviour regardless of whether they were sexually active before (Gilliam, Woodhams, Sipsma & Hill 2017:340). In reality, achieving responsible sexual behaviour is a battle yet to be won for many adolescents in townships because they still fall pregnant, contract STIs, and face other negative consequences of irresponsible sexual behaviour (Marcell, Morgan, Sanders, Lunardi, Pilgrim, Jennings, Page, Loosier & Dittus 2017:404; Nkani & Bhana 2016:1).

2.5.1 Making informed decisions

Loew, Mackin &and Ayres (2018:5) revealed that sexually responsible adolescents are self-aware or conscious of the decisions they take with regard to sexual practices that have the likelihood to influence their commitment to personal goals and values. Consciousness in decision-making leads to certain sexual activities that preserve life goals and values. In essence, proper decision-making related to sexual responsibility helps adolescents actively take the lead in preventing unplanned pregnancies, knowing their boundaries and standing by them, and understanding obstacles and how to combat them (Larsson et al. 2021:3).

- **Commitment to personal goals and values**

Personal values and sexual and reproductive goals have an impact on adolescents' decisions or intentions to practice responsible sexual behaviour. For example, some school-going adolescents choose to be sexually responsible because they fear unplanned pregnancies could prevent them from achieving important life goals such as finishing school and staying healthy (Larsson et al. 2021:3; Loew et al. 2018:4; Michielsen et al. 2014:57).

Sexual responsibility involves deliberate goals and focusing on achieving something (Loew et al. 2018:4). It reflects that adolescents know what they want their life to be, hence the need to be careful in their behaviour. Women, in particular, are more responsible in autonomously and proactively thinking of the costs and benefits of certain risky sexual behaviours on their education. Studies revealed that some women go to the extent of aborting unplanned pregnancies rather than dropping out of school (Larsson et al. 2021:3; Loew et al. 2018:4).

2.5.2 Safer sexual behaviour

Responsible sexual behaviour among adolescents involves being aware of the consequences of unsafe sex, such as unintended pregnancies, HIV and other STIs (Mokwena & Morabe 2016:83).

- **Abstinence**

According to Mokwena and Morabe (2016:83), sexual abstinence means not having sex, and it is a primary safer choice in promoting responsible sexual behaviour during adolescence if practised consistently and correctly. Absolute abstinence prevents unintended pregnancies and STIs among adolescents. However, studies show that few adolescents abstain from sex, as it is very difficult to commit to absolute sexual abstinence (Mokwena & Morabe 2016:83; Michielsen et al. 2014:57; Larsson et al. 2021:3). Hence, there is a need to develop strategies for adolescents to avoid sexual temptation.

With secondary abstinence, a person chooses to be abstinent after having sex; however, this is not true abstinence. Many adolescents have intentions to abstain until marriage, but some lose focus when they feel that they are in love, and they lose their purity in the process (Mokwena & Morabe 2016:83). Still, secondary abstinence promotes pregnancy and STI prevention more effectively than persons who continue to actively engage in sex (Michielsen et al. 2014:55).

Conversely, absolute abstinence is a natural part of human development. However, eventually an adolescent moves on to sexual engagement (socially and emotionally) during the transition from childhood to adulthood. Henceforth, the need for safer sex

practices and knowledge remains important among adolescents (Larsson et al. 2021:3). Notably, few adolescents preserve their virginity these days. Many adolescents engage in pre-marital sex, and most adolescents in Muanda's (2018:9) study revealed that they have favourable acceptance of peers who engage in pre-marital sex. According to Mokwena and Morabe (2016:83), it is challenging for adolescents to maintain their virginity because their peers consider virginity foolish and applaud those who engage in sex.

- **Factors contributing to abstinence**

Adolescents' decision to abstain is considerably affected by their environment: socio-economically, psychologically/emotionally, physically, morally and spiritually (Esan & Bayajidda 2021:3).

- **Adolescents' attitudes towards abstinence**

Adolescents sometimes intentionally abstain from sex based on individual beliefs. Different factors influence individual attitudes towards abstinence, such as beliefs, knowledge, self-efficacy, a developing body, aspirations, skills, age and values (Pulerwitz et al. 2019a:S8). According to Muanda et al. (2018:5), most adolescents who engage in abstinence as a form of responsible sexual behaviour are scared of STIs, unintended pregnancies and their consequences.

In addition, some adolescents may feel that they are too young to engage in sexual activities, which is good but often short-lived; adolescents do not remain scared indefinitely. Hence, the need to develop solid strategies to promote responsible behaviour among adolescents (Larsson et al. 2021:3; Michielsen et al. 2014:55). Loew et al. (2018:5) revealed that adolescents who understand why they want to be sexually active, what type of sexual activity they are interested in, what type of safe sex methods they will use, what type of contraception method to use, and which communication method to employ to communicate with partners typically commit to responsible sexual behaviour and often commit to abstinence.

Adolescents with positive attitudes towards their choice not to be sexually active cannot be coerced by their partners. They understand that no one should ever force

someone or try to persuade them to engage in sexual activities against one's will (Michielsen et al. 2014:58).

Adolescent girls' strong attitude against sex before marriage and having children out of wedlock greatly impacts their intention to engage in responsible sexual behaviour. Moreover, a fear of judgements in social circles, and respect for the norms and culture of the community predict an adolescent's decision to be abstinent (Larsson et al. 2021:3; Muanda et al. 2018:5). According to Muanda et al. (2018:5), prior studies have shown that life events like growing up in poverty have a significant effect on adolescents who aspire to work hard to break the cycle of poverty. As a result, an adolescent who believes engaging in sex might take away their opportunity to escape poverty remains abstinent. It places them in a better position to promote responsible sexual behaviour. However, thinking long-term, the question still remains, for how long will the adolescent remain abstinent (Esan & Bayajidda 2021:4)?

According to Esan and Bayajidda (2021:4), some adolescents choose to abstain to avoid aggressive reactions from their parents regarding pre-marital sex, which is sometimes risky. Others abstain from sex to protect their reputation and that of their families. Abstinence ultimately prevents stigmatisation because if other people know an adolescent is sexually active, they may make negative retorts. Still, Gillespie et al (2022:1018) suggested that fear of stigmatisation does not guarantee permanent abstinence, so there is a need for permanent solutions in promoting responsible sexual behaviour when adolescents start to engage sexually.

Social pressure on adolescents not to burden their parents with the consequences of an unintended pregnancy, HIV and STIs could inspire adolescents to abstain from sex. Parents' disapproval of adolescents engaging in sex can also inhibit their engagement in sex. Parents play an important role in their child's sexual behaviour, and they have solid expectations of their children, such as finishing school, getting a job, becoming financially secure, and getting married, among others. Some adolescents thus work very hard to increase their family's trust through abstinence, especially those who are still young. Conversely, late adolescents base their decisions to abstain on individual reasons rather than family approval. The adolescent's decision to abstain can thus be

purely individually based, regardless of parental approval (Larsson et al. 2021:4; Muanda et al. 2018:5).

For many adolescents, the fear of unintended pregnancies comes from the financial implications of the situation. For adolescent girls, fear of a distorted image and the emotional effects of a pregnancy motivates them to abstain to avoid a negative body image (Muanda et al. 2018:5). Self-respect also motivates adolescents to abstain from sex and preserve their virginity until the right time. Virginity, in many cultures, brings pride and respect to the adolescent and their family.

Most adolescents feel they do not have the strength or become emotionally confused about why they should maintain abstinence. Hence, they consider abstinence as the most responsible sexual behaviour in which they can engage, and parents similarly emphasise abstinence until adolescents are sure of what they want. The amount of direction the adolescents feel they have over their environment will suggest whether maintaining abstinence will be easy or difficult to accomplish. This will affect their intention to abstain from sex willingly.

According to the WHO (2014:1), most adolescent pregnancies happen in low and middle-income countries, and South Africa is not spared. Poor adolescents are most affected by socioeconomic status. Globally, one in five adolescents gives birth, mostly in rural township areas and among less educated communities. Education and a high socioeconomic status thus promote the practise of responsible sexual behaviour (Jansen 2021:43).

An adolescent may feel socially immature, especially early and mid-adolescents. Abstinence allows the adolescent to focus on other achievements like schoolwork and planning for a career. Late or older adolescents are more worried about the stigma associated with being known as sexually active and the effects on their reputation.

Relationship characteristics also affect the plan of those in a relationship, in terms of whether they can be involved in sexual intercourse. For instance, communication, commitment, economic stability, security, the presence of real love, and a lack of

doubts about the relationship can contribute to decisions to abstain (Muanda et al. 2018:5; Obare & Kabiru 2017:1; Haberland & Rogow 2015: S20).

The physical nature of the body also affects adolescents' intention and readiness to engage in sexual activities. It is noteworthy that age plays a part in the decision to be abstinent: older adolescents are more knowledgeable on how to prevent potential health risks by taking contraceptives and using condoms; hence, most of them decide not to abstain. Conversely, young adolescents may feel too young to engage in sex and decide to abstain. There are also health benefits to abstinence; for example, it is a sure way of preventing unintended pregnancies and the risk of becoming infected with STIs (Muanda et al. 2018:5; Michielsen et al. 2014:55).

Finally, moral and religious beliefs may contribute to adolescents' commitment to abstinence. For example, some adolescents follow their church doctrine and are directed by the Bible. Others may just strongly feel that it is the right thing to abstain (Muanda et al. 2018:6). However, Ngidi et al. (2016:98) highlighted that religion might work against them when adolescents want to talk about sexual matters with older people and the community.

- **Barriers to abstinence**

This refers to people or situations that prevent adolescents from refraining from having sex despite knowing the benefits. There might be circumstances that tempt an adolescent to have sex (Muanda et al. 2018:9; Michielsen et al. 2014:55).

South Africa is a low to middle-income country and consists of poor people who are often less educated. The less educated the community, the higher the rate of adolescent pregnancy. Pregnant adolescents also face the risk of dropping out of school and end up uneducated (Underwood, Jones, Demissie & Rasberry 2021:964).

Evidence revealed that adolescents are often dissuaded from abstinence due to peer pressure (Ngidi et al 2016:98). For instance, they want to prove to peers that they are "the man": males want to boost their reputation among their counterparts. In contrast, women want to show their men that they can reproduce, proving their fertility or that

they are good in bed. This supposedly secures their position in the relationship (Muanda et al. 2018:6; Michielsen et al. 2014:55).

Pressure or expectations from important persons in an adolescent's network may thus motivate or prevent adolescents from complying in willingly practising abstinence as responsible sexual behaviour (Larsson et al. 2021:3). Abstinence requires self-control and the ability to stand up to pressure (Ngidi et al. 2016:100).

Social acceptance of certain norms, like the association between an adolescent and peers with deviant behaviour that leads to peer pressure, drives adolescents to irresponsible sexual behaviour (Esan & Bayajidda 2021:4; Ngidi et al. 2016:98). For instance, a girl or boy may have a boyfriend or watch pornography just to fit in with the group. As a result, the adolescent ends up engaging in permissive sexual behaviours, some of which are irresponsible (Yu et al. 2021:S36).

Wrong information shared among adolescents leads to the acceptance of myths and misconceptions about abstinence. According to Ngidi et al. (2016:98), adolescents find it easier to share their sexual health problems confidently and privately with friends in their age group than with older persons. Culture and religion also often do not permit discussions about sexual issues with elders (Mokwena & Morabe 2016:83). Hence, even if adolescents want to know more about abstinence from elders, it is difficult to engage an elder in the discussion.

A lack of parental supervision may also leave an adolescent at the mercy of peers who encourage pre-marital sex. Peer pressure compels adolescents into irresponsible sexual behaviour as some adolescents are compelled to engage in sex due to the need for money and peers encouraging this solution (Michielsen et al. 2014:55). Moreover, adolescents have a strong desire for pre-marital sex because of curiosity, peer pressure, testing for virility/fertility, taking it as an opportunity to gain experience and as a reward for giving or receiving gifts (Michielsen et al. 2014:55).

In many South African societies, it is a norm for adolescent girls to experience pressure to get married and bear children early, or they may have limited educational and employment prospects. In low and middle-income countries, over 30% of girls

marry before they are 18 years old. This norm demotivates adolescents in these communities from having the intention to engage in good sexual behaviours like abstaining to prevent pregnancies and delaying their sexual debut (WHO 2014a:1).

- **Protected sex**

In order to avoid an unplanned pregnancy, adolescents are expected to avoid unprotected sexual intercourse at all times and avoid consuming intoxicating substances such as alcohol and drugs, as these influence behaviours. Women are always at the forefront in the prevention of unplanned pregnancies, while men are toiling behind (Loew et al. 2018:6; Michielsen et al. 2014:57).

Male adolescents prefer to use condoms. However, some adolescents have negative attitudes towards condom use, offering reasons such as a lack of sexual pleasure, partners mistaking condom use as suggestive of having a disease, and tearing of the condom (Larsson 2022:4).

- **Contraceptive use**

Safer sexual behaviour involves using contraception to prevent pregnancies, and safer sex choices appropriately assist individuals planning to have children and the best spacing between children (Lopez, Bernhole, Chen & Tolley 2018:3).

Safe family planning methods include the use of birth control and emergency contraception and protective sheaths. Research revealed multiple methods of birth control (the use of dual contraception) maximise risk prevention and unplanned pregnancies. Yet, the availability and consistent consumption of condoms are limited among adolescents (Moore, Beksinska, Rumphs, Festin & Gollub 2015:135).

The attitude of adolescents, partner preference, and women's menstrual cycle have also been found to influence contraceptive use among adolescents (Larsson et al. 2022:3; Moore et al. 2015:135). According to Muanda et al. (2018:7), most adolescents concurred that contraceptives and condoms are an excellent way of preventing pregnancies and STIs. There was also consensus that unmarried adolescents have the same right as married individuals to use and have access to

contraceptives because they are equally sexually active, and adolescents can thereby commit to preventing unwanted pregnancies. However, a minority of adolescents believed that unmarried adolescents should not use contraceptives. Fear of the side effects of contraceptives strongly contributes to their non-commitment to using contraceptives (Larsson et al. 2021).

The fear of stigmatisation and judgements by health personnel offering SRH services cause adolescents not to commit to using SRH services such as family planning. Larsson et al. (2021:4) and Muanda et al. (2018:7) revealed that some health professionals are indiscreet, treat adolescents poorly, and are reluctant to sell them contraceptives. However, some adolescents prefer to access contraceptives in a clinic or hospital where nurses and doctors are trained and offer proper SRH examinations, even though some doctors are reluctant to give minors contraceptives. Others prefer private services to avoid shame and embarrassment because of judgements and discrimination from providers (Muanda et al. 2018:8).

- **Perceived views on the challenges in using contraceptives**

Community and family disapproval of adolescent girls engaging in sex and their use of contraceptives discourage adolescents from accessing and using contraceptives. In addition, embarrassment due to the stigma associated with premarital sex discourages female adolescents from using contraceptives freely and actively. However, the community and family's strictness is not balanced as they are less strict with males whose sexual behaviours are typically overlooked (Larsson 2022:3).

According to Esan and Bayajidda (2021:4), some cultures do not have a problem talking to adolescents about sexual issues. In others, gender norms and acceptance negatively affect SRH services among males and females. Evidence also shows that males lack a greater commitment to contraceptive use than female adolescents. Hence, males remain ill-prepared to deal with SRH issues. However, in the face of the world we live in now, some parents believe the courage to talk about sexual responsibility with adolescents positively promotes safe sexual acts among adolescents (Pulerwitz et al. 2019a:S7).

Moreover, early marriage is encouraged among adolescents in some societies because early marriage and early sexual initiation predispose women to having many children during the course of adulthood (Ahmed 2015:9; Mburano 2014:103). Furthermore, children are regarded as a source of pride and are expected to bring money to their parents when they grow up. It has been a norm from time immemorial that parents look after children and nurture them while they are young, and in return children will look after their parents when they are grown up (Milimo, Zulu, Svanemyr, Munsaka, Mweemba & Sandoy 2021:1: Ahmed 2015:9). For these reasons, many adolescents see no reason to be sexually responsible by committing to the use of contraceptives as they are socialised to the norm that children will be their source of economic safety when they grow old as parents (Muanda et al. 2018:7).

- **Lack of information, myths and misconceptions**

Globally and countrywide, both male and female adolescents have different levels of understanding about contraceptives. Minimal information, myths and misinformation are common about contraceptives used to prevent unintended pregnancies and STIs around South Africa (Bornekog et al. 2021:2). A study carried out in 2015 in Mpumalanga Province revealed that most adolescents in the province had limited knowledge and understanding of sexuality and reproductive health matters affecting them. This included critical issues like methods of preventing pregnancy, the transmission of STIs and sexual abstinence, among others (Nkhwashu & Mafukata 2015:1080). Esan and Bayajidda (2021:3) revealed that parents are a primary source of information, and as such, they should avoid lies and give adolescents correct information about contraceptives.

- **Financial constraints**

Lack of money to access health centres makes it difficult for some adolescents to commit to using contraceptives (Muanda et al. 2018:6). Economic difficulties like poverty also cause parents to fail to meet the needs of their children. As a result, adolescents engage in transactional sex to meet these needs, or they do not try to access contraceptives at all (Esan & Bayajidda 2021:3).

- **Side effects of contraceptives**

The negative effects of contraceptives discourage adolescents from their use. Lack of sexual pleasure typically also discourages male adolescents from using condoms (Larsson et al. 2021:3).

2.5.3 Adolescents' careful selection of partner(s)

Being sexually responsible involves intentionally selecting responsible sexual partners. The adolescent's number of sexual partners determines whether a person will engage in responsible or irresponsible sexual behaviour. Ultimately, responsible sexual behaviour involves respecting partners and openly communicating with them about all sexual activities (Bhushan et al. 2022:67).

Literature has shown that adolescents decide whether to have a sexual relationship with a certain partner mainly based on the level of commitment in the relationship. In addition, men have been shown to fully support their partners using contraceptives, especially dual methods if there is a full commitment in the relationship (Gilliam et al. 2017:340).

The common characteristics of relationships among school-going adolescents in South Africa are casual or serious with no intention of marriage (Bhushan et al. 2022:68). However, some adolescents are involved in important relationships that might lead to marriage or engagement. A trusting and caring relationship often sustains sexual responsibility among adolescents. The types of relationships in which adolescents engage determine whether these relationships have sexual health risks or not (Loew et al. 2018:6; Michielsen et al. 2014:57).

2.5.4 Open communication in adolescent relationships

Sexual responsibility among adolescents involves open communication between partners before the relationship gets intense. This entails discussing methods of preventing pregnancy and STIs and setting individual sexual boundaries so that there is an understanding of each other's comfort zones. However, even though abstinence is an individual decision, it works well when both partners agree to it and maintain

open communication so that there is consensus (Bhushan et al. 2022:68; Loew et al. 2018:7).

Suggestions have been made that adolescents need to be informed and trained on the components of a healthy relationship. For instance, the ability to communicate with a partner, which involves receiving consent every time there is engagement in sexual activity (Marcell et al. 2017:405) is critical.

In order to achieve sexual responsibility, an adolescent should be a good communicator of sexual needs (Sunarsih et al 2020:4). There must be mutual respect between partners, equality and fairness, trust, and honesty, and all parties must be responsible enough to protect themselves and their partners from STIs, HIV, and unplanned pregnancies. However, many adolescents still show some hesitancy to engage partners in issues of sexual responsibility for different reasons, including fear of being dumped, issues of stigmatisation and confidentiality, and the adolescents' fake sense of being in control of sexual matters (Gumindega & Maharaj 2022:22; Michielsen et al. 2014:57).

Adolescents who are faithful and remain with one partner protect their partner from STIs and unplanned pregnancies. By engaging in self-initiated HIV counselling and testing, better quality of life is promoted. It also allows for effective planning for the future based on freedom from worries about HIV, access to treatment and prevention of the spread of HIV. Economic stability, security and the presence of real love and a lack of doubts about the relationship can contribute to decisions to abstain (Muanda et al. 20118:5; Obare & Kabiru 2017:1; Haberland & Rogow 2015: S20; Ntsepe, Simbayi, Shisana, Rehke, Mabaso, Ncitakalo, Davids & Naidoo 2014:140).

2.5.5 Prevention of HIV/AIDS

Knowing one's HIV status remains the central focus of sexual responsibility among adolescents. However, a fraction of the total population of adolescents goes for HIV testing and counselling (Larsson et al. 2021:3; Loew et al. 2018:5; Michielsen et al. 2014:57). According to Ntsepe et al. (2014:141-145), some South Africans, including adolescents, do not know their HIV status. The study revealed that it was more unlikely

for Blacks and Indians to self-initiate HIV testing and counselling compared to the White racial group (Ntsepe et al. 2014:141).

- **Hindrances to self-initiated HIV counselling and testing**

Some reasons for adolescents not taking responsibility for HIV testing are inaccurate perceptions of the risks of testing for HIV, fear of testing positive, stigma and discrimination associated with knowing that a person tested positive for HIV (Ntsepe et al. 2014:141). Poor health services by health professionals who are afraid of needle pricks that predispose them to HIV infection, have also been shown to discourage adolescents from going to clinics to check their HIV status. Adolescents are sensitive to the way they are handled when the health professional withdraws their blood. For instance, overtly showing their discomfort in withdrawing blood makes the adolescent feel uneasy (Koto & Maharaj 2016:57).

Lack of HIV knowledge and awareness has been reported in many studies as extra challenges adolescents have both in and out of relationships (Patsani, Parida, Jena, Behera, Pradhan, Patra, Pati, Kaur & Acharya 2023:6). Not knowing this status predisposes adolescents to HIV infection if they are not using condoms (Mayimbo, Musenge & Ngoma 2019:1; Ntsepe et al. 2014:142).

According to Koto and Maharaj (2016:57), it is difficult to provide confidential counselling and consultation related to HIV because of the existing infrastructure. For instance, curtains or boards divide some consultation rooms, which are not soundproof. Other people might listen to the conversation, and this compromises confidentiality during HIV testing. Most adolescents want privacy and confidentiality, so they end up not checking their HIV status at all. However, Ntsepe et al. (2014:142) pointed out that many adolescents would consider taking responsibility for their sexuality if there is an understandable HIV-testing process and assurances that the process and results remain confidential.

Sharing one's HIV status with a partner is a responsible approach to safe sexual behaviour. However, stigma and discrimination are powerful hindrances. In Lesotho, nurses were reportedly scared to go for HIV testing because of stigma and discrimination (Koto & Maharaj 2016:58). If nurses fear discrimination and stigma

against them and their families if other people know that they are HIV positive, adolescents know they will not be spared either (Twinomugisha, Ottemoller & Daniel 2020:4).

Adolescents are also indirectly affected by nurses' mental well-being; for instance, most do not get enough counselling, they do not get enough health education about their status, and they do not know how to handle their cases (Tesfaye, Dessie, Berhane, Assefa, Semahegn, Canavan & Fawzi 2020:116). Adolescents consequently hide their status, especially from their partners, and this causes HIV to spread further if adolescents do not adhere to safe sexual practices (Koto & Maharaj 2016:59). According to Koto and Maharaj (2016:58), other consequences of keeping one's HIV status secret include depression, stress, and social isolation.

Sometimes, adolescents do not go for HIV testing because they previously attended the health facility and were turned away for different reasons. Adolescents seldom return for the test, compromising their sexual responsibility (Koto & Mahara 2016:58).

2.6 ADOLESCENTS' ATTITUDES TOWARDS CERTAIN SEXUAL BEHAVIOURS

Other studies concur that young people aged 15-24, acknowledged the consequences of risky sexual behaviour, but they still engaged in such practices (Ngidi et al. 2016:99; Yager et al 2017:398; Nkani & Bhana 2016:1; Shisana et al. 2014:36; Kembo 2013:151).

2.7 UNSAFE SEX/RISKY SEXUAL BEHAVIOURS AMONG ADOLESCENTS

According to Vhembo (2013:7), risky sexual behaviour is sexual activities where participants put themselves at risk of experiencing negative outcomes, which include STIs, unwanted pregnancies and distress (Nkosi & Pretorius 2019:110).

Evidence reveals that globally and in Africa, there are regional variations in the proportion of condom use at last sexual intercourse among females. The variation was attributed to differences in health education approaches and policies in different

regions. In South Africa, for instance, policies allow adolescents to legally abort a pregnancy as early as 12 weeks. This influences the uptake of condom use among adolescents as they know an unplanned pregnancy can easily be aborted. However, non-condom uses places adolescents at risk of HIV infection and other STIs (Ngidi et al. 2016:99).

Even though legal termination of a pregnancy is meant to offer adolescents a second chance to realise their personal goals, most adolescents still do not use protection and end up having multiple pregnancies, knowing they will terminate, however support for teenage mothers reduces repeat pregnancies by using contraception (Caderbaum, Yoon, Lee, Desai, Brown, & Clark 2022:78; Ali et al. 2021:5).

2.7.1 Unprotected sexual intercourse among adolescents

These are acts of sexual intercourse performed without the use of condoms and may predispose the adolescent to the risk of contracting STIs, including HIV, which causes progressive failure in the immune system (Vhembo 2013:7). The HIV pandemic continues to threaten the lives of adolescents in South Africa and worldwide. HIV infections were eight times higher among women in the adolescent years than among men of the same age (Shisana, et al 2014:42). In addition, unprotected sexual intercourse bears the major consequence of an unintended pregnancy (Mokwena & Morabe 2016:83).

2.7.2 Multiple sexual partners

Evidence has shown that many adolescents have multiple sexual partners. This risky sexual behaviour places adolescents at risk of infections with HIV and other STIs (Ali et al. 2021:5).

According to a statement concerning South Africa's Demographic and Health Survey (2016:7), 17% of men and 5% of women reported having two or more sexual partners in the past 12 months. Some respondents reported condom use during high-risk sex (58% females and 65% males), while the rest did not use a condom. Furthermore,

45% of women and 55% of men reported having sex with a partner who was neither their spouse nor lived with them (Ngidi et.al 2016:99; Nkani & Bhana 2016:1).

2.7.3 Early onset of sex among adolescents

Past studies revealed that a considerable number of adolescents had early-onset sexual intercourse(Ahanhanzo et al. 2018:90; Ahanhanzo, Sossa-Jerome, Sopoh, Tchandana, Azandjeme & Tchandja 2018:90). Early onset of sex among adolescents predisposes them to unplanned pregnancy and HIV because their sex organs are not strong enough to prevent tearing. Tears offer a conducive area for pathogens' entry into the body (Ahanhanzo et al 2018:90).

Early sexual intercourse among school-going adolescents was exacerbated by adolescents who refuted sexual abstinence, exposure to pornographic movies, peer influence and parents' absence in adolescents' sexual life (Ahanhanzo et al. 2018:90).

2.7.4 Transactional sex

Abject poverty drives some vulnerable adolescents into transactional sex. Adolescents sell their bodies for money and special gifts. This predisposes them to irresponsible behaviours such as unprotected sex that comes with transactional sex because they are not in a strong position to negotiate safer sex (Embelton et al. 2017:423). Research also revealed that some adolescent mothers engage in transactional sex after childbirth due to being an orphan, as a rust of poverty, limited employment opportunities and an increased rate of school dropout after pregnancy, placing adolescents at risk of HIV infection (Bhushan et al. 2022:68).

2.7.5 Alcoholism

Heavy drinking is associated with increased risk-taking behaviour and sexual exploitation (Mokwena & Morabe 2016:83). Some adolescents frequently drink alcohol beyond measure, especially when they meet among themselves. This impairs their memory system severely, reducing their ability to carry out thoughtful and logical thinking. Due to immaturity, adolescents are less able to weigh the negative

consequences of heavy drinking, such as engaging in unprotected sex, leading to pregnancy and infections with HIV and other STIs (Mokwena & Morabe 2016:83-84).

2.7.6 Drug use

Drug use is associated with increased risk-taking behaviour and exploitation. Being intoxicated with drugs often causes a person to lose control, resulting in unprotected sex and unplanned pregnancy (Mokwena & Morabe 2016:84, Yussof, Sahril, Rasadi, Zaki, Muhamad & Ahmad 2014:4).

2.7.7 Consequences of irresponsible sexual behaviour

- **Unplanned pregnancy among adolescents**

Experiencing an unplanned pregnancy and STIs during adolescence is a cause for concern. Hence, studies revealed the prevention of pregnancy and STIs remains the central focus of sexual responsibility among adolescents (Larsson et al. 2022:3; Loew et al. 2018:5; Michielsen et al. 2014:57).

Unplanned pregnancies among adolescents bring about unexpected parenting and financial strain. Pregnancy may also be a barrier to goal attainment. Adolescents who fall pregnant face stigma in the family, community and at school, as unplanned teen pregnancies are frowned upon and show a lack of sexual responsibility (Larsson 2021:4; Loew et al. 2018:5; Michielsen et al. 2014:57).

Education is a major protective factor against early pregnancy: the more years of schooling individuals have, the fewer early pregnancies are reported. Birth rates among adolescents with low education are higher than for those with secondary or tertiary education. Some uneducated adolescents do not know how to avoid becoming pregnant, or are unable to obtain and use contraceptives correctly (WHO 2014a:2).

- **HIV and other STIs**

According to STATS SA (2016:9), South Africa has the highest burden of disease due to HIV. The prevalence of HIV remained constant, with 6.2% and 5.6% of youths

afflicted between 2007 and 2016. Even though there was a slight decline from 2014, the prevalence of HIV among youth in South Africa remains relatively high. Available data indicate that 26 new HIV infections occur every hour among adolescents.

Projections show that of the 10 leading causes of death among adolescents in 2025, tuberculosis will be the number one killer, followed by HIV/AIDS (STATA SA 2018:X). As evidenced by statistics, if adolescents continue to engage in risky sexual behaviour, the disease burden will remain high in South Africa.

Contracting STIs during adolescence is a cause for concern among many adolescents. In 2015, an estimated 12.7% of the total population lived with HIV in South Africa. Approximately one-fifth were South African women in their reproductive years (15-45 years). Many orphaned adolescents were also HIV positive because of mother-to-child transmission. However, these individuals are a risk to their partners if they decide to engage in sex without protection (Kidman & Anglewicz 2017:4).

A high prevalence of STIs among adolescents is a big threat to efforts by different stakeholders in South Africa to ensure healthy, economically active and highly educated adolescents (Nkani & Bhana 2016:4). Safer sex among adolescents prevents long-term infertility, studies revealed that adolescents do not seek treatments for STIs in time, and some receive backdoor abortions, which destroy their reproductive system. Complications, such as total infertility, may result from this destruction of the reproductive system.

- **Illegal abortions**

Pregnant adolescents are more likely than adults to have unsafe abortions globally. An estimated three million unsafe abortions occur globally every year among girls aged 15-19 years. Unsafe abortions contribute substantially to lasting health problems and maternal deaths among 15-19-year-olds in many low and middle-income countries, including South Africa (Shisana et al. 2014:36; Nkani & Bhana 2016:1; Kembo 2013:151; Yager et al. 2017:398).

- **Overburdened health professionals**

According to Koto and Maharaj (2016:58), health professionals experience stress and burnout because of the added workload from health complications of teen pregnancies and unsafe abortions. An estimated three million girls aged 15-19 undergo illegal abortions every year globally. In low and middle-income countries, teen pregnancy and childbirth complications are a leading cause of maternal death and morbidity among this population (WHO 2014:2).

- **Infertility**

Some unplanned adolescent pregnancies result in unsafe abortions, predisposing adolescents to infertility complications. If the procedure does not expel all products of conception, or if damage to the uterus happens during the abortion process, life-long fertility challenges may ensue (Sajadi-Ernazarova & Martinez 2023:40).

- **SRH-related cancers**

These cancers are more common among adolescents who engage in unprotected sex. Proper sexual behaviour prevents reproductive health-related cancers, such as cervical cancer, and testicular and prostate cancer (Zhao, Qiu, Yan, Li, Yang, Zhang, He & Zhou 2022:1).

- **Diminishing sexual desire and enjoyment**

Many adolescents who start sex early experience problems with sexual enjoyment or desire later on (Larsson et al. 2021:3).

- **Underweight infants, stillbirths and new-born deaths**

The chances of being underweight, stillbirth and new-born death are 50% higher among infants of adolescent mothers than among infants of women aged 20-29 years. Infants of adolescent mothers are more likely to have low birth weights, which affects the development and growth of the child (Sedgh et al 2015:227; STATS SA 2018:14; WHO 2014:1). It is also evident that most adolescents deliver still babies or experience new-born death (WHO 2014:1).

- **School dropout**

School dropout rates are significant, especially among pregnant girls, due to a lack of support from parents, teachers and peers. They are consequently unable to balance pregnancy, motherhood and schooling (Bhushan et al. 2022:68). Some may not drop out per se, but they can delay the completion of schooling. This has an effect on their probability of continuing with further education. However, there is evidence that adolescents who continue with schooling after childbirth tend to become very successful because they make sacrifices and work hard for the sake of their child to have a bright future (Nkosi & Pretorius 2019:110).

- **Emotional stress**

Adolescent pregnancy can cause emotional stress when adolescents have difficulties divulging their condition to their parents. Disclosure of the biological father; peer rejection; isolation; stigmatisation; perception and insensitivity among some people who are supposed to help; and negative attitudes towards teen pregnancy among health professionals may exacerbate the adolescents' anxiety, leading to psychological trauma if left unattended (Nkosi & Pretorius 2019:110).

2.8 FACTORS ASSOCIATED WITH RISKY SEXUAL BEHAVIOUR AMONG ADOLESCENTS

2.8.1 Sexual and Reproductive Health Policies and laws

Policies and guidelines are intended to protect children, but they fail to empower them to take charge of their own decisions based on their own thinking (Wakjira & Habedi 2022:71). Instead, most adolescents' SRH follow standardised policies and laws created to protect them out of context. Most of the time, this leads to errors of judgement by adolescents because they tend to apply the SRH laws where they do not fit. For instance, the right to one's body and reproduction is inappropriately used by school-going adolescents when they engage in unprotected sex, resulting in teen pregnancy. Hence, adolescents tend to enforce their sexual rights without taking responsibility for them, resulting in consequences of irresponsible sexual behaviour (Nkosi & Pretorius 2019:110).

2.8.2 Lack of SRH education and knowledge among adolescents

Education is a major protective factor against early pregnancy: the more years of schooling adolescents have, the fewer early pregnancies are reported. However, there is a lack of comprehensive sex education in South Africa. Birth rates among adolescents with low education are higher than for those with secondary or tertiary education. Education is the best exit to poverty as it increases individuals' chances of employment. Uneducated adolescents remain trapped in poverty because their employment opportunities are slim (Mayimbo et al. 2019:2).

Ultimately, adolescent mothers' capacity to participate in sexual responsibility is diminished as they do not have sustainable and independent livelihoods. This increases their economic dependence on men for money through transactional sex, their inability to obtain adequate HIV prevention knowledge and resources, and difficulties in negotiating safer sex methods (Bhushan et al. 2022:68; Statistics South Africa 2016:11).

Some uneducated adolescents do not know how to avoid becoming pregnant or are unable to obtain and use contraceptives correctly. Even where contraceptives are widely available, many sexually active adolescents are less likely to use contraceptives; in Africa, the rate of those who take contraceptives ranges from 3-49% (WHO 2014a:2).

2.8.3 Sexual coercion

Sexual coercion mostly affects adolescent girls because they are unable to refuse sex due to widespread sexual violence (Esan & Bayajidda 2021:4; Vetten 2014:2; WHO 2014:2). A recent study of adolescents in South Africa revealed that childbirth during adolescence increases adolescent girls' vulnerability to poor partnerships and low gender-equitable norms associated with HIV-related sexual behaviours, intimate partner violence, low relation power, and non-communication about HIV prevention (Bhushan et al. 2022:67).

2.8.4 Lack of parental or caregiver support on adolescent SRH

Orphaned adolescents who live in child-headed families are at an increased risk of exploitation by perpetrators because they are vulnerable and do not have support from a parent. In Kenya, institutional care better protects orphaned adolescents from sexual exploitation than orphaned adolescents who stay in family-based care (Embelton et al. 2017:422).

In general, orphans in sub-Saharan Africa are at a greater risk of experiencing a forced sexual encounter in comparison to their non-orphaned peers. However, some adolescents lack parental support and guidance on SRH despite their parents being alive and well, and this exposes them to irresponsible sexual behaviour. This suggests the protective effects of parental supervision and support, especially related to transactional sex and sexual violence (Bhushan et al. 2022:68; Embelton et al. 2017:422).

2.8.5 Attending school

A culture of learning has an impact on adolescents' intention to engage in irresponsible sexual behaviour. Being in school is strongly associated with reduced sexual risks associated with being sexually active (Bhushan et al. 2022:68).

2.8.6 Not belonging to a religion

Adolescents for whom religion is of little importance are more likely to engage in transactional sex, but adolescents nurtured in the church receive support and SRH education that prevents them from engaging in premarital sex (Powell et al. 2017:169).

2.8.7 Poverty

According to STATS SA (2016:22), in 2016, 53.8% of South African citizens lived in poverty, and the unemployment rate was 26.5%. Mpumalanga Province has recorded significant job losses since, and unemployment has been exacerbated by Covid-19. This forces adolescents to pursue all possible avenues to survive, even if they put

themselves at risk of sexual exploitation. Transactional sex is the end result of economic hardship (Bhushan et al. 2022:68). Jansen (2021:43) concurs, revealing that adolescents belonging to low socioeconomic groups are at a high risk of substance use and sexual exploitation.

2.9 POLICIES, GUIDELINES, PROGRAMMES AND INTERVENTIONS AIMED AT ADOLESCENTS IN SOUTH AFRICA

2.9.1 International Conference on Population

In 1994, the conference established a comprehensive guide on developmental policies and programmes on adolescent SRH. These programmes and policies are still in force in South Africa. Many programmes yielded good results in maximising sexual responsibility and reproductive behaviours worldwide. However, there is still a need for more effort; specifically in townships where sexual responsibility is lacking among many adolescents. The government of South Africa reviewed and revised population policies in 1997, which were anchored in apartheid ideology to protect young people from early childbearing, according to the strategies suggested at the International Conference on Population (WHO 2019:1). The latest population policy was reviewed in 2000 (Editorial 2019:S1).

2.9.2 The Convention on the Rights of the Child

This policy was established to protect children against all threats. Adolescents have rights in South Africa and STATS SA (2018:14) stated that “vulnerabilities and needs of the adolescents remain unaddressed or partially addressed compared to other segments of the children population”. One of the conventional areas of concern is risky sexual behaviour experienced among adolescents on a daily basis. The vulnerabilities of this behaviour include teenage pregnancies, adolescent mortality and morbidity from HIV and AIDS infections and other sexual reproductive health problems like illegal abortions (STATS SA 2018:14).

2.9.3 South African Schools Act 1996 as ammended

Even though the South African Schools Act of 1996 as amended (2011), legislates that learners should go back to school during the course of their pregnancies and after delivery, it remains a challenge to promote girls' empowerment through education since many adolescents repeatedly engage in irresponsible sexual behaviour (Bhushan et al. 2022:68). As a result, pressure mounts on the education system to provide effective education services to students with different cohorts in the same grade (Nkosi & Pretorius 2019:110).

2.9.4 Promotion of Equity and Prevention of Unfair Discrimination Act No 4 of 2000

This policy does not allow unfair discrimination against school-going adolescents who become pregnant. However, some adolescents take advantage and do what they want, falling pregnant while still at school, which signifies sexual irresponsibility. This act forces teachers to work with limited resources (both human and financial) to support pregnant adolescents whose learning progress is often lagging (Bhushan et al. 2022:68).

2.9.5 The Ministry of Education, Health and Social Development of South Africa and representatives from African states' commitment

These stakeholders made a commitment in December 2013 to invest in youths and adolescents. These ministries work together on integrated health programmes, such as the development of life skills and behaviour change, reducing risky sexual behaviours and paying attention to life-threatening infections caused by risky behaviour (United Nations Population Fund (UNFPA) 2015b:3).

2.9.6 South Africa through the African Agenda 2063

South Africa has made significant strides towards reducing gender inequalities in social structures, such as improving educational opportunities for a girl child, patriarchy, economic empowerment and ending child marriage. However, the country

is still struggling to curb gender-based violence, including harmful practices with dire consequences on women's sexual responsibility (National Development Programme 2019:67).

2.9.7 The South African National Policy Instruments

The main national policy instruments related to children protection include but not limited to the Constitution, National Development Plan (NDP) Vision, The Children's act, Convention on the rights of the Children and the National Youth Policy 2015-2020. These stakeholders emphasise the protection of young people from STIs and unplanned pregnancies, by providing for a coordinated and integrated approach for government departments and civil society organisations to provide an effective response system for child victims and those at risk of abuse, neglect and exploitation (Social development 2017:4).

2.9.8 The Sustainable Developmental Goals (SDGs)

Sustainable Development Goals (SDGs) are commitments made by heads of state, and South Africa is one of the states. The targeted goals of sustainable development are ensuring healthy lives and promoting well-being at all age groups (adolescents inclusive) through access to sexual and reproductive care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes. Despite these commitments, there is evidence that adolescents continue to engage in irresponsible sexual behaviour. Few adolescents participate in programmes meant to uplift their sexual behaviours (STATS SA 2018:14: UNICEF 2017:5; UNFPA 2015b:5).

2.9.9 International Technical Guidance on Sexuality Education

Schools in South Africa provide sex education based on the Curriculum and Assessment Policy Statement (CAPS). The subject's content and topics progress across grades, and the values and skills are relevant to Life Orientation. School health services also cater for adolescents' SRH needs and knowledge (Social development 2017:4).

Despite the efforts and commitments by different stakeholders, many townships of Mpumalanga Province report adolescents still engage in risky sexual behaviour. One teen pregnancy is too many. Even though these commitments are in place, there is a need for long-term improvements in youths' responsible sexual behaviour. Meanwhile, the consequences of risky sexual behaviour among adolescents are still causing problems in different circles of the nation, with townships most affected. However, working jointly with all stakeholders may increase the chances of success (UNFPA 2015a:5-7).

The global strategy for women's and children's health focuses on the girl child's sexual health and welfare to prevent maternal mortality. In order to prevent teen pregnancies and their complications, the WHO, in partnership with other stakeholders, proposed different strategies that countries like South Africa adopted. These include preventing child marriages and enhancing understanding and support to reduce teen pregnancies. The country also promotes adolescents' use of contraceptives to prevent unplanned pregnancies. The government of South Africa also does not tolerate forced sex. However, with high rates of gender-based violence, perpetrators continue to commit crimes like coerced sex, and they do not face the full force of the law (WHO 2017:6).

Moreover, different stakeholders rally against unsafe abortions among adolescents, and the nursing board regulates and promotes competent midwifery to prevent adolescent maternal deaths. However, despite these efforts, the consequences of irresponsible sexual behaviour linger (Mayimbo et al. 2019:1).

2.9.10 Statutory Rape Policy

Sexual consent means agreeing to take part in every type of sexual engagement, given prior to sexual activity by each person involved. Rape or sexual assault is any sexual activity that takes place with or without consent with a minor (Sexual offences and related matters amendment Act No 32, 2007:35).

The age of consent in South Africa is 16 years for everyone, though a child is legally a person under the age of 18 years (Sexual Offences and Related matters Amendment Act 32 of 2007:9-15). Interestingly, Carella, García-Pereiro, Pace, and Paterno (2020:2) suggested that rape between 16 and 17-year-old males and females carries no or lesser sexual consequences than among young adolescents under 15 years of age.

2.10 THEORETICAL FRAMEWORK: THEORY OF PLANNED BEHAVIOUR

The TPB depicted in Figure 1.1 (Ajzen 1991:182) guided the theoretical framework of the study to explain planned and deliberate sexual behaviours engaged in by adolescents in the Mpumalanga Province of South Africa.

This theory predicts human behaviour that is deliberate and planned. In the same way, sexual responsibility can be deliberate and planned. According to the TPB, the person's intention to initiate a behaviour willingly depends on the combination of their personal attitude, behavioural norms and perceived control factors. The TBP proposed that intention is a predictable, deliberate and planned human behaviour (Ajzen 1991:180). The researcher investigated how strong or weak adolescents' intentions were to engage in responsible sexual behaviour. Behavioural intention ultimately determines whether adolescents decide to engage in responsible or risky sexual behaviours and to what extent were they willing to perform these sexual behaviours (Ajzen 2012:18).

According to the TPB, an attitude is an evaluation of ideas, events, objects, or people, which plays a part in the person's intention to initiate responsible behaviour. Moreover, attitudes are generally positive or negative (Ajzen 1991:180). An exploration of adolescents' attitudes towards certain behaviours assisted the researcher in answering whether sexual responsibility was viewed as favourable or not, and what attitudes adolescents had towards sexually responsible behaviour (Ajzen 2012:18).

Perceived control is the amount of direction the adolescent felt they had over the environments in which they lived. Meanwhile, norms are attitudes and behaviours that are normal, typical, or average, and they determine others' approval or disapproval of

the behaviour. The researcher conducted an analysis of the impact of subjective norms and perceived behavioural control affecting sexual responsibility among adolescents (Ajzen 1991:180).

This framework provided an understanding of why adolescents decide to engage in certain responsible sexual behaviours and what hinders them from practising those behaviours; to what extent adolescents were willing to perform responsible sexual behaviours willingly; as well as understanding the beliefs that led them to practice certain behaviours. Adolescents' attitudes towards responsible sexual behaviour allowed the researcher to understand their appraisal of certain behaviours in which they engaged. The TBP also enlightened the researcher on adolescents' interpretations of sexual responsibility and whether they are favourable or unfavourable in relation to their beliefs. The researcher also conducted an evaluation of the outcomes of such behaviour (Ajzen 2012:19).

According to Ajzen (2012:18), norms are individuals' perceptions or opinions about what significant others believe the individual should do, and what behaviours are deemed normal in a specific situation or context and not considered risky. Social norms and perceived control beliefs work hand in hand in producing certain sexual behaviours among adolescents.

The social norms referred to the broad range of permissible, but not necessarily required, behaviours adolescents performed, which are expected or desired under the given circumstances (Ajzen 1991:188).

The subjective norms construct enlightened the researcher on the effects of a combination of social pressures or expectations and actions among important persons in an adolescent's network (Ajzen 1991:188).

The perceived behavioural control aspect explored adolescents' willingness and challenges in efforts to ensure responsible sexual behaviour. For instance, the study explored adolescents' perceptions of the ease or difficulty of performing responsible sexual behaviour across situations, acts based on past experience, assumed impediments and obstacles (Ajzen 2012:18).

2.11 SUMMARY

The review of literature highlighted adolescents' demographic profile in Mpumalanga Province and the policies and interventions directed at promoting responsible sexual behaviour among this population. The discussion of literature followed the key concepts related to the research topic. The TPB directed the researcher's discussion of the key concepts 'sexuality', 'sexual behaviour of the adolescents', 'responsible and risky sexual behaviours'. The TPB also provided the framework of discussion, focusing on attitudes, subjective and perceived normative beliefs that motivate or prevent an adolescent from willingly engaging in responsible sexual behaviour.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter discusses the research methods and designs. It provides a clear explanation of the data collection approach used and the analysis and interpretation of that data. The research design and methods provided a framework to achieve the purpose and objectives of the study and obtain answers to the research questions. Moreover, the research methodology illuminated how the researcher conducted the study from start to finish by conducting mixed-method research (Leedy & Ormrod 2019:146; Brink et al. 2018:44).

3.2 RESEARCH OBJECTIVES

The study's first two objectives quantitatively explored and described school-going adolescents' patterns of sexual behaviour and determined their knowledge and attitude in relation to responsible sexual behaviour. The third and fourth objectives of this study were to qualitatively explore and describe the challenges adolescents faced in achieving responsible sexual behaviour, and community members' viewpoints concerning adolescents' responsible sexual behaviour. The last objective was to develop and validate effective strategies to promote responsible sexual behaviour among school-going adolescents.

3.3 RESEARCH APPROACH AND DESIGN

A research approach is a plan and procedure researchers follow to answer research questions. In contrast, a research design is an overall approach used to address research questions, including specifications to enhance the study's integrity (Polit & Beck 2017:582; Creswell & Plano Clark 2018:77. This study was conducted using a mixed-method design, combining both quantitative and qualitative approaches in data collection and analysis processes.

The following questions guided the study: *What are the patterns of sexual behaviour among adolescents? To what extent do adolescents understand the concept of responsible sexual behaviour? To what extent do adolescents practice responsible sexual behaviour? What are adolescents' attitudes with regard to responsible sexual behaviour? What are the challenges encountered by adolescents to achieve responsible sexual behaviour? What are community members' viewpoints regarding adolescents' responsible sexual behaviour? What are the most effective strategies to promote responsible sexual behaviours among school-going adolescents?*

In mixed-method research, the researcher collects, analyses, integrates data, and draws inferences from quantitative and qualitative research approaches in a single study (Creswell & Plano Clark 2014:68). This study followed a sequential, explanatory mixed-method design to answer the above questions.

3.3.1 Mixed-method research design

The researcher's main reason for using a mixed-method design was that the combination of a quantitative and qualitative approach would address the research problem from different perspectives (Fouché et al. 2021:420). The combination of qualitative and quantitative approaches provided better answers to questions than if the researcher adopted a single approach. The quantitative data generated in Phase I provided answers on the patterns of adolescents' sexual behaviour that could be generalised, which would not have been possible with a purely qualitative approach. Conversely, the participants' perceptions and experiences, together with adolescents' challenges in achieving responsible sexual behaviour explored in Phase II, provided detailed and personal evidence, which would have been impossible to explain if the researcher only adopted a quantitative approach. Combining quantitative and qualitative data ultimately contributed to a better understanding of sexual behaviour among adolescents, which resulted in the discovery of contradicting or supportive evidence of a lack of sexual responsibility among adolescents, adding richness to the study.

The qualitative component in Phase II used words to describe the researcher's analysis and interpretation of adolescents' perceptions and experiences and

community members' views of challenges adolescents face in achieving responsible sexual behaviour. The qualitative component received priority over the quantitative component. The sequential explanatory mixed-method design thus allocated greater weight to the second phase (Fouché et al. 2021:428; Creswell & Plano Clark 2018:65).

3.3.1.1 Paradigm

Gray et al. (2018:24) maintain that a paradigm is a way of looking at a natural phenomenon. It is a worldview that encompasses a set of philosophical assumptions that guide one's approach to inquiry, providing a model or framework for observing and understanding what we see and how we understand it. The study followed the pragmatist paradigm, focusing on obtaining knowledge that was truthful or close to the truth. This was facilitated by validating evidence based on socially constructed knowledge and the realities surrounding adolescents' experiences of sexual responsibility.

Guided by Polit and Beck (2017:736), the study's focus was on the research problem, namely a lack of sexual responsibility among school-going adolescents as the driver of the inquiry. The researcher believed that the research questions were more important than the methods and assumptions in the paradigm used. Hence, the research questions guided the research. Both induction and deduction promoted the generation of strategies to facilitate responsible sexual behaviour, and these were verified using a pluralistic view (Creswell & Plano Clark 2018:39-43; Gray 2018:24). The pragmatist paradigm was suitable for this study since it supported the combination of qualitative and quantitative research methods within the same study, making it possible for the researcher to employ the strengths of both approaches. Pragmatism was important to ensure the practicality of the study since sexual behaviour is a broad topic; the researcher thus made use of the best methods that yielded good empirical results (Gray 2018:194; Polit & Beck 2017:739).

3.3.1.2 The sequential explanatory mixed-method study

The researcher used a sequential explanatory mixed-method study. This design is defined “as one of the mixed-method designs, which occurs sequentially in two distinct phases, quantitative and qualitative phase” (Creswell & Plano Clark 2018:77).

With this method, the researcher first conducted quantitative research by collecting and analysing the data to obtain quantitative results. The researcher then developed further questions to qualify and describe the statistical findings emanating from the quantitative results, thus enabling a clearer explanation and analysis of the concept of adolescent sexual responsibility in more detail using qualitative research. Hence, as the name ‘explanatory’ indicates, the qualitative inquiry is a follow-up explanation to initial quantitative data results to get a deeper meaning of the findings. The sequential explanatory mixed-method approach meant that a qualitative study followed the initial quantitative study. The design prioritised the qualitative data (QUAL-quan) (Creswell & Plano Clark 2014:16).

a) Phase I: Quantitative research design

The study started with Phase I, with the researcher collecting quantitative data from school-going adolescents using a questionnaire as data collection tool. Socioeconomic and family characteristics, knowledge of reproductive health, initial and current/most recent patterns of adolescents’ sexual behaviour, adolescents’ attitudes towards responsible sexual behaviour, and their knowledge, use, and evaluation of reproductive health services were investigated. The researcher facilitated the investigation but avoided bringing personal opinions into the study to prevent bias. Controlling the study using structured procedures and formal instruments, namely the questionnaire, resulted in the collection of numeric data. Before conducting the study, the researcher also defined the concepts, variables, and measurement method, and these did not change throughout the study.

b) Phase II: Qualitative research design

The researcher used the results from the quantitative phase to inform the qualitative data collection process, thus providing deeper and further explanations of the quantitative results (Creswell & Plano Clark 2018:65). The follow-up qualitative questions focused on school-going adolescents' challenges in realising responsible sexual behaviour. A nested sample of 14 school-going adolescents who participated in Phase I provided qualitative data during two focus group discussions.

Key stakeholders in the community where adolescents live also participated in Phase II. Face-to-face interviews were conducted with 10 teachers, 10 health and NGO professionals and 10 parents. The key stakeholders were asked to offer their views on school-going adolescents' sexual behaviours and challenges in achieving responsible sexual behaviour. Participants were selected based on their strong connection with the information that arose from the quantitative phase (Creswell & Plano Clark 2018:65). Qualitative data were analysed using a thematic data analysis approach. The researcher was passively involved in data collection, posing questions to the participants and audio recording the conversations.

c) Integration of quantitative and qualitative data

The mixing of data occurred in two ways. First, the quantitative data (Phase I) were integrated during the development of tools designed to collect data in the qualitative phase. The second mixing of data happened after qualitative data collection and analysis in Phase II. The researcher integrated both sets of quantitative and qualitative data, and from the integrated results, strategies were developed to promote responsible sexual behaviour among school-going adolescents.

The sequential explanatory mixed-method design appealed to the researcher because of a strong interest in both quantitative and qualitative approaches, as the design is deeply rooted in these two approaches. Mixed-method research is also practical and flexible and produces rigorous and credible research outcomes (Creswell & Plano Clark 2018:300).

The study was conducted, analysed and reported separately on each phase, providing readers with a clear delineation of the research phases, making it easy to understand and comment where necessary. It is an emergent approach, whereby the qualitative phase was a follow-up on the results of the quantitative phase, allowing flexibility and depth in the collected information (Creswell 2011:85).

According to Fouché et al. (2021:420), mixed-method research establishes a better understanding of the research problem; hence, the researcher utilised this approach; the strengths of the quantitative and qualitative methods complemented each other, thus generating the best answers to the problem of poor sexual responsibility among school-going adolescents.

Leedy and Ormrod (2019:6) and Creswell (2014:8) concur and state the quantitative approach focuses on objectivity, precise measurements and predictions. In contrast, the qualitative approach aims to understand and obtain rich and in-depth information, where subjectivity and context play an important role. Hence, with more than one source of data, sufficient information was generated that had both breadth and depth in covering the wide concept of sexual responsibility among school-going adolescents. Using both quantitative and qualitative designs also enabled a vigorous validation and production of reliable conclusions. The mixed-method design ultimately encouraged the researcher to use an intuitive approach to research and provided a deep understanding of the constant experiences of adolescents' everyday sexual and reproductive lives in order to engage in sexual responsibility (Gray 2017:117).

3.4 STUDY SETTINGS

3.4.1 Phase I: Quantitative study

Two high schools in the township were sites for the study. The researcher withheld the names of the schools and township to promote the participants' confidentiality and privacy. The province and township were ideal for the study because of the high rate of consequences related to school-going adolescents' irresponsible sexual behaviour, such as the high incidence of HIV infections and teen pregnancies (Nkhwashu & Mafukata 2015:1080).

The researcher received permission to conduct Phase I from relevant authorities in the provincial Department of Education, in Mpumalanga Provincial, the district, and at the circuit level in the township. The researcher first visited each school to gain the principals' and Life Orientation teachers' permission to study at their premises. The researcher thus secured permission and was allocated facilitators who were Life Orientation teachers to assist in accessing respondents. This visit also secured dates and times when data collection could start.

During the second visit to the schools, the researcher distributed consent and assent forms to the school-going adolescents to sign after verbally giving them full information about the research, reinforcing information provided on the information sheet. The information sheet gave further information for respondents and their guardians to refer to for a better understanding of the research. The researcher stressed that the decision to participate in the study was voluntary. The consent form emphasised that there were two phases in the study, and there was a possibility that some of the school-going adolescents would participate in both the first and second phases.

3.4.2 Phase II: Qualitative study

The second phase of the study took place in two schools previously used for Phase I, two health facilities, and households in the township. A nested sample of school-going adolescents who participated in the first phase who were capable of providing further information participated in focus groups during Phase II (qualitative). Key stakeholders and community members who were able to provide information on the topic of adolescents' sexual behaviour also participated in this phase. These were parents, teachers, NGO and health professionals. Face-to-face interviews were conducted with these participants.

3.5 RESEARCH METHODOLOGY

A research method refers to all the techniques used in conducting the study. Thus, the methodology represents the techniques involved in the process of gathering data for the study's specific purpose (Kothari & Garg 2019:6). The researcher followed two distinct phases in collecting data: Phase I was a quantitative study conducted in the

form of a survey, and Phase II was qualitative, where data collection occurred through face-to-face interviews with key stakeholders, and two focus group discussions were held with school-going adolescents.

The third stage of the study entailed mixing data by integrating quantitative and qualitative findings and developing and validating effective strategies to promote sexual responsibility among school-going adolescents. Nine people validated the strategies, as explained in Chapter 7. Figure 3.1 is an overview of the research methodology.

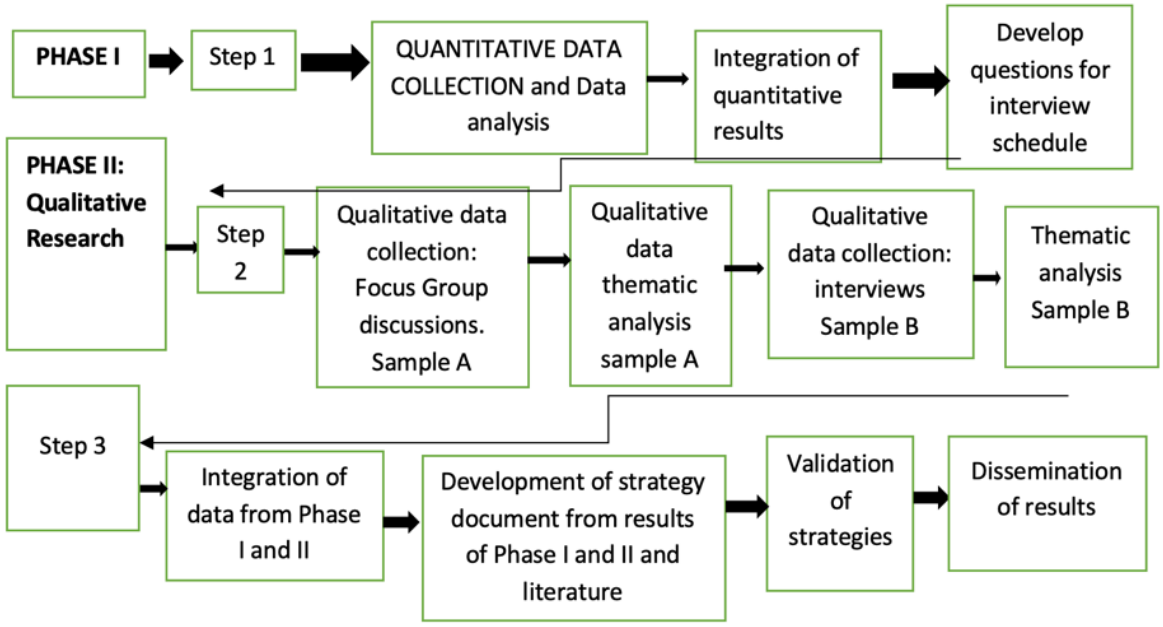

Figure 3.1: Sequential explanatory mixed-method study (Adapted from Creswell and Plano Clark 2018:79)

3.5.1 Phase I: Quantitative study

Quantitative research is systematic, objective and formal, with strict control of possible influences, and the findings are generalised to the whole population (Fouché et al. 2021:29). This quantitative phase was non-experimental and descriptive in nature. Brink et al. (2012:112) and Polit and Beck (2017:14) state that a non-experimental design describes the phenomenon, and explores and explains the relationships between variables, obtaining opinions, attitudes, needs or facts regarding a

phenomenon. It resulted in empirical evidence about adolescents' sexual behaviour patterns.

The main objective of this study was to determine and describe the patterns of sexual behaviours among school-going adolescents by exploring the extent to which school-going adolescents understand and practice the concept of responsible sexual behaviour. Hence, questions related to school-going adolescents who are sexually active, in terms of first-time and current sexual behaviours, how much knowledge adolescents possessed regarding sexual responsibilities, and their attitudes towards different sexual behaviours, were addressed. The questions also explored school-going adolescents who were practising abstinence and their use of certain SRH services in order to realise sexual responsibility. This careful isolation of variables and the use of a structured questionnaire allowed the researcher to control extraneous variables (Fouché et al. 2021:39).

Statistical Package for Social Sciences (SPSS) version 20.0 was used to analyse the data. The researcher first cleaned the data by checking for consistency and missed information, sorting each data item, and verifying the research variables. An Excel spreadsheet was used to code responses, and these were entered into SPSS version 20.0. Descriptive statistics (frequencies, percentages, mean and standard deviations) and inferential statistics (Chi-Square tests) were used. The data are presented as composite frequencies in tables, figures, pie and bar graph charts, with supporting descriptions. These graphic presentations provide visual forms of the results and thus ensure a better understanding of the findings. The Chi-Square results were also used to examine whether there were significant associations between the variables. Inferential statistical analysis was used to draw conclusions from the data using deductive reasoning (Creswell & Plano Clark 2018:210; Creswell & Plano Clark 2011:209).

3.5.1.1 Research strategy

A cross-sectional mixed survey strategy gathered information from respondents. The collected data created an overall picture of school-going adolescents' sexual responsibility. The concept 'cross-sectional survey' means, during data collection, a

relatively large group of school-going adolescents (252) answered a series of questions designed from the WHO questionnaire on adolescent sexual and reproductive health. The information was gathered by exploring patterns of sexual behaviour among a school-going adolescent population aged 15-19 years. To avoid respondents copying and sharing information among each other, Life Orientation teachers acted as invigilators during the sessions. Data were collected once-off, without repeating the process with the intention of generalising the results from the sample to the population. The cross-sectional survey provided quantitative or numeric descriptions of the patterns and trends in attitudes among school-going adolescents towards responsible sexual behaviour (Creswell 2014:13; du Plooy-Cilliers et al 2014:148; Antonius 2013:39).

A cross-sectional survey was the ideal design for this phase since the researcher wanted to collect a large amount of data from many individual respondents at one point in time and in a standard form (Brink et al. 2018:85). Surveys are versatile, and it was thus possible to conduct the research at two schools. In addition, this approach was cost-effective since the survey was conducted at schools where large groups of school-going adolescents were present. Therefore, the survey saved more time than most other data collection methods, as the questionnaire was administered to a large number of school-going adolescents in a class setting. In addition, the survey was completed anonymously without any names connected to the questionnaires, which tends to encourage candid responses to sensitive issues related to adolescent sexual behaviours (du Plooy-Cilliers et al. 2014:160).

Despite the mentioned advantages of the survey, the researcher was aware that there was a need for an extensive understanding of the nature of errors that could occur in the process of collecting and interpreting surveys. Since surveys are artificial and potentially superficial, there was additional attention to detail to prevent returned questionnaires with missing information. Hence, the researcher emphasised to participants before administering the questionnaires that they should ask for assistance during questionnaire completion if a need arose from the researcher, and these were answered to the best of the researcher's knowledge. Those questions related to topics raised in the questionnaire that required answers beyond the

researcher's expertise were referred to appropriate persons (du Plooy-Cilliers et al. 2014:160).

3.5.1.2 Study population

According to Polit and Beck (2018:273), a research population is an entire set of individuals or objects with common characteristics. The population for the quantitative phase was high school-going adolescents in grades 10-12, aged 15-19 years. Adolescents in this age group start to engage in different sexual behaviours at this stage, and due to their young age and immaturity, some sexual behaviours are irresponsible. This age group could provide information on patterns of sexual behaviours among school-going adolescents (Nkhwashu & Mafukata 2015:1080).

a) Sample

According to Fouché et al. (2021:228), a sample is a subset of the total population, which involves taking a smaller number of units from a population as representative or having specific characteristics of that total population.

In this study, the use of a sample instead of the whole population promoted feasibility and representativeness because it is seldom possible for the whole population to participate in research. Consequently, various challenges, including time constraints, a lack of resources (human and financial), and the effort needed to deal with overwhelming data that would have been difficult to process, analyse and interpret, were counteracted (Sarantakos 2013:344).

- **Sample size**

A sample size calculation followed guidelines from Fouche et al. (2021:231) and the researcher used the guidelines to determine the size of the quantitative sample. The researcher calculated the sample size as follows: school-going adolescent enrolments for grades 10-12, aged 15-19 years in the chosen township of Mpumalanga Province in 2018, when the study started: resulting in a total of 1 197. The researcher used this population to calculate the sample size for the township. Therefore, the sampling interval was calculated as the total population divided by the sample size.

Using the specific margin of error of 5%; at the confidence interval of 95%; from the Research Advisor calculations, a sample size of 291 participants was ideal for the study. The researcher randomly selected the sample using class registers, selecting the fourth interval starting from one. Table 3.1 shows only part of the Research Advisor calculator necessary for the study:

Table 3.1: Required sample size

95% confidence interval	Margin of error			
Population size	5.0%	3.5%	2.5%	1.0%
1000	278	440	606	906
1200	291	474	674	1067
1500	306	515	759	1297
2000	322	563	869	1655
2500	333	597	952	1984

Fouche et al (2021:231)

- **Sampling procedure**

According to Polit and Beck (2018:743), sampling is the process of selecting a portion of the population to represent the entire population. Probability sampling was used by employing a systematic sampling technique to achieve a representative sample. Fouche et al. (2021:231) also explain probability sampling refers "to whether or not each unit, whether an individual or social artefact in the population has an equal opportunity to be a part of the sample". The sampling method requires that the sample fits with the parameters of the research (Gray 2014:147; Cresswell & Plano Clark 2011:174).

A sampling frame came from class registers of school-going adolescents in grades 10, 11, and 12 in two high schools in the township. Each high school-going adolescent aged 15-19 had an equal chance to participate in the study.

The researcher picked every 4th school-going adolescent in the sampling frame, starting with the first participant, randomly picked on the class register. By using the systematic sampling technique to select 291 participants at a 95% confidence interval,

the researcher chose respondents from the sampling frame at a 4th sampling interval until the sample size was reached, which was calculated as follows: Total population of adolescents in grades 10, 11, and 12 in 2018=1997/219 =4th interval.

- **Inclusion criteria**

The inclusion criteria for respondents for the study stipulated that male and female adolescents should have been in school, aged 15-19 years, living and attending school in one of the high schools in the township. Speaking and understanding English at a basic level was necessary. This population was ideal because, at this stage, adolescents are mature and understand the subject of sexuality; hence, they could provide rich information for the study. Schools in the township were eligible because they are a place to impart knowledge, and all schools use English as the medium of instruction.

- **Exclusion criteria**

Non-school-going adolescents and school-going adolescents not residing in the township of choice did not partake in the study because the researcher wanted to hear from adolescents with first-hand experience in the township.

3.5.1.3 Quantitative data collection

Data collection is a precise and systematic process of gathering information that addresses the research problem (Polit & Beck 2018:731). Data collection involved important aspects such as the data collection plan, instrument, issues of validity and reliability. Data came from school-going adolescents who met the study's inclusion criteria.

- **Data collection tool development**

Polit and Beck (2018:191) define a data collection tool/instrument as a formal written document used to collect and document information. The researcher developed a self-administered questionnaire as data collection tool. A questionnaire is a document used to gather self-reported data consisting of a standardised series of questions

relating to the research topic to be answered in writing by respondents (Fouché et al. 2021:11; Polit & Beck 2018:740).

The researcher developed the questionnaire by modifying the WHO questionnaire on adolescents' SRH. Some questions came from related empirical literature and studies on similar topics, resulting in well-thought-out, specific, clear, and relevant questions that were in line with the research questions. In the design of the questionnaire, the researcher paid special attention to the wording, making it easily understandable and unambiguous, avoiding leading questions and stating the questions in a positive style. Some questions were open-ended, and follow-up questions were posed to obtain richer information.

Apart from considering particular design issues, the researcher consulted the supervisor and a statistician as experts. The ethical review committee also reviewed and approved the questionnaire before the study commenced. Pilot study was conducted to test the data collection tool before it was distributed to the respondents. Ambiguous, leading questions and all concerns raised during pretesting were corrected (Creswell & Plano Clark 2018:83; Polit & Beck 2017:177).

- **Characteristics of the data collection instrument: Questionnaire**

The questionnaire contained closed-ended questions, checklists, and rating scales. It had simplified and quantified responses, and participants had to tick boxes rather than having to write or type out long answers. The tool was in English at the grade 9 level since all the participants were learning English as a medium of instruction at school

A questionnaire was ideal for this study for many reasons: relative to interviews, questionnaire completion was once-off, and they were less costly. Distributing questionnaires to groups like school-going adolescents was manageable, less expensive and practical, and less time-consuming than most other data collection methods. With a fixed amount of funds, a larger and geographically diverse sample was covered. Unlike interviews, the questionnaire offered the participants the possibility of complete anonymity. This was useful, especially since the information to be gathered was sensitive for some. The direct absence of an interviewer when completing the questionnaire also likely minimised interviewer bias (Creswell & Plano

Clark 2018:179). The researcher extracted large amounts of data in a standardised form.

One of the misgivings of questionnaires is that, in order to conduct a successful study, the researcher must know and extensively understand the nature of errors that could occur during the process of collecting and interpreting the data and this could be a challenging endeavour for a novice researcher (du Plooy-Cilliers et al. 2014:160). However, the researcher felt the questionnaire could be potentially superficial and artificial, largely because the questionnaire contained closed-ended items and misinterpreted questions may have gone undetected. However, self-administering the questionnaire with the assistance of Life Orientation teachers combated some of the misgivings of questionnaires and achieved a high response rate.

The questionnaire contained six sections, each representing variables related to sexual responsibility among school-going adolescents, specifically eliciting information on patterns of sexual behaviours among adolescents and their attitudes towards responsible sexual behaviour. Biographic data and family characteristics were at the fore to assist in describing the school-going adolescents' profiles. The other five variables elicited information regarding adolescents' current sexual behaviours; knowledge related to reproductive health; patterns of sexual behaviours of those who were sexually active and those who had never experienced sexual intercourse; attitudes towards responsible sexual behaviour; and an evaluation of their use and knowledge of SRH services at adolescents' disposal (See attached Questionnaire in Appendix J).

- **Pilot testing**

A pilot study is a mini version of the research study and is mainly used to pre-test the measurement instrument before conducting the main study (Fouché et al. 2021:236). Twenty adolescents participated in the pilot study. Piloting the questionnaire ensured that the questions were well-worded, with clear instructions, and this assisted the researcher in evaluating how much time was needed to complete the questionnaire. This facilitated adjustment to the questionnaire based on the needs identified and increased the validity and reliability of the study. Changes were made to address grammar errors, the numbering of question items, and some questions respondents

did not understand where rephrased. The participants used for the pilot study were not included in the final sample to prevent subjective bias (Fink 2015:5; du Plooy-Cilliers 2014:257).

- **Data collection process**

The researcher was the principal data collector and met with the principal one week before the administration of the questionnaire to discuss the study. The principal assigned Life Orientation teachers to assist the researcher with access to students, explaining the purpose of the research and requesting students participate voluntarily.

The researcher collected most quantitative data using a self-administered questionnaire, administered in schools during free periods or Life Orientation classes with the help of Life Orientation teachers. Students completed the questionnaires and returned them to the researcher or teacher. Some students failed to complete and return the questionnaire. Enforcing follow-up ensured that the respondents who volunteered to respond to the questionnaires returned the completed questionnaire before the class ended, increasing the response rate. However, the researcher stressed that returning the questionnaire was voluntary.

3.5.1.4 Quantitative data management and analysis

Data collected quantitatively were analysed before proceeding to Phase II (qualitative study). This involved a series of steps, outlined by Creswell and Plano Clark (2011:71):

- **Preparing the data for analysis**

The researcher started by converting the raw data into a form useful for data analysis. This included using a Microsoft Excel spreadsheet, where data scoring was carried out by assigning numeric values to each response, cleaning data entry errors from the database, creating special variables and computing variables that comprised multiple items and forming scales. The researcher developed a codebook with the variables, their definitions, and the numbers associated with the response options (Creswell & Plano Clark 2018:210).

- **Exploring the data**

The researcher cleaned the data by checking for consistency and missed information, sorting data items and verifying variables for the study. The Excel spreadsheet was used to code responses related to the major variables.

- **Analysis of Data**

A statistician assisted with descriptive and inferential data analysis. Coded responses were entered into SPSS version 20.0, and the programme was used to analyse the data. Descriptive statistics (frequencies and percentages) and inferential statistics (Chi-Square tests) were used.

- **Representing the data analysis**

At this stage, the researcher visually inspected data trends and evaluated whether the data were normally or abnormally distributed (Creswell & Plano Clark 2011:209). The data were presented as composite frequencies in tables, figures, pie and bar graph charts, with supporting descriptions. These graphic presentations provide visual forms of the results and thus ensure a better understanding of the findings. The Chi-Square results were also used to examine whether there were significant associations between the variables (Creswell & Plano Clark 2018:210; Creswell & Plano Clark 2011:71).

3.5.1.5 Internal and external validity of the quantitative study

Validity is “the degree to which the instrument measures the variables of the study” (Kothari & Garg 2019:70). This means that the measuring instrument should measure what it is expected to measure (Fouché et al. 2021:200).

Validity can be erroneous due to the quality of data collection instrument, the implementation of measures, or the data collection process itself. Validity is evaluated in two ways in this study (Kothari & Garg 2019:70):

Internal validity refers to whether the research method or design answered the research question. This validation evaluated errors in the results that emerged even

though certain controls were in place. The threats to internal validity were participant attrition, selection bias, and maturation of participants (Creswell & Plano Clark 2011:211).

External validity is "the ability of the study to generalise the findings from a specific sample to a population, sample or settings other than the one studied" (Polit & Beck 2012:727). In essence, this validity focuses on determining whether the results apply or concerns the soundness of the research's results: whether the results are unbiased and well substantiated (Antonius 2013:21; Creswell & Plano Clark 2014:211).

The study's findings represented adolescents' sexual responsibility as portrayed in the real world of school-going adolescents. In order to generalise the study's findings, the researcher used four criteria for judging the soundness of the quantitative research instrument, in this case, the questionnaire: internal validity, external validity, reliability, and objectivity (Kothari & Garg 2019:70).

a) Validity

- **Content validity**

Content validity is the degree to which the questionnaire had an appropriate sample of items to measure sexual responsibility among adolescents. This measured the extent to which the questionnaire provided wide coverage of the topic of sexual responsibility among adolescents. To prevent threats to content validity, the researcher observed a content validity index (CVI), the most widely used index in quantitative evaluations. The questionnaire was an adaptation of the WHO questionnaire designed for interviewing adolescents on aspects of SRH after an extensive literature review on the topic and consultation with the supervisor to include the research questions of the study. The questionnaire for the study was designed to cover a wide range of aspects of sexual responsibility (Polit & Beck 2018:280; https://www.who.int/reproductivehealth/topics/adolescence/questionnaire.pdf).

- **Face validity**

“Face validity is the extent to which the instrument looks like it is measuring the target construct” (Polit & Beck 2018:728). Face validity refers to the relevance and transparency of the study as it appeared to the respondents. The researcher evaluated the threats to face validity while pilot testing the questionnaire, asking the respondents to evaluate if the questionnaire measured aspects of sexual responsibility and was well designed before conducting the main study. The respondents agreed that the study covered and measured the concept of sexual responsibility among adolescents. The researcher used the comments to rectify the data collection tool, where necessary.

- **Construct validity**

Construct validity evaluates if the questionnaire corresponds to other variables, like theoretical concepts; in essence, construct validity measures the quality of the research (du Plooy-Cilliers et al. 2014:256). In order to avoid threats to construct validity, the researcher was clear about the purpose and what exactly was being investigated before the collection of data started. The questionnaire was appropriate and suitable, and pilot testing the questionnaire assisted the researcher in asking well-worded questions with the same meaning for the participants. Where there was no clarity, the wording was changed. The questionnaire results were followed by face-to-face, open-ended interviews and group discussions to avoid mono-method bias and reinforce the findings. Here the researcher designed the interview schedules with questions that probed into surprising and contradictory results from the quantitative data (Kothari & Garg 2019:70; Creswell & Plano Clark 2018:252).

- **Criterion-related validity**

According to Polit & Beck (2017:725), criterion-related validity refers to whether scores relate to some external standard, such as scores on a similar instrument. Criterion-related validity helped the researcher to assess how accurately the questionnaire predicted sexual behaviours in relation to other behaviours and experiences among adolescents, such as the effects of drugs and alcoholism on their sexual responsibility, and this reflected the study’s accuracy. To achieve this validity criterion, the questionnaire was pre-tested and adapted from the WHO questionnaire according to the study’s needs. It was also compared with instruments used by other researchers

and their results. The qualitative research approach provided a follow-up to the quantitative research results, and the researcher purposefully selected participants from the pool of respondents who initially participated in the quantitative phase who were ideal for providing the best explanations (Kothari & Garg 2019:70)

3.5.1.6 Reliability of the questionnaire

Reliability is “a consideration that a particular technique, when applied repeatedly to the same object, would yield the same result each time” (Polit & Beck 2017). The questionnaire was checked if it consistently measured sexual responsibility among adolescents when it was repeatedly used with school-going adolescents and in similar circumstances during the pilot study and the actual study. Gray (2017:370) explains that reliability reflects the measure’s stability, internal consistency, and equivalence.

- **Stability**

According to Gray (2014:370), “stability of an instrument is the extent to which the test achieves similar or consistent scores on two separate occasions”. Stability excluded the instrument’s vulnerability to irrelevant or nonessential variables that the researcher did not want to include through random sampling and the test-retest approach while pretesting the instrument. The stability of the questionnaire gives confidence that no confounding happened during the study; hence, the researcher promoted the high stability of the questionnaire through systematic random sampling of school-going adolescents using a class register as a sampling frame, randomly picking schools from a closed container (randomisation). This presented a random sample, and every school-going adolescent had an equal chance of participation. Randomisation ensured standardisation of the conditions under which the study took place with no variation from a group of adolescents from different schools (Polit & Beck 2017:188).

Another test of stability involved conducting a pilot study which is a mini version of the research, mainly used to pre-test the methods and instruments to be used in the main and rigorous study to evaluate if they are valid and reliable (Polit & Beck 2017:195).

Test-retest reliability is a form of determining the reliability of the questionnaire. It entails the researcher evaluating the stability and consistency of the scores received

from sampled participants over time. This means that, before subjecting the actual adolescent participants to the study, the researcher twice administered the questionnaire to a small pilot sample of 20 adolescents at an interval of one week. The researcher compared the scores for each interval objectively by calculating a correlation coefficient. Correlation coefficient is a tool for describing the magnitude of the direction of a relationship between two variables that gave a value range from .70 to 1 Polit & Beck 2012: 331; Creswell & Plano Clark 2014:211). This informed the researcher that the relationship between variables was perfect.

Piloting also ensured a well-worded questionnaire with clear instructions, and the researcher evaluated the time needed to complete the questionnaire. This pilot study facilitated adjustments to the questionnaire based on the needs identified. In this study, adjustments were made to Section 2's structure of the question. At first, respondents were asked to indicate sources of information as most important, second most important and preferred, which caused confusion. After adjustment, the respondents were asked to indicate the most preferred source. Minor grammatical errors and questions' numbering were adjusted. The pilot study respondents were not included in the final sample to avoid subjective bias (Fink 2015:5; Creswell 2011:211).

- **Internal consistency**

Scales and tests were evaluated for their internal consistency to rule out threats caused due to a failure to identify important quantitative results that need explanation (Polit & Beck 2017:307). The Likert scales in the questionnaire were designed to measure specific attributes and nothing else, such as attitudes towards sexual behaviour. The researcher maintained consistency by investigating all possibilities for explanations and followed up on significant and non-significant predictor results. The Cronbach's alpha ranged from .00 to 1.

- **Equivalence**

Equivalence is the extent to which two or more independent coders agree on the scoring (Polit & Beck 2017:334). The researcher was assisted by the statistician during data analysis, and an agreed-upon codebook was developed after consensus agreement.

3.6 PHASE II: QUALITATIVE STUDY

The researcher conducted Phase II after completing Phase I. This meant the collected data were analysed and revealed preliminary results. At this stage, the researcher connected the results from the first dataset extracted from the quantitative phase and used them in developing qualitative questions for further inquiry in Phase II. The qualitative process acted as a follow-up on the quantitative findings, thus further explaining the results from the quantitative phase (Creswell & Plano Clark 2018:234).

Thus, the research findings obtained from Phase I was used to inform and refine the interview schedules for Phase II, linking the quantitative findings to qualitative data collection, building a dependent relationship between the two phases.

The quantitative findings revealed adolescents still engage in unprotected sexual intercourse, fall pregnant, have multiple sexual partners, and engage in bad sexual behaviours, among others, despite SRH services and support at their disposal. The adolescents also revealed a lack of parental involvement in sex-related matters. It was against this background that the researcher further investigated the problem of sexual irresponsibility among adolescents by qualitative inquiry. Phase II employed a qualitative interview schedule based on the quantitative findings to collect data (Creswell & Plano Clark 2018:185).

3.6.1 Research approach

Even though there are different approaches to collecting qualitative data (ethnography, phenomenology, grounded theory, and case studies), this study used a phenomenological approach, entrenched in human lived experience as described by those who experienced or are experiencing the phenomenon. This approach was interpretive and attempted to obtain meaning from adolescents' lived experiences of sexual behaviour, specifically in relation to the challenges they face in achieving sexual responsibility. The community's viewpoints on adolescents' sexual behaviour were also explored (Creswell 2014:14). The researcher gained a deeper understanding of adolescents' sexual behaviours, knowledge and attitudes concerning

sexuality and the challenges they encounter in their quest to engage in responsible sex.

3.6.1.1 Study setting

The qualitative study was conducted at multiple sites. The schools provided the site for teachers and school-going adolescents chosen to participate in the second round of interviews. The clinic provided the site for health professionals and NGO officials. The Mpumalanga Provincial Department of Health granted the researcher permission to conduct the study. The researcher visited the district health offices and clinics to seek permission for the research and received the go-ahead. The researcher then arranged interview dates and times, and accessed the participants. The circuit councillor consented to interviews with parents in his area in selected households.

3.6.1.2 Study population

Different populations participated in the qualitative study, namely school-going adolescents, parents, teachers, healthcare professionals, and NGO officials.

a) Sample

The school-going adolescents should have participated in Phase I and had key attributes of benefit to the qualitative phase, like having a child during adolescence. Secondary participants were those who deal with adolescents, able to offer their expert experiences on this issue of sexual responsibility among adolescents. All participants were eligible if they resided in the township. These were parents, teachers, health professionals and NGO officials.

b) Sampling procedure

Creswell and Plano Clark (2018:176) cited that purposive sampling means researchers intentionally select participants who have experienced the central phenomenon or key concept being explored in the study. This involved selecting certain units or cases based on a specific purpose rather than randomly.

The study used purposive sampling, ensuring that each participant fitted with the research population and was in a position to assist in answering the research questions Gray et al 2017:345). Because of its emergent approach, the phenomenological approach made it possible for the researcher to select the best participants to answer research questions. However, it was initially challenging to plan what quantitative results to follow up on and which participants to utilise in the second phase. Ultimately, everything fell into place as new themes emerged (Creswell 2014:224).

c) Sampling adolescents

A small sample of 14 school-going adolescents who participated in the initial phase was purposefully assigned to two focus group discussions, with seven participants in each group (Creswell & Plano Clark 2018:175). In order to counteract the challenges in selecting school-going adolescent participants, the researcher followed these considerations:

- The researcher intentionally selected school-going adolescents using a maximum variation sampling strategy whereby adolescents with experience in sexual responsibility issues, in particular, were selected. These participants were in a position to provide in-depth information to follow-up questions from Phase I.
- The adolescent participants should have participated in Phase I, and were in grades 10, 11, and 12, without regard for gender, sexual orientation, or being sexually active or not. They should have been able to read, write, speak, and understand English, and resided in the selected township.
- The researcher selected school-going adolescents who were typical or representative of different groups for the follow-up. This provided a better understanding of how groups differed by looking at typical scores or trends within groups in the quantitative sample.
- Participants who scored extreme levels outside the norm were selected to understand why they might have scored as they did. For example, those who

reported engaging in unprotected sex and those who had unplanned pregnancies during adolescence.

- School-going adolescents who belonged to age groups that were most sexually active participated in interviews to evaluate why they might have differed. In this case, school-going adolescents aged 16 to 17 years were participants because the Phase I results revealed this age group was the most sexually active.
- Participants who differed in their scores on significant predictors like behavioural attitudes involving alcoholism, drug use, and engaging in one-night stands were selected along with adolescents who were known to be responsible so that reasons behind different results were explored (Creswell & Plano Clark 2018:175).

d) Sampling teachers

Ten teachers who taught Life Orientation in the three grades (10, 11, and 12) with at least one year of experience teaching Life Orientation in high schools in the proposed township participated in the interviews. The researcher evaluated their expert opinions and views about sexual responsibility among adolescents. Teachers were ideal for participating in this study because they work with school-going adolescents every day and are known to have vast experience and knowledge about adolescents' sexual behaviours (Nkosi & Pretorius 2019:109).

e) Sampling parents

The ward councillor in the area of study in the township granted permission for parents' participation with strict adherence to Covid-19 requirements. Parents consented before partaking in the study. The researcher purposively selected parents with school-going adolescents under their care who lived in the selected township. A sample of 10 participants agreed to face-to-face interviews to answer follow-up questions that arose from the quantitative results. Parents were ideal for this study because they are the cornerstone in the sexual and reproductive growth of a child. However, the quantitative results revealed that a considerable proportion of parents were barely involved in the adolescents' sexual growth, hence the need for further investigation.

f) Selecting Healthcare and NGO professionals

Ten healthcare and NGO professionals from the township clinic were purposefully selected and provided key information on school-going adolescents' sexual behaviour.

3.6.1.3 Qualitative data collection

In this study, follow-up questions were initially tentative while establishing a research proposal, which was submitted to the ethical review committee for approval. However, the quantitative results led to new follow-up questions for the qualitative phase (Creswell 2014:2).

Qualitative data were collected through semi-structured interviews, with questions based on the quantitative results (Polit & Beck 2012:738). All interviews were conducted by the researcher until data saturation was reached. The researcher followed up on interesting and unexpected findings (Creswell & Plano Clark 2018:189).

Different themes emerged and were exhaustively discussed until no new information could be generated. Hence, the researcher had clear corroborated versions of certain aspects of sexual responsibility among adolescents, as revealed in Phase I (Creswell & Plano Clark 2018:190; Creswell 2014:224; Singh 2013:86).

a) Focus groups discussions with adolescents

A focus group is a group interview used to determine individuals' attitudes, behaviours, preferences and dislikes, and participants are interviewed simultaneously by a facilitator (du Plooy-Cilliers et al. 2014:183). Two focus group discussions were conducted. Each focus group participating in Phase II comprised seven participants with a similar background, which promoted a comfortable and dynamic group. Participants were at ease to express their viewpoints during the discussions. A small group was used to counteract the risk of Covid-19 infections and maintain privacy since sexual issues under investigation were a sensitive topic for some. The

researcher explained the importance of maintaining the confidentiality of information shared and asked respondents not to share information with anyone. A confidentiality form was signed (see Annexure K). Therefore, a group of at least seven participants was acceptable. Data saturation was reached with the two group discussions, each lasting 35-45 minutes (Polit & Beck 2017:497).

Focus group discussions were ideal for data collection among adolescents because the participants shared similar geographical attributes, like the same school and township. This promoted quick cooperation with each other. These discussions were important and effective as the researcher obtained the viewpoints of many adolescents in a short time. Those who were hesitant to answer certain questions on the questionnaire opened up during group discussions. This might be due to participants reacting unconsciously to what others were saying, thereby leading to a deeper expression of opinions. Focus groups were more cost-effective and time efficient since all participants were located at the school. The discussions allowed the researcher to explore and verify certain perspectives and experiences that became known by probing (Creswell 2013:164; Polit & Beck 2017:511). However, the disadvantages of focus group discussions were that some adolescents were uncomfortable expressing their views in front of a group and remained less active (Polit & Beck 2017:511).

b) Data collection procedure

The researcher re-introduced the study to school-going adolescents who participated in Phase I, as some had already forgotten about it. This was done by reading the contents of the information sheet, outlining what the study was about, and sharing the primary aim and objectives of Phase II. Participants were reassured that their identities were under protection and confidentiality would be maintained. Responses were audio recorded after obtaining participants' permission, and participants were encouraged to speak audibly to ensure clear recordings. The researcher demonstrated the proper use of the audio recorder before the actual interview and outlined the general group etiquette. The researcher played a passive facilitator role, whereby open-ended questions were asked, and the discussion proceeded among school-going

adolescents. The researcher intermittently asked follow-up questions by probing to seek clarity. Both sessions lasted less than an hour.

The key questions posed to school-going adolescent participants were:
1. School-aged adolescents are persons in the age group 15-19 years, which is highly sexually active. What is your understanding of responsible sexual behaviour among adolescents?

2. What are the challenges you encounter to achieve responsible sexual behaviour? Probing: So, in other words, do you just give him (sex) so that you maintain the relationship? After sex, then what? What is this? Is it just sex? Explain deeper. Therefore, in other words, do you mean boys are abusing girls (by leaving them after having sex with them)?

3. What could be done to promote responsible sexual behaviour among adolescents? Probing: At what stage do you think school teaching about sexual-related issues can start? Parents are saying adolescents as young as grade 7 are sexually active, what do you think? Oh, it (sex) starts mainly in grade 10. Parents said it is better to start as early as possible (from grade 7) teaching sexual-related issues, what is your opinion?

4. To what extent are parents playing their role in adolescents' life? What else can you say about this? What is the role of parents in this? Are they doing much in this case? Where did you learn about sexual-related issues?

5. Who do you prefer to be your source of information, for example, teachers or health professionals? If sexual and reproductive health education comes from schoolteachers rather than health professionals, will this not be too much of a burden to the Department of Education? Then the suggestion by adolescents is that Life Orientation should be the main subject for teaching sexual-related matters and be taken seriously. Please, explain deeper.

c) Interviews with key stakeholders

The researcher dug deeper by using key stakeholders in the community as participants to explore the issue of sexual responsibility among school-going adolescents. The decision to interview key stakeholders was because school-going adolescents are still too young to deal with issues of sexual and reproductive health alone. There is a need for collaborative assistance to ensure their sexual responsibility (Babbie 2013:250; Creswell 2013:163-164).

The researcher chose face-to-face interviews because they allow high response rates. Participants are less likely to refuse to talk to an interviewer who directly solicited their cooperation than completing questionnaires. Interviews were also feasible for the study because interviews offered some protection in terms of confidentiality and privacy. Ambiguous or confusing questions were answered directly since the researcher had a chance to assess whether questions were misunderstood and provided clarification.

A quiet location free from distractions provided an ideal environment. The depth of questioning in interviews and probing further enhanced the quality of the data, thus preventing missed information. The researcher did not have control over question ordering as some questions were randomly answered during the discussion. However, the researcher gained additional data by observing the participants' facial expressions, body movements, and tone of voice. Interviews were costly in terms of time and travelling from one site to another, and interviews prevented anonymity because the interviewees knew each other (Babbie 2013:250-254; Creswell 2013:164; Polit & Beck 2017:306).

Face-to-face interviews with parents

The following broad topic areas guided the interview: What are your views of "responsible sexual behaviour" among adolescents in their community? The researcher intermittently applied probing by asking questions to elicit more information. These are some of the probing questions: What role do the community/family/parents play in sex education? What are the societal/community beliefs, and attitudes with regard to responsible sexual behaviours among adolescents? What challenges prevail in ensuring responsible sexual behaviour among adolescents? What promotes responsible sexual behaviour among

adolescents in the community? Why is there an absence of parents in sex-related discussions these days?

Face-to-face interviews with teachers

For teachers, the key questions include: What is your understanding of responsible sexual behaviour among adolescents? What is the education department's role in ensuring responsible sexual behaviour among adolescents? What challenges are you facing with adolescents' sexual responsibility? What is your perception of the effectiveness of the Life Orientation subject in achieving responsible sexual behaviour?

Healthcare and NGO professionals' interviews

Their key questions were: What is your understanding of responsible sexual behaviour among school-going adolescents? What are health professionals doing to promote responsible sexual behaviour among school-going adolescents? What challenges are you facing in the promotion of responsible sexual behaviour among adolescents? What are the challenges adolescents encounter with access, use and knowledge of health facilities and their services?

3.6.1.4 Qualitative data management and analysis

The qualitative data management and analysis process involved several steps, as advocated in Creswell (2018:208). Qualitative data were analysed thematically using Creswell's thematic analysis process.

Preparing the data for qualitative data analysis

Face-to-face interviews and focus group discussions were audio recorded and stored safely. The researcher personally transcribed the recordings to protect the raw data from the public domain, creating an attachment to the data. In the process, the researcher removed personal information that could link to the participant; for example, names and places of residence to protect participants' privacy and confidentiality.

Exploring and analysing the data

According to Creswell (2014:200), “coding is the process of organizing the data by bracketing similar pieces of information and then giving a word presenting a category in the margins.” The researcher started by familiarising herself with the data by transcribing the interactions and then reading these transcripts repeatedly or listening to the recordings and writing down notes in the margins of the transcripts to develop a general understanding of the data and form broader categories of information (Creswell & Plano Clark 2018:207). This second step involved linking research questions with emerging themes in relation to the participants’ understanding of sexual responsibility and actual sexual encounters among adolescents. This led to the development of codebooks. However, the researcher relied on codes that were generated while writing the research proposal and previous literature reviews as a baseline to guide the analysis of the qualitative data. The codebook had records of old and new codes that emerged during the process of analysing the qualitative data.

The codebook assisted in the organisation of the data and facilitation of agreement on the content. As data coding continued, some new codes emerged while some old ones were removed. Meaningful features of the data became clearer in relation to the study’s objective, which is to promote responsible sexual behaviour among school-going adolescents. The next step entailed coming up with themes, whereby the researcher sorted relevant data extracts, combined and split them (Polit & Beck 2017:562; Creswell & Plano Clark 2018:217).

Presenting the qualitative data analysis

The next step was to present the analysis results using statements and a discussion to provide evidence of the themes. The presentation was further achieved by providing subthemes or subcategories, citing specific quotes from actual participants, and various data sources to depict different findings and views (Creswell & Plano Clark 2018:209).

Interpretation of qualitative results

In the discussion section, the qualitative results were explained and evaluated on whether they answered the research questions. This was done by drawing comparisons between past studies and literature. At this stage, personal experiences

and assessments of the meanings of results played a part, and this resulted in the researcher's attachment to the study.

3.6.1.5 Integration of quantitative and qualitative results

The quantitative and qualitative results and findings were merged at the integration stage. The combined quantitative and qualitative results led to conclusions or inferences. The mixed findings were interpreted and supported by the literature.

3.6.1.6 Development and validation of strategies to promote responsible sexual behaviour

The integrated findings were used to develop strategies to promote responsible sexual behaviour among school-going adolescents (Polit & Beck 2017:628; Creswell 2018:215). Logical reasoning was applied in the strategy development process, which entails drawing inferences or conclusions, and both deductive and inductive reasoning were used during this process. Evidence from the literature and qualitative and quantitative data were used to reach concluding statements, resulting in the development of strategies.

These strategies were given to field experts, experts in strategy development, nurses, teachers, and health professionals dealing with adolescents' sexual and reproductive health to validate and make suggestions for improvement (Creswell & Plano Clark 2018:212).

The participants also received a soft copy of a summary of the proposed strategies that needed to be assessed against a set of criteria, together with a letter that provided relevant information and requested participants' consent. An agreement on the timespan was reached to allow them to familiarise themselves with the strategies and give feedback. After their feedback, the necessary changes were made. Ultimately, the final strategy document described the research findings with proposed strategies (Creswell & Plano Clark 2018:214).

3.7 TRUSTWORTHINESS IN QUALITATIVE RESEARCH

To ensure trustworthiness, the following strategies were used, as described by Polit and Beck (2017:557) and Creswell (2013:246-255):

Credibility: The researcher ensured credibility through prolonged engagement and investing sufficient time in collecting information. The researcher obtained enough information about the adolescents' sexual responsibility and school environments to test the strengths, myths and misconceptions of this topic, where adolescents were free to express themselves. An audio recorder recorded the conversations, while the researcher wrote field notes and observed the participants' responses. The researcher also checked for misinformation that stemmed from distortions introduced by the researcher or participants. The researcher performed member checking by taking the data, analyses, interpretations and conclusions back to the participants so that they could judge the accuracy and credibility of the findings before finalising the research results.

Dependability: The researcher ensured uniformity of the main interview question schedules for both focus groups except during probing to promote dependability. In addition, an audio recorder was used to record the conversations while the researcher wrote field notes to ensure a clear audit trail. The researcher received corroborating evidence by conducting both quantitative and qualitative studies sequentially and using secondary participants to gain a deeper meaning of sexual responsibility among adolescents.

Confirmability: This study provided a thick description of the research process, debriefing, and a peer review will be performed on the final document.

Transferability: The researcher provided a dense description of sampling methods and the whole research process so that readers may make decisions and judge the study's process and its findings.

3.8 ETHICAL CONSIDERATIONS

According to Gray (2014:68), ethics refer to human conduct with respect to morality, thus ethics relate to matters of what is right or wrong. Ethical research means conforming to the standards of conduct given in the social research platform because of the interaction between the participant and researcher trying to search for the truth from the participant (Babbie 2013:32). Overall, research ethics were adhered to and protected the participants' interests, safety and rights. This entailed examining potential risks and managing these, protecting their confidentiality and obtaining informed consent from participants. The researcher conducted this study with integrity (Singh 2013:30) and used the following steps to do so:

3.8.1 University's permission to conduct the study

The Institutional Review Board reviewed the research proposal to guarantee that participants' rights and interests would be protected. This offered some assurance that the risks participants might face during the research were minimal (du Plooy-Cilliers et al. 2014:267). In this case, the University of South Africa's Research Ethics Clearance Committee protects human subjects who participate in research studies, ensures the research is of high quality, and thus approved the researcher's proposal.

To obtain ethical clearance, the researcher completed the research proposal and submitted it with the following documents: the abstract of the proposal gave an outline of the main issues of the research study, the background and purpose of the study, the research problem, research questions and accompanying objectives. The review touched on issues of the population and sampling, the design and methodology, including instruments, data collection and analysis processes, informed consent, voluntary participation, anonymity, confidentiality, harm, risk benefits, and access and permission to sites. The ethics committee reviewed the proposal, granted permission and provided an ethical clearance certificate that gave the researcher permission to conduct the study.

3.8.2 Access to the sites

Access to the study sites was important for the success of the study. The researcher established rapport, goodwill and cooperation with the institutions' management and gatekeepers, and followed protocol in obtaining permission from the officials involved with the institutions. As such, letters asking for permission were written and distributed to the heads of departments of research at the Department of Education and Department of Health in Mpumalanga Province, who gave the researcher their approval. The researcher presented these approval letters to principals, healthcare and NGO professionals and ward councillors, who verbally gave their consent. The researcher also furnished each gatekeeper with the research proposal, copies of the questionnaire and interview schedules, and they granted her permission to conduct the study on their premises and using the institutions' participants.

3.8.3 Informed consent

Informed consent refers to a communication process where the researcher ensures prospective participants know about the research by being open and honest from the outset. The researcher visited the sites a few days before the actual completion of questionnaires and interviews, thoroughly explained the research purpose, risks, benefits and alternatives, and formally asked them to participate in the study. Prospective participants completely understood what was required of them, and were informed of the researcher's protection of their identities and publication of results. It was entirely up to the individual, parents or guardians to decide whether to participate in the research study (Creswell 2014:96).

The researcher used no coercion to force participation; subjects were free to terminate their participation at any time. This study considered informed consent based on voluntary participation, competence, full information, and comprehension since the study required participants' commitment and investment of energy. In the end, participants signed informed consent forms (Bless et al. 2013:30) (see Annexure F for the consent form).

3.8.4 Non-maleficence

According to Polit and Beck (2017:139) and Bless et al. (2013:27), “the participants must not be harmed by participating in the research project.” As such, no harm or adverse events happened during the research, like harming human dignity, worthiness, potential, and uniqueness of each individual. The researcher conducted the study in a sensitive manner after fully informing participants of the study and establishing rapport. This was done using a variety of methods: visiting participants prior to data collection to explain and provide prospective participants with written information to read the document in their own time; having teachers explain to students what the research entailed; protecting privacy throughout the study and ensuring that the results were truthfully reported based on the data collected on the ground. Despite all the above precautionary measures that were put in place to prevent harm to participants, some participants might have felt emotional stress due to the sensitivity of some questions, and some did not complete the questionnaire. However, nobody came forward with complaints.

3.8.5 Beneficence

Beneficence means “the study should bring about the benefits” (Bless et al. 2013:29). In this case, strategies to promote sexual responsibility among adolescents were beneficial to promote a reduction in teen pregnancies, STIs, and school dropout rates. The participants did not ask for any financial rewards for their participation.

3.8.6 Anonymity

The researcher made sure no recordings were made of participants’ real names at any stage of the research process to protect their identities, names and addresses. The researcher also protected the name of the township of choice in Mpumalanga by not naming it during the study to protect the research participants, and the researcher did not conduct unnecessary visits with the participants (Bless et al. 2013:330).

3.8.7 Confidentiality

The researcher ensured confidentiality, and information about the participants' identities did not match their responses. Only the researcher and those who were helping the researcher knew their identities, not the public. This, increased rapport between the researcher and participants. The researcher protected confidentiality during the research by protecting the information that was collected. The researcher also ensured the safe storage of audio recordings; used code names in all published reports; respected participants' secrets; and confirmed that everyone involved in the focus group discussions signed the confidentiality binding form (see Annexure K).

3.9 SUMMARY

The researcher gave a detailed explanation of the mixed-method design that was used to gather, analyse and interpret data. A sequential explanatory mixed-method design was employed during the study. The main population of the study comprised school-going adolescents, parents/guardians, teachers, health personnel and NGO staff who operated and dealt with adolescents in the area of study. The researcher used random sampling to select a sample and gather information for the quantitative strand in Phase I. Self-completed, structured questionnaires were used to collect the quantitative data. An analysis of the quantitative data was then done, first cleaning the data and loading it on Microsoft Excel, then the statistician analysed the data with SPSS software.

The researcher continued to the qualitative research approach in Phase II. The purposive sampling approach produced participants for the qualitative study. The data-gathering method was diverse and included face-to-face interviews and focus group discussions in schools, households, and health institutions. The researcher conducted a thematic analysis of the qualitative data. Mixed-method data analysis ensued in Phase II, and led to the development of strategies to promote responsible sexual behaviour among adolescents. Next, Chapter 4 provides a detailed discussion of the research results from Phase I.

CHAPTER 4
DATA ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS FOR PHASE I

4.1 INTRODUCTION

This chapter presents the analysis and interpretation of the data from the quantitative strand (Phase I) of the sequential explanatory mixed-method research study. The research was conducted in one of the townships in Mpumalanga Province, South Africa. Data were collected from school-going adolescents aged 15-19 years in grades 10-12 using a standardised questionnaire adapted from WHO questions for adolescent SRH.

Phase I addressed the following research objectives:

- To explore and describe school-going adolescents' patterns of sexual behaviour
- To determine school-going adolescents' knowledge and attitudes towards responsible sexual behaviour

4.2 DATA ANALYSIS

SPSS version 20.0 was used to analyse the data. The researcher first cleaned the data by checking for consistency and missed information, sorting each data item and verifying the study's variables. An Excel spreadsheet was used to code responses, which were entered into SPSS version 20. Descriptive statistics (frequencies and percentages) and inferential statistics (Chi-Square tests) were performed. The data are presented as composite frequencies in tables, figures, pie and bar graph charts, with supporting descriptions, thus ensuring a better understanding of the findings (Creswell & Plano Clark 2018:210). The Chi-Square results were used to examine whether there were significant associations between the variables.

4.3 QUANTITATIVE FINDINGS

The study's findings are presented according to data from various sections of the questionnaire.

- Section 1: Adolescents' demographic characteristics
- Section 2: Adolescents' knowledge and sources of sexual and reproductive health
- Section 3: Adolescents' patterns of sexual behaviour
- Section 4: Adolescents' attitudes towards certain sexual behaviours
- Section 5: Adolescents' use of SRH services

4.3.1 Section 1: Respondents' demographic characteristics

Of 291 sampled (n=100%) adolescents, 252 (n=87%) responded by completing the distributed questionnaires. Respondents' demographic characteristics were explored as they provided a broad understanding of the school-going adolescent population. This enabled the researcher to draw a crucial conclusion about school-going adolescents' sexual behaviours. Items 1.1 to 1.11 in the questionnaire collected demographic data from school-going adolescents. These demographic characteristics are discussed according to respondents' age, gender, school grade, the importance of religion, parental presence in the adolescent's life, and the educational level of adolescents' parents. Table 4.1 illustrates these characteristics.

Table 4.1: Respondents' demographic data

Demographic variables	Frequency	Percentage (%)
Gender		
Male	97	38%
Female	155	62%
Age range		
15-16 years	78	31%
17-18 years	131	52%
18-19 years	43	17%
School grade of respondents		
Grade 10	65	25.79%

Demographic variables		Frequency	Percentage (%)
Grade 11		80	31.75%
Grade 12		107	42.46%
Adolescents' parents			
Mother	**Yes**	219	86.9%
	No	33	13.1%
Father	**Yes**	213	84.5%
	No	39	15.5%
Parent educational level			
Father	**Primary**	5	2.0%
	Secondary	98	38.9%
	Tertiary	149	59.1%
Mother	**No education**	3	1.2%
	Primary	14	5.6%
	Secondary	112	44.4%
	Tertiary	123	48.8%
Adolescent Religion	**Not important**	30	12%
	Important	73	29%
	Very important	149	59%

- **Gender representation**

Among the respondents, 155 (62%) were female, and 97 (38%) were male. There were more female respondents than males because there were more girls attending the sampled schools than boys.

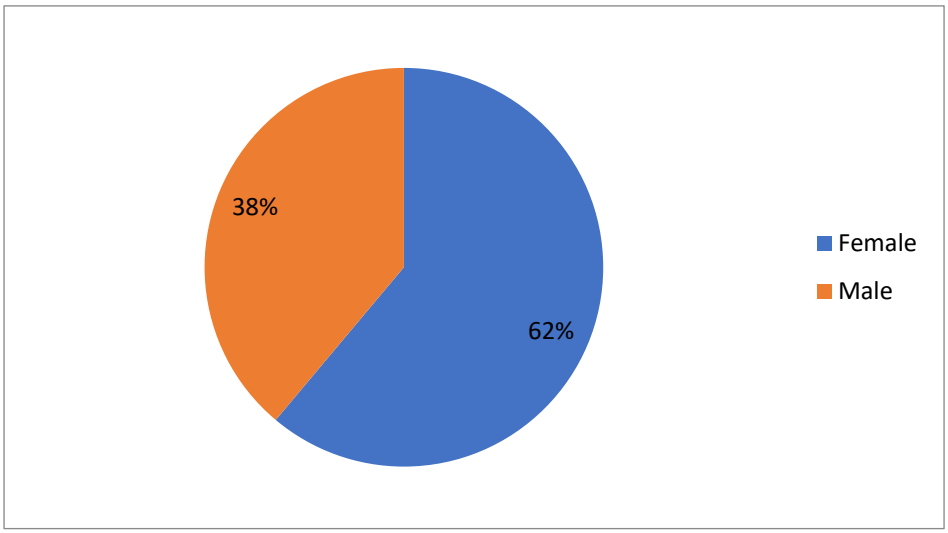

Figure 4.1: Respondents' gender representation

- **Respondents' age**

This item in the questionnaire identified respondents' age as this would be valuable during the analysis of data. The researcher anticipated this data would reveal if there was a relationship between age and adolescents' sexual behaviour.

The responses show that the majority (n=131; 52%) of respondents were in the age range of 16 to 17 years. Seventy-eight (31%) respondents were 15 to 16, while a minority of respondents (n=43; 17%) were aged 18 to 19.

The majority of the respondents were females of all ages ranging from 40% to 60% in all age groups, and males were less in all age groups, ranging from 31% to 60%. Figure 4.2 offers detailed information on respondents' age and gender.

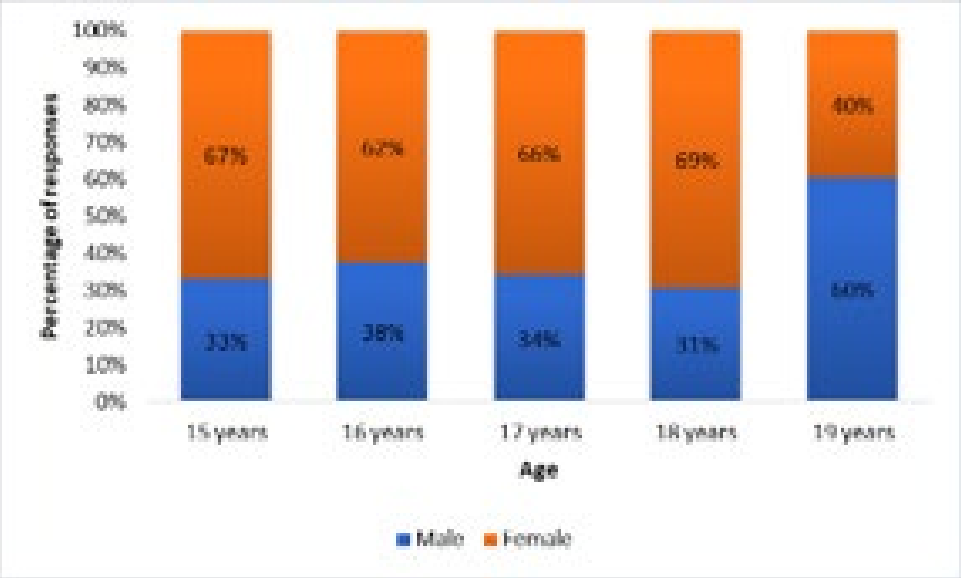

Figure 4.2: Age and gender of school-going adolescents

- **Respondents' school grades**

The majority of respondents (n=107; 43%) were in grade 12, followed by grade 11 respondents (n=80; 32%) and grade 10 respondents (n=65; 32%). This difference is attributed to lower classes not attending school during most of 2020 due to Covid-19 lockdowns, though the upper classes attended school. Figure 4.3 illustrates the respondents' grade level.

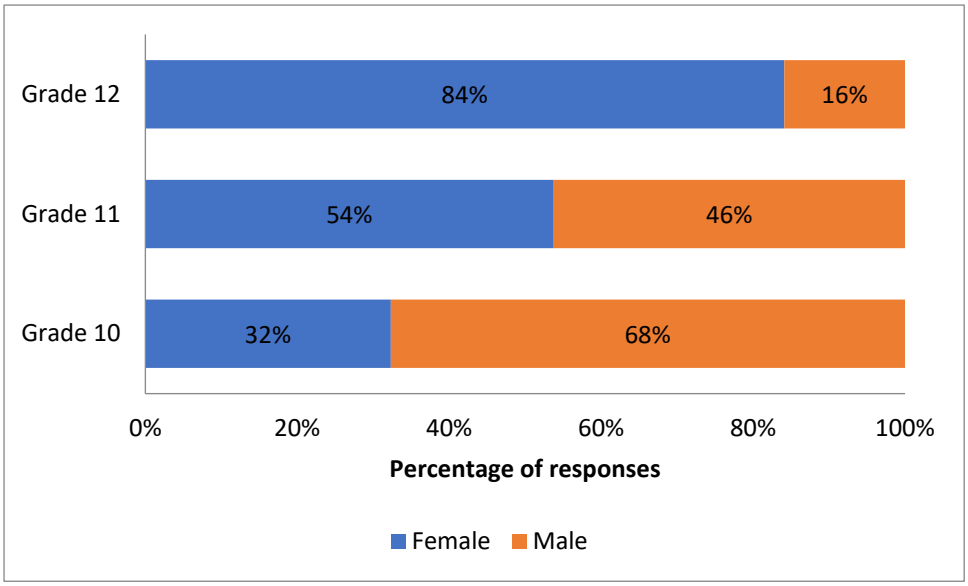

Figure 4.3: School grades of school-going adolescents

- **Importance of religion among adolescents**

The adolescents' religion was assumed to be associated with a later age of first sexual intercourse and fewer risky sexual behaviours, such as unprotected sex. Hence, the respondents were asked to rate whether religion was important in their life, selecting from three dimensions: very important, important, and not important. Most adolescents (n=222; 88%) viewed religion as important, while a few (n=30; 12%) viewed religion as not important. Table 4.1 shows the importance of religion to adolescents.

- **Parental presence in adolescents' sex life**

The question items required that adolescents confirm if their parents were alive, and if they ever had sex-related discussions with their parents. Adolescents need parental guidance to perform responsible sexual behaviour. Items 1.6 to 1.11 evaluated aspects related to parents that were assumed to have an impact on adolescents' sexual behaviour.

The majority of the school-going adolescents (n=432; 87%) indicated their parents were alive, while 72 (14%) adolescents said their parents were not alive. Table 4.2 shows the parents' presence in the adolescents' lives.

- **Educational level of adolescents' parents**

Questionnaire items 1.6 to 1.11 asked the respondents to indicate their parents' educational level. It is assumed that educated parents may pass on necessary information about SRH to their children.

The majority of school-going adolescents' parents had a tertiary education; 98 (38%) fathers and 123 (49%) mothers obtained a tertiary education. On average, adolescents' parents achieved secondary levels of education, where fathers contributed to n=98 (40%) and mothers n=123 (49%) of the sample. However, a fraction (n=3; 1.0%) of the adolescents' mothers were illiterate without any education.

Therefore, most respondents' parents were educated. Even though it was assumed that educated parents might pass necessary information about SRH to their children, the findings revealed most parents were absent in discussions about their adolescents' sex life. Table 4.1 above offers detailed information on the parents' literacy level.

4.3.2 Section 2: Knowledge and sources of information on SRH (question items 2.1 to 2.9)

In this section, the questionnaire items wanted respondents to indicate their preferred sources for SRH information from the list of sources given; Table 4.4 summarises their responses. The majority of adolescents preferred schoolteachers (38%) and mothers (31%) as sources of information. It is surprising that friends (7%), films and videos (4%) were the least-preferred sources of information, since it is assumed that adolescents primarily get SRH information from their friends and the media.

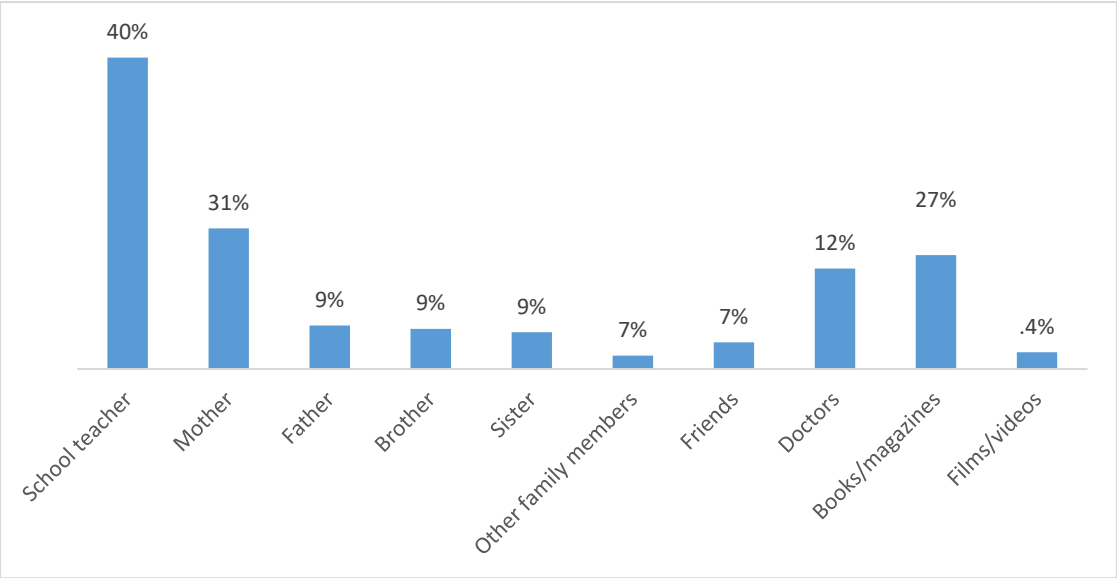

Figure 4.4: Adolescents' preferred SRH information sources

- **Parents as sources of SRH information**

The question items explored fathers and mothers as sources of SRH information for adolescents. The majority of respondents (n=78; 31%) preferred mothers as sources of information, while the minority (n=23; 9%) preferred their fathers as sources of information. This shows that mothers are preferred over fathers as sources of SRH information, and this confirms the nurturing aspect of mothers. Figure 4.4 shows mothers and fathers as adolescents' SRH information sources.

The adolescents were further asked to rate discussions on SRH between them and their parents by indicating the frequency of discussion as never, often and occasionally. Most respondents (n=305; 61%) indicated never having sex-related discussions with parents, and the minority (n=74; 15%) reported occasionally having sex-related discussions with their parents. A significant number of adolescents (n=125; 25%) indicated often having sex-related discussions with parents.

While school-going adolescents preferred parents as sources of SRH information, most parents were absent from adolescents' sex life, offering minimal SRH information. Table 4.1 above outlines the parents' presence in the adolescents' lives, and Table 4.2 shows the frequency of adolescents' sex-related discussions with parents.

Table 4.2: Frequency of discussions on sex-related matters between adolescents and father/mother

		Frequency	Percent	Valid Percent	Cumulative Percent
Father	Never	172	68.3	68.3	68.3
	Often	64	25.4	25.4	93.7
	Occasionally	16	6.3	6.3	100.0
Mother	Never	133	52.8	52.8	52.8
	Often	61	24.2	24.2	77.0
	Occasionally	58	23.0	23.0	100.0

- **School teachers as sources of SRH information**

The majority of school-going adolescents (n=100; 40%) preferred schoolteachers as sources of SRH information. Figure 4.4 above shows the number of respondents who preferred teachers as sources of SRH information.

- **Brothers and sisters as sources of SRH information**

A minority of school-going adolescents (n=23; 9%) preferred brothers or sisters as sources of SRH information. Figure 4.4 above shows the school-going adolescents' preference for siblings as sources of SRH information.

A further question in item 1.13 determined the number of school-going adolescents' siblings who had pregnancies during adolescence. Most school-going adolescents (n=161; 64%) had no older siblings who had unplanned pregnancies during their adolescence, but some did (n=91; 36%). Table 4.3 is a summary of the number of siblings who had unplanned pregnancies during adolescence. This confirms that adolescents with older siblings who had pregnancies during adolescence may be aware of the consequences of teen pregnancy and learn SRH matters from reliable siblings.

Table 4.3: Older siblings' who had unplanned pregnancies during adolescence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	161	63.9	63.9	63.9
	Yes	91	36.1	36.1	100.0
	Total	252	100.0	100.0	

- **Friends as sources of SRH information**

This question item investigated if friends were preferred sources of SRH knowledge. Only a small proportion of respondents (n=18; 7%) preferred friends as sources of information (see Figure 4.4).

- **Other family members as sources of SRH information**

The question item explored other family members as sources of SRH information. Only a few respondents (n=18; 7%) chose other family members as sources of SRH information. This shows that the role that used to be played by extended family members is no longer effectively recognised. In the past, adolescents were nurtured and informed about SRH by extended family members like aunts and uncles. Figure 4.4 above shows these findings.

- **Magazines/books and films and videos as sources of SRH information**

A few respondents (n=68; 27%) chose books/magazines as sources of adolescent SRH information. Figure 4.4 above shows these findings.

- **Films and videos as sources of SRH information**

Films/videos received the lowest preference (n=1; 0.4%) as sources of SRH information. Even though friends, videos and films are typically preferred as sources of SRH information for adolescents, the results were surprising since very few respondents chose these, despite being born to a techno-savvy generation. Figure 4.4 above shows these findings.

- **SRH Classes attended by school-going adolescents**

The question items further explored the number of school-going adolescents who attended classes meant to teach SRH topics and the adolescents' perceptions of the adequacy of classroom SRH learning.

A high attendance of SRH-related classes was reported by respondents (n=175; 70%). However, a significant number of respondents (n=24; 14%) did not know if they attended classes on SRH. The results showed that many respondents (n=53; 21%) never attended SRH classes, and some did not know if they attended SRH classes. This is alarming and reflects adolescents' ignorance since SRH classes are offered in schools through the Life Orientation subject.

A further question asked school-going adolescents to confirm the adequacy of SRH classes. Most adolescents (n= 170; 67%) confirmed the need for more SRH classes, while some (n=41; 16%) confirmed that they needed fewer SRH classes. Some respondents (n=38; 15%) felt that the SRH classes were about right, and only a minority (n=3; 2%) were not sure if they needed SRH classes at all. Figure 4.5 below shows the number of respondents who attended classes on SRH. The findings confirm that adolescents have SRH knowledge gaps that need to be addressed.

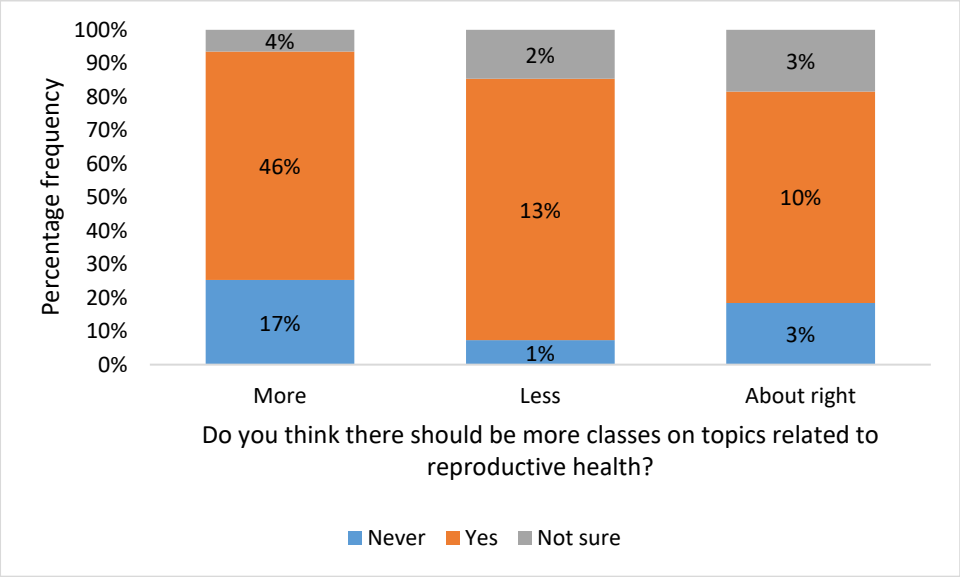

Figure 4.5: SRH classes attended and their adequacy

4.3.3 Section 3A: Sexual abstinence among school-going adolescence (Questionnaire items 3.36 to 3.43)

This section was for school-going adolescents who had never experienced sexual intercourse. Those who had sexual experiences were asked to skip this section and not respond to the question items. The questions asked respondents to share why they abstain using a five-point Likert scale, rated as Applies (A), Not Sure (NS), Don't Know (DK), and Do not apply (NA).

A few respondents (n=14; 25%) felt that they were not ready. An average number of respondents viewed sex before marriage as wrong (n=18; 32%), they were afraid of getting pregnant (n=18; 32%), and they were scared of getting HIV/AIDS or other STIs (n=18; 32%). A few respondents “did not get the opportunity” to be involved in any sexual activities (n=10; 19%). Table 4.4 presents the descriptive statistics on reasons for sexual abstinence among adolescents.

Table 4.4: Descriptive statistics on reasons for sexual abstinence among adolescents

Items	Mean	Std. Deviation	Percentages (%)				
			NA	A	DA	DK	NS
I don't feel ready to have sex.	0.58	0.82	60.4	24.5	12.3	2.8	0
I have not had the opportunity.	0.66	0.99	56.2	19.0	21.0	1.0	2.9
I think sex before marriage is wrong.	0.75	1.01	54.3	32.4	6.7	4.8	1.9
I am afraid of getting pregnant.	0.69	0.96	54.3	32.4	6.7	3.8	2.9
I am afraid of getting HIV/AIDS or other sexually transmitted infections.	0.59	0.72	54.3	32.4	13.3	54.3	32.4
Overall mean score	**0.65**	**0.90**					

4.3.4 Section 3B: Current/most recent patterns of sexual behaviours in school-going adolescents’ lives (Question items 1.15 to 1.18 and 3.1 to 3.8)

In this section, question items explored the behaviours in which school-going adolescents engaged. The question items asked the respondents about their partying,

alcohol use and drug use, sexual encounters, age groups of school-going adolescents' partners, the types of sexual relationships they engaged in, the socioeconomic status of their partners, and the duration of their sexual relationships.

- **Partying among school-going adolescents**

The question items explored respondents' partying frequencies in the last month. The results showed a below-average number of respondents (n=117; 46%) did not attend parties in the last month. More than half of the respondents (n=136; 54%) reported going to parties in the last month. Figure 4.6 presents some frequencies related to respondents' partying patterns in the last month:

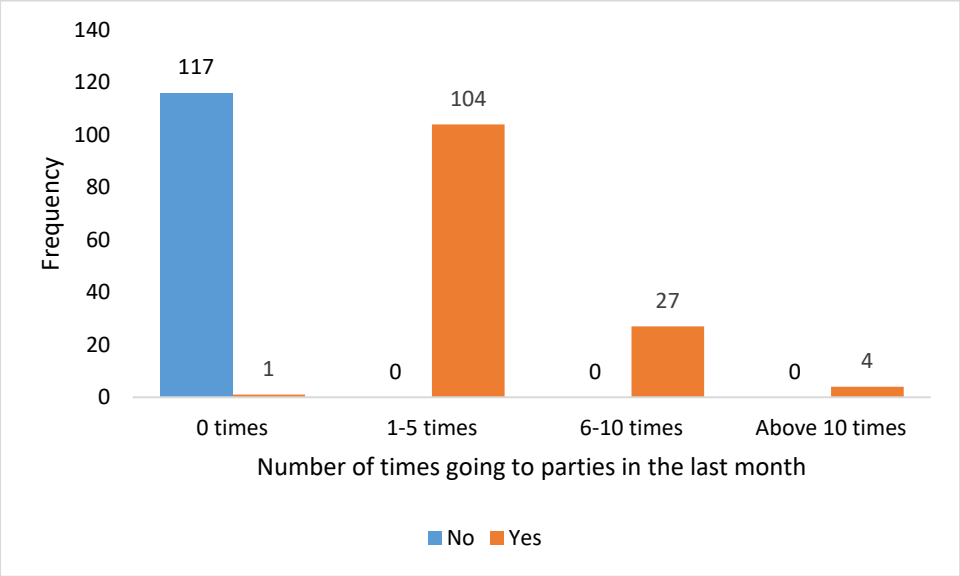

Figure 4.6: School-going adolescents' frequency of partying

- **One-night stands among school-gong adolescents**

A further question asked respondents if they had ever engaged in one-night stands at parties. A high number of respondents (n=78; 35%) reported having one-night stands, while 142 (65%) did not have one-night stands at parties.

A further question asked respondents if they took precautions to avoid pregnancy during those one-night stands; 176 (81%) respondents indicated that they never did anything to avoid pregnancy, 22 (9%) said they always avoided pregnancy, and 20 (8%) reported that they sometimes took action to avoid pregnancy. About 34 (14%) were not eager to say whether they avoided pregnancy or not. Some partying patterns

among adolescents are known to expose adolescents to irresponsible sexual behaviours, and the above discussion confirms that most adolescent parties predispose them to sexual irresponsibility.

Table 4.5: One-night stand after partying

		How many times did you have one-night stands after attending parties in the last month?				Total
		0 times	1-5 times	6-10 times	Above 10 times	
Some young people have one-night stands, perhaps after a party or after drinking. Has this happened to you?	No	0	0	0	0	142 64.5%
	Yes	30 13.3%	16 7.1%	3 1.3%	29 12.8%	78 34.5%
Have you avoided pregnancy during one-night stands?	Never					176 (69.8%)
	Always					22 (8.7%)
	Sometimes					20 (7.9%)
	Missing					34 (13.5%)

- **Drug use frequency among school-going adolescents**

The question items asked school-going adolescents to indicate their drug use frequency in the last month. The respondents who indicated not using drugs at all in the last month were below average (n=122; 48%). However, most participants (n=131; 52%) reported that they indulged in illicit drugs such as *Nyaope, Marijuana*, and *Wonga*. The results thus show that the majority of school-going adolescents used drugs (see Figure 4.7).

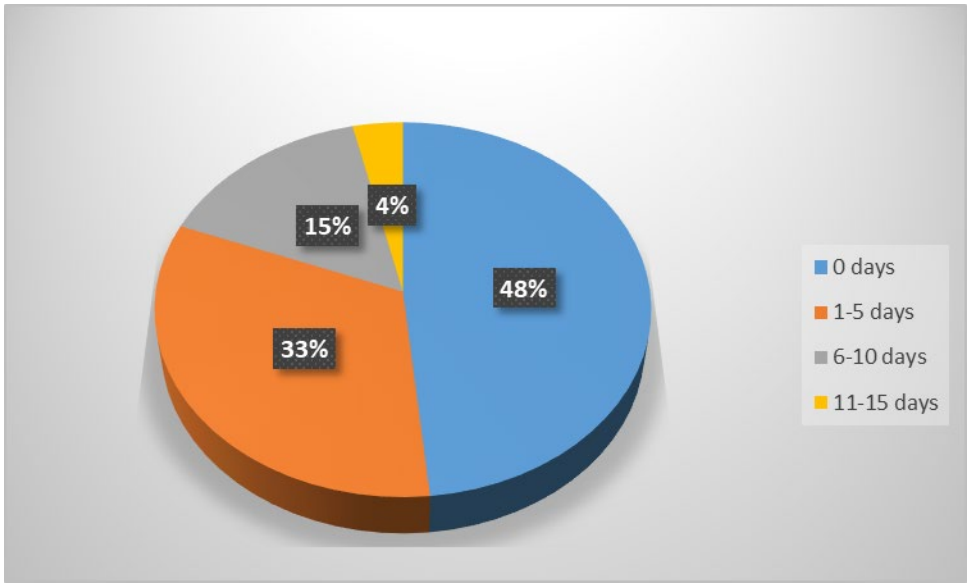

Figure 4:7: School-going adolescents' frequency of drug use in the last month

- **Alcohol use and casual sex among school-going adolescents**

The question item explored alcohol use among school-going adolescents in the last seven days. Most respondents (n=148; 59%) reported that they were not drunk in the last seven days, and a significant number of adolescents (n=104; 41%) reported that they always got drunk after taking alcohol. Some adolescents (n=85; 33%) reported casual sex under the influence of alcohol. The statistics on casual sex after alcohol use among school-going adolescents are offered in Figure 4.8.

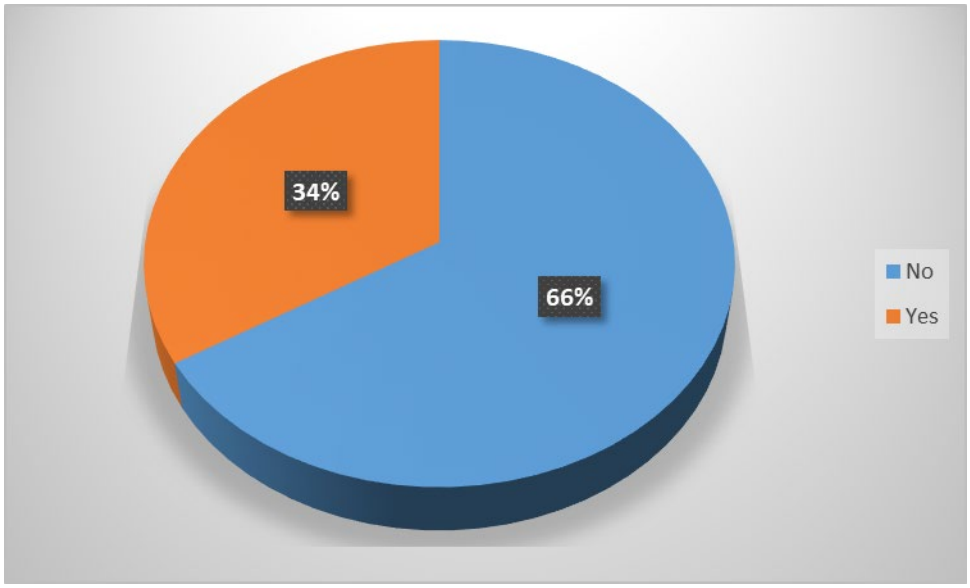

Figure 4.8: Casual sex while drunk among school-going adolescents

- **Age groups of school-going adolescents' partners**

The question items explored the ages of the respondents' partners. The majority of males (n=84; 87%) reported dating young women aged 15-19 years. Only a few males (n=9; 9%) reported dating women aged 20 years and older, and a minority of males (n=4; 3%) did not indicate the age groups of their partners.

On the other hand, the majority of girls (n=80; 55%) indicated dating adolescent boys aged 15-19 years. However, a significant number of girls (n=61; 42%) reported dating older men, aged 20 years and older. A minority of girls (n=4; 3%) did not share the age of their partners (see Table 4.6).

Table 4.6: School-going adolescents' partners and their age groups

		How old is/are the girlfriends in years?					Total
		NA	14- 16 years	17-19 years	20- 22 years	Above 22 years	
How many girlfriends do you have?	NA	4 4.1%	0 0%	0 0%	0 0%	0 0%	4 (4.1%)
	1-2 girlfriends	0 0%	43 44.4%	24 24.8%	3 3.1%	3 3.1%	73 (75.3%)
	3-4 girlfriends	0 0%	4 4.1%	10 10,3%	2 2.1%	0 0%	16 (16.5%)
	5-6 girlfriends	0 0%	2 2.1%	0 0%	1 1%	0 0%	3 (3.1%)
	7-8 girlfriends	0 0%	0 0%	1 1%	0 0%	0 0%	1 1%
Total		4 (4.1%)	49 (50.6%)	35 (36.1%)	6 (6.2%)	3 (3.1%)	97 (100%)
How many boyfriends did you have	NA	4 2.8%	0 0%	0 0%	0 0%	0 0%	4 2.75%
	1-2 boyfriends	0 0%	10 6.7%	69 46.5%	42 28.3%	7 4.7%	128 86.2%
	3-4 boyfriends	0 0%	1 0.6.%	0 0%	7 4.8%	0 0%	8 5.5%
	5-6 boyfriends	0 0%	0 0%	0 0%	0 0%	4 2.6%	4 2.6%
	7-8 boyfriends	0 0%	0 0%	0 0%	1 1%	0 0%	1 1%

	How old is/are the girlfriends in years?					Total
	NA	14- 16 years	17-19 years	20- 22 years	Above 22 years	
Total	4 (2.8%)	11 (7.3%)	69 (46.5%)	50 (33.1%)	11 (7.3%)	145 (100%)

- **Types of sexual relationships among school-going adolescents**

The question items asked about respondents' relationships. The findings show that casual relationships were highest among male respondents (n=79; 81%). A few school-going adolescent boys (n=7; 7%) indicated that their relationship is important and might lead to marriage. On average, school-going adolescent girls (n=35; 24%) indicated their relationship is important and might lead to marriage.

A few school-going adolescents (both boys and girls) indicated their relationship is 'serious with no intention to marry'; 7 (7%) boys and 22 (15%) girls. The minority of respondents indicated that they were engaged to be married; 3 (3%) were boys, while 4 (3%) were girls. These findings reflect that the majority of adolescents' relationships were casual. Table 4.7 presents the relationship types in which school-going adolescent girls and boys engaged.

Table 4.7: Types of school-going adolescent relationships

	How would you describe your relationship with the current partner (s)					Total
	NA	Casual	Serious with no intention of marriage	Important might lead to marriage	Engaged to be married	
BOYS	4 4.1%		0 0	0 0	0 0	4 4.1%
Total	4 4.1%	79 81.4%	7 7.2%	7 7.2%	3 3.1%	97 100
GIRLS	3 2.1%	1 0.7%	0 0	0 0	0 0	4 2.8%
Total	3 2.1%	81 55.9%	22 15.2%	35 24.2%	4 2.8%	145 100%

- **Duration of sexual relationships among school-going adolescents**

The question items asked about the duration of sexual relationships among school-going adolescents. Most female respondents (n=83; 57%) indicated that they were involved in short-term sexual relationships, lasting 1-11 months. A significant number of female adolescents (n=56; 37%) also indicated that their sexual relationships lasted 1 to 4 years. A minority of adolescents indicated that their relationships lasted less than one month and 5-8 years, respectively (2%; n=3 each). The results show that most adolescents engage in relationships that do not last a long time, and this predisposes adolescents to engage in sex with many partners during adolescence, which poses a risk for HIV and STI infections.

Table 4.8 outlines statistics of the duration of school-going adolescents' relationships.

Table 4.8: School-going adolescents' relationships duration and number of partners

	How many years are you in a relationship with the partner you are with?				Total
	Less than 1 month	1- 11 months	1 year to 4 years	5-8 years	
GIRLS	3	83	56	3	145
Total	2.1%	57.2%	38.6%	2.1%	100%
BOYS	4	46	46	1	97
Total	4.1%	47.4%	47.4%	1%	100%

- **The socioeconomic status of the partners of school-going adolescents**

The question items asked school-going adolescents to indicate the economic status of their partners. The respondents could choose from responses, namely: partner is a full-time student; partner is working; and partner is neither at school nor working. The results suggested that most of the male respondents (n=79; 82%) were in relationships with full-time students. A few (n=6; 6%) indicated that they were dating girls in the working-class.

Similarly, the majority of female respondents (n=97; 67%) were in relationships with full-time students. However, a significant number of female school-going adolescents (n=37; 26%) confirmed dating working-class partners. A few (n=8; 6%) shared that

their partners neither study nor work. The results show that some adolescent girls date working-class partners, and there is a probability that working partners act as economic safety nets for female school-going adolescents. Table 4.9 presents the economic status of the partners of school-going adolescents.

Table 4.9: Economic status of school-going adolescents' partners

	The person you are in a relationship with is/are (specify if you have more than one partner)				Total
	NA	Full-time student	Working	Neither	
Boys	4 4.1%	0	0	0	4 4.1%
Total	4 4.1%	79 81.5%	6 6.1%	8 8.2%	97 100%
Girls Total	3 2.1%	97 66.9%	37 25.5%	8 5.5%	145 100%

4.3.5 Section 3C: The following question items were only for school-going who had experienced sexual intercourse (question items 3.9 to 3.35)

The respondents who were abstaining were asked to skip this part and move on to the next set of questions.

To understand more about sexual responsibility among adolescents, the respondents were asked about their current sexual patterns using the following variables: number of sexual partners, penetrative sexual intercourse, methods of prevention used on the first sexual encounter and following sexual encounters, discussions about contraceptives between the partner and adolescent, the frequency of sexual intercourse and methods of prevention used currently, regrets and level of concern among adolescents regarding the risk of infection with HIV or other STIs.

- **Number of sexual partners of school-going females**

It is evident in the graph below that most female respondents had 1-2 boyfriends who were aged between 17-19 years and 20-22 years. Unlike the male respondents, the

female respondents opted for partners who were relatively older than them. Figure 4.9 illustrates the number of sexual partners among adolescent girls.

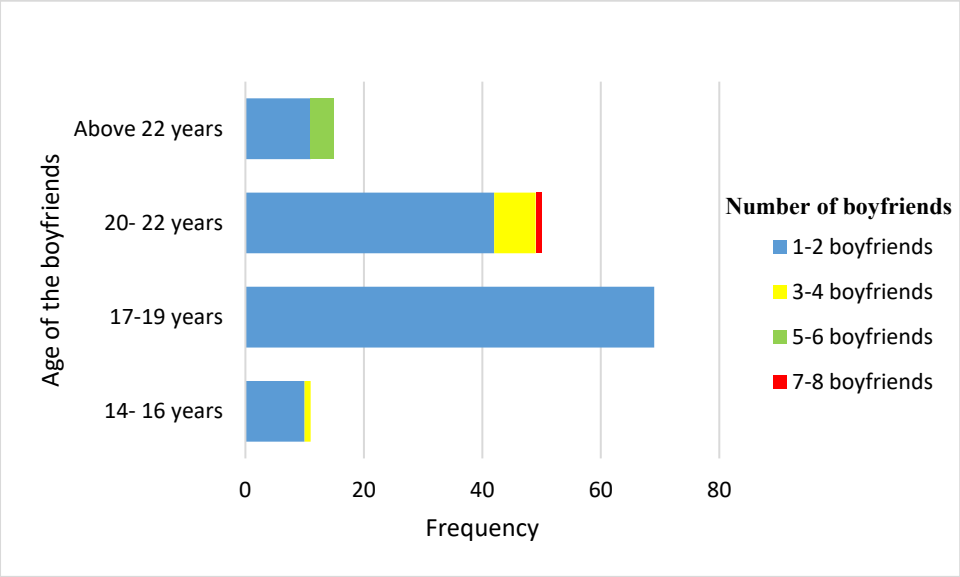

Figure 4.9: Number of sexual partners of school-going adolescent girls

- **Penetrative sexual intercourse among school-going adolescents**

Penetrative sexual intercourse among school-going adolescents was explored to understand patterns of sexual behaviour. A majority of male respondents (n=85; 88%) indicated that they started engaging in sexual intercourse, while a minority of male respondents (n=12; 12%) were not sexually active.

Most female respondents (n=118; 81%) reported having penetrative sexual intercourse in the last month. Table 4.10 gives a detailed overview of adolescents' sexual partners.

Table 4.10: Sexual intercourse and number of partners adolescents had

SEX WITH PARTNERS		Did you have any penetrative sexual intercourse with your partners		Total
		No	Yes	
How many boyfriends do you have sex with?	NA	4 2.8%	0 0	4 2.8%

SEX WITH PARTNERS		Did you have any penetrative sexual intercourse with your partners		Total
		No	Yes	
	1-2 boyfriends	23 15.8%	105 72.4%	128 88.2%
	3-4 boyfriends	0 0	8 5.5%	8 5.5%
	5-6 boyfriends	0 0	4 5.5%	4 2.8%
	7-8 boyfriends	0 0	1 0.7%	1 0.7%
Total		27 18.6%	118 81.4%	145 100%
How many girlfriends do you have sex with?	NA	4	0	4 4.1%
	1-2 girlfriends	8 8.2%	65 67%	73 75.3%
	3-4 girlfriends	0	16 16.4%	16 16.4%
	5-6 girlfriends	0	3 3.1%	3 3.1%
	7-8 girlfriends	0	1 1%	1 1%
Total		12 12.3%	85 87.6%	97 100%

- **First sexual experiences of adolescents**

The question items asked respondents to confirm their age at first sexual experiences; if the sex engagement was planned or not; and was the sexual intercourse forced, persuaded, or of free will.

The results show that the median age of respondents at first sex was 15.5 years and the age range at first sex was 10-19 years. An above-average number of respondents (n=65; 55%) confirmed that they were willing to have sexual intercourse for the first time. Some respondents (n=25; 21%) confirmed that they had sexual intercourse because their partner persuaded them. A minority (n=28; 18%) said they were forced into their first sexual encounter by their partner.

Regarding planning for first sexual intercourse, 86 (73%) respondents confirmed that they had unexpected sexual intercourse, while 32 (27%) respondents had planned to have sex. Table 4.11 reflects school-going adolescents' first sexual experience.

Table 4.11: School-going adolescents' first sexual experiences

		How you ended up having sexual intercourse		
		Applicable		
Think back to the time you had your first sexual intercourse with your partner. Would you say	I forced	8 (6.8%)		
	I persuaded	13 (11%)		
	Partner persuaded	12 (10.1%)		
	Partner forced	20 (17.5%)		
	Both willing	65 (55.1%)		
Total		118 (100%)		

How did you end up having sexual intercourse	
Planned	22 (27.1%)
Unexpected	86 (72%)

- **Methods of prevention used by school-going adolescents on first-time sex**

This question item further explored methods of pregnancy prevention school-going adolescents used during their first sexual intercourse. More than half of the respondents (n=118; 58%) confirmed that they used a method of prevention. A significant number of respondents (n=85; 42%) confirmed having sexual intercourse for the first time without taking any action to prevent falling pregnant.

The results suggest that almost half of the respondents (n=98; 48%) used condoms to prevent pregnancy. Fourteen (7%) respondents used injections, 8 (4%) used withdrawal, 6 (3%) used 'safe period' for prevention, and 3 (1%) used the pill as a prevention method. Table 4.12 shows the methods of prevention school-going adolescents used during their first sexual intercourse.

Table 4.12: Method of pregnancy prevention used by school-going adolescents during first-time sexual intercourse

		What method did you use on your first-time sexual intercourse?							Total
			Condom	Pill	Injection	Withdrawal	Safe period	Other	
On that first time, did you and your partner do anything to avoid pregnancy?	No	85	0	0	0	0	0	0	85 (41.95)
	Yes	118	98 (48.3)	3 (1.48%)	14 6.9%	8 3.9%	6 3%	6 3%	118 (58.1%)
Total		203 100%	98 48.3%	3 1.5%	14 6.9%	8 3.9%	6 3%	6 3%	203 (100%)

- **Regrets after first sexual intercourse among school-going adolescents**

The question item further asked respondents whether they had regrets after their first sexual encounter. An above-average number of respondents (n=107; 52.7%) did not regret their first sexual intercourse, and a significant number of respondents (n=96; 47.3) regretted the act.

Among adolescents who regretted their first sexual experience, many (n=56; 28%) were respondents who confirmed that they started to have sex in middle adolescence. Many late adolescents (n=25; 12%) also regretted having sexual intercourse for the first time. Only a minority of the adolescents (n=12; 6%) who confirmed that they started to have sex in early adolescence regretted their first sexual encounter. Table 4.13 shows the finer details about regrets at first sexual intercourse among adolescents.

Table 4.13: Regrets among school-going adolescents at first sexual intercourse

		Did you regret having sexual intercourse that first time?		Total
		Not regretted	Yes regretted	
How old were you the first time you had sex?	Not applicable	16 (7.9%)	3 (1.5%)	19 (9.4%)
	10-13 years	11 (5.4%)	12 (5.8%)	23 (11.3%)
	14-17 years	70 (34.5%)	56 (27.6%)	126 (62.1%)
	18-19 years	10 (4.9%)	25 (12.3%)	35 (17.2%)
Total		107 (52.7)	96 (47.3)	203 (100%)

- **Frequency of sexual intercourse among school-going adolescents**

Among the respondents who were sexually active, many (n=64; 29%) confirmed having sexual intercourse more than 20 times. A considerable number of respondents confirmed having sexual intercourse 2-5 times (n=42; 19%) and 16-20 times (n=41; 18%). Respondents who had sexual intercourse 6-10 times were few (n=11; 5%), and a minority (n=12; 6%) confirmed having sexual intercourse only once. The results confirm that most school-going adolescents continue to engage in sexual intercourse after their first encounter, and only a few stopped. Further information is illustrated in Table 4.14 below.

Table 4.14: Frequency of sexual intercourse among school-going adolescents

		How many times you and your partner have full intercourse?							Total
		NA	once only	2-5 times	6-10 times	11-15 times	16-20 times	More than 20 times	
Did you ever discuss contraception with partners?	Never	19 8.6%	24 10.9%	12 5.5%	6 2.7%	0 0	12 5%	12 5.5%	84 38.2%
	Before first intercourse Yes	0 0	16 7.3%	3 1.4%	16 7.3%	4 1.8%	12 5.4%	25 11.3%	76 34.5%
	After first sexual intercourse Yes	0 0	2 0.9%	2 0.9%	8 3.6%	3 1.4%	18 8.9%	27 12.3%	60 27.3%
Total		19 8.6%	42 19.1%	17 7.7%	30 13.6%	7 3.2%	41 18.6%	64 29.1%	220 100%

- **Frequency of prevention of pregnancies and STIs (question item 3.17)**

Further question items asked adolescents about the frequency of their use of prevention methods and the method they used. Most school-going adolescents (n=165; 75%) confirmed using various methods to prevent pregnancies and STIs after their first sexual intercourse. However, of those who used various methods, many (n=90; 41%) indicated that they sometimes used preventive methods and below-average respondents (n=75; 34%) always used them. A minority of adolescents (n=55; 25%) confirmed that they did not use any method.

Condoms were the highest preventive method used (n=113; 51%). However, 58 (26%) always used condoms, while 39 (17.7%) used condoms sometimes. Thirty (14%) respondents indicated using injectable contraceptives.

About 18 (8%) and 16 (7%) used the withdrawal method and pills, respectively. Safe period (a portion of the menstrual cycle when conception is least likely to occur) was used by 5 (3.2%) respondents, and 1 (0.5%) used 'other methods'. Table 4.15 reflects the methods respondents used to prevent pregnancies and STIs, and the frequency of their use.

Table 4.15: Methods used to prevent and frequency of use

		What method do you and your partner mostly use?							Total
		None	Condom	Pill	Injection	Withdrawal	Safe period	Other	
Apart from the first time, did you and your partner ever use any method to avoid pregnancy?	Never	55 25%	0 0	0 0	0 0	0 0	0 0	0 0	55 25%
	Always	1 0.5%	58 26.4%	3 1.4%	7 3.2%	4 1.8%	2 0.9%	0 0	75 34%
	Sometimes	2 0.9%	39 17.7%	11 5%	23 10.4%	9 4.1%	5 2.3%	1 0.5%	90 41%
Total		58 26.4%	113 51.4%	16 7.3%	30 13.6%	18 8.2%	7 3.2%	1 0.5%	220 100%

A further question asked male adolescents' if they had ever impregnated a partner, and female adolescent respondents were asked if they had been pregnant. About 85% of male school-going adolescents indicated that their partners never got pregnant, and 15% confirmed that they got pregnant. Figure 4.10 shows the rate of male adolescents' partners who fell pregnant.

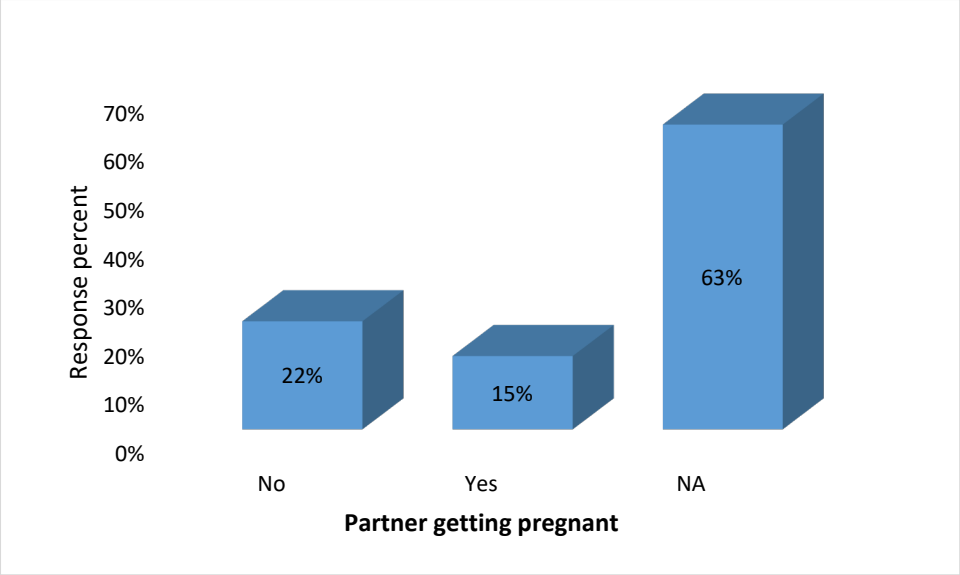

Figure 4.10: Male adolescents' partners who fell pregnant or did not fall pregnant

Female school-going adolescents who were involved in sexual intercourse were asked if they had fallen pregnant. Figure 4.11 presents the results.

Of the female school-going adolescents who were sexually active, 16% confirmed that they fell pregnant, while 34% said they had never been pregnant. On average, 50% of the female respondents indicated that the question was not applicable to them. Figure 4.11 below shows the frequency with which female school-going adolescents became pregnant.

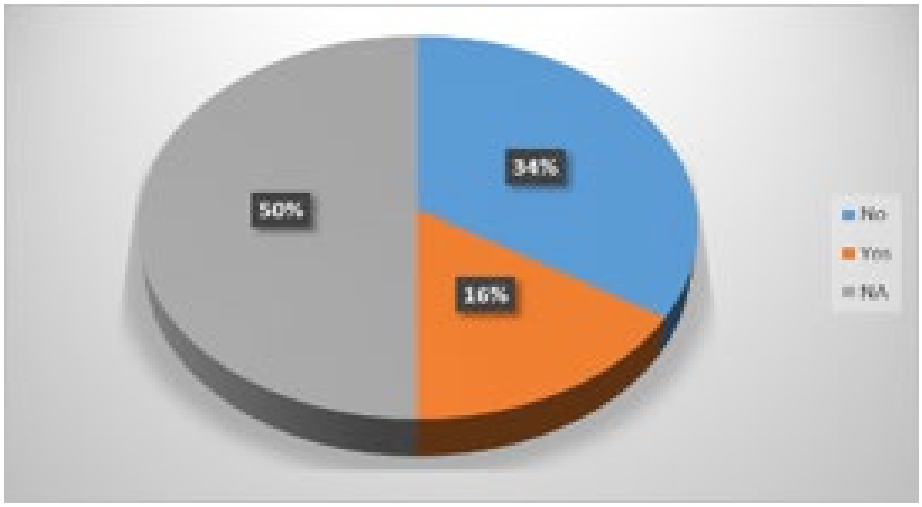

Figure 4.11: Female school-going adolescents who became pregnant

A further question asked what happened to the pregnancies. Some pregnancies were aborted (n=33; 15%), a few respondents (n=4; 1.8%) reported miscarriages, while 8 (4%) reported live births. Nine (4%) respondents reported currently being pregnant (see Table 4.16).

Table 4.16: What happened to the pregnancy?

What happened to the pregnancy?						Total
Not applicable	Currently pregnant	Terminated	Miscarriage	Live birth	Not sure	
165	0	0	0	0	0	165
75%	0	0	0	0	0	75%
0	9	33	4	8	1	55
0	4.1%	15%	1.8%	3.6%	0.5	25%

- **Partner communication about SRH and decision-making on prevention methods**

The question item asked school-going adolescents to confirm if they communicate with their partners about prevention methods, which method they use, and whose decision it was to use that method. A significant number of respondents (n=84; 38.2%) reportedly never discussed methods of prevention with their partners, and a few (n=60; 27.3%) discussed prevention methods.

School-going adolescents were asked to indicate whose decision it was to use preventive methods. The majority (n=118; 56.3%) confirmed that it was a joint decision. Many respondents (n=56; 25.5%) confirmed their responses as 'my decision'. A minority (n=27; 12%) confirmed that it was their partner's decision.

The results suggest that SRH communication among partners was jointly done, and SRH decision-making among school-going adolescents and their partners centred on the use of condoms and injectable contraceptives as preventive methods.

Evidently, there is communication between partners about contraceptives, suggesting support from partners to use preventive measures in order to achieve sexual

responsibility. Table 4.17 outlines more details about decision-making related to prevention methods adolescents and their partners employed.

Table 4.17: SRH communication and decision-making among adolescents and their partners on what method to use

		Whose decision was it to choose the SRH method you are using?				Total
		Not applicable	My decision,	Partner's decision	Joint decision	
What method do you and your partner mostly use?	None	19 8.7%	3 1.4%	2 0.9%	10 4.6	34 16%
	Condom	0 0	32 16.5%	14 7.2%	68 35.1%	114 52%
	Pill	0 0	6 2.7%	3 1.3%	7 3.2%	16 7%
	Injection	0 0	10 4.5	4 1.8%	16 7.23%	30 14%
	Withdrawal	0 0	3 1.4%	2 0.9%	13 5.9%	18 8.%
	Safe period	0 0	1 2.2%	2 0.9%	4 1.8%	7 3%
	Other	0 0	1 0.5%	0 0	0 0	1 1%
Total		19 9%	56 26%	27 12%	118 54%	220 100%

- **Concern for risk of infection with HIV or other sexually transmitted diseases (STDs) among sexually active school-going adolescents (Question items 3.23 to 3.25)**

Question items probed respondents' concerns about contracting HIV and other STIs. The highest number of respondents (n=97; 44.1%) confirmed that they were not concerned about HIV, while many respondents (n=76; 34.5%) stated they were very concerned. A minority of respondents (n=47; 21.4%) reported that they were somewhat concerned about catching AIDS or other STIs from their partners. Figure 4.12 illustrates adolescents' level of concern about the risk of HIV and other STIs and methods used to reduce the risk.

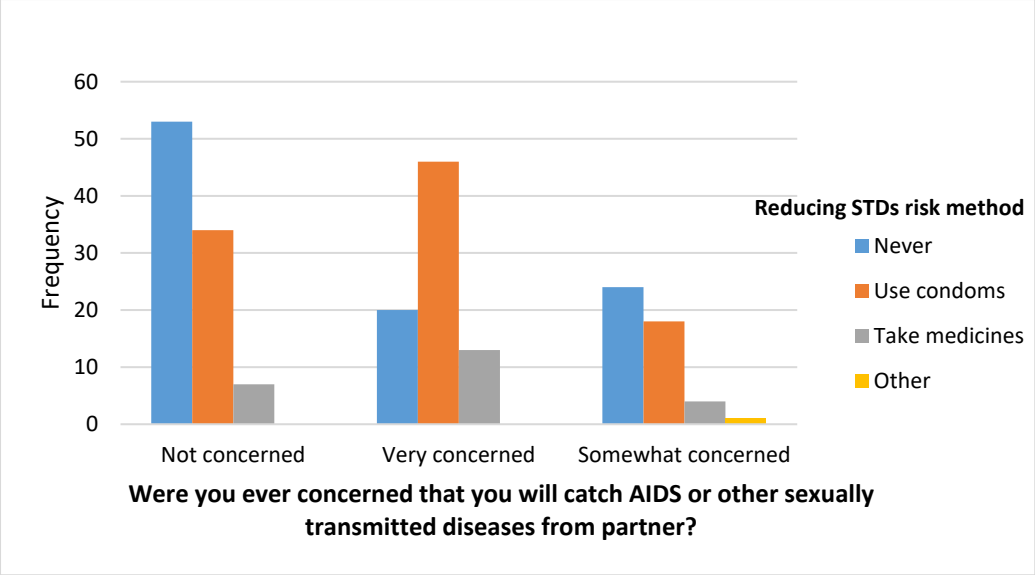

Figure 4.12: Sexually active school-going adolescents' concern over catching HIV/STD and methods of reducing the risk of infection

- **School-going adolescents who had sexual intercourse against their will (Question items 3.26 to 3.28)**

The question items asked school-going adolescents' about forced sex. The majority of respondents (n=165; 75%) confirmed that they were not forced to have sexual intercourse against their will, while some (n=55; 25%) confirmed being forced to have sex by a stranger, relative or an older person. Further information is illustrated in Table 4.18.

Table 4.18: Forced sexual intercourse

		How many strangers, relatives or older persons have forced you to have sexual intercourse against your will?					Total
		Not applicable	1- 3 people	4-6 people	7-9 people	more than 9 people	
Some young people are forced to have sexual intercourse against their will by a stranger, relative or an older person. Has this happened to you?	No	163 75%	0	0	0	0	165 75%
	Yes	0 0	46 20.9%	5 2.3%	3 1.4%	1 0.5%	55 25%
Total		163 75%	29 21%	5 2%	3 1%	1 1%	220 100%

- **School-going adolescents who paid and received money and gifts in exchange for sexual intercourse (question items 3.32 to 3.35)**

The question items asked respondents to confirm if they ever paid money or gifts for sex. The majority (n=186; 74%) confirmed that they never offered money or gifts in exchange for sex, while some (n=33; 13%) did. The result shows that sexual transactions are prevalent among school-going adolescents, and this exposes them to risky behaviours. Figure 4.13 reflects the frequency of adolescents paying money in exchange for sex.

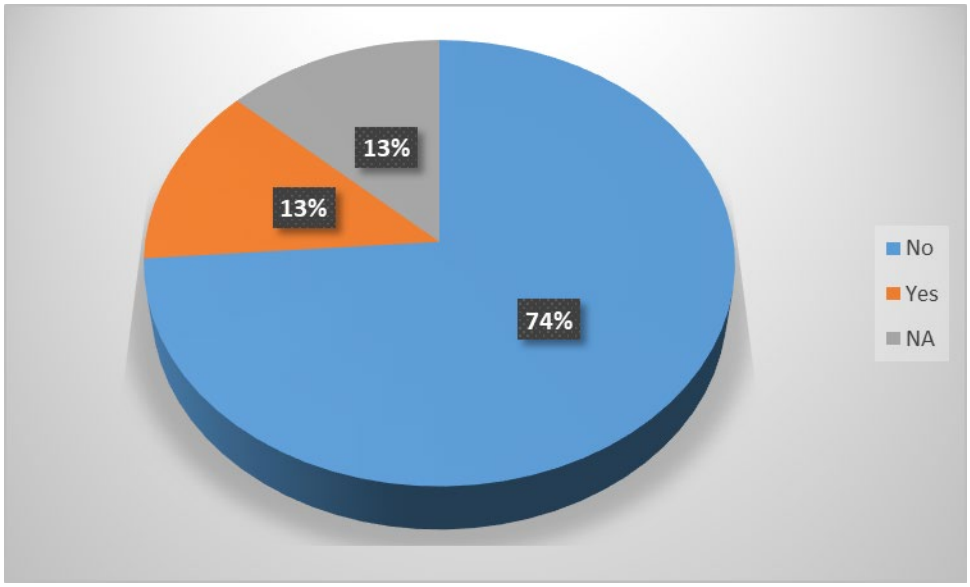

Figure 4.13: School-going adolescents who paid money in exchange for sex

A further question asked respondents if they ever received money or gifts in exchange for sexual intercourse. The majority of respondents (n=173; 69%) confirmed that they never received money or gifts in exchange for sexual intercourse, though a few (n=45; 18%) did (see Table 4.19).

Table 4.19: Money or gifts payment for sexual intercourse among school-going adolescents

		Frequency	Percent	Valid Percent	Cumulative Percent
Did you receive money in exchange for sex	No	173	68.7	79.4	79.4
	Yes	45	18%	21%	100.0
	Total	218	86.5	100.0	

		Frequency	Percent	Valid Percent	Cumulative Percent
Missing	System	34	13.5		
Total		252	100.0		

- **Avoid pregnancy after receiving money**

The question item asked respondents if they avoided falling pregnant when there was an exchange of money or gifts for sex. Most respondents (n=32; 70%) confirmed that they never took any action to avoid falling pregnant. A significant number of respondents (n=4; 9 %) indicated they always took action to avoid falling pregnant. A minority of adolescents (n=4; 8%) indicated that they sometimes took measures to avoid falling pregnant, and six (13%) indicated the question was not applicable. Figure 4.14 shows a summary of the responses.

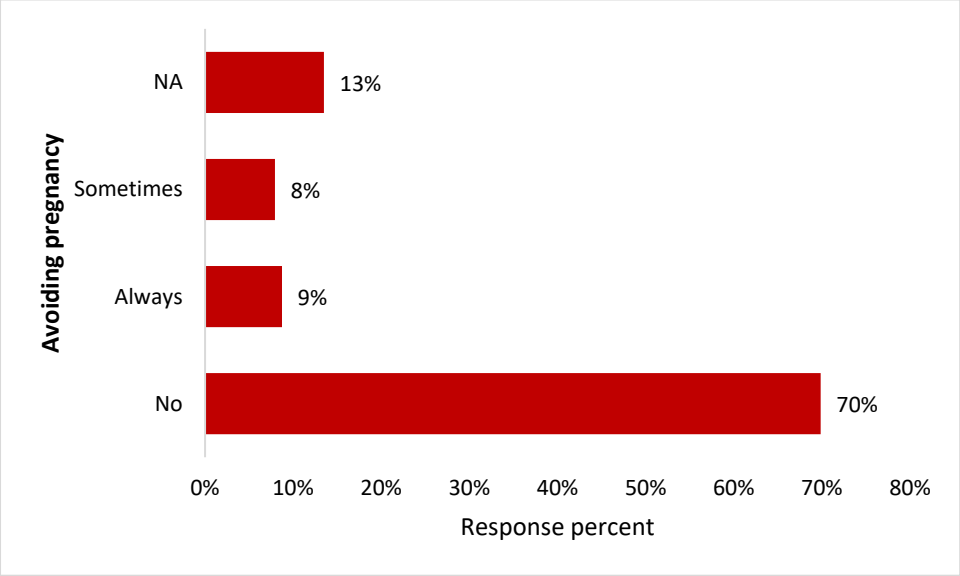

Figure 4.14: Avoiding pregnancy after receiving money in exchange for sex

4.3.6 Section 4: Attitudes of school-going adolescents towards responsible sexual behaviour (Question items 4.1 to 4.15)

The question items asked school-going adolescents about their attitudes towards responsible sexual behaviour using a five-point Likert scale measure, rated as agree (A), disagree (D), do not know (DK) and not sure (NS).

The overall mean score for the scale was 1.85, suggesting that most of the respondents were in agreement with the items on the Likert scale. The overall standard deviation of 1.81 was relatively low, implying low variability in the responses on the scale.

The majority (n=219; 87%) of respondents agreed that it is all right for unmarried boys and girls to go on dates. Many school-going adolescents (n=181; 72%) also agreed that there is nothing wrong with kissing, hugging and touching each other, as well as having sexual intercourse if the couple loves each other. The minority of respondents (n=50; 20%) disagreed that a boy could force a girl to have sex if he loves her; however, an above-average number of respondents (n=161; 63.9%) confirmed that they do not know whether a boy can force a girl into sex. This revelation is alarming considering the vast amount of information available on the issue of consent and reflects a possible contributor to the high rate of rape cases in South Africa.

Notably, a significant number of respondents (n=91; 36%) agreed that a boy will not respect a girl who agrees to have sex with him and that one-night stands are ok. Many respondents (n=111; 44%) also agreed that a boy and a girl should have sex before they become engaged to see if they are suited to each other. On the other hand, some respondents (n=116; 46%) felt girls should remain virgins until they marry. The majority of respondents (n=176; 69.8%) confirmed that they did not know whether one-night stands were right or wrong.

Furthermore, many respondents (n=176; 70%) indicated that it is all right for boys and girls to have sex with each other, provided they use protection to prevent an unintended pregnancy. A high percentage of respondents (n=137; 54.4%) also confirmed that they could insist on condom use every time they have sex. An above-average number of respondents (n=131; 52.4%) indicated that they would never contemplate having an abortion, and the majority of respondents (n=156; 62.3%) confirmed that the regular use of contraception was the woman's responsibility. Most respondents (n=201; 80%) confirmed that adolescents should be in love with someone before having sex with them, and many (n=197; 78.3%) indicated that they would refuse to have sex with someone who is not prepared to use a condom. A summary of these statistics is presented in Table 4.20.

Table 4.20: Descriptive and frequency statistics of attitudes of school-going adolescents towards responsible sexual behaviour

Items	Mean	Std. Dev	Percentages (%)			
			A	DK	NS	D
I believe it's all right for unmarried adolescent boys and girls to have dates.	1.89	12.04	86.79	0	0	13.21
I believe it's all right for adolescent boys and girls to kiss, hug and touch each other.	1.55	1.04	71.6	11.1	3.6	12.7
I believe there is nothing wrong with unmarried adolescent boys and girls having sexual intercourse if they love each other.	1.58	1.31	59.9	23.8	2.4	13.9
I think that sometimes a boy has to force a girl to have sex if he loves her.	1.69	1.05	20.6	63.9	7.1	7.9
A boy will not respect a girl who agrees to have sex with him.	2.02	0.79	36.1	29.4	10.7	23.4
A boy and a girl should have sex before they become engaged to see if they are suited to each other.	2.21	1.18	44.2	29.0	9.1	16.7
I believe that girls should remain virgins until they marry.	1.95	1.10	46	17.5	12.7	22.6
I believe that boys should remain virgins until they get married.	2.11	1.24	34.1	30.2	11.1	24.6
I think one-night stands are ok.	2.24	1.18	27.4	56	8.3	7.5
It Is alright for boys and girls to have sex with each other, provided they use methods to stop pregnancy.	1.94	0.84	69.8	13.1	4.0	13.1
I am confident that I can insist on condom use every time I have sex.	1.59	1.05	54.4	9.9	8.7	27
I would never contemplate having an abortion myself or for my partner.	2.06	1.31	52.4	23.8	4.8	19.1
It is mainly the women's responsibility to ensure that contraception is used regularly.	1.89	1.15	62.3	19.0	7.5	11.1
I think you should be in love with someone before having sex with them.	1.66	1.02	80	5.2	7.2	7.6
I would refuse to have sex with someone who is not prepared to use a condom.	1.42	0.91	78.3	6.3	7.9	7.5
Overall mean score	**1.85**	**1.81**				

4.3.7 Section 5: Utilisation of health services related to sexual and reproductive health by school-going adolescents (Question items 5.1 to 5.12)

The question items asked about adolescents' use of SRH services. This section investigates the trends in their use of SRH services and their acquisition of SRH knowledge.

- **Health facilities' utilisation by school-going adolescents**

The question item asked respondents about their use of different health facilities to obtain SRH services or knowledge on contraception, pregnancy, abortion and STIs. The majority of respondents (n=201; 80%) confirmed that they visited a health facility or doctor of any kind to receive SRH services or information, and the minority of school-going adolescents (n=51; 20%) never visited a health facility or any health professional. Table 4:21 shows the number of adolescents who visited health facilities or doctors' rooms and the frequency of their visits.

Table 4.21: School-going adolescents' frequency of visiting health facilities or doctors

		How many times have you sought services or information from the doctor or a nurse for these services in the last twelve months?						Total
		.00	1-3 times	4-6 times	7-9 times	10- 12 times	did not seek care	
Have you ever visited a health facility or doctor of any kind to receive SRH services	No	-	0 0	0 0	0 0	0 0	51 20.2%	51 20.2%
	Yes		133 52.8%	63 25%	4 1.6%	1 0.4%	0 0	201 79,8%
Total								252 100%

- **Health facilities utilised by school-going adolescents for SRH services and reason for their visit**

The question items further explored the types of healthcare facilities school-going adolescents attended to receive SRH information and services. The results show that a majority of school-going adolescents (n=97; 48%) visited the government clinic. Many respondents (n=51; 26%) did not select any health facility, and some (n=32; 16%) visited healthcare centres. A few school-going adolescents (n=15; 8%) visited hospitals, and a minority (n=6; 3%) utilised doctors' practices for SRH.

The most (n=54; 27%) sought-after SRH service at health facilities was contraceptives. A significant number of adolescents (n=38; 19%) went for STI treatment, and sought pregnancy tests (n=13; 7%). About 10 (5%) went for maternal and child health (MCH), and a minority (n=2; 1%) required other services like HIV testing and abortions. Figure 4.15 below shows the healthcare facilities utilised by adolescents and SRH provided.

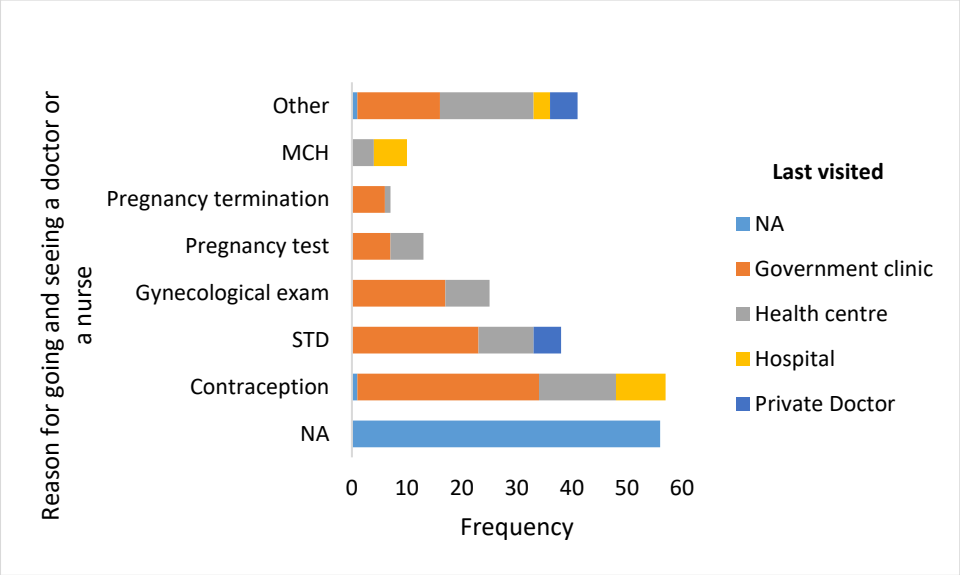

Figure 4.15: Health facilities and services utilised by school-going adolescents

- **Posters and brochures about contraception, STDs and pregnancy**

The question items asked school-going adolescents to confirm the different SRH informational sources they came across at the healthcare facilities they visited. The majority (n=154; 64%) did not see any posters, and a below-average number of adolescents (n=87; 36%) confirmed that there were posters at healthcare facilities.

Many respondents (n=192; 76%) confirmed there were no SRH brochures, and 49 (20%) confirmed that brochures were available.

Each facility was investigated for its contribution to SRH information dissemination using brochures. The highest number of respondents (n=84; 35%) confirmed no brochures were available at the government facility, and a significant number (n=49; 20%) said these were available at the healthcare centre. A minority (n=7; 3%) confirmed brochures' availability at hospitals. However, all respondents who went to private doctors confirmed that they received brochures.

Table 4.22 shows the frequency with which adolescents saw posters and brochures about contraception at health facilities.

Table 4.22: Availability of posters and brochures about contraception at facilities

		Thinking about your last visit, did you go to a:					Total
		NA	Government clinic	Health centre	Hospital	Private doctor	
At this facility, did you see any posters about contraception	No	52 21.6%	59 24.5%	30 12.4%	8 3.3%	5 2.1%	154 64%
	Yes	0 0	42 17.4%	30 12.4%	10 4.1%	5 2.1%	87 36%
Total		52 21.6%	101 41.9%	60 24.9%	18 7.5%	10 4.1%	241 100%
At the facility, were you given any brochures	No	52 21.6%	84 34.9%	49 20.3%	7 2.9%	0 0	192 79.7%
	Yes	0 0	17 7.0%	11 4.6%	11 4.6%	10 4.1%	49 20.3%
Total		52 21.6%	101 41.9%	60 24.9%	18 7.5%	10 4.1%	241 100%

- **Contraception discussion between school-going adolescents and health professional**

The question items asked respondents if they ever had discussions about contraception, pregnancy and STIs with healthcare professionals at the health

facilities they visited. Many respondents (n=145; 60%) confirmed that they never had contraception talks at healthcare facilities, while some (n=96; 40%) had contraception talks.

An above-average number of respondents (n=122; 50%) discussed pregnancy at health facilities, and others (n=119; 49%) did not. Many (n=143; 59%) confirmed attending healthcare sessions on STIs, while some (n=98; 41%) did not. The table below shows each health facility's contribution to sharing SRH information about pregnancies, contraception and STIs with adolescents.

Table 4.23: Health worker health education about contraception and pregnancy

Thinking about your last visit, did you go to a:							
		N/A	Government	Health Centre	Hospital	Private Doctor	Total
Did you attend talk on contraception	Yes	1 0.4%	56 23.2%	18 7.5%	11 4.6%	10	96 (39.8%)
	No	51 21.2%	45 18.7%	42 17.4%	7 2.9%	0 0	145 50.2%
Did you request contraceptives after talks	Yes No	52(21.6%) 0	52(21.6%) 49(20.3%)	37(1.3%) 23(9.5%)	11(4.6%) 7(2.9%)	8(3.3%) 2(0.8%)	160(6.4%) 81(36.6%)
Did the doctor or nurse talked to you about pregnancy	No	57(21.1%)	37(15.4%)	25(10.4%)	6(2.5%)	0	19(49.4%)
	yes	1(0.4%)	64(26.5%)	35(14.5%)	12(5%)	10(4.1)	12250.6%)
Did the doctor/ nurse talked to you about Sexually Transmitted Sex	No	50(20.8%)	31(12.9%)	17(7.1%)	0	0	98(40.7%)
	yes	2(0.8%)	70 (29%)	43(7.8%)	18(7.5%)	10(4.1%)	241(100%)

Comfortable asking questions

The question items asked school-going adolescents to confirm if they were comfortable asking healthcare professionals SRH questions. An above-average number of respondents (n=138; 57%) were not comfortable asking questions, while others (n=103; 43%) were comfortable asking questions. A further question asked about the adequacy of answers to their questions during consultations, and many respondents (n=136; 56%) answered 'adequately', though 105 (44%) respondents felt their questions were not answered adequately (see Table 4.24).

Table 4.24: Comfortable asking questions

		Thinking about your last visit, did you go to a:					Total
		NA	government clinic	Health centre	hospital	Private doctor	
Were you comfortable enough to ask questions?	No	50 20.0%	66 27.4%	21 8.7%	1 0.4%	0 0	138 57.3%
	Yes	2 0.8%	35 14.5%	39 16.1%	17 7.0%	10 4.1%	103 42.7%
Total		52 21.6%	101 41.9%	60 24.9%	18 7.5%	10 4.1%	241 100%
Were the questions you asked during the consultation answered adequately	No	50 20.8%	40 16.6%	15 6.2%	0 0	0 0	105 (43.7%)
	Yes	2 0.8%	61 25.2%	45 18.6%	18 7.5%	10 4.1%	136 56.3%
Total		52 21.6%	101 41.9%	60 24.8%	18 7.5%	10 4.1%	241

- **Adequacy of confidentiality at health facilities**

Question items asked adolescents to confirm if they were afforded enough confidentiality during consultations. The majority of adolescents (n=193; 80%) indicated that enough confidentiality was offered at health facilities during consultations (see Table 4.25).

Table 4.25: Adequacy of confidentiality during consultation at healthcare facilities

		Thinking about your last visit, did you go to a:					Total
		Health facility not known	Government clinic	Health centre	Hospital	Private doctor	
Was there enough confidentiality?	No	32 13.3%	13 5.4%	3 1.2%	0 0	0 0	48 19.9%
	Yes	20 8.3%	88 36.5%	57 23.7%	18 7.5%	10 4.2%	193 80.1%
Total		52 21.6%	101 41.9%	60 24.9%	18 7.5%	10 4.1%	241 100%

4.4 EFFECT OF RESPONDENTS' BIOGRAPHICAL PROPERTIES ON VARIOUS ASPECTS OF ADOLESCENT SEXUAL BEHAVIOURS

4.4.1 Association between adolescents' gender and attitudes towards responsible sexual behaviours

The researcher investigated if there is a relationship between adolescents' gender and attitudes towards responsible sexual behaviours, and whether the relationship was statistically significant or not. The Chi-Square test was conducted under the following hypothesis:

H_0: There is no statistically significant relationship between adolescents' gender and attitudes towards responsible sexual behaviours.

H_1: There is a statistically significant relationship between adolescents' gender and attitudes towards responsible sexual behaviours.

Table 4.25 depicts the findings. According to the Chi-Square test results, the p-value of 0.562 exceeds the threshold value of 0.05, suggesting the acceptance of the null hypothesis. From these results, there was no statistically significant relationship between adolescents' gender and attitudes towards responsible sexual behaviours.

This means adolescents' attitude towards responsible sexual behaviours are independent of their gender. Table 4.26 outlines the relationship between adolescents' gender and attitudes towards responsible sexual behaviours.

Table 4.26: Relationship between adolescents' gender and attitudes towards responsible sexual behaviours

	Value	Def.	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.977[a]	4	.562
Likelihood Ratio	3.262	4	.515
Linear-by-Linear Association	.442	1	.506
N of Valid Cases	252		
a. three cells (30.0%) have an expected count less than 5. The minimum expected count is .39.			

4.4.2 Association between adolescents' age and attitudes towards responsible sexual behaviours

To investigate if there is a significant association between adolescents' age and attitudes towards responsible sexual behaviours, a Chi-Square test was conducted under the following hypothesis:

H_0: There is no statistically significant association between adolescents' age and attitudes towards responsible sexual behaviours.

H_1: There is a statistically significant association between adolescents' age and attitudes towards responsible sexual behaviours.

The results suggest the rejection of the null hypothesis since the p-value of 0.000 is below the threshold value of 0.05. In conclusion, at a 5% level of significance, a statistically significant association between adolescents' age and attitudes towards responsible sexual behaviours existed. This means the individual's age influences their attitudes towards responsible sexual behaviours. Table 4.27 depicts the findings.

Table 4.27: Relationship between adolescents' age and attitudes towards responsible sexual behaviours

	Value	Def.	Asymp. Sig. (2-sided)
Pearson Chi-Square	63.369[a]	16	.000
Likelihood Ratio	65.734	16	.000
Linear-by-Linear Association	20.354	1	.000
N of Valid Cases	252		
a. Fifteen cells (60.0%) have an expected count of less than 5. The minimum expected count is .04.			

4.4.3 Association between drinking alcohol and attitudes towards responsible sexual behaviours

The third hypothesis investigated if there is a significant association between drinking alcohol and attitudes towards responsible sexual behaviours. This Chi-Square test was conducted under the following hypothesis:

H_0: There is no statistically significant association between drinking alcohol and attitudes towards responsible sexual behaviours.

H_1: There is a statistically significant association between drinking alcohol and attitudes towards responsible sexual behaviours.

According to the results, the p-value is 0.003, which is below the threshold value of 0.05. This suggests the rejection of the null hypothesis at the 5% level of significance. In conclusion, a statistically significant association between drinking alcohol and attitudes towards responsible sexual behaviours existed. Table 4.28 depicts the findings.

Table 4.28: Relationship between drinking alcohol and attitudes towards responsible sexual behaviours

	Value	Def.	Asymp. Sig. (2-sided)
Pearson Chi-Square	23.154[a]	8	.003
Likelihood Ratio	33.550	8	.000
Linear-by-Linear Association	.037	1	.848

	Value	Def.	Asymp. Sig. (2-sided)
N of Valid Cases	252		
a. Six cells (40.0%) have an expected count less than 5. The minimum expected count is .26.			

4.4.4 Association between adolescents' level of schooling and attitudes towards responsible sexual behaviours

The fourth hypothesis was to investigate if there is a significant association between adolescents' level of schooling and attitudes towards responsible sexual behaviours. A Chi-Square test was conducted under the following hypothesis:

H_0: There is no statistically significant association between adolescents' level of schooling and attitudes towards responsible sexual behaviours.

H_1: There is a statistically significant association between adolescents' level of schooling and attitudes towards responsible sexual behaviours.

The results displayed in Table 4.28 suggest the rejection of the null hypothesis since the p-value of 0.000 is below the threshold value of 0.05. It can be concluded that at a 5% level of significance, a statistically significant association between adolescents' level of schooling and attitudes towards responsible sexual behaviours exists. These means adolescents' attitudes towards responsible sexual behaviours are influenced by the individual's level of schooling. Table 4.29 shows the relationship between adolescents' level of schooling and attitudes towards responsible sexual behaviours.

Table 4.29: Relationship between adolescents' level of schooling and attitudes towards responsible sexual behaviours

	Value	Def.	Asymp. Sig. (2-sided)
Pearson Chi-Square	37.252[a]	8	.000
Likelihood Ratio	41.036	8	.000
Linear-by-Linear Association	22.136	1	.000
N of Valid Cases	252		
a. Eight cells (53.3%) have an expected count less than 5. The minimum expected count is .01.			

4.5 EFFECT OF RESPONDENTS' BEHAVIOURS ON VARIOUS ASPECTS OF ADOLESCENTS' SRH

4.5.1 Association between getting drunk and pregnancy prevention method

Furthermore, the researcher examined the association between getting drunk and using pregnancy prevention methods. A Chi-Square test was done under the following hypotheses.

H_0: There is no statistically significant association between getting drunk and pregnancy prevention.

H_1: There is a statistically significant association between getting drunk and pregnancy prevention.

Table 4.29 suggests the acceptance of the alternative hypothesis of the existence of a statistically significant association between getting drunk and employing pregnancy prevention methods, as supported by the p-value of 0.000, which is less than 0.05. The association is statistically significant at 5%. This means there is a link between getting drunk and using pregnancy prevention methods. Results from the chi-square test are displayed in Table 4.30.

Table 4.30: Association between getting drunk and pregnancy prevention

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	34.308[a]	4	.000
Likelihood Ratio	35.474	4	.000
Linear-by-Linear Association	22.581	1	.000
Number of Valid Cases	219		

4.5.2 Association between being drugged with drugs during the week and pregnancy prevention method

There is an assumed relationship between the number of times adolescents used drugs within a week and their use of pregnancy prevention methods. In order to

statistically examine the association, a chi-square test was conducted. The following hypotheses were tested:

H_0: There is no statistically significant association between the number of times adolescents used drugs within a week and their use of pregnancy prevention methods.

H_1: There is a statistically significant association between the number of times adolescents used drugs within a week and their use of pregnancy prevention methods.

According to the findings, a probability value of 0.006 (which is less than the threshold value of 0.05) implies the existence of a statistically significant association between the variables. These results suggest the acceptance of the alternative hypothesis, which states there is a statistically significant association between the number of times adolescents used drugs within a week and their use of pregnancy prevention methods. The results suggest that being under the influence of drugs affects individuals' decisions whether to use any method to prevent pregnancy. Results from the analysis are shown in Table 4.31.

Table 4.31: Association between numbers of times drugged with drugs within a week and pregnancy prevention method.

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.265[a]	6	.006
Likelihood Ratio	19.701	6	.003
Linear-by-Linear Association	12.144	1	.000
N of Valid Cases	219		

4.5.3 Association between having casual sex while drunk and pregnancy prevention method

There is an assumed relationship between having casual sex while drunk and using pregnancy prevention methods. In order to statistically examine the association, a chi-square test was conducted. The following hypotheses were tested:

H_0: There is no statistically significant association between having casual sex while drunk and using a pregnancy prevention method.

H_1: There is a statistically significant association between having casual sex while drunk and using a pregnancy prevention method.

According to the findings, a probability value of 0.001 (which is less than the chosen threshold value of 0.05) reflects the existence of a statistically significant association between having casual sex while drunk and using a pregnancy prevention method. These results suggest the acceptance of the alternative hypothesis, which states there is a statistically significant association between having casual sex while drunk and using a pregnancy prevention method. The results suggest that having casual sex while drunk influences individuals' decisions on whether to use any method to prevent pregnancy. Results from the analysis are shown in Table 4.32.

Table 4.32: Association between having casual sex while drunk and pregnancy prevention method

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.545[a]	4	.001
Likelihood Ratio	19.175	4	.001
Linear-by-Linear Association	13.919	1	.000
N of Valid Cases	219		

4.6 SUMMARY

The quantitative analysis, presentation and discussion of Phase I's data were provided in this chapter. With the help of tables, figures and graphs, findings from six sections of a questionnaire were presented and discussed. From the results, there was no statistically significant relationship between adolescents' gender and attitudes towards responsible sexual behaviours. However, the individual's age influenced their attitude towards responsible sexual behaviours. A statistically significant association between adolescents' level of schooling and attitudes towards responsible sexual behaviours existed. This means adolescents' attitudes towards responsible sexual behaviours are influenced by their level of schooling. Drinking alcohol, being drugged and engaging

in casual sex also influenced individuals' attitudes and decisions to use any method to prevent pregnancy. Chapter 5 presents the data analysis, discussion and literature control of the qualitative findings from Phase II.

CHAPTER 5
DATA ANALYSIS, PRESENTATION, DISCUSSION AND LITERATURE CONTROL OF PHASE TWO'S FINDINGS

5.1 INTRODUCTION

This chapter presents the data analysis and findings of the qualitative phase (Phase II) with literature control. Qualitative data were collected from school-going adolescents using focus group discussions, and key stakeholder informants were involved in face-to-face interviews. Interview schedules were used as data collection tools.

The first section focuses on the analysis and findings of the focus group discussion with school-going adolescents, referred to as sample A. These school-going adolescents were a subset of the sample that was used for the quantitative phase. Findings from the face-to-face interviews with teachers (sample B), parents (sample C), healthcare and NGO professionals (sample D) are discussed later in this chapter.

A table indicating the themes, categories and sub-categories related to the relevant samples precede each theme's discussion. In-text references are also offered to support the discussion.

Objectives of the chapter:

- To determine school-going adolescents' knowledge and attitude towards responsible sexual behaviour.
- To explore the challenges school-going adolescents face in achieving responsible sexual behaviour.
- To explore and describe community members' viewpoints with regard to school-going adolescents' responsible sexual behaviour.

5.2 DATA ANALYSIS

Qualitative data were analysed thematically using Creswell's analysis process (Creswell 2014:200). This process involved the following steps:

5.2.1 Preparing the data for qualitative data analysis

Audio-recorded data from the focus group discussions were stored in a safe place soon after data collection. The researcher personally transcribed the recordings by listening to the recordings and writing down notes in the margins of the transcripts to develop a general understanding of the data and form broader categories of information (Creswell & Plano Clark 2014:207). The researcher personally typed the recordings to protect the raw data from the public domain and for the researcher to become more familiar with the data. This enhanced the researcher's attachment to the data. The researcher removed personal information that could link to the participant; for example, the names and places of their residence, to protect the participants' privacy and confidentiality.

5.2.2 Exploring and analysing the data

Data coding was carried out following Creswell & Poth's thematic analysis process (Creswell & Poth 2018:184) aimed at reducing the data by breaking down the interview text into meaningful and manageable segments. This reduced the bulk of the content.

This coding step involved linking research questions with emerging themes from the data. Coding was carried out by organising the data and bracketing similar pieces of information, then writing the word representing the category in the margins. Nodes were created to gather and store relevant pieces of statements, called references.

This led to the development of codebooks. However, the researcher also relied on codes generated during the literature review as a baseline to guide the qualitative data analysis process. A codebook was composed of records of old and new codes that emerged during the process of analysing the qualitative data. The codebook assisted in the organisation of the data and facilitation of agreement on the content. As data

coding continued, other new and interesting codes emerged, while less applicable ones were removed. Moreover, meaningful features of the data became clearer in relation to the study's objectives.

Thematic networking was the next step, whereby the researcher sorted relevant data extracts, combined and split them, exploring the links that existed between the explicit statements and implicit meanings in the participants' narratives, leading to the interpretation and organisation of the themes. However, the process was not linear because the researcher had to go back and forth rigorously checking the interviews and the text so that the themes made logical sense.

The next step was to present the results of the analysis using statements, and convincingly discussing the evidence of the themes. A detailed description of the methodology used in this phase was provided in Chapter 3.

5.3 SECTION 1: MAIN THEMES FROM SAMPLE A

Three main themes emerged from sample A. These are discussed in Table 5.1.

Table 5.1: Themes from Sample A (School-going adolescents)

Theme 1: Adolescents' understanding of responsible sexual behaviour
Theme 2: Adolescents' knowledge of SRH
Theme 3: Utilisation of health facilities
Theme 4: Challenges school-going adolescents encounter in achieving responsible sexual behaviour

5.4 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE A (SCHOOL-GOING ADOLESCENTS)

The data from sample A were collected using two focus group discussions involving school-going adolescents from a township in Mpumalanga Province. The participants shared typical information on the meaning of responsible sexual behaviour, challenges adolescents face in achieving responsible sexual behaviour, and ways to promote

responsible sexual behaviour. The discussion was held with school-going adolescents because they are directly affected by the consequences of irresponsible sexual behaviour.

5.4.1 Demographical profile of sample A

Fourteen adolescents aged 15 to 19 participated in two focus groups, with seven participants in each group. Six participants were male (43%), and eight participants were female (57%). This was in line with the proportion of female to male school-going adolescents.

The participants were in the middle to late adolescence group. The majority of adolescents (43%) were between 17 and 18 years, and attending grades 11 and 12. Fewer sampled adolescents were in grade 10. The selection of participants was determined by evidence from Phase I, reflecting that the adolescents' age contributed to responsible sexual behaviour. More mature adolescents were more eager to participate than young adolescents, and they provided more in-depth knowledge that contributed meaningfully to the study. Table 5.2 outlines the demographical profile of sample A's participants.

Table 5.2: Demographic data of adolescent participants

Demographic variables	Frequency	Percentage (%)
Gender:		
- **Male**	6	43%
- **Female**	8	57%
Age range:		
- **15-16 years**	5	36%
- **17-18 years**	6	43%
- **18-19 years**	3	21%
Level of schooling0		
- **Grade 10**	3	21%
- **Grade 11**	6	43%
- **Grade 12**	5	36%

Table 5.3: Sample A: Participant-specific information

PARTICIPANT	GENDER	GRADE
1	Male	11
2	Male	12
3	Male	11
4	Female	10
5	Female	11
6	Female	11
7	Female	12
8	Female	12
9	Female	12
10	Female	11
11	Male	12
12	Male	11
13	Female	10
14	Male	10

5.4.2 Theme 1: Adolescents' understanding of responsible sexual behaviour

Two categories emerged under theme 1, namely prevention of HIV/AIDS, other STIs, and unplanned pregnancy, and the protection of moral values. The participants perceived these aspects as the true essence of sexual responsibility among adolescents. Table 5.4 indicates theme 1's categories and subcategories.

Table 5.4: Theme 1: Adolescents' understanding of responsible sexual behaviour

Theme	Category	Subcategory
Adolescents' understanding of responsible sexual behaviour	Prevention of HIV/AIDS, other STIs and unplanned pregnancy	• Condom use • Contraception use • Faithfulness • Commitment • Knowing own and partner's HIV status • Absolute sexual abstinence
	Protecting moral values	• Personal moral values • Family values • Community values

5.4.2.1 Category: Prevention of HIV/AIDS, other STIs and unplanned pregnancy

In this category, several sub-categories emerged, namely *consistent condom use, contraception use, faithfulness, commitment, knowing one's own and one's partner's HIV status, and absolute sexual abstinence.*

Regarding the sub-category *consistent condom use,* the adolescents agreed that sexual responsibility means consistently taking measures to protect themselves from HIV and other STIs. Participant 14 shared: *"You should always use protection not that today you do and the next you do not use condoms".* Ngidi et al. (2016:100) suggest that inconsistent condom use predisposes individuals to HIV and other STIs, despite adolescents receiving SRH education.

With regard to the sub-category *knowing one's own and one's partner's HIV status*, the findings revealed that the adolescents were aware one of their sexual duties was to take responsibility for knowing the HIV status of their partner(s) and screening for STIs before engaging in sex with them. However, only a few went for HIV testing. Participant 2 explained: *"You have to test yourself and know status of your partner oh my gosh, I am scared."* Participant 12 also said, "*sexual responsibility means not infecting each other by checking if I don't have STDs."*

Knowing one's own HIV status remains the central focus of sexual responsibility among adolescents. However, a fraction of the total population received HIV testing and counselling (Larsson et al. 2021: 3; Loew et al. 2018:5; Michielsen et al. 2014:57; Born et al. 2015:10). Kidman and Angelwicz (2017:4) warned that adolescents are a high-risk group for HIV infection, especially orphans. HIV infection is normally attributed to sexual transmission or maternal infection. Hence, adolescents should check their status, regardless of whether they are sexually active or not.

Under the sub-category *contraception use,* most adolescents revealed their understanding of responsible sexual behaviours related to preventing unwanted pregnancies. Participant 7 reflected: *"You have to protect yourself against pregnancies which you do not want…It will be irresponsible, cruel, and a burden to me to bring a*

baby to this world when I am not in a position to feed, clothe and let alone to look after a child when I am also a child. So I will prevent…"

According to Taukeni and Ferreira (2016:1) and Nkhwashu and Mafukata (2015:1077), the consequences of an unplanned pregnancy are mostly attributed to situations where unprotected penetrative sexual intercourse is unplanned.

Under the sub-categories *faithfulness and commitment,* many adolescents confirmed that faithfulness and commitment reflect responsible sexual behaviour, but they revealed that they do not rely on one sexual partner because partners cheat. Adolescent 5 said, "*Since our male partners cheat, I can also do the same. We do not commit."* This finding is supported by Smith et al. (2022:NP1275), who revealed that among adolescents, there were high odds of multiple sexual partners (more than two) and Born et al. (2015:510) reported 29% of males and 34% of females had more than one partner.

In the sub-category *absolute sexual abstinence,* some participants confirmed that sexual responsibility means abstaining from sexual intercourse. Participant 14 revealed, *"I will not sleep with boys before marriage, its wrong. I want to be responsible with my life".* This finding is similarly emphasised by Born et al. (2015:510), who claimed 41% and 43% of male and female adolescents in their study, respectively, had never had sexual intercourse. The authors (Born et al. 2015:514) suggest that adolescents were ready to use contraceptives and condoms to prevent unplanned pregnancies and STIs after receiving SRH education.

5.4.2.2 Category: Protecting moral values

In this category, some adolescents understood responsible sexual behaviour through the lens of attitudes that assist them in deciding what is wrong and what is right in terms of sexual behaviour. The sub-categories associated with this category were *personal moral values, family values, and community values.*

In the sub-category *personal moral values,* the participants suggested responsible sexual behaviour as a commitment to individual beliefs, such as life-long learning,

abstaining from sex, waiting for the right time to get married, and having emotional and physical readiness to engage in sexual encounters. This was revealed in this statement. "*Good self-morals means that you do not sleep around catching all sorts of diseases and having pregnancy and delay yourself in achieving my personal goals"* (Participant 8).

According to the WHO (2014a: 1), life-long learning prevents early adolescent pregnancies because the more schooling adolescents have, the less likely they are to become teen parents. This concurs with other studies, which revealed that adolescents often become sexually responsible because of their commitment to life-long goals (Larsson et al. 2021:3; Loew et al. 2018:4).

In the sub-category *family values,* some adolescents understood responsible sexual behaviour as following family rules and abiding by them. These rules include no pregnancy before marriage, maintaining abstinence, and making the family proud. "*I will follow the rules of our family so that I do not tarnish the image of my parents by falling pregnant while I am a child myself and bringing a bastard in the home"* (Participant 4). According to Esan and Bayajidda (2021:4), adolescents often choose to abstain to avoid aggressive reactions from their parents regarding pre-marital sex, which is sometimes risky.

In the sub-category, *community values,* adolescents felt that sexual responsibility means protecting one's purity until marriage: *"No sex before marriage, that's what is acceptable in our society. If I fall pregnant they will know that I was having sex*" (Participant 7).

Literature suggests that fear of judgement in social circles, and respect for the norms and culture of the community, help adolescents remain abstinent (Larsson et al. 2021:3; Muanda et al. 2018:5). However, Muanda et al. (2018:5) pointed out that the pressure, expectations and actions of important persons in an adolescent's network may motivate or prevent adolescents from complying in willingly practising abstinence as responsible sexual behaviour (Larsson et al. 2021:3).

5.4.3 Theme 2: Adolescents' knowledge of SRH

Theme 2 encompassed seven categories, namely: Open communication between partners; knowledge of the pros and cons of being sexually active; learning about adolescent's preferred source of SRH information; knowledge of where SRH services are available to adolescents; adolescents' preferred sources of information; and a conducive environment for SRH learning. These are illustrated in Table 5.5.

Table 5.5: Theme 2: Adolescents' knowledge of SRH

Theme	Category	Subcategory
Adolescents' knowledge of SRH	Open communication between partners	• Confident • Honest • Supportive • Knowledgeable partner • Sources of preventive methods • Methods of prevention • Benefits and side effects
	Learning about adolescent's preferred source of SRH information	• Role of parents • Role of religion • Role of the media • Role of peers and significant others
	Knowledge of the pros and cons of being sexually active	• Consequences of unprotected sex • Sex as a response to the call of nature
	Conducive environment for SRH learning	• Noise-free and non-threatening environments • Culturally sensitive environments
	SRH incorporated in Life Orientation classes	• Strengthening and reinforcing Life Orientation teachings
	Active participation in informative SRH programmes and activities	• Engaging adolescents in SRH workshops, sports

Theme	Category	Subcategory
		activities and meetings with support groups • Media to disseminate SRH information • Up-to-date SRH information and testimonials

In this theme, the adolescents understood responsible sexual behaviour broadly as being equipped with SRH knowledge to make informed decisions about their sex life. The sub-categories associated with it were: *open communication between partners; knowledge of the pros and cons of being sexually active; learning about adolescent's preferred source of SRH information; knowledge of where SRH services are available to adolescents; adolescents' preferred sources of information; and a conducive environment for SRH learning.*

5.4.3.1 Category: Open communication between partners

In this category, four sub-categories emerged, namely confident, honest, supportive, and knowledgeable partners. Most participants said adolescents should be confident of what they want from the relationship, communicate about it honestly and insist on what they want. This prepares the adolescents emotionally and physically and further prevents instances of regret and doubt about whether the sexual act was the right thing to do. In the absence of adequate preparation, sexual acts may end up as allegations of rape. Participant 3 revealed that, "*Responsible sexual behaviour as knowing what you want before having sex and be open about it from start with your partner."* Participant 5 suggested: *"Some of the rape allegations are a result of miss-communication where partners are not honest or clear about what they want from our relationship. Some girls lead us on into sex and later regret it and cry us foul…"*

The adolescents also understood that, to achieve sexual responsibility, the adolescent and partner should have the correct knowledge and information of SRH and support each other. Adolescent 13 cited, *"It is difficult to maintain sexual responsibility when my partner does not understand these things like condom use*

every time we have sex, does not support me and we always fight and he threatens to leave me."

The above finding agrees with Loew et al (2018:7) suggestion that sexual responsibility involves having open communication with one's partner before the relationship gets intense, concerning methods of preventing pregnancy and STIs. Individual sexual boundaries should also be discussed so that there is an understanding of each other's comfort zone. For instance, even though abstinence is a personal decision, it works best when both partners agree to it and maintain open communication (Loew et al. 2018:7).

On the subcategory, *knowledge of where SRH services are available to adolescents,* many adolescents confirmed that they understand responsible behaviour as taking action and being responsible for asking for information about where to obtain SRH information. A participant *cited "it is a* shared *duty of a woman to make sure she doesn't fall pregnant by asking for information and taking action. Otherwise boys only cares when you are pregnant and they don't want the child.*" (Participant 13).

Wakjira (2021:98) suggests that adolescents should know how to access SRH services, where they are found, and how to use such services.

5.4.3.2 Category: Adolescents' preferred source of SRH information

This category had several subcategories, like *role of parents, religion, the media, peers and significant others* promoting responsible sexual behaviour among adolescents.

Under the sub-category *the parent's role,* participants said parents need to understand adolescents prefer them as primary sources of SRH information. Hence, parents should be there when needed. Some adolescents cited that they prefer sources of information that are free and educative, and they want to share sex-related issues with their parents. However, other adolescents felt that they could not discuss sex-related matters with their parents. Adolescent 1 said, *"I need my parent to tell me things of growing up. Parents should lead adolescents by example and stop to choose their*

boyfriends or having many boyfriends without commitment to best adolescent sexual life."

Under the sub-category *peers and trusted significant others*, participants said these are people whom adolescents feel comfortable sharing sex-related discussions with and who provide them with SRH information. Adolescents felt that peers promote or destroy school-going adolescents' sexual responsibility if peer-to-peer SRH information is incorrect. Participant 9 emphasised, "*I cannot definitely talk about these things with my mother or father. How can I? It is embarrassing though I would want to. I don't trust my friends 100% though. Some friends are jealous."*

This finding is supported by Ngidi et al. (2016:98), suggesting that adolescents find it easier to share their sexual health problems with friends of their age group confidently and privately than with an older person. This is because culture and religion do not always allow discussions on sex-related issues with elders (Duby et al. 2022:12).

Regarding the sub-category *role of religion,* findings revealed that some adolescents are religious and taught about sex-related issues at church. Religion plays an important role in teaching children what the Bible says, especially on aspects related to adultery. This deters some adolescents from engaging in sexual intercourse before marriage. Participant 4 claimed, "*When I started adolescence my parents used to teach me about the bible and sex…I used to listen and it helped me to push until late adolescents before I started having sex."*

Moral and religious beliefs may contribute to adolescents' commitment to abstinence, as highlighted by Muanda et al. (2018:6). Their study's findings revealed that some adolescents followed their church doctrine and were directed by quotations from the Bible. However, some adolescents just strongly feel that it is the right thing to abstain, despite religious influences. Participant 11 shared: "*I was raised as a child of God. I will not engage in sex before marriage. It is wrong".*

However, Wakjira (2021:65) and Ngidi et al. (2016:98) cautioned that religion might work against adolescents who want to talk about sexual matters with older people and

their community. Also, the church promotes abstinence, which is almost impossible for most adolescents these days (Gillespie et al. 2022:19).

In terms of the sub-category, the *role of media* in disseminating SRH information, adolescents felt that they have access to readily available information through smartphones and the internet. *"I can google everything I want about sexual things but the information is too much. I choose what I want to hear*" (Participant 2).

5.4.3.3 Category: Knowledge of the pros and cons of being sexually active

In the sub-category, *knowledge of the pros and cons of being sexually active,* school-going adolescents said they should equip themselves with information related to sex well before engaging in the act. *"The adolescent should be responsible enough to gather all information he /she needs about sex so that you make an informed decision"* (Participant 11). This was echoed by participant 12 citing, "*when we start menstruating we are told that not to sleep with boys because we will fall pregnant".*

This finding revealed that adolescents know the consequences of being sexually active, however, they still indulge in risky sexual behaviour. Dube et al. (2017:1006) argued that casual sexual relationships and experiences, other than those involving penetrative sexual intercourse, have little effect on adolescents' psychological well-being. However, casual penetrative sex negatively affected more girls than boys causing psychological distress, drug and alcohol use.

5.4.3.4 Category: Conducive environment for SRH learning

Regarding this category, a conducive environment is one that promotes or allows learning to take place. Two sub-categories emerged, namely *noise-free non-threatening environments, and culturally sensitive environments.*

Under the sub-category *noise-free and non-threatening environments to learn issues about sex,* school-going adolescents revealed that they want a free and non-threatening space where they learn to deal with issues of good sexual behaviour.

Participant 10 said, "*I wish I could have an outing with my parents and sit and discuss these things. I feel alone and overwhelmed".*

Regarding the *culturally sensitive environments* sub-category, the adolescents confirmed that culture contributes positively to adolescents' sexual responsibility in different aspects. The positive contribution of culture is demonstrated, for instance, in the acceptance of positive cultural practices like circumcision. Findings revealed that adolescents confirmed circumcision minimises the risk of STI and HIV infections. Participant 14 cited "*some cultural ways like circumcision has been there for a long time and is still used to protect us from STIs".*

However, in this study, culture was suggested to have a negative influence on the sexual responsibility of adolescents. There is an erosion of culture these days, and though it is used to protect adolescents, it is also a hindrance to acquiring SRH skills. Participant 3 cited, "*these days our aunts are jealous to see us having good boyfriends who want to marry. So how can I go to my aunt for guidance on sexual behaviour, some will want to take our boyfriends for their kids…"*

There should be a desensitisation of negative cultural practices like the norm that does not allow parents to discuss issues of sex with their children. Participant 1 highlighted that, "*There is need for accepting that there are changes in culture, for example that it is taboo for a parent to discuss sex related issues with child but we need them to teach and guide us."*

Gillespie et al. (2022:1019-1020) support the above findings, stating that some parents and community members have shifted the focus from social norms and cultures that hinder the prevention of unplanned pregnancies and instead promote contraceptive use. Hence, some parents are looking for ways to support their adolescents' sexual responsibility, such as going with them to the clinic to get contraceptives or reminding them of their next appointment. This shows that some parents are going against the norms that prevent adolescents from using contraception.

5.4.3.5 Category: SRH incorporated in Life Orientation classes

Regarding this category, the qualitative research supported the findings from Phase I, where many adolescents indicated that they prefer a schoolteacher to provide education on SRH.

In the sub-category *strengthening and reinforcing Life Orientation teachings,* adolescents shared they pay more attention to teachers than other sources, and teachers command focus. On another note, teachers are ideal because some children are scared to express themselves in front of their parents at home. However, at school, adolescents talk and learn freely with regard to issues of sexual responsibility. Participant 8 emphasised: "*If the Life orientation teacher comes to class and says this is work, students will listen and focus. But with other people from outside students will not be taken seriously by school-going adolescents. I feel free to talk to the teacher more than my parents".*

Gillespie et al. (2022:1019) and Nkosi and Pretorius (2019:111) commented on the positive impact of sexual education in schools, such as alerting students about the importance of responsible sexual behaviour. However, the education sector is also facing challenges, such as a lack of resources (staff and time), preventing it from rendering SRH education successfully.

5.4.3.6 Category: Active participation in informative SRH programmes and activities

The sub-category of *engaging adolescents in SRH workshops, sports activities and meetings with support groups* emerged as one of the ways to help adolescents divert attention from sex. Sports activities and other programmes were mentioned by adolescents to have the power to divert their thinking about sex, and adolescents will be too occupied and under the supervision of an adult. Adolescent 3 cited that, *"We see each other after school when our parents are at work. We do not have anything to do or occupy us from 2 0'clock when we finish school. Just think what we will be doing all this time. Give us something to do such as sports".*

This finding is supported in Ninsiima et al (2021:7) that adolescents who equip themselves with knowledge and find time to focus on their wellbeing are unlikely to indulge in risky sexual behaviour.

The findings thus revealed that support groups are important in strengthening the use of SRH services among adolescents. However, few school-going adolescents participated in them. Adolescent 2 suggested that, *"support groups where adolescents sit down and discuss these things will promote sexual responsibility but it is boring to go there every time".*

Ninsima et al. (2022:1) revealed that structural barriers, such as negative attitudes among health workers, and individual barriers, like a lack of knowledge among adolescents, prevent adolescents from using SRH services at their disposal.

Under the sub-category*, using the media to disseminate SRH information*, the findings revealed that many adolescents now have smartphones, and they can be reached easily in large numbers through social platforms like WhatsApp, YouTube, Twitter, Facebook, and TikTok. Adolescents confirmed that they spend more time on social media than engaging in face-to-face communication. The media can thus play an important role in disseminating important messages to promote responsible sexual behaviour. Adolescent 1 explained: *"I do not have time to outdated talk and talk from my grandmother when I can get this information from media."*

Conversely, other adolescents felt the media promotes irresponsible sexual behaviour when sharing too much information on explicit sex, such as pornography. Adolescents do not always know what to select and then end up with wrong messages and ideas. *"We do have too much information to choose from, the media is buzzing with how to do sex. However, some parents are too reserved they don't give adolescents phones because we do not have the skill to select what is good and what is wrong."* (Adolescent 12).

The sub-category *up-to-date SRH information and testimonials* emerged as ways to reach out to adolescents, and first-hand SRH information was suggested to assist

adolescents in gaining accurate SRH information, so that they make informed SRH decisions.

5.4.4 Theme 3: Utilisation of health facilities

Table 5.6: Theme 3: Utilisation of health facilities

Theme	Categories	Sub-categories
Utilisation of health facilities	Access to sexual and reproductive health	• Non-use of SRH services • Increase adolescents' motivation to use SRH services at public institutions • Provide affordable contraceptives at private healthcare institutions
	Unconducive healthcare facilities	• Lack of privacy and confidentiality at healthcare facilities • Judgements and harassment
	Attitudes towards choice of termination of pregnancy (CTOP) service	• CTOP as a positive promoter of sexual responsibility • CTOP as murder • Lack of confidentiality

5.4.4.1 Category: Access to sexual and reproductive health

Most school-going adolescents agreed that the government had put SRH programmes and structures in places like clinics, equipped with most services that adolescents might need. This category gave rise to several sub-categories, namely the *non-use of SRH services, increased adolescent motivation to use SRH services at public institutions, and provide affordable contraceptives at private healthcare institutions*. The literature supports the finding that most adolescents know of public and private institutions as providers of SRH services, but they do not like to use these public services. They would rather use private facilities (Wakjira 2021:63).

Regarding the sub-category *non-use of SRH services by adolescents,* the study's findings revealed that most school-going adolescents did not make use of SRH services despite being sexually active. Participant 6 shared: "*I do not have any challenge we do have clinics with most of the things we need, we getting them there but we do not like to go."* Wakjira (2021:63) concurs that a very few adolescents make use of SRH services. The existing literature thus supports that adolescents are aware of SRH services at clinics, but most rely on peers for information, though they do not always trust them as sources of information (Wakjira 2021:93).

In the sub-categor*y,* increase adolescents' motivation to use SRH services at public institutions, Participant 12 cited, "*most boys who need SRH services are embarrassed to get help and scared to be judged for not using condoms".* Literature suggests that adolescents are sensitive to a lack of information and privacy, and they fear their parents and unfriendly healthcare staff (Wakjira 2021:64).

It was also determined that *affordable contraceptives at private healthcare institutions* would assist school-going adolescents who do not want to go to public clinics for free SRH services. Most adolescents in townships cannot afford to attend private facilities for such services, but Participant 5 expressed: *"at least at private clinics there is some privacy but it's expensive."* Ninsiima et al. (2021:5) concur, revealing that barriers in accessing youth-friendly sexual reproductive services included the costs of services and/or transportation, lack of privacy and confidentiality.

5.4.4.2 Category: Unconducive health facilities

In this category, two sub-categories emerged, namely *judgements and harassment, and lack of privacy and confidentiality*. School-going adolescents confirmed that they are very sensitive to issues of SRH, and they do not like people passing judgements or dictating to them without being asked. Participant 11 revealed that, "those *who are supposed to help us judge us and talk too much. I just want to get what I want and go".*

Under the sub-category *lack of privacy and confidentiality at public hospitals and clinics*, the school-going adolescents cited that they do not like to go to public places

for SRH services due to the lack of privacy and confidentiality. Participant 8 revealed their predicament by saying, *"there is no privacy at clinics. What about if I meet a neighbour at the clinic and she learns that I prevent? Something should be done to make sure nobody picks up what I am at the clinic for so that I feel comfortable".* According to Wakjira (2021:65), one of the factors that hinder the utilisation of SRH services and affect responsible sexual behaviour among adolescents is the fear of being seen by their parents at the facilities. Moreover, adolescents' fear of disclosure that they are sexually active and the stigma attached to it were shown to influence the use of SRH services. This is coupled with shaming from parents and the community (Duby et al. 2022:12).

5.4.4.3 Category: Attitudes towards choice of termination of pregnancy (CTOP) service

Sub-categories included: C*TOP as a positive promoter of sexual responsibility, CTOP as murder, and a lack of confidentiality*. School-going adolescents had mixed feelings about using CTOP service at the clinic. Some accepted CTOP as a positive promoter of SRH, while others felt that it was a bomb ready to explode because adolescents may have unprotected sex knowing that if they fall pregnant, they can abort the pregnancy safely and free of charge. They felt this increased the rate of unplanned pregnancies, infections with HIV and other forms of STIs.

Most sexually active school-going adolescents confirmed that they know safe and legal abortions are now available locally at the clinic in the township. Adolescents revealed that legal abortion is a responsible way of managing unplanned pregnancies. Adolescent 3 mentioned, *"Now in our area abortion is available at clinic unlike some time ago. It will help us to continue with our education".*

Non-use of CTOP services for fear of discrimination was cited by some adolescents because some parents and community members regard aborting a pregnancy as committing *murder,* despite the gestational age of the foetus. Hence, if news of an abortion came to parents' and the community's attention, stigmatisation would ensue. Participant 7 said*, "So adolescents fear facing stigmatisation because everyone will know. I would rather not go there."*

Ninsiima et al (2021:12) concurred with the above assertion, suggesting that parents and the community have negative attitudes towards youth who utilise family planning services. Some do not believe adolescents under 18 years can be sexually active. Hence, adolescents fear stigmatisation if their parents and the community discover they committed murder by aborting a pregnancy.

Lack of confidentiality took centre stage in most school-going adolescents' discussions on the choice of service to use. Some adolescents made use of the safe and legal abortions offered at the clinics, while others opted for backyard abortions, which they said offers privacy. Adolescent 8 related: "*The clinic offers the abortion service where everyone access health service including my neighbours and relatives. But I will not go there it's too public I will be a laughing stock."* According to Gresh and Maharaj (2014:688), promoting legal abortions for unplanned pregnancies among females contributes to honouring women's SRH rights and promoting choices that best suit the person. This is preferable to stigmatising the adolescent. However, Ninsiima et al (2021:12) indicate that lack of privacy at health care facilities influence the utilisation of SRH services by adolescents because it is a public place, chances of meeting a parent at the health care facility are high. Hence adolescents prefer not to go there (Wakjira 2021:77).

5.4.5 Theme 4: Challenges school-going adolescents encounter in achieving responsible sexual behaviour

This theme describes the challenges school-going adolescents encountered in achieving responsible sexual behaviour. Eight categories emerged, namely overwhelming pressure, parents' misgivings, lack of commitment to long-term relationships, poor use of SRH services by school-going adolescents, culture as a barrier to SRH communication, too much idle time for adolescents, media fallacies, and an inability to wait for the right time to have sex. These are shown in Table 5.7 below:

Table 5.7: Theme 4: Challenges school-going adolescents encounter in achieving responsible sexual behaviour

Theme	Category	Sub-category
Challenges adolescents encounter in achieving responsible sexual behaviour	Overwhelming pressure	• Pressure during transition and adjustment (too many expectations from significant others) • Peer pressure • Partner pressure • Parent/guardian and community expectations to remain a virgin
	Parents' misgivings	• Parents are not leading by example • Gross parent absence in adolescent sexual health
	Lack of commitment to long-term relationships	• Unsatisfying relationships • Short moments of joy • One-night stands • Multiple sexual partners
	Poor use of SRH services by school-going adolescents	• Difficulty in accessing service • Laziness • Lack of confidentiality • Unavailability of contraceptives • Not well-equipped school-based SRH service
	Culture as a barrier to SRH communication	• It is taboo to have sex-related discussions with parents
	Too much idle time for adolescents	• Lack of activity after school • Lack of adult supervision
	Media fallacies	• Wrong SRH information from the media
	Inability to wait for the right time to have sex	• A boring partner who is not ready • Immature males and not financially stable

5.4.5.1 Category: Overwhelming pressure

The category gave rise to several sub-categories, including *pressure during transition and adjustment, partner pressure, peer pressure, parental and community expectations to remain a virgin.*

With regard to the sub-category *pressure during transition and adjustment* from childhood to adulthood*,* most male participants revealed that it is extremely difficult to control hormones once aroused. They said they lack experience in self-control due to their immaturity, and often regret their behaviour after sex because they do not have time to use condoms to protect themselves. Male participants shared they had sex when they were not emotionally and physically prepared, often behind the strictest of parents' backs. Hence, most adolescents cited that practising absolute sexual abstinence to promote sexual responsibility was impractical. This is evidenced in the following statement by Participant 1, "*majita hawakhoni kutiphatsa when they are sexually aroused" (Boys find it difficult to control themselves…)*. The findings are similar to those of Pringle et al. (2017:1), who revealed higher levels of salivary testosterone were associated with more sexual activity in some adolescent males and females.

Moreover, a lack of personal skills to practice safer sex due to hormonal pressure, lack of self-control and immaturity, resulted in adolescents giving in to unplanned sex. The overwhelming urge of the moment drove them and sometimes led to unplanned and unprotected sex.oore et al. (Pringle et al. 2017:1; 2014:676) and Michielsen et al. (2014:57) concurred with this finding and said adolescence is as a period when children change emotionally, physically and psychologically. This transition contributes to behaviour changes due to confusion.

With regard to the sub-category, *peer pressure,* the adolescents revealed that they face extreme pressure from peers and are discriminated against if someone claims they are virgins. Adolescent 9 said, "*Some adolescents are forced to engage in one night stands just to prove a point that they can do it (sex) which predispose them to consequences like infection with STIs including HIV and AIDS and unplanned pregnancies."*

Ngidi et al. (2016:98) agree that adolescents rely on peers' opinions and information on sexuality because they are easy to talk to and often available for discussions. However, the adolescents revealed that they really wanted to talk to their parents, but they were seldom available.

In the sub-category *partner pressure*, female participants revealed that it is difficult to maintain responsible sexual behaviour, especially in terms of sexual abstinence, because most boyfriends do not believe new millennials should maintain their virginity. The following statement illustrates this claim: *"We are pressurised by our boyfriends to have sex intercourse..., for example when you tell him that you are not ready they leave you for the next weak girl because they do not get what they want and they do not believe any girl is a virgin"* (Participant 6).

With regard to the sub-category *parent and community pressures,* permissive sexual behaviour and sexual beliefs among adolescents are frowned upon and stigmatised in the community and by parents, leaving adolescents feeling pressured to sexually behave. Adolescents felt forced to maintain abstinence and purity despite their difficulties in suppressing their over-active sexual hormones.

In the sub-category *parent and community expectations to remain virgins,* the argument between adolescents' permissive sexual behaviour versus sexual abstinence led to parents and the community at large being at loggerheads with adolescents. The study's findings revealed that millennial adolescents have permissive sexual beliefs that are frowned upon by the community and parents because this permissiveness predisposes adolescents to risky sexual behaviours. Adolescents also strongly believed that there is nothing wrong with sleeping with different people or having multiple sexual partners as long as the partners use protection. Adolescent 9 said, "*I do not see the reason why our parents want us to remain virgins as long as we take good care of ourselves when we sleep with our boyfriends or boyfriends. I have already tested the forbidden fruit… Laughs".*

Hence, most adolescents said practising absolute sexual abstinence to promote sexual responsibility was impractical. Some adolescents had unprotected sex at an early stage and even behind a strict parent/guardian's back. This created tension and

rebellion between family members and adolescents, thus further predisposing adolescents to risky sexual behaviours.

This view is illustrated in this statement by Participant 4, "*It is not our fault to have sex…its nice and we just follow nature and my hormones… just do not pressurise force us not to have it… Kumnanzi (it feels nice)…"*. The findings indicate that hormones play a role in some adolescents' initiation of sexual activities. Most adolescents' sexual activities are affected by hormones, yet they do not have the experience to control themselves. The effects of hormones also make it difficult for adolescents to abstain from sex (Milimo et al. 2021:3; Ahanhanzo 2018:89; Pringle et al. 2017:9).

5.4.5.2 Category: Parents' misgivings

In the category, some parents were playing a negative role in raising sexually responsible adolescents. Some of the sub-categories included *parents do not lead by example, and gross parental absence in adolescents' sexual health.*

In the sub-category, *parents are not leading by example,* findings revealed that some parents are not leading adolescents by example to achieve responsible sexual behaviour. Participant 14 emphasised: "*Our parents no longer respect us, they have unbecoming sexual behaviour in front of us, what do we learn from them. Some even choose to leave us for a boyfriend then where do we run*. *They lack commitment to their partners and many lack intact lack family life. What do we learn from them?"*

With regard to the sub-category *absence of parents in adolescent's life*, adolescents felt that parents do not have time for them. They reported: *"…our parents leave us to the mercy of friends, teachers, internet and televisions to get sex information or puberty things. They avoid the topic but we need to hear these things from them"* (Participant 4).

These findings reveal that adolescents yearn for parents' guidance in sexual and reproductive health, but they do not get this guidance they are looking for. As a result, friends and media fill that gap by proving SRH information which sometimes is wrong

and misleading leading to irresponsible sexual behaviour. This concurs with a study conducted in Ahanhanzo et al. (2021:13), who found parents are absent from adolescents' sexual life, influencing whether an adolescent will behave sexually responsible or irresponsible.

5.4.5.3 Category: Lack of commitment to long-term relationships

In the category, *lack of commitment to long-term relationships,* most school-going adolescents revealed that they lacked commitment in their relationships. This category led to various sub-categories, such as *unsatisfying relationships, one-night stands, short moments of joy, and multiple sexual partners.*

In the sub-category *unsatisfying relationships,* the adolescents expressed that during first encounters, both parties would be willing to commit to each other but consequently become unsatisfied and bored with each other. Participant 14 said, "*We are still young, adventurous and meet different characters and tastes. I am too young to commit.*" Either partner or both move on to the next person and 'divorce' the current partner.

On the other hand, with the sub-category *short moments of joy,* school-going adolescents revealed that they do not commit to long-term relationships because they know that nothing tangible comes from these relationships. *"Once boyfriends have sex with girls they dump them and go for the next girls…boys they just want what they want (sex)…we are left heartbroken"* (Participant 14).

Under the sub-category *one-night stands*, adolescents revealed some adolescents cross the line and have one-night stands, especially at parties where alcohol and drugs are involved. This predisposes them to HIV and other STIs if no protection is used.

The *multiple sexual partners* sub-category was also common among school-going adolescents. This exposes them to greater risks for the consequences of irresponsible sexual behaviour. "*An adolescent girl would have a boyfriend for different reasons such as one for airtime, pocket money, jewellery and other luxuries. On the other hand, boys want status among other boys by having many girlfriends*." (Participant 10).

Gilliam et al. (2017:340) suggested that adolescents make decisions on whether to have a sexual relationship with a certain partner mainly based on the level of commitment in the relationship. In the same vein, males support their partners more in using contraceptives, especially dual methods, if there is a full commitment in the relationship than if there is no commitment at all (Gilliam et al. 2017:340).

5.4.5.4 Category: Poor use of SRH services by school-going adolescents

The study's findings revealed that most adolescents do not make use of SRH services. Sub-categories that emerged were *difficulty in accessing services, laziness, lack of confidentiality, unavailability of contraceptives, and not well-equipped school-based SRH services.*

In the sub-category *difficulty in accessing SRH services,* the findings revealed that some adolescents do not have time to visit clinics due to commitments to their schoolwork, especially those in grade 12 who go to school every day. Some adolescents cited a lack of transport fare to go to the clinic. Adolescent 8 said, *"I do have problems with time, I am always at school for me to go to clinic."* Adolescent 14 cited "*sometimes we fail to have even R20 to catch a local taxi to clinic."* The findings are supported by Wakjira (2021:65), who revealed that adolescents do not access SRH services because of a lack of money to travel, and lack of resources like time.

In the sub-category *lack of confidentiality,* adolescents said they do not feel comfortable at public clinics where there is a chance of meeting a person whom they know. This can jeopardise their confidentiality and privacy. Participant 5 cited, "*Preventing its sensitive because neighbour will talk about me to my parents or other people. Then everyone will know that I now have sex.*" Wakjira (2021:65) supports this notion that adolescents fear being seen and it being known that they take contraceptives.

On the sub-category of *laziness*, Participant 3 explained: "*I do not have any challenge we do have clinics with most of the things we need, we getting them there but we are lazy to go."*

In the sub-category *unavailability of contraceptives,* adolescents reported, "*Most of us we use injections. Sometimes we do find one type or all of them out of stock. We are forced to take that which is available. This disturbs our periods*." (Adolescent 13). It was also noted that *school-based sexual and reproductive health services are not well equipped,* though the participants felt that adolescents mostly rely on teachers to learn about SRH. There are few Life Orientation teachers, and some schools are not well equipped to meet the needs of all adolescents. Participant 6 said, "*there are less qualified teachers to teach us. Just imagine one teacher teaching more than 200 students of LO?"* Nkosi and Pretorius (2019:110) also suggested that teachers do not have the capacity to reach all adolescents.

5.4.5.5 Category: Culture as a barrier to SRH communication

Concerning the category *cultural barrier as an SRH communication barrier,* one sub-category emerged*,* namely *it is taboo to have sex-related discussions with parents.* Most school-going adolescents felt the African culture had long created barriers to communicating about sex-related issues. Adolescents did not feel free to express themselves to their parents, and parents shared these misgivings. Hence, most adolescents felt that their parents lied about SRH matters and adolescents are forced to rely on other sources for SRH information. However, information from outside sources might break or build sexual responsibility among adolescents. Overall, most adolescents did not rely on their parents for SRH information.

Participant 2 said, "*It has always been taboo for a child to feel free to talk about sex with your parents. This acts as a barrier for us to learn through parents who are most trusted sources of information".*

Adolescent 9 also shared, *"…Because they think they are giving too much information to the child which would lead to misbehaviour".* Adolescent 6 said, "It *is not just on for my parent to talk to me about sex. Maybe they think that it feels embarrassing to know that my child is doing it.* Our *parents lie to us they think we do not know what happens behind closed doors…"* (laughs).

Participant 1 commented: "*even though I have so many sources of information, I am safe when it is coming from my parent."*

Duby et al. (2021:12) and Nkhwashu and Mafukata (2015:1084) proposed that the communication barriers between the adolescent and parents were overcome by the roles aunts and uncles played, as well as other cultural rites that adolescents experienced. Nowadays, this is no longer the case for many families, as parents opt not to send their children for cultural rites performed by elders, like circumcision. They rather send them to surgeons for circumcision.

According to Ngidi et al. (2016:98), adolescents find it easier to share their sexual health problems with friends of their age group than with an older person. This is because culture and religion do not permit discussions of sexual issues with elders, and they spend more of their time with friends than with their parents.

5.4.5.6 Category: Too much idle time for adolescents

In this category, two sub-categories emerged, *lack of activity after school, and lack of adult supervision.* Adolescents revealed that most schools in the township closed at 2 o'clock, and they *lacked extra-curricular activities* after school or did not participate in available ones. Most adolescents remained idle and lacked supervision after school because their parents were at work. A *lack of adult supervision after school* meant school-going adolescents ended up spending time with their boyfriends unsupervised, and this often led to them engaging in sex. Participant 10 said, "*When we are alone with our boyfriends we enjoy ourselves, we romance and end up having sex even when did not plan it. Sometimes it even happens in our homes."*

Participants also revealed that they had ample time for alcohol consumption and drug use throughout the week. Participant 11 cited, "*There is too much time for us and as a result have time for alcohol consumption and drug use throughout the week*."

As mentioned earlier, Yusoff et al. (2014: 100S) reported illicit drug use among adolescents in Malaysia had become a public health issue. Drug use led adolescents to engage in adverse behaviours, such as smoking and drinking alcohol, which

predisposed them to irresponsible sexual practices (Borneskog et al. 2021:5; Desai et al. 2019:51; Ahanhanzo et al. 2018:90). Jansen (2021:43) revealed that adolescents from low socioeconomic status were reported to be at a high risk for substance use like alcohol, if parental social support is not available. When adolescents get drunk, there is a high risk that some adolescents end up having unprotected sex, resulting in STIs, casual sex, and some end up with unplanned pregnancies. As a consequence, school dropout rates increase (Desai et al. 2019:51).

5.4.5.7 Category: Media fallacies

With regard to the *media fallacies* category, the study revealed most school-going adolescents' sources of information were the media, such as television, phones, books and magazines. They selected different sexual behaviours based on these sources. Most available information was a fallacy though, and the messages do not promote responsible sexual behaviours among adolescents. Some adolescents no longer wanted to listen to elders' SRH advice. Adolescent 1 explained, *"I do not have time to outdated talk and talk from my grandmother when I can get this information from social media."* Participant 5 also said, "We *learn about things like spiking of drinks at parties, using drugs and other behaviours such as one night stands, twosome and three some through media. We know about these things through different platforms such as tiktok, and dating sites. We have too much information because parents buy us phones."*

Born et al. (2015:510) suggest that adolescents are influenced negatively by the sexual behaviours they see in the media. Mass media provides more important information than parents, using quality pictures of aspects of adolescents' sexual needs and wants, electronically and in print. Hence, the images promote imaginations that stimulate an adolescent to imitate the behaviour depicted in the scene. This increases the risk of adolescents imitating sexual behaviours that are risky (Borneskog et al. 2021:2; Ahanhanzo et al. 2018:89).

5.4.5.8 Category: Inability to wait for the right time to have sex

Two sub-categories emerged, namely *a boring partner who is not ready, and immature males who are not financially stable.* Most millennial males indicated that they do not

have the patience to wait for a partner who is boring. Adolescent 2 cited, *"I cannot wait for a partner's time when the girl is ready physically and emotionally to have sex. I would rather pick and drop whenever I like."* The female participants shared these views. Adolescent 2 mentioned: *"I can-not wait for these small boys to grow up and be financially stable, they are not reliable they can abandon you anytime."*

According to Born et al. (2015:514), adolescents need education on different aspects of SRH, including waiting for the right time. After sexual education, school-going adolescents often show an eagerness to change for the better and are more likely to practice responsible sexual behaviours by using condoms, discussing their preferences with their partner, and they have a greater understanding of abstinence.

5.5 SECTION 2: MAIN THEMES FROM SAMPLE B

One main theme emerged from sample B, as shown in Table 5.8.

Table 5.8: Theme for sample B

Theme 1	Teachers' perceptions of adolescent sexual responsibility

5.6 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE B (TEACHERS)

In section two of Phase II, qualitative data were collected from 10 teachers through face-to-face interviews. Even though data saturation was reached with six participants, the interviews continued until all 10 teachers were interviewed. Five teachers were male (50%), five were female (50%), and their ages ranged from 33 to 45 years. All teachers had at least a diploma in education at the tertiary level, and all had at least two years' experience working with school-going adolescents.

An interview schedule was used as a data collection tool, and interviews were conducted at high schools in the township. Expert Life Orientation teachers were asked about sexual behaviour among school-going adolescents.

Table 5.8: Teachers' demographical profiles

Demographic variables	Frequency	Percentage (%)
Gender:		
- **Male**	5	50%
- **Female**	5	50%
Age range:		
24-30 years	3	33%
31 -34 years	3	33%
35 -45 years	4	34%
Level of schooling		
- **Tertiary**	10	100%

Table 5.9: Sample B: Participant-specific information

Name	Gender	Age	Educational level	Experience in Teaching Life Orientation
Teacher 1	Male	33	Degree	5
Teacher 2	Female	45	Degree	10
Teacher 3	Female	24	Diploma	2
Teacher 4	Female	26	Diploma	2
Teacher 5	Male	30	Diploma	3
Teacher 6	Male	43	Degree	10
Teacher 7	Female	34	Diploma	5
Teacher 8	Male	41	Diploma	4
Teacher 9	Male	40	Degree	7
Teacher 10	Female	24	Diploma	2

5.6.1 Theme 1: Teachers' perceptions of adolescent sexual responsibility

In theme 1, two categories emerged, namely teachers as SRH information providers, and challenges hindering adolescents from achieving responsible sexual behaviour. Table 5.10 shows the categories and subcategories related to teachers' perceptions of adolescents' sexual responsibility.

Table 5.10: Theme 1: Teachers' perceptions of adolescent sexual responsibility

Theme	Categories	Sub-categories
Teachers' perceptions of adolescent sexual responsibility	Teacher as SRH information provider	• Educators as providers of accurate SRH knowledge • Educating children on social skills • Identifying children in need of SRH • Supportive role
	Challenges hindering adolescents from achieving responsible sexual behaviour	• Misinterpretation of children's rights • Difficulties in disciplining adolescents at school • Ill-equipped teachers • Peer pressure • Lack of expert knowledge on SRH • Time constraints • Minimal workforce and extra work • Parents' over-reliance on school SRH education

5.6.1.1 Category: Teacher as SRH information provider

In this category, several sub-categories emerged, namely *educators as providers of accurate knowledge of SRH, educating children on social skills, identifying children in need of SRH, and providing a supportive role.*

In the sub-category of *teachers as providers of accurate SRH knowledge*, the teachers stated that they educate adolescents on social skills and give them correct SRH information. This was revealed in the statement below:

Teacher 1 said, "*we teach children for them to acquire skills such as how to handle sexual abusers such as boys taking advantage of girls, respect for body, need for consent to get consent to have sex, and taking responsibility to use condoms and*

other methods to prevent STIs and unplanned pregnancies respectively. It is unfortunate that adolescents who do not attend school have knowledge gaps regarding sexual behaviours and teachings on sexual responsibility."

Nkosi and Pretorius (2019:110) similarly reported, "educators are the motivators and enablers of schooling and promoters of responsible sexual behaviours among adolescents whether an adolescent is or is not pregnant."

Providing accurate SRH information was of particular importance for this study to promote responsible sexual behaviours and safer sex among school-going adolescents. Teacher 2 said: *"we are one of the first point of access to accurate information on sexual and reproductive health by adolescents. We work hand in hand with health care professionals and NGOs collaborating our knowledge".*

With the growing rate of pregnancies among school-going adolescents, their early exposure to sexual information is beneficial if adolescents listen to elders' and teachers' teachings (Nkosi & Pretorius 2019:110). However, sexual education could itself be troublesome as adolescents learn more and become too inquisitive, and start to experiment. Teacher 6 echoed the same sentiments by saying, *"Yes we teach them these things about puberty, but were are also scared as parents even though I am a teacher that adolescents are too experimental, they will want to learn more through doing it".*

According to Powell et al. (2017:169) and Gillespie et al. (2022:1020), the introduction of the Life Orientation subject in schools' curricula was aimed at teaching and equipping children with *social skills,* reducing the incidence of pregnancy and HIV infections among school-going adolescents. The subject intended to provide information to adolescents on where they can access contraceptives and reproductive healthcare services, thereby creating an understanding and reducing unintended adolescent pregnancy, STIs and HIV infections.

Moreover, the Department of Education in 2015 introduced condom distribution in schools for learners in disadvantaged communities and schools where there is a high prevalence of teenage pregnancies. However, in a study carried out to evaluate the

programme's effectiveness, stakeholders were concerned that the strategy might not yield the expected dividends. Some parents and churches felt that children were too young to be talking about sexual intercourse, so they did not encourage or support SRH teachings in schools (Nkosi & Pretorius 2019:110).

Educators *provide a supportive role* to adolescents in school. Support includes helping pregnant adolescents, sexually coerced adolescents, and adolescents in need of SRH, such as providing them with sanitary towels.

Teacher 4 said, *"A pregnant adolescent should not be left behind, we are supposed to provide her with lesson plans while waiting to deliver, at school sometimes she does not cope with work and pregnancy…Either way adolescents need our support with their sexual and reproductive health like provision of sanitary towels so that they do not look for money from boyfriends to buy these essential things."*

Nkosi and Pretorius (2019:113) also revealed that educators often end up using the skills that mothers use, such as caring and nurturing attributes, to counsel and support adolescents.

5.6.1.2 Category: Challenges hindering adolescents from achieving responsible sexual behaviours

Regarding this theme, the categories that emerged were a *misinterpretation of children's rights, difficulties in disciplining adolescents at school, ill-equipped teachers, peer pressure, lack of expert knowledge on SRH, time constraints, minimal workforce and extra work, and parents' over-reliance on school SRH education.*

In terms of *misinterpretations of children's rights*, teachers felt that school-going adolescents do not understand the meaning of their rights, and thus misuse these rights by indulging in irresponsible sexual behaviours and not listening to teachers, parents or community members. Teacher 7 said, "*Most adolescents know their SRH rights and not the responsibilities that go with them. When we reprimand them they tell us to get off their case because they are practicing their rights."*

Nkosi and Pretorius (2019:113) concur that “adolescents misinterpret children’s rights taught because they lack awareness and insight regarding the impact of their own behaviour resulting from the application of children’s rights out of context”.

In the sub-category *difficulties in reprimanding adolescents*, teachers were of the opinion that it is very difficult to reprimand adolescents who misinterpret their “rights” and engage in risky sexual behaviours, despite their vulnerability. “… *Because adolescents say that they have rights to their bodies and to do what they want with it. They tell us to get off their case”* (Teacher 3). Gillespie et al. (2022:1019) discovered that adolescents discuss sex-related issues among themselves, but they do not actually have a true understanding of SRH.

Under the sub-category *ill-equipped teachers,* teachers felt that they do not have enough skills and resources to manage adolescents’ sexual responsibility. Teacher 4 explained, “*we are doing something which we do not have skills or resources. It was going to be easier if maybe the schools could have clinics which provide these services at schools. Because they don’t go to the clinics either.”*

A *lack of expert SRH knowledge* was also mentioned, and the teachers reported concerns that they are given a task for which they are not well trained. Teacher 5 said, “*this role needs someone who is trained in SRH but this role is left to teachers who are ill-equipped and do not have the necessary skills to support the learner emotionally. I also do not feel comfortable to talk about sex to children”.*

Gillespie et al. (2022:1019) support the above observation, stating that some teachers focus more on abstinence because they do not feel comfortable talking about sex. There were also reported *time constraints*, and teachers revealed that they have less time and too much work to attend to learners individually. As a result, the learners receive bits and pieces of information. Teacher 8 said, *“we work from half seven in the morning to 2 o’clock. It’s not enough time for us to give individualised attention which a pregnant child needs and to give in-depth life orientation classes but we have to do that.”*

With regard to the sub-categories *extra burden and minimal workforce*, the teachers expressed that the teacher-student ratio and a lack of respect for teachers are concerning. This does not create a good learning environment because it is difficult to control many students at one time. Teacher 9 said*," You find that one teacher teaches more than 100 students and you have a class with more than one adolescent pregnant. Another challenge, you find that when busy teaching some learners will be busy kissing each other in class without even listening to you. Even with punishment, they don't care they will repeat that. So how am I supposed to change behaviour of that child? We are not allowed to give corporal punishment".* Gillespie et al. (2020:1020) similarly observed that lack of resources hinders the provision of SRH health education in schools.

Parents' over-reliance on school SRH education, revealed that even though parents are expected to play their part as SRH information disseminators, supporters and educators, the majority of adolescents could not get sufficient assistance from their parents. Instead, parents rely on schools to teach SRH and discipline adolescents with regard to their sexual responsibility. "I *don't think some parents even bother to sit down with their children and talk about sex and responsibilities that come with it. What happens in classes with the slightest chance that they get in class you won't believe it. Lovers do it seated on each other. Parents on the other side blame us teachers and believe their children" (*Teacher 9)

Teacher 10 clarified the above sentiments and cited, "*Some kids lack manners they do it (sex) in class. Only had it been there are secret cameras in class you will understand me. Parents are they doing enough at home or are just saying teachers will see?"*

However, the findings revealed the absence of parental involvement in sex-related matters with adolescents. Teacher 2 emphasised, "*instead, most of the information about sex issues come from schoolteachers, peers, and media. Yet some parents still complain that we teach children adult staff which they should not know. We are confused."* These findings concur with Gillespie et al.'s (2022:1020) views that teachers give limited SRH education (with reservation), because the subject of sex and contraceptive use is a sensitive and moral issue. Some teachers are not

comfortable to advise on contraception because this feels like promoting sleeping around. Moreover, some parents do not allow contraception-related discussions, preferring messages of abstinence. This creates a dilemma on how best to tackle the issue (Gillespie et al. 2022:1020).

Regarding *peer pressure in schools,* adolescents listen more to their peers than to what teachers say about SRH. Teacher 1 said, "*how can the learners change their sexual behaviour when they listen to bad advices from friends who do not have sufficient or who have wrong SRH information, and who have also failed to practice sexual responsibility themselves. You find that the adolescent want flashy life at school when she is not working or rich, just to show-off to friends?"*

The findings agree with those of Ngidi et al. (2016:99), suggesting that adolescents listen more to their peers than their parents. However, Gillespie et al. (2022:1020) found that even though adolescents share amongst themselves, they have knowledge gaps about SRH.

5.7 SECTION 3: MAIN THEMES FROM SAMPLE C

One theme emerged from the data gathered from the parents, as shown in Table 5.11.

Table 5.11: Theme 1: Parents as educators, supporters and SRH information disseminators

THEME 1	Parents as educators, supporters and SRH information disseminators

5.7.1 Parents' demographical profile

In section 3, qualitative data were collected from 10 parents through face-to-face interviews. An interview schedule was used as a data collection tool, and interviews were conducted at two local clinics in the township. Four male participants and six female participants were interviewed. All participants were educated up to tertiary level. This is shown in Table 5.12.

Table 5.12: Demographical profile of Sample C (parents)

Demographic variables	Frequency	Percentage (%)
Gender:		
- **Male**	4	40%
- **Female**	6	60%
Age range:		
30-40years	6	60%
41-50 years	4	40%
Level of schooling		
- **NONE**	2	20%
- **Primary**	2	20%
- **Secondary**	2	20%
- **Tertiary**	4	40%

Table 5.13: Sample C: Participant-specific information

Age	Name	Educational level	Gender	Employed?
40	Parents 1	Secondary	M	Yes
50	Parents 2	None	F	No
39	Parent 3	Tertiary	M	Yes
38	Parent 4	Tertiary	F	Yes
37	Parent 5	Tertiary	F	Yes
45	Parent 6	Primary	M	No
40	Parent 7	Primary	F	No
37	Parent 8	Tertiary	F	No
52	Parent 9	secondary	M	No
44	Parent 10	None	F	Yes

5.8 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE C (PARENTS)

5.8.1 Theme 1: Parents as educators, supporters and SRH information disseminators

In this theme, 12 categories emerged, as described in Table 5.14.

Table 5.14: Theme 1: Parents as educators, supporters and SRH information disseminators

Theme	Category	Sub-category
Parents as educators, supporters and SRH information disseminators	Influence of sex hormones during adolescence	• Inability to control hormones • Permissive sexual behaviour.
	Parents give adolescents too much freedom	• Allow children to grow independently • Total adolescent independence without accountability is worthless • Termination of pregnancy • Parents' hopelessness
	Parent indecisiveness	• Embarrassment • Inquisitiveness among children • Shy parents
	Parents' over-reliance on other sources of SRH information	• Teachers have knowledge gaps • Church messages mainly promote abstinence • Conflicting messages
	Conflicting messages	• Hypocrites
	Peer pressure	• Alcoholism • Drug intoxication • Spiking of drinks • Promiscuity
	Poor family structure in adolescent homes	• High rate of divorce • Child-headed families • Single-parent headed family
	High cost of living in South Africa	• Promiscuity • Poverty
	Lack of parental involvement and support in adolescent's life	• Lack of commitment • Bought love • Lack a listening ear and proper observation
	Lack of control at home	• Spoiled adolescents • Lack of strict control

Theme	Category	Sub-category
		• Early parenting and low self-confidence to raise an adolescent
	Changing times, changing norms and values	• Difficult generation • Lack of respect for parents • Poor supportive environment by significant others • Parents' work commitments • Accepting the effects of changing times
	Culturally the subject of sex is too sensitive	• It is taboo and disrespectful

5.8.1.1 Category: Influence of sex hormones during adolescence

The sub-categories that emerged were: *Inability to control hormones; and permissive sexual behaviour. An inability to control highly active hormones* was mentioned, as parents were of the opinion that sexual hormones hamper adolescents' ability to be sexually responsible. They felt adolescents do not have the necessary experience or knowledge to deal with highly active hormones. Many parents echoed the same statement that adolescents do not act out of their free when sex hormones are active in the adolescent's body. Parent 1 cited, *"high active hormones plays a major role when it comes to adolescent sexual behaviours*". The transition to adolescence was assumed to be accompanied by immaturity and confusion among most adolescents.

Parents also revealed that immaturity plays a role when it comes to sexual responsibility, because even school-going adolescents with the privilege of having parents who guide and teach them about sex fall pregnant or contract HIV and other STIs.

"Children will always be children, they do whatever they sexually feel and like at that time. They do not know how to control the sexual desires because of immaturity". (Parent 2)

Parents also agreed the *adolescence stage is overwhelming and confusing* for many adolescents when they are trying to learn about changes in their body, including sexual characteristics. They become vulnerable to vultures who take advantage of their vulnerability.

Parent 2 said, "*There is a lot of factors for example, being over anxious, and confusion, which leads to anxiety and acting so strange by our children as they start being sexually active and they push us away. The rely mostly on outside"*

Another sub-category, '*secretive stage*', had parents revealing that many adolescents become secretive about SRH. This secret is often kept by a close friend. However, secrecy places adolescents at risk of exploitation if the information comes out or falls into the wrong hands. Parent 9 said, "*Our children are not free to share with us parents so that we give them advice on sexual responsibility*. *Yet they are confused with things*".

Gillespie et al. (2022:1019) suggested that adolescents push their parents away because they promote abstinence rather than contraceptives. The study illuminated that, as much as some parents condone adolescents who are sexually active and discipline them accordingly, adolescents also still have sex under the strictest parent's back. Adolescents are secretive over the issues of sex and are not comfortable talking to their parents about the topic.

5.8.1.2 Category: Parents give adolescents too much freedom

In this category, various sub-categories emerged, namely *allowing children to grow independently, adolescents' total independence is worthless without accountability, freedom for termination of pregnancy, and parents' hopelessness.*

In *allowing children to grow independently,* some parents said they give school-going adolescents space to grow and experience life. These parents revealed that they teach their children about sex-related issues openly. Afterwards, adolescents have the space to explore the reality of their sexual life and make their own mistakes and learn from them. Parent 4 said, "we *have been there as teenagers, let them learn by seeing".*

There were also parents who afforded their adolescents too much freedom, including in terms of sexual responsibility. These parents claimed their adolescents were old enough to learn to take responsibility for their life choices, including sexual responsibility, without parents' close monitoring.

In the sub-category, *school-going adolescents' total independence without accountability,* there were parents who strongly opposed the idea of adolescents' independence, claiming it is a big mistake with consequences. Parent 3 said, *"independence to adolescents mean too much freedom to do what they want including drinking alcohol, smoking, sex, and some indulging in drugs".* Parents who contested the idea of adolescent independence indicated that this is practically a sign of permissiveness on their part because this age group grows physically, but mentally, they are still babies and need guidance. These parents felt it necessary to intervene until the adolescent reached 21 years, when the parents give adolescents their keys to life. Parent 4 explained, *"Those parents who feel and think that their kids are old enough to make good decisions show pure laziness and it is costing our children. We are giving them independence immaturely when actually they should be well protected from the harsh reality of sexual life"*. Gillespie et al (2022:1019) concurs with this parent's reflection that some parents were encouraging others to teach their children about preventing an unplanned pregnancy as a means of taking accountability for their actions. An unplanned pregnancy leads to school drop-out and disturbed career prospects.

On the '*termination of pregnancy (CTOP)'* aspects, many parents felt the provision of TOP services at the township clinic has led to a spike in school-going adolescents falling pregnant. This was attributed to the fact that there is no longer any fear of unplanned pregnancy among adolescents since they can easily abort it. Parent 5 shared: *"we have a challenge now that our children say they know their rights and freedom. They just sleep with boys without protection or prevention, they fall pregnant and go to the clinic even when I refuse to consent as a parent".* Parent 3 said, *"I told my child that here at home we do not kill, we do not do abortions."*

The sub-category *parents' hopelessness* was expressed by parents who failed to understand the CTOP service is a way of empowering female children to achieve their

goals when they fall pregnant without planning for it. Parents emphasised that after a first abortion, a girl should desist from having repeated unplanned pregnancies. However, some school-going adolescents continued to have multiple pregnancies and aborted them. Parent 6 said disappointingly that, *"We parents we end up appealing to the adolescent not to abort the pregnancy because it is against our beliefs. What can we do now?"* According to past literature, parents are looking for alternative ways to prevent unplanned pregnancies among adolescents (Gillespie et al 2022:1019).

Parents felt that there was not much they could do to promote sexual responsibility among adolescents if the adolescents did not want to listen. Inasmuch as abortion is a way of empowering a girl child to solve a problem and realise her goals, parents felt *hopeless* since adolescents from 12 years can have an abortion. Parent 10 said, *"Now TOP has given our children the green light to sleep around, get infected with STIs. They do not want to listen, they do not want to take pills, and they end up dead."*

5.8.1.3 Category: Parent indecisiveness

Various sub-categories emerged, including *embarrassment*, and the *inquisitiveness of the child,* fearing that the child will ask too many questions that are difficult to answer. Some parents revealed that they are undecided about teaching young persons about sex-related matters since their young children will know what is meant to be sacred.

Ultimately, *parents were shy* to know if their school-going adolescents had started having sex. As a result, parents either ended up discussing or not discussing sex-related matters with their children, but sometimes these discussions came too late.

Parent 1 supported this finding by saying*, "Yes some of us parents are shy…feels like I am encouraging my child to sleep with boys. Maybe he/she had not even started and I end up instilling those thought in him /her and they ask too much. Disappointingly so, sometimes you end up being too late to raise that issue*".

A lack of SRH communication between parents and adolescents leads to insufficient knowledge being obtained from a reliable and trusted person. Some parents only offer messages of maintaining purity and to avoid pregnancy without clear explanations due

to taboos and culture (Duby et al. 2021:12). However, Gillespie et al. (2022:1021) indicated that some parents are shifting from the social norms related to communicating about sexual matters with their adolescents. These social norms reject adolescents' access to SRH information. However, parents agree that it is responsible to support and guide adolescents to prevent unplanned pregnancies so that adolescents finish school and have a better future (Ahanhanzo et al. 2018:90).

5.8.1.4 Category: Parents' over-reliance on other sources of SRH information

Different sub-categories emerged, namely *teachers have knowledge gaps, and church messages mainly promote abstinence.*

Regarding *teachers having knowledge gaps*, findings revealed that most parents relied on SRH information from schoolteachers and churches because parents avoided this topic because of their own reservations. Parent 7 explained: *"I see that my child now knows too much and I ask child where did you learn that and reply that my teacher taught us this; my teacher taught us that… (Pause)…what can I do I am embarrassed. I just leave it like that for schools to continue at least she knows something good".*

Findings revealed that adolescents obtain most SRH information from schools and less from parents. Schools create awareness and involvement in the SRH acquisition. Most parents avoid SRH discussions with their adolescents (Niinsima et al. 2021:13).

On the other hand, relying on churches is fatal because churches promote sexual responsibility mainly through abstinence and school-going adolescents often still have sex after attending church. Parent 1 said, "*I like my child to learn from church doctrine about sex but I feel that the messages of abstinence only sent to the school-going adolescents by the church are no longer very effective because many adolescents are to wise for nothing and sexually active. It's better to teach them about condoms also…*" (Gillespie et al. 2022:1020). Church leaders and some parents agreed that they stick to abstinence messages when it comes to educating adolescents on sexual responsibility. However, this limits adolescents' choice in protecting themselves when they are already sexually active, leading to unplanned pregnancies.

In the sub-category*, conflicting messages* from the parents, adolescents' knowledge acquired at school, and other SRH sources of information pose a challenge to promoting sexual responsibility. Parent 7 said, "*It depends on how sexual responsibility is approached per family or community at large. At home I teach my children not to sleep with boys while at school they are taught to take pills to prevent pregnancy. Who will she learn from then?*"

Conflicting messages from parents, schools, and the media confuse adolescents on the best course of action to take. As a result, adolescents become confused and follow their hearts, sometimes making mistakes that lead to pregnancies and HIV infections (Gillespie et al. 2022:1018).

In sub-category *hypocrites* emerged as those parents who tell their children to behave responsibly while they themselves misbehave in front of the adolescent. The child will copy what they see from their parents. Parent 10 said, '*Train the children according to our ways of doing things they learn from home whereby parents lead the way; children follow what parents' do, not what the mouth say only. Therefore, as parents we should lead by example of sexually responsibility."*

The findings reveal that some adolescents are unhappy with the sexual behaviours their parents exhibit in front of their children. Training and educating children should be exemplary (Duby at al. 2021:13).

5.8.1.5 Category: Peer pressure

Alcoholism, drug intoxication, spiking of drinks and promiscuity emerged as sub-categories. Parents were of the opinion that most peers influence their school-going adolescents to misbehave sexually for the wrong reasons, such as being *promiscuous* in order to get money for *drugs and alcohol* to feel good. As a result, adolescents rely on these references, living the joys of that moment, experimenting with sexual practices that expose them to unplanned pregnancies and HIV infection.

Nkani and Bhana (2016:7-8) concur with the above finding, stating that school-going adolescents often try new things due to peer pressure, leading to a loss of conduct

with parents' policies, which would also contribute to their poor sexual decision-making.

5.8.1.6 Category: Poor family structure in adolescent homes

Regarding this category, a few sub-categories emerged, namely the *high rate of divorce, child-headed families, and single-parent headed families.*

Most families in the township have divorced or do not live together as a family, leading to *single or child-headed families*. Raising children separately leaves children prone or exposed to dangers of sexual exploitation (especially the girl child), and rebellion, like having unprotected sex at an early stage. Some children are left alone to feed themselves and are forced to look for alternative ways to earn money, and sexual transactions become an option.

Parent 5 echoed the effects of divorce by saying, *"Parents at this moment (divorce) are trying to satisfy their new relationships and not involving themselves with their children who will be in need of their guidance and some children are left to look after themselves."*

There is a high rate of single-parent headed homes where parents sometimes bring new partners home to their children. This may be traumatic to the adolescent as they experience being cut off from their perception of proper family life. Children learn from what they see others do.

Parent 10 said, "*Here in our township there is no concrete family life. The parents live with girlfriends or vice versa. I am still young to stay without a lover. When I go out, my adolescent child also go out or bring a lover in my home. How can I teach my child when myself I am failing?"*

Anyanwu et al. (2020:7) revealed similar findings that parents were indiscreet with their alcohol use and sexual behaviour, thus exposing adolescents to risk factors for irresponsible sexual behaviours, and creating difficulties in disciplining and controlling the child. Family unity, as opposed to family conflict, brings about harmony in the

family, promoting effective care and building good parent-child relationships. The good relationship supports good behaviour among children (Anyanwu et al. 2020:6).

5.8.1.7 Category: High cost of living in South Africa

The sub-categories included aspects related to the high cost of living, namely *promiscuity and poverty.* In this study, parents stated some adolescents sell their bodies for money willingly, or their parents send them to do so (*promiscuity)*. With the ravaging effects of an unstable economy, most parents lost their jobs and income, which led to *poverty.* Hence, parents turn a blind eye if their school-going adolescent girls sell their bodies to support the family. In other words, they withdraw from their child's sex-related behaviours in order to protect their economic safety net.

"Looking at the demands of cost of leaving we are facing these days and worsened with the coming of Covid 19, some parents are busy overlooking the child's sexual behaviour when she brings expensive goods at home without knowing where the money came from. This limits their parental conscience of protecting their children from prostitution" (Parent 6).

Anyanwu et al (2020:5) proposed that the impact of poverty is most felt by adolescents whose parents are jobless, child-headed families, or after parental divorce, to mention just a few. This forces adolescents to support themselves and their families. The amount of money an adolescent's family has determines if the adolescent will participate in deviant and risky sexual behaviours, such as prostitution.

5.8.1.8 Category: Lack of parental involvement and support in adolescent's life

In this category, three sub-categories emerged, namely *lack of commitment, bought love, and the lack of a listening ear and proper observation.* In the sub-category, *lack of commitment,* participants raised concerns over some parents' lack of commitment (especially males) to raising children in a responsible manner. Many men in the township were said to be absent and not supporting their children. Most women have taken both the role of father and mother in the adolescent's life, which is often too much for them. Parent 10 cited, "*Some parents especially men here lack commitment*

to their children. Women are raising their children alone while men are enjoying themselves with other women".

Poverty favoured men more than women, with men leaving their children at the mercy of their mothers who are also unemployed. This results in a reversal of gender roles and single parenthood leaving room for feelings of worthlessness, conflict, boredom and loneliness. This void in adolescents may be filled with self-destructive behaviours, such as risky sexual practices, drug and alcohol abuse and violence (Anyanwu et al. 2020:5).

In the sub-category *bought love,* parental lack of availability in adolescents' life is replaced with money, and adolescents are easily bought with flashy gifts from their parents. However, some parents confirmed that this money is being used by adolescents to buy sex, drugs and alcohol. These behaviours impair adolescents' proper decision-making ability to engage in responsible sexual behaviour. Instead, they are drawn to one-night stands and unprotected sex. Parent 2 said, *"Money is the source of wayward behaviour by many school-going when they show off with money they are given by parents for upkeep and use that money to buy sex".*

Moreover, drug dealers are selling illegal drugs to school-going adolescents as young as 10 years in the township. School-going adolescents are therefore becoming drug addicts under the nose of their parents. According to Parent 9, *"They (adolescents) have access of drugs and alcohol, buying these with the money their parents give them which makes the matters worse. Drug pushers know that kids do have money and they are targeting them. Teachers tell us not to give children money instead prepare lunch boxes but adolescents refuse to carry them. They want money instead to buy."*

Excessive partying and alcohol use among adolescents was also a result of other kids throwing parties and inviting their friends; sometimes without their parents' knowledge. At parties, various unbecoming behaviours are practised by school-going adolescents. Parent 7 explained, *"Rich kids have money, too much of it. Parents of these days just flush their money to kids when adolescents demand parent's quality time. In return children have money and too much of it, in such that adolescents afford to throw*

parties and risk wayward sexual behaviour. That is where they drink alcohol, sexually experiment, some engage intentionally in promiscuous sexual acts by paying for sex." Anyanwu (2020:8), had similar findings that some adolescents are disrespectful and engage in sexual risk sexual activities, drink alcohol, smoking marijuana and use harmful substances. Authoritative parenting styles have shown evidence of protection of adolescent's sexual behaviour compared to an authoritarian and permissive parenting style even though it is not always the case, as some of the adolescents may rebel against such style.

Most parents also reportedly *lacked a listening ear and proper observation* of the school-going adolescent's red flags in sexual behaviour. They consequently miss the SRH changes happening in the adolescents, and parents often only realise once it is too late and the adolescent's sexual behaviour is out of control. Some school-going adolescents bottle up important sexual matters because parents do not listen to them or offer appropriate support.

Parent 9 explained, *"Unfortunately, many parents do not believe that the township is rotten with drugs like Nyaope and alcoholism has taken hold of many school-going adolescents. Yes, here and there we pick up that there is something that is going on. For example, a child may come home not able to walk, or intoxicated with drugs, or drunk with alcohol and we do not see it. Sometimes a child try to tell me something and I brush it off".*

A lack of parental monitoring of adolescents' behaviour enhances opportunities for unsafe practices, such as substance use and sexually risky acts. However, parents who set rules and monitor their adolescents consistently prevent deviant behaviour among them (Anyanwu et al. 2020:7).

5.8.1.9 Category: Lack of control at home

In this category, several sub-categories emerged, namely *a lack of strict control, early parenting, and low self-confidence in raising an adolescent.* Participants raised concerns over parents who do not control their adolescents and allow them to do

whatever they want. Parent 8 cited that *"adolescents have a lot of freedom leading to sexual irresponsibility because there is no control from home and strong hand."*

Parents also believed that if *strict control* of adolescents is maintained, this will reduce the consequences of unbecoming behaviour like STIs or unplanned pregnancies by minimising time out with the wrong crowd. Parent 4 said, "*I minimise time when my child is out of the house. She knows the rules of the house. You cannot just leave girl child at the mercy of the streets in the name of love. We are killing our kids. Monitor closely your adolescents, let them know the boundaries and see what happens. I am a testimony of my children, they are all well-off now."*

The above finding is in agreement with Anyanwu et al. (2020:7) who revealed that parents who are strict, set rules and monitor their children are likely to promote good behaviour in children and prevent delinquent behaviour.

For the sub-category, *early parenting and low self-confidence in raising an adolescent,* young parents and single parents were concerned that they sometimes tend to lose confidence in raising a responsible school-going adolescent. They felt they tend to compete with their children for sexual pleasures, and are too busy with their own life. Parent 1 reported: "*me having children before mature age is affecting me because I lack confidence to guide my own adolescent towards sexual responsibility, As a parent, I am still competitively sexual young, and my adolescent want to enjoy life without any limitation also. What will I say and how?"*

The findings revealed older siblings who had unwanted pregnancies during their adolescence made it difficult for parents to enforce control on the school-going adolescent who is following in the footsteps of an elder sibling. However, parents also noticed that some adolescents were learning from the consequences of their elder sibling's adolescent pregnancy.

Parent 1 cited, "*you do not know what we are going through the hands of these children…if tell her to stop sleeping with boys, she backlashes at me telling me that even my sister was doing it. Let me make my mistakes. Now she is pregnant."*

Parent 5 had a different experience with her daughter: "*My younger daughter has seen what her elder sister passed through when she fell pregnant while at school. She struggled with the baby alone when the father of the child refused to have anything to do with child because he was a married man. She is focused."* The above finding concurs with Ninsiima et al. (2021:14), who revealed not all adolescents engage in risky sexual behaviours for different reasons, such as learning from other people's mistakes, like a sibling or parent who suffered the consequences of risky sexual behaviours.

5.8.1.10 Category: Changing times, changing norms and values

In this category, the findings reflected hopelessness among parents and the community. Five sub-categories came up, namely *a difficult generation, lack of respect for parents, poor supportive environment by significant others, parent's work commitments, and accepting the effects of changing times.*

Most parents of the millennial *generation felt that school-going adolescents are too difficult to discipline* because they no longer listen to elders. Parent 10 reported: *"The do not listen to us so what can we do?"*

Parent 11 echoed the same sentiments that adolescents are impossible: "*Nowadays, it's as if as a parent I don't teach my children things about sexual responsibility anymore. In fact, I used to talk about these things but they listen with one ear and throw it all out through another ear. All of my children fell pregnancy in their adolescence. It is painful. But what can I do? I have accepted that times change but now I personally take them to the clinic for injections".*

According to Yu et al. (2021: S33), adolescents watch pornography despite their parents telling them not to do so. As a result, adolescents tend to copy and engage in all sorts of irresponsible sexual behaviours based on what they see. Gillespie et al. (2022:1019) suggests that some parents have accepted that abstinence is impractical; hence, they have shifted to promoting contraceptive use.

In the sub-category *lack of respect for parents,* the findings revealed that some adolescents do not listen to their parents, lack respect and some bully their parents. Parents in these circumstances feel they have no option but to leave school-going adolescents to make their own choices on their SRH. Hence, adolescents are prone to risks of irresponsible sexual behaviour.

"*We want to teach our children on how to take care of themselves but they do not want… they become violent and rebellious …they tell us that we are backward and they have rights.…especially on the issue of abstinence we want you (researcher) to tell us what we can do besides just looking nje"* (Parent 6).

Gillespie (2022:19) and Pulerwitz et al. (2019a: S7) support the above finding that incidences of irresponsible sexual behaviours are higher than in the past, when morals and values played a big role and were respected by adolescents.

In addition, the lack of proper mentorship from siblings, aunts, family friends and the community at large has led to a *poor supportive environment,* prompting irresponsible behaviour among school-going adolescents. Some parents were concerned about the erosion of support from different members of the family and community looking after each other's children. Parent 10 expressed, "*sometime ago, other relatives like aunts were used to communicate issues of growing up including sexual matters. This way parents were saved from talking such matters and children were free to talk and learn these matters. But now, each man is for himself. Even when I see a child misbehaving I will keep quiet"*

Gillespie et al. (2022:1019) and Nkhwashu and Mafukata (2015:1084) shared similar observations of poor communication and sexual education between mothers and adolescent daughters in a township of South Africa. This was confirmed by a majority of mothers who did not have information on whether their daughters were sexually active. Most just hoped their daughters were still virgins without playing an active role in their child's sexual life due to personal and cultural reasons.

Lack of time with children due to *work commitments* meant parents were concerned they return home exhausted with work-related issues and do not have the time, energy

or commitment for their school-going adolescents who need them most at this stage for guidance. Parent 7 gave a statement, *"I am going to work, husband is going to work. There is no time with the children. As a result, house helpers and school teachers are the ones who mostly spend time and groom my children. For children to be free to discuss with me sexual related matters or anything that is happening to him or her becomes a problematic because of the time I arrive home, I will be tired, and I need to rest."*

5.8.1.11 Category: Culturally the subject of sex is too sensitive

Under this category, the sub-categories *it is taboo* and *disrespectful to discuss sex-related matters* appeared. Some parents believe that African norms do not allow parents to discuss sex-related issues with a child. Parent 2 said, *"…that is why they do not get involved in these sexual related issues because it is taboo and disrespectful. There are more comfortable people to talk to such as bomalume and aunts*."

Parent 7 provided an insightful picture of the effect of culture: *"now I cannot sit with my child and talk about sex or contraceptives, in African culture, it is just off. Though it is advisable for each parent to sit with her own child, that's somehow a sensitive issue for the parent to sit and talk about these sexual matters"*.

Gillespie et al. (2022:1018), Powell et al. (2017:173) and Nkani and Bhana (2016:4) revealed that adolescent contraceptive use is taboo for many parents. Despite the high prevalence of teen pregnancies in Black communities, the majority of parents still disapproved of responsible sexual practices like contraceptive use by adolescents. Without parental support, adolescents become secretive about their sexual and reproductive health-seeking behaviour until it is too late. They fear scrutiny and judgement.

5.9 SECTION 4: MAIN THEMES FROM SAMPLE D

In this section, one theme appeared from the data collected from healthcare and NGO professionals, namely health professionals' role in adolescents' SRH (see Table 5.15).

Table 5.15: Health care and NGO professionals' role in adolescent SRH

THEME	Health care and NGO professionals' role in adolescent SRH

5.9.1 Demographic profile of healthcare and NGO professionals

In section 4, qualitative data were collected from 12 healthcare and NGO professionals through face-to-face interviews. An interview schedule was used as a data collection tool, and interviews were conducted at two local clinics in the township. Five male participants and seven female participants were interviewed. All participants were educated up to tertiary level. Table 5.16 shows the demographic profile of healthcare professionals and NGO staff. Their age range was 25-40 years.

Table 5.16: Demographic profile of healthcare and NGO professionals

Demographic variables	Frequency	Percentage (%)
Gender:		
- **Male**	5	38%
- **Female**	7	62%
Age range:		
- **25 -30 years**	4	33.3%
- **31 -35 years**	4	33.3%
- **36--40 years**	4	33.3%
Level of schooling		
- **Tertiary**	12	100%

Table 5.17: Sample D: Participant-specific information

Participant	Gender	Title
HP 1	F	Registered general nurse (RGN)
HP 2	F	Professional Nurse (PN)
HP 3	F	Professional Nurse
HP 4	M	Doctor
HP 5	F	RGN
HP 6	M	PN
HP 7	M	PN
NGO 1	M	Youth motivator
NGO 2	F	Youth motivator
NGO 3	F	Peer-to-peer adolescent

Participant	Gender	Title
NGO 4	F	Peer-to-peer
NGO 5	F	Youth motivator

5.10 ANALYSIS, DISCUSSION AND LITERATURE CONTROL OF SAMPLE D: HEALTH CARE PROFESSIONALS AND NGO STAFF

5.10.1 Theme 1: Health care and NGO professionals' role in adolescent SRH

One theme emerged, namely healthcare and NGO professionals' role in adolescents' sexual responsibility. Three categories emerged, namely healthcare professionals as supporters, information disseminators and service providers of SRH, the dilemma of health care and NGO professionals in adolescent SRH, and NGO sexual and reproductive health programme challenges. These are described in Table 5.18 below.

Table 5.18: Themes, categories and subcategories

Theme	Category	Sub-category
Health care and NGO professionals' role in adolescent SRH	Healthcare professionals as supporters, information disseminators and service providers of SRH	• SRH Knowledge and information disseminator • Motivator and promoter of SRH consumption among adolescents • Accessibility point of the SRH service • Updater policies, messages and programmes • Promoter of continuity of the SRH programmes • Promoter of school-going adolescents' active participation
	Health professionals' dilemma in providing school-going adolescents' with SRH information	• Mixed feelings about CTOP • Illegal abortions • Decreased uptake of condom use and health education

Theme	Category	Sub-category
	NGO sexual and reproductive health programme challenges	• Non-participation of school-going adolescents • Lack of continuation with the SRH programmes • Repeating strategies • Lack of resources

5.10.1.1 Category: Health care and NGO professionals as supporters, information disseminators and service providers of adolescent SRH

In this category, several sub-categories emerged, namely *SRH knowledge and information disseminator, motivator and promoter of SRH consumption among adolescents, accessibility point of the SRH service, updater of policies, messages and programmes, promoter continuity in the SRH programmes, and promoter of school-going adolescents' active participation.*

Adolescents' *knowledge of where to access SRH providers* is important since it influences their sexual behaviour. Healthcare professional (HP) 1 said, "*The best place for adolescents to get sexual related help nowadays is at the local clinics, hospital, pharmacies or at doctors"*.

Under the sub-category *motivator of SRH consumption,* HPs motivate school-going adolescents to use youth-friendly services to promote their responsible sexual behaviour. *"Most parents and adolescents globally agree with the introduction of youth friendly services and adolescents are allowed choose a health care provider that they can relate to and comfortable with"* (HP 2).

Regarding adolescents' motivation, the HPs confirmed that school-going adolescents are secretive about their sexual engagements and are not comfortable coming to clinics for fear of being seen and judged until a healthcare provider motivates and reassures the adolescent of their confidentiality.

HP 1 said,*" adolescents we meet at the clinic want to be attended very fast and go. They don't want to be seen or known that they prevent or that bayajola (they have sex). Some do not come at all because of that".*

Some school-going adolescents have bad attitudes towards healthcare professionals. HP2 said, "*Some adolescents say we are judgemental, we should avoid talking too much. Then how can I give health education, should we tell them what?"*

Different initiatives were devised by health facilities to provide the best possible SRH services to adolescents with the aim of increasing the demand for these services, in turn, promoting responsible sexual behaviour among adolescents (Denno et al. 2015:S23).

Another sub-category that emerged was *promoting continuity of SRH utilisation* by training healthcare providers/clinic staff on the implementation and supervision of SRH, and being approachable and friendly when offering these services. HP 5 maintained, *"We are trained in adolescents SRH and we are attend staff development programmes so that we provide adolescent health continuously and effectively."*

In the sub-category *promoting adolescents' active participation,* the HPs agreed that adolescents get easily frustrated and demotivated; hence, they need as much motivation as possible to continue partaking in SRH. The participants emphasised that HPs should always seek consent for every procedure carried out on an adolescent since adolescents feel discomfort when contact is involved during the procedure. HP 2 said, "*we touch them during physical examination sometimes both public and private parts regardless of the gender. This create discomfort. In a male, touching might lead to erection causing anxiety, lack of proper explanation of procedures, and lengthy discussions discourage adolescent to seek help related to sexual and reproductive issues."*

Information dissemination occurs in and out of the health facility to increase adolescents' knowledge base of SRH; fiendly and approachable HPs can provide this service. HP 2 voiced her views by saying, *"adolescents want compassionate, respectful and empathetic health providers who provide confidential interactions, who*

are not biased and who are able to give knowledge as well as seeking consent before any procedure." The study's findings agree with that of Marcell et al (2017:405), who suggested that HP should avoid unnecessary body contact with adolescents to promote a sense of comfort around each other.

Marcell et al. (2017:405) and Denno et al. (2015: S26) also stated that a healthcare provider's interpersonal communication style can facilitate or deter adolescents from engaging with HPs who should be supporting responsible sexual behaviour among adolescents.

Regarding *promoting active participation in SRH,* many initiatives are applied in South Africa's healthcare facilities to improve SRH uptake among adolescents. HP1 said that *"there is lack of participation from most adolescents. We included youth friendly corners, created a fast lane for adolescents so that they do not que, training of health staff to implement SRH and making sure there is enough stock to meet adolescent needs*."

Nurses and doctors promote active participation by letting adolescents choose topics of discussion and actively participate in their own care. They also motivate adolescents to be confident when asking and answering questions and when interacting with HPs. HP 4 said, "*Some adolescents do not know which questions to ask, they lack confidence and feel embarrassed when talking about sensitive topics like SRH problems."*

Greater self-confidence when interacting with a healthcare provider would help adolescents to improve their own health and develop into healthy and successful adults (Marcel et al 2017:405).

Gillespie et al (2022:1019) attributes a lack of participation in SRH utilisation to the practicality of health education sessions, which focus mainly on social norms like abstinence. This study's findings concur with research carried out in Uganda and Mozambique that revealed an increase in the uptake of SRH services, such as family planning and STI services, after training health workers, facilitating district capacity

building and improving healthcare providers' supervision (Marcell et al 2017:405; Denno et al. 2015: S26).

Regarding *information dissemination by health professionals,* health information is shared at clinics on different topics, including SRH. HP 2 said*, "Information is spread daily by holding health education sessions every morning before starting work. Free health care is provided and condoms are within reach in corridors and consultation rooms."*

The importance of information dissemination was suggested in studies conducted in Nigeria, China, and South Africa, respectively, where multiple strategies, including information distribution and awareness targeting adolescents and the provision of free condoms and contraceptives, resulted in 14-fold increased odds of contraceptive and condom use. Madagascar franchised clinics for adolescent networking and subsidised SRH services, extensive community outreach projects, social marketing and mass media communication to increase clinic attendance. Improvements in youth/adolescent-friendly services were also linked to multimedia HIV-prevention campaigns, and clinic attendance improved for HIV testing. This was a huge benefit to the promotion of responsible behaviour (Esan & Bayajidda 2021:3; Denno et al. 2015: S26).

Out-of-facility sexual and reproductive health services mean health services are brought to the community where the adolescents live and meet. Potential places include schools, workplaces, streets, malls, homes, youth centres, pharmacies, storefronts, and public toilets. HP 6 said, "*We have nurses who carry school health programmes and we go there monthly. Condoms are also placed on strategic places to promote access like in toilets at shops…"*

Healthcare providers and NGO professionals receive proper training in South Africa, but they felt a need for continuous training according to new trends so that the needs of adolescents match their expertise. A study in Kenya also revealed that services provided in schools carrying messages of abstinence, faithfulness and condom use combined with annual HIV testing motivated adolescents to use SRH services. Youth centres proved to be costly to run, and few adolescents attended them; rather, older

youths are the ones who frequented those places in most countries (Denno et al. 2015 :S36).

5.10.1.2 Category: Health professionals' dilemma in providing school-going adolescents' with SRH information

A sub-category, *mixed feelings about CTOP*, emerged and HPs understood that school-going adolescents who are 12 years and older have the right to decide what to do about their pregnancy without telling their parents. The HP faces a dilemma of being confidential and not divulging information to parents, despite the risk that the adolescent will have repeated pregnancies. HP 4 cited, "*it is so hard to see early adolescents coming to terminate without a parent's knowledge that the child is pregnant."*

HP 7 reflected on the dilemma of adolescents who repeatedly fall pregnant and terminate those pregnancies. *"I have met several adolescents who did not come only once but twice or more for termination. This shows that kids are having unprotected sex despite the education we give after first termination".*

Even though some healthcare professionals have beliefs against abortion, they have an ethical duty not to impose these beliefs on an adolescent who wants to abort. HP 2 rectified the misconception about healthcare providers neglecting adolescents who come for abortions at the clinic *"Work is work it should be done, we have our beliefs yes but if a health professional feels that she cannot carry the abortion, the task is assigned to the health professional who does not have a problem with abortion. So it is not true that we as health professionals we neglect adolescents when they need our TOP service."*

In the same vein, health professionals render abortion services without judging or turning adolescents away. "*Legal abortions are safe, hence they improve the quality of life for adolescents since they will be able to continue with their education and they can plan when they want to have children.*" (Health professional 1).

Gillespie et al. (2022:1019), however, refuted this finding, stating that some adolescents do not go for SRH at clinics for fear of being judged. However, the study revealed that adolescents' treatment at various clinics differs.

The sub-category *illegal abortions* emerged, and findings revealed that most abortions in the township happened in backyards and were illegal. With the advent of CTOP in the township, there should have been zero tolerance for illegal abortions, but they still exist. HP 3 said, "*Surprisingly, we attend to adolescents who come to the clinic with complications of illegal abortions"*. According to Koto and Maharaj (2016: 58), HP have stress and burnout because of the added workload that is created by complications due to unsafe abortions.

Decreased uptake of condom use and health education was also mentioned. NGOs promote sexual responsibility by promoting safer sex, preventing STIs and HIV infection, as well as unplanned pregnancies. Condoms were distributed after health education. Those who wanted injectable contraceptive methods were encouraged to attend clinics. However, some school-going adolescents just take condoms and do not use them. NGO 2 said," t*here is decreased uptake of condom and contraceptive use despite our efforts. We do health education and supply condoms however we are happy that we are contributing meaningfully to adolescents' SRH."*

James et al. (2018:5) revealed that many healthcare facilities do not meet the criteria of adolescent youth-friendly services. However, they offer some services, such as HIV counselling and testing and family planning, which is commendable.

5.10.1.3 Category: NGO sexual and reproductive health programme challenges

Regarding this category, various sub-categories emerged: *non-participation of school-going adolescents, lack of continuation with the programme, repeating strategies, and being under-resourced.*

The healthcare professionals confirmed that government clinics run SRH programmes with the support of NGOs such as Love Life and Right to Care to promote responsible sexual behaviour among adolescents. However, these entities have reported a *lack of*

active participation by most township adolescents. NGO 3 cited, "*adolescents easily get bored with repeating same programmes and they stop participating and some of them do not take part at all".*

Denno et al. (2015:S36) agree with the finding that few early and middle adolescents attend youth-friendly programmes. Instead, it appears older youths are the ones who frequent these places in most countries.

A *lack of continuity with the SRH programme* was also reported. Programmes to promote the uptake of SRH services at clinics lack active participation by many school-going adolescents, despite significant changes in the sexual behaviour of those few adolescents who partook in the programmes. However, the challenge is a lack of continuity in terms of NGO programmes and adolescent participation. NGO 4 said, *"Adolescents who were in the group started to stop coming until we were left with a few who also felt tired of coming to our meeting place"*

James et al. (2018:4) support this finding and claim management systems that facilitate adolescent and youth-friendly service did not meet the standards of a youth-friendly service.

To address *under-resourced* challenges*,* NGOs are sometimes placed at the clinic with a few staff and transport services to meet the needs of communities and reach adolescents. However, NGO 4 voiced her concern: *"I used to work with four other guys sharing the schools in this township but now two are no longer working. We also do not have reliable transport to go to schools as often as possible. Time constraints also play a part when we go to school, children will be attending lessons and after school they do not want to stay anymore."*

Regarding sub-category *repeating strategies,* NGO staff agreed that adolescents easily get bored with the same messages about sexual responsibility, so they become de-motivated. "*We try to do sports activities and health education sessions but most of the adolescents just feel that they have already heard about it somewhere, so they stop attending. Only those who feel the need for our help come forward but they also stop after some time." (NGO 5)*

James et al. (2018:8) emphasise many facilities failed to meet the criteria of providing relevant information, education and communication to promote behaviour change consistent with adolescent and youth services.

5.11 SUMMARY

The study's qualitative data were analysed in Chapter 5 using a thematic data analysis approach. Different themes emerged. Adolescents' understanding of responsible sexual behaviour, SRH knowledge and information among adolescents, utilisation of SRH services and challenges hindering adolescents from achieving responsible sexual behaviour were all discussed.

The findings revealed that adolescents had a great understanding of the meaning of responsible sexual behaviour. However, some adolescents are seemingly surrounded by too much information, though few confirmed that they are saturated with SRH information. Hence, most of the adolescents felt a need for more SRH classes.

Adolescents' use of SRH services was analysed, and the findings revealed poor access to SRH services at different facilities. A lack of parental involvement, coupled with idleness, has been shown to increase adolescent sexual irresponsibility. Most adolescents confirmed that they indulge in alcohol and substances, which was concerning to both parents and adolescents. The challenges adolescents faced in achieving responsible sexual behaviour were varied, and among others, a lack of parental involvement in adolescents' sexual life, poor utilisation of SRH health facilities, and alcoholism and substance use were mentioned.

Different stakeholders partook in the study to give their views about sexual irresponsibility, including parents, teachers, healthcare providers and NGO professionals. HPs were regarded as supporters, information disseminators and service providers of adolescent SRH. Stakeholders were regarded as SRH knowledge providers, motivators for the consumption of SRH, an accessibility point for SRH services, advocators of adolescent SRH, policy, messages and programme updaters, promoters of continuity in the SRH programmes, and promoters of adolescents' active

participation in SRH programmes. Next, Chapter 6 integrates the quantitative and qualitative findings.

CHAPTER 6
DISCUSSION OF THE INTEGRATED DATA FROM PHASES I AND II

6.1 INTRODUCTION

The chapter discusses the integrated data from Phases I and II. Mixing data in a mixed-method study implies a separation of data on one continuum and combining data on the other continuum (Creswell 2018:209). In this chapter, a discussion on the integrated results of this mixed-method study is provided according to Santos, Erdmann, Meireles, Lanzoni, Cunha and Ross (2017:3) and Creswell (2015:542). In this study, quantitative data were obtained from school-going adolescents in Phase I. These results were then used as a foundation for collecting qualitative data in Phase II, utilising a subset of adolescents who responded in Phase I and key participants from the community where the adolescents live.

The integrated results from both Phase I (quantitative research) and Phase II (qualitative research) were used as evidence to develop and validate strategies to promote responsible sexual behaviour among school-going adolescents. The data generated from the questionnaire, focus group discussions, and field notes are discussed jointly.

In the discussion, the respondents of Phase I are school-going adolescents and the participants from Phase II are referred to as school-going adolescents, parents, teachers, HPs and NGO officials to maintain clarity. In this section, both quantitative and qualitative findings were integrated to provide an in-depth understanding of the research problem, namely sexual irresponsibility among school-going adolescents.

6.1.1 Interpretation of qualitative results

In the discussion section, qualitative and quantitative results were mixed, explained and evaluated whether they answered the research questions. To that end, comparisons were also made to past studies and other literature. At this stage, personal experiences were removed from the analysis and the researcher focused on

data gathered in its pure form. An assessment of the meanings of the findings resulted in the researcher's attachment to the study.

Quantitative and qualitative results combined led to conclusions or inferences, whereby the researcher interpreted the results and developed strategies to promote responsible sexual behaviour among school-going adolescents. This addressed the research questions, and meta-inferences were conclusive, utilising follow-up qualitative data to provide a better perspective of sexual responsibility rather than simply relying only on quantitative results (Polit & Beck 2017:591; Creswell & Plano Clark 2018:58). Figure 6.1 illustrates the integration of the research findings from Phase I and Phase II.

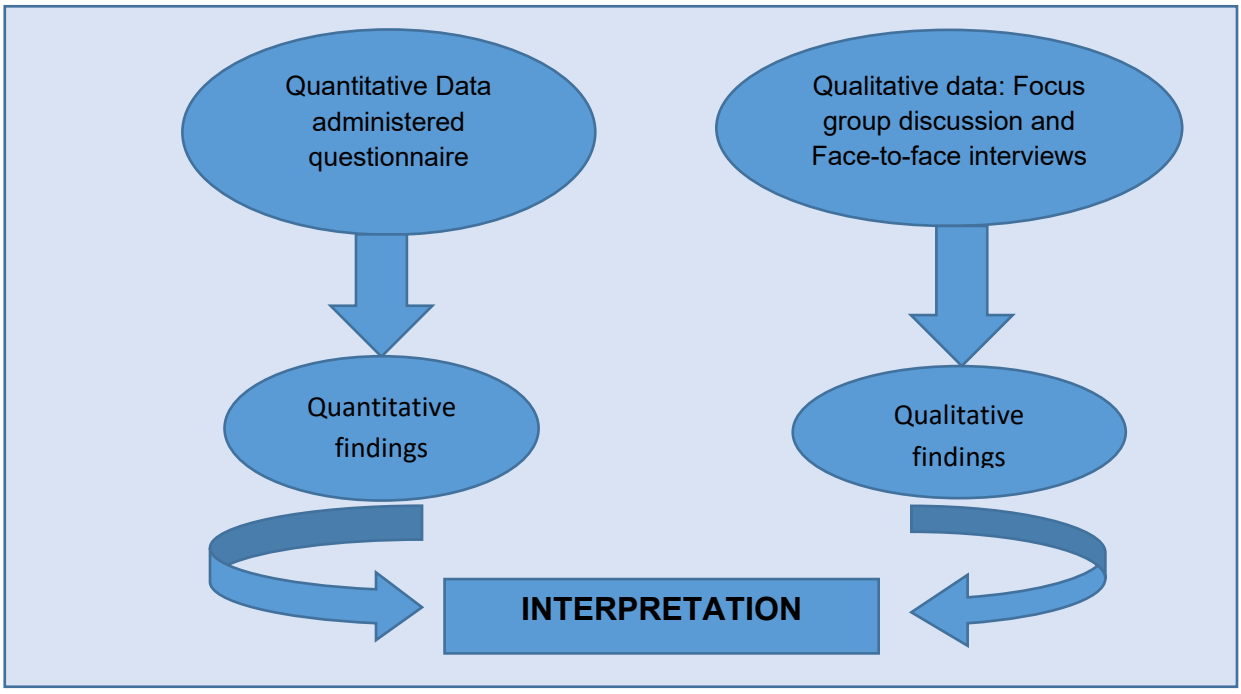

Figure 6.1: The integration process in sequential explanatory mixed-method studies

6.2 THE MEANING OF RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS AND DIFFERENT STAKEHOLDERS

Literature describes responsible sexual behaviour as maintaining SRH and well-being by making informed decisions and safer sex choices. This may include abstinence, respecting one's partner, having open communication about all forms of sexual activity

and taking precautions against unplanned pregnancies and STIs (Nkani & Bhana 2016:1). The school-going adolescents and key participants' understanding of responsible sexual behaviour corresponds to a large extent with the description in the literature.

School-going adolescents understood responsible sexual behaviour expressed in four ways: preventing unplanned pregnancies, HIV/AIDS and other STIs, protecting their moral values, communicating with partners, and acquiring essential SRH information (Section 5.4.2).

Key participants mostly understood responsible sexual behaviour as not having sex before the appropriate time. The main message from the key participants was maintaining the moral aspect of sex by practising abstinence until a person is married, preventing HIV/AIDS and other STIs, and acquiring essential SRH information. The participants perceived consistent and correct condom use, contraception use, faithfulness and commitment to the success of a safer relationship and knowing one's own and one's partner's HIV and STI status and sexual abstinence as the true essence of sexual responsibility among adolescents.

Nkosi and Pretorius (2019:110) and Gillespie (2022:1020) found that with the growing rate of teen pregnancy, adolescents' early exposure to sexual information is beneficial if they listen to their elders' and teachers' teachings. According to Powell et al. (2017:169), the Life Orientation curriculum in schools aims to teach and equip school-going adolescents with social skills and provide information on where they can access contraception and reproductive healthcare services. This creates an understanding and support system to reduce adolescent pregnancy by promoting the use of contraceptives (Gillespie et al 2022:1020).

6.3 SRH KNOWLEDGE AND INFORMATION

The adolescents who took part in the study were born in the new millennium (millennial generation) and were seemingly surrounded by too much SRH information from different sources. However, despite such a large amount of information, the

adolescents indicated that they needed more SRH classes. Adolescents confirmed gaps in their SRH knowledge (Section 5.4.3).

Gillespie (2022:1020) similarly revealed that many school-going adolescents still experience reproductive health knowledge gaps, and there is a need for SRH education at schools, health facilities and adolescent homes.

6.4 BEHAVIOURS AND ATTITUDES PREDISPOSING SCHOOL-GOING ADOLESCENTS TO SEXUAL IRRESPONSIBILITY

The study's findings show that there are a couple of risky behaviours that school-going adolescents engage in that predispose them to irresponsible sexual behaviour: Excessive partying leads to casual unprotected sex. Alcohol and drug use are also prevalent among school-going adolescents in the township. Sexual transactions were also confirmed, and other behaviours, such as rebellion and poor adjustments in the transition from childhood to adolescence were reported (Section 5.4.5.3).

Men pressure girls to have sex by persuading or forcing them. On the other hand, male school-going adolescents also felt their girlfriends pressured them to level up with working-class boys economically, and when they failed, they ended up being dumped or shared with another partner (Section 5.4.5.8).

A significant number of adolescents confirmed that they were practising sexual abstinence to protect themselves from unplanned pregnancies, HIV and other STIs. Among those abstaining, some adolescents cited that they felt pressured by their partners and peers to have sex (Section 5.4.5.1).

A lack of personal skill to ensure safer sex due to hormonal pressure, lack of self-control and immaturity, meant school-going adolescents gave in to unplanned and unprotected sex. They also reported inconsistent use of contraceptives due to the overwhelming urge of the moment. Most adolescents felt that controlling their sexual desire when aroused is very difficult, and a lack of experience in self-control and immaturity meant adolescents often regretted the act (Section 5.4.5.1).

According to Patsani et al. (2023:6), acts of sexual intercourse performed without the use of condoms predispose adolescents to contracting HIV and other STIs, and the HIV pandemic continues to threaten and kill adolescents.

Some school-going adolescents felt overwhelmed by family and community pressure to behave in a certain way for which they were unprepared. This created tension and rebellion among adolescents. In addition, some adolescents had sex due to curiosity when their parents told them not to sleep with boys without explaining why to abstain (Section 5.4.5.1).

Too much idle time available for adolescents and lack of parental monitoring also resulted in school-going adolescents having time for alcohol consumption and drug use, predisposing them to sexual irresponsibility (Section 5.4.5.6). Casual relationships such as engaging in one-night stands and casual sex were also reported among participants. Ngidi et al. (2016:1) concur there is inadequate condom use among men and women who have multiple sexual partners. Gilliam et al. (2017:340) suggested that adolescents make decisions on whether or not to have a sexual relationship with a certain partner mainly based on the level of commitment in the relationship.

The current relationships adolescents engaged in were mostly casual (81.4%) one-night stands and short moments of joy with no attachment. Multiple sexual partners were also prevalent among school-going adolescents, characterised by a lack of commitment to long-term relationships. Participants reported most relationships lasted less than a year and were unsatisfying (Section 5.4.5.3). However, adolescents prioritised physical intimacy like sexual touching and intercourse.

Casual sex and poor relationships are detrimental to the psychological well-being of adolescents, causing psychological distress and an increase in drug/substance and alcohol use and consecutively risky sexual behaviour. More boys' than girls' relationships are casual sexual relationships (Ali et al. 2021:5; Dube et al. 2017:9).

6.5 UTILISATION OF SRH SERVICES BY SCHOOL-GOING ADOLESCENTS

The school-going adolescents' utilisation of SRH services is poor even though the majority of adolescents visited the clinic for services other than SRH. Moreover, most adolescents engaged in sexual intercourse (87.6%). Poor use of SRH services is attributed to difficulties in accessing SRH services, laziness on the part of adolescents, and lack of privacy and confidentiality at healthcare facilities. An unavailability of preferred contraceptives, fear of judgements and stigma, and fear that parents will know they are sexually active were also mentioned. School-going adolescents are thus secretive about their sexual behaviours (Section 5.4.5.4).

Conversely, some adolescents in higher grades claimed they had no time to go to the clinic as they were always at school doing extra lessons, even on weekends (Section 5.4.5.4). Other adolescents exhibited a lack of knowledge about where they could get contraceptives. Ignorance, myths and misconceptions regarding adolescent SRH services led to low consumption of hormonal contraceptives and safe sexual behaviours by school-going adolescents. It was also reported that some adolescents did not like healthcare staff who are said to be rude, insensitive to their needs, judgemental and stigmatising (Section 5.4.4.2).

Due to the low use of contraceptives, some adolescents fall pregnant. However, most pregnancies do not reach full term because school-going adolescents legally or illegally terminate the pregnancy to avoid the stigmatisation attached to the situation. They also want to continue schooling; Taukeni and Feirreira (2016:1) reported the same findings (Section 5.4.5.3).

6.6 THE ROLE OF DIFFERENT STAKEHOLDERS IN PROMOTING RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS

6.6.1 The role of parents in school-going adolescents' sexuality

Many school-going adolescents confirmed that they need their parents, especially mothers, to play an educative, supportive and information dissemination role in their

lives. However, most adolescents never discussed sex-related matters with their parents, especially their fathers (Section 5.4.5.5).

Parents are sensitive and scared of promoting sex among adolescents through sex-related discussions. Some parents are also shy and feel it is culturally taboo to discuss these matters with their children. It was also reported that parents might avoid the topic by being too busy for such discussions, while others went to the extent of lying when faced with SRH questions (Section 5.4.5.5). Duby et al. (2022:12) concur, stating that most parents avoid discussing sexual matters with adolescents because they feel the adolescents are not mature enough to learn about sex. Some are embarrassed to bring up the topic of sex.

Most parents were found to give too much SRH freedom to school-going adolescents without attaching responsibility and accountability to the behaviour (Section 5.8.1.2). It was evident that many parents relied on other stakeholders to support school-going adolescents in SRH, such as health professionals and teachers. As a result, adolescents in such situations do whatever they want, including engaging in unprotected sex (Section 5.8.1.4).

Mpondo et al. (2018:430), Embelton et al. (2017:423), Marcell et al. (2017:408) and Nkhwashu & Mafukata (2015:1085) suggested that adolescents regard (mothers in particular) as a major influence of knowledge dissemination, leading to healthy SRH behaviour. Mothers supposedly give daughters information on different life stages and life skills to deal with potentially difficult situations. Sadly, these issues are not addressed by all parents, and there is a need for programmes that strengthen parenting skills.

Greater parental supervision or monitoring systems were shown to increase or decrease adolescents' intention to engage in sex. Parental monitoring decreases earlier initiation of sex, frequency of sex, number of sexual partners, and risky sexual activity. Increased time at home with parents also minimises the chances of sneaking out to have sex with partners due to close parental monitoring (Ahanhanzo 2018:90).

6.6.2 Adolescents' religion as a promoter or hindrance to responsible sexual behaviour

Many school-going adolescents reported that religion is important in their lives (41%). Parents also confirmed they support adolescents who go to church. However, some stakeholders warned against an over-reliance on churches for SRH information, claiming churches promote sexual responsibility mainly through abstinence, and adolescents still have unprotected sex after church services. Even adolescents who confirmed that religion is important to them fell pregnant (Section 5.8.1.4).

Mokwena and Morabe (2016:84) support the role of religion among some religious parents, adolescents, and communities in South Africa. The church is preferred by many as one of the primary messengers of sexual health programmes for adolescents to counteract adolescents' irresponsible behaviours and permissive sexual messages from other sources. However, few school-going adolescents abstain from sex absolutely, and they find it very difficult to commit to lasting relationships.

Studies also suggest that adolescents who do not embrace abstinence initiate sex earlier than those who favour abstinence. Hence, they recruited those who were practising abstinence through sexual temptation. As a result, abstaining adolescents are pressured by peers to initiate sex and some end up giving in to the pressure. Past studies also revealed the same findings (Ahanhanzo et al. 2018:90; Mokwena & Morabe 2016:83).

6.6.3 Teachers' role in school-going adolescents' sexual behaviour

School teachers were among the most preferred SRH information disseminators by school-going adolescents. Through Life Orientation classes, most adolescents gain basic knowledge of SRH. However, an above-average number of adolescents (67.4%) needed more SRH information to fill some gaps in their knowledge (Section 5.6.1.2). Moreover, teachers felt ill-equipped to provide in-depth SRH information because of their lack of expert knowledge in SRH, lack of resources, difficulties disciplining school-going adolescents on the grounds of SRH violations, and giving sex education to some against their beliefs. Time constraints to discuss in-depth issues of SRH with the

minimal workforce, and additional work, made their role less effective in promoting responsible sexual behaviour. The situation is exacerbated by parents' over-reliance on teachers for school-going adolescents' SRH education without them taking responsibility for their children's SRH. Some teachers focused more on abstinence-only teachings because they felt uncomfortable discussing sex and other contraceptives (Section 5.6.1.2).

In Section 5.6.1.1, the SRH education imparted at schools was deemed helpful but partially ineffective because a significant number of adolescents still engage in irresponsible sexual intercourse and risky behaviour. These findings concur with Nkosi and Pretorius (2019:110), who suggest teachers are the cornerstone of imparting SRH knowledge. Gillespie (2022:1019-1020) also mentioned that many school-going adolescents still experience reproductive health knowledge gaps, and there is a need for comprehensive SRH education at schools, health facilities and adolescents' homes.

6.6.4 The role of healthcare and NGO professionals in school-going adolescents' SRH

There are many SRH programmes and policies in place meant to promote responsible sexual behaviours among school-going adolescents, but some failed to yield the expected results because adolescents still proclaim knowledge gaps. Different stakeholders, like NGOs, offer various programmes to guide school-going adolescents in sexual responsibility. However, most NGO programmes are not permanent. Hence, this lack of continuity and permanence makes adolescents reluctant to commit to something temporary. On the other hand, some school-going adolescents enrolled in NGO programmes dropped out because of a repetition of information, leading to boredom (Section 5.10.1.3).

Adolescents felt that SRH at healthcare facilities is fragmented, moving from one consulting room to another, coupled with rude professionals who are too busy yet too slow. They complained about too much time being spent at clinics and the stigma attached to adolescents who want to prevent/terminate a pregnancy, and they lamented a lack of privacy and confidentiality. This discourage adolescents from using healthcare facilities' SRH services (Section 5.4.4.3).

Conversely, health professionals felt that they received proper training in South Africa, but there is a need for continuous training according to new trends so that the needs of school-going adolescents match their expertise. Studies have revealed that training healthcare workers on SRH improves the uptake of SRH services by school-going adolescents (Section 5.10.1.1) (Marcell et al 2017:405; Lubinga et al. 2016:101; Denno et al. 2015: S26).

6.7 PERCEIVED CHALLENGES FACED BY SCHOOL-GOING ADOLESCENTS TO MAINTAIN RESPONSIBLE SEXUAL BEHAVIOUR

The school-going adolescents and key participants perceived different challenges to achieving responsible sexual behaviour. Adolescents voiced their concern that their parents barely discuss SRH issues with them though they are supposed to educate their children about this topic (60.5%). Meanwhile, parents were often scared, shy, and felt it was not the right time to have these discussions with the adolescents (Section 5.8.1.9). Culture and norms also prevent school-going adolescents from having sex-related discussions with their parents. Some parents ultimately lied about certain sex-related matters, thus creating a wide information gap between parents and adolescents' SRH (Section 5.4.5.5).

Most school-going adolescents said practising absolute abstinence is almost impossible (Section 5.4.5.3). Some also engaged in casual sexual relationships, which lacked commitment. Female participants revealed that it is difficult to maintain responsible sexual behaviours, especially through abstinence, because most boyfriends do not believe millennial should maintain their virginity. Mostly, males pressure adolescent girls to have sex by persuading them, threatening to leave, or forcefully. On the other hand, male school-going adolescents felt that they were pressured by their girlfriends to level up with working-class boys.

Adolescents lack correct SRH information even though they are surrounded by significant sources of information. They do not have the skills to select the correct SRH information, and most follow SRH information from the media that pleases them, which is often misleading. School-going adolescents thus have unprotected sex at an early stage, and even behind a strict parent/guardian's back (Section 5.4.5.7). This creates

tension and rebellion between family members and adolescents, further predisposing adolescents to risky sexual behaviours. According to Esan and Bayajidda (2021:3) and Embelton et al. (2017:423), parents are educators, guides, SRH information disseminators, and supporters of adolescents' SRH. Without parental support, many adolescents engage in irresponsible sexual behaviours and suffer the consequences, such as contracting HIV infections and other STIs, and unplanned pregnancies.

It was also determined that too much idle time for school-going adolescents results in alcohol consumption and drug use throughout the week. This is worsened by parents' absence in the adolescent's life and a lack of close parental monitoring (Section 5.4.5.6).

Patsani et al. (2023:6) support these findings, stating that illicit drug use among adolescents has become a public health issue in Malaysia. Drug use led to adolescents' smoking, alcohol use and casual unprotected sex, which predisposed them to the consequences of irresponsible sexual practices. Other studies echoed the same sentiments (Borneskog et al. 2021:5; Desai et al. 2019:51; Ahanhanzo et al. 2018:90). Jansen (2021:43) revealed that adolescents from low socioeconomic status without parental support reported a higher risk for substance use like alcohol.

Lack of community support on school-going adolescents' SRH makes sexual responsibility a debated issue. It is no longer the case that one's child is your own or that it takes a community to raise a child. The community might want to discipline one's child, but some parents do not approve of their children receiving discipline from people other than the immediate family. As a result, everyone ignores ill-behaved school-going adolescents in the absence of their parents. However, neighbours are often the first to know about a child's irresponsible behaviour, but they may choose to keep quiet instead of alerting the adolescent's parents (Section 5.8.1.11).

The application of children's rights is partly misunderstood. Disciplining school-going adolescents at school and home on the grounds of violating their SRH is very difficult. This is because adolescents enforce their SRH rights without being accountable and responsible for their actions and the consequences of irresponsible sexual behaviour (Section 5.8.1.11). In this study, teachers and parents felt that adolescents do not

understand the meaning of their rights and thus misuse them by indulging in irresponsible acts and not listening to teachers' or parents' discipline (Section 5.6.1.2).

Parents felt children's rights had given school-going adolescents a leeway to behave as they please. Parents consequently reported they no longer have the power to control adolescents' SRH (Section 5.8.1.11).

Nkosi and Pretorius (2019:113) claim adolescents misinterpret children's rights because they lack awareness and insight regarding the impact of their own behaviour due to the application of children's rights out of context. Gillespie (2022:19) and Pulerwitz (a) et al. (2019: S7) support the above finding that incidences of irresponsible sexual behaviours are higher than in the past, when morals and values played a big role and were respected by adolescents.

Peer pressure was another cause for concern among teachers and parents because it prompted some school-going adolescents who were otherwise sexually responsible for changing and adopting irresponsible sexual behaviours (Section 5.8.1.6). Gillespie et al. (2022:1019), discovered that adolescents discuss sex-related issues among themselves and pressure each other to engage in behaviours they do not entirely understand. Ngidi et al. (2016:98) agree that adolescents rely on peers' opinions and sexual information because they are easy to talk to; their friends are also often available to them. Peers are thus acting as placeholders for parents as sources of SRH information, despite being the least-preferred sources.

Pressure also comes from family and community norms for adolescents to maintain abstinence and purity despite difficulties suppressing their over-active sexual hormones. Moreover, there is poor transition adjustment from childhood to adulthood among school-going adolescents, they lack the personal skills to ask for safer sex, and lack of self-control and maturity. Adolescents thus give in to unplanned (and often unprotected) sex due to the overwhelming urge of the moment (Section 5.4.5.1).

Patsani et al. (2023:6) concurs and reports adolescence as a period when children change emotionally, physically and psychologically. This transition contributes to confusion and sexual behaviour changes, which may, at times, be risky.

6.8 SUMMARY

Chapter 6 presented a discussion on the integrated quantitative data (Phase I), obtained from school-going adolescents, and the qualitative data (Phase II) obtained from school-going adolescents, parents, teachers, healthcare and NGO professionals. Findings were supported with literature where applicable.

Some school-going adolescents exhibited irresponsible sexual behaviour patterns, like not taking contraceptives or not using protection during sex. Drinking alcohol, partying excessively and abusing substances were also discussed. Some of the school-going adolescents used preventive methods but did not consistently use them, thereby predisposing themselves to unplanned pregnancies, HIV and other STIs.

The majority of adolescents used public health facilities where there was a concern over the lack of privacy and confidentiality. Most adolescents could not afford private practice charges and ended up not utilising SRH services at all. Some adolescents cited that they preferred to learn about SRH from a parent rather than someone else, especially friends whom they did not trust. However, other adolescents said they cannot discuss sex with their parents and are forced to look to friends for information.

Some adolescents are religious and taught about sex-related issues at church, especially on aspects of adultery, to deter them from engaging in intercourse before marriage. Ultimate, a conducive learning environment to present good sexual behaviour should be provided. Culture positively supports sexual responsibility among adolescents, but it can also have a negative influence on adolescents. There is an erosion of culture these days; culture used to protect adolescents through teachings on sexual responsibility, but it is currently a hindrance to adolescents acquiring such SRH skills.

Schoolteachers and mothers were reportedly the most preferred sources of SRH information, and a few school-going adolescents participated in programmes offered by NGOs in the area. School-going adolescents had mixed feelings about using CTOP service at the clinic. Fear of discrimination if they were caught by their parents and community members thus deterred some adolescents from accessing SRH services

at healthcare facilities. Chapter 7 develops and validates strategies to promote responsible sexual behaviour among adolescents.

CHAPTER 7
THE DEVELOPMENT AND VALIDATION OF STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS

7.1 INTRODUCTION

Chapter 7 discusses the process followed in developing and validating the strategies to promote responsible sexual behaviour among school-going adolescents. The strategies' development was based on the findings from Phase I (quantitative study) and Phase II (qualitative) and supportive literature, as discussed in Chapter 6. The final objective was reached when field experts validated the strategies.

7.2 DEVELOPMENT OF STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS

Strategies are high-level plans to achieve one or more goals under conditions of uncertainty, and this usually involves setting goals, determining actions to achieve the goals, and mobilising resources to execute the action (Oxford Dictionary 2019, sv "strategy"; SALDRU 2016:1).

Logical reasoning was applied to develop the strategies. Logical reasoning entails a process of drawing inferences or conclusions (Burns & Grove 2011:8); both deductive and inductive reasoning were used during this process. Evidence from the literature, qualitative and quantitative data was used to reach concluding statements, and strategies were proposed to address these statements. These strategies were given to field experts, experts in strategy development, nurses, teachers, and health professionals dealing with adolescents' sexual and reproductive health to validate and make suggestions for improvement.

7.3 VALIDATION OF THE STRATEGIES

After the purposively selected strategy validators agreed to participate, they received a hard or electronic copy of the proposed strategies, a validation form and a letter

explaining the validation process. They were asked to validate according to the criteria of clarity, comprehensiveness, applicability, adaptability, credibility and validity on a scale of 1 to 10. A rating of 1 to 3 was deemed unacceptable, 4 to 7 was acceptable with corrections, and 8 to 10 was acceptable as it was.

Twelve field experts were approached via social media to participate, and two indicated they were unavailable. Ten participants initially agreed to participate, but eventually, nine participated in the validation process. Table 7.1 indicates the wide-ranging attributes of the nine participants in terms of their employment, employers, field expertise and academic qualifications.

Table 7.1: Attributes of the field experts

Descriptor	Frequency
Position	
Professional nurses	3
Teachers	3
NGO professional	1
Supervisor	1
Strategy expert	1
Total	**9**
Employed by:	
University	1
High schools	3
Clinical facility	5
Total	**9**
Expertise	
General nursing	3
Adolescent health	2
Education	3
Strategy experts	2
Academic qualifications	
Doctoral degree	1
Master's degree	2
Degree and diploma	6
Total	**9**

Table 7.2 displays the results of the validated strategies. Based on the comments on these strategies, varied inputs were received. Some comments supported the evidence reflected in the concluding statements.

Table 7.2: Results of the validated strategies

Criteria	Not acceptable	Acceptable with recommended changes	Acceptable as described	Comments from experts
Clarity			8	Very clear
Comprehensiveness		7		Comprehensible, but there is a need to link theory with the strategies
Applicability			8	Both adolescents who abstain and sexually active's strategies were addressed
Adaptability		6		Conflicting statements on enforcing adolescents' SRH and expectations of parents and community
Credibility			9	Well presented
Validity			8	Valid

7.3.1 The theoretical framework used to guide strategies development

The strategies were guided by the constructs of the TPB, according to Ajzen (2012:18). These include:

Behavioural intention is a motivational factor that drives behaviour. Behavioural intention is influenced by beliefs about the likely outcomes of the behaviour and an evaluation of these outcomes (behavioural beliefs) (Ajzen 2012:18). In this study, adolescents' sexual behaviour patterns were measured against attributes, such as pregnancy prevention, STI prevention, and intentional risky behaviours. This was a situational analysis where the researcher identified and evaluated adolescents' intention to perform certain behaviours, determining either responsible or risky sexual behaviours. Strategies with rationales were thus developed. Recommendations were also formulated to counteract such behaviours so that responsible sexual behaviour among adolescents could be promoted.

Attitude towards behaviour is another construct composed of behavioural beliefs and outcome evaluations. A person's appraisal of a given behaviour results in either

favourable or unfavourable attitudes toward the behaviour. This study assessed a combination of behavioural intentions (behavioural beliefs) and outcome evaluations to understand adolescents' attitudes towards responsible sexual behaviour. Unfavourable attitudes were diagnosed, and strategies were formulated to contain adverse sexual attitudes and discourage them. Favourable attitudes towards responsible sexual behaviours were used to develop strategies that enhance and promote sexual responsibility.

Subjective norms are social pressures to perform or not to perform a given behaviour Ajzen 2012:19). A combination of social pressure or expectations and actions from important persons and the motivation to comply give rise to perceived social pressure or a subjective norm. These were explored by investigating significant others' (like parents, teachers, health professionals and NGO personnel) views on the meaning of responsible sexual behaviour and their expectations of how adolescents should conduct themselves in the community.

The perceived power of these factors (control beliefs) on the adolescents' perceived behavioural control was determined. Perceived behavioural control was explored by investigating the challenges adolescents face in achieving responsible sexual behaviour, based on the adolescents' perspective and reinforced by parents, teachers, health and NGO professionals. These beliefs were used to develop strategies that promote sexual responsibility with input from significant others like parents, teachers, health and NGO professionals (Ajzen 2012:18).

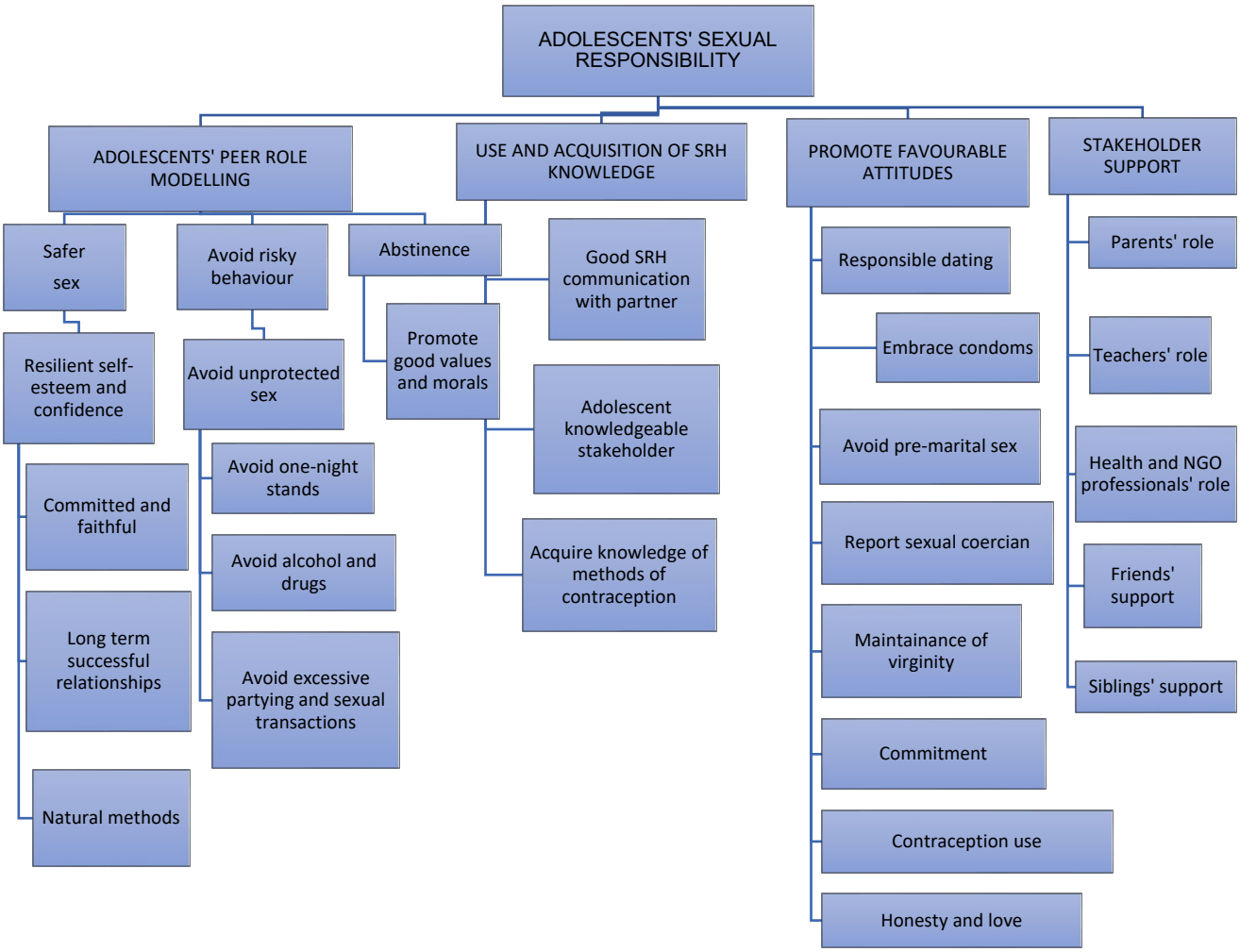

Figure 7.1: Diagrammatic presentation of validated strategies

7.4 PRESENTATION OF DEVELOPED AND VALIDATED STRATEGIES

After the problematic areas in adolescent sexual behaviour were determined, strategies were developed to promote their sexual responsibility. A rationale for each strategy is presented, followed by recommendations for implementation. Experts validated the strategies, and their suggestions were incorporated into the final strategy document.

7.5 STRATEGY 1: ENCOURAGE ADOLESCENT PEER ROLE-MODELLING OF RESPONSIBLE SEXUAL BEHAVIOUR

Rationale of the strategy

Facilitate and support adolescents to be examples of a sexually responsible person to other adolescents who do not practice responsible sexual behaviour. The strategies focused on encouraging responsible sexual behavioural intentions and attitudes among adolescents, as described in the TPB (Ajzen 2012:18).

Recommendations

- Engage in intentional responsible sexual intercourse by always correctly using condoms and contraceptives.
- Practice good attitudes towards responsible sexual behaviours, such as commitment, faithfulness and consistency in sexual engagements and relationships.
- Build resilience in the face of difficulties like hormonal over-activity hindering the achievement of responsible sexual behaviour and practise self-control.
- Promote the use of consistent and correct dual protection to prevent both unplanned pregnancies and STIs at the same time.
- Abstain from sex and wait for the right time, if possible. Abstinence is a 100% sure way of promoting responsible sexual behaviour.
- Show a determination to succeed in preserving purity or preventing STIs, HIV and unplanned pregnancies until late adolescence; at least until a person is strong enough physically, mentally and economically to face the consequences of being sexually irresponsible.
- Desist from pressure from peers, partners and sexual hormones, as these overwhelming burdens predispose adolescents to unplanned and unprotected sexual behaviours, risking being infected with STIs and HIV.
- Participate in activities like sports to prevent idleness, resulting in sex.
- Avoid easily giving in to unplanned or forced sex after committing to abstinence without planning and preparing for such behaviour to prevent regrets, unplanned pregnancies, and STIs.

- Avoid multiple sexual relationships as they predispose individuals to the risk of contracting HIV and STIs from different partners.
- Be open to accepting CTOP rather than seeing abortion as immoral and wrong. Regard legal abortions as a way of giving an adolescent a second chance at life to achieve set life goals.
- Do not make a habit of having unprotected sexual intercourse, falling pregnant, and terminating multiple pregnancies, as this might have future consequences on SRH.
- Listen to good SRH advice from important significant others like parents because they have been there and have seen the consequences of irresponsible sexual behaviours.
- Practice caution in listening to SRH information from the internet and other media, as some of this information is misleading and promotes risky sexual behaviours.

7.6 STRATEGY 2: ENCOURAGE SCHOOL-GOING ADOLESCENTS AS PROMOTERS AND PROTECTORS OF MORAL VALUES, BELIEFS AND GOOD SRH ATTITUDES

Rationale of the strategy

It is envisaged that this strategy's implementation could change the bad morals and attitudes some adolescents have towards sex-related issues, which could destabilise responsible sexual behaviours among adolescents.

Recommendations

- Do not look down on traditional SRH advice from elders, as wisdom comes with age.
- Erase the bad attitude of "let me make my own mistakes" by falling pregnant or risking being infected with HIV at the expense of realising valuable goals in life.
- Learn to respect the rights of yourself and others when engaging in intercourse.
- Take responsibility for your sexual needs by accepting guidance from experts like teachers, elders, health and NGO professionals dealing with adolescent SRH.
- Respect the community in which adolescents live so that even when adolescents are sexually lost, the community can assist.
- Intentionally set personal goals, values and beliefs and how to meet them to achieve sexual responsibility.

- Invest in a lasting relationship.
- Desist from looking down on good values and beliefs instilled by parents.
- Be aware of your own values and those of your partner to create mutual agreement.
- Cultivate a culture of honesty in the sexual relationship.
- Be morally responsible and know that abortion is not a ticket to sleeping around without condoms or contraceptives.
- Erase the myths and misconceptions among adolescents that there are no longer virgins in this generation.
- Be a good testimony of sexual purity for others to imitate. Refuse to be a statistic in adolescent pregnancy, STIs and HIV infections.

7.7 STRATEGY 3: THE SCHOOL-GOING ADOLESCENT AS A GOOD AND INFORMED COMMUNICATOR ON SRH ISSUES

Rationale for the strategy

It is envisaged that this strategy's implementation could change the bad communication skills among some adolescents regarding sex-related issues with their partners, parents, and health professionals.

Recommendations

- Adolescents should engage in honest communication about sex-related issues.
- Adolescents should be confident of what they want from the relationship and communicate on their needs.
- Set individual sexual boundaries and communicate them so that there is an understanding of each other's comfort zone.
- Choose together with a partner the best methods to prevent adverse consequences of sexual and reproductive ill behaviours and gather information on where to get contraceptives and how to use them.
- Get as much support as you can from a partner, since strong support from a partner conquers problems in relationships and promotes sexual responsibility.
- Partners should acquire SRH knowledge continuously so that different stakeholders give SRH support accordingly.

- Participate actively with partners in functional youth-friendly services, programmes and activities designed to engage adolescents in sex education that equips them with knowledge that promotes responsible sexual behaviour.
- Maintain continuous and consistent exposure to positive information on sexual and reproductive health to guard against media fallacies.
- Engage in peer-to-peer sex-related discussions that are productive and informative to maintain sufficient SRH information.

7.8 STRATEGY 4: AN ADOLESCENT AS AN SRH KNOWLEDGEABLE STAKEHOLDER

Rationale for the strategy

It is envisaged that adolescents equipped with correct SRH knowledge are better off than adolescents without this knowledge. Knowledge of SRH may change the level of risk in which adolescents engage. Adequate and accurate SRH information has the power to change irresponsible sexual behaviours among adolescents.

Recommendations

- Gather adequate and accurate information on SRH by accessing different sources of SRH knowledge to keep abreast with information on SRH.
- Avoid spreading myths and misconceptions about SRH to prevent incorrect SRH information from being acquired, which can be toxic to adolescents' sexual responsibility.
- Read and watch the media regularly to review issues about SRH and equip the self with knowledge of the pros and cons of being sexually active.
- Communicate regularly with significant others about correct SRH issues to be an ambassador for sexual responsibility among adolescents.
- Learn to have a positive attitude towards SRH and avoid negative influences, myths and misconceptions because these influence decision-making.
- Be proactive on SRH issues and avoid laziness by seeking SRH services and stay abreast of appropriate information.

7.9 STRATEGY 5: RESPONSIBLE ALCOHOL DRINKING AND NON-USE OF SUBSTANCES BY SCHOOL-GOING ADOLESCENT

Rationale for the strategy

It is envisaged that it is difficult for school-going adolescents to accomplish responsible sexual behaviour while coping with opposing forces in the background. However, with the implementation of the strategies, adolescents could conquer alcoholism and substance abuse.

Recommendation

- Stop drinking alcohol or drink alcohol responsibly since alcohol predisposes adolescents to sexual irresponsibility.
- Stop substance use during adolescence since drugs permit a person to indulge in risky sexual behaviours, like unprotected sex and one-night stands.
- Attend supervised parties or parties without alcohol to prevent sexual temptations when drunk.
- Exercise restraint when drinking alcohol with or without a partner and drink in an open space where there are other people to prevent temptations.
- Participate in programmes that divert adolescents from alcoholism and drugs.
- Promptly seek help if you feel you are addicted to drugs and alcohol to resolve the problem before it worsens.
- Commit to rehabilitation to fight drug and alcohol addiction.

7.10 STRATEGY 5: PROMOTE RESILIENT, SELF-ESTEEMED AND SELF-CONFIDANT SCHOOL-GOING ADOLESCENTS

Rational for the strategy

It is recommended that a resilient, self-esteemed, and self-confident school-going adolescent will conquer all behavioural sexual challenges, despite obstacles.

Recommendation

- Join support groups to encourage and build each other up physically, emotionally, mentally and socially to gain resilience.

- Stay away from violent sex as it destroys the sex organs, promoting the entry of deadly organisms such as HIV, bacteria and fungi into the reproductive system.
- Avoid stigmatising each other's relationships or sexual choices to promote self-esteem.
- Seek information on sex-related issues, which are difficult to tackle.
- Respect and uphold cultural differences in a relationship.

7.11 STRATEGY 6: THE SCHOOL-GOING ADOLESCENT AS A COMMITTED, FAITHFUL PARTNER IN LONG-TERM HEALTHY AND SUCCESSFUL SEXUAL RELATIONSHIPS

Rationale for the strategy

It is envisaged that a commitment to one faithful partner in a sexual relationship could change adolescents' attitudes towards long-term relationships, build trust and love, minimising their risk of exposure to STIs, HIV and unplanned pregnancy from different partners.

Recommendations

- Create a fulfilling and trusting relationship among sexual partners and remain faithful to one partner.
- Create a relationship that promotes high self-esteem, like appreciating a partner as they are.
- Do things together to maintain a strong bond and prevent boredom in the relationship.
- Present unity (united front) and avoid infiltration in the relationship by third parties, as infiltration affects the stability of the relationship.
- Prevent heartbreaks/trauma by being faithful in a relationship. Do not cheat, but discuss any likes and dislikes in a relationship openly to remain on the same page.
- Promote a pleasurable relationship full of happiness and good memories. Create good memories together; these will be needed when the relationship goes awry.
- Communicate problems in a relationship and solve them constructively to maintain stability.
- Respect the relationship, as this is the foundation for all successful relationships.

- Avoid short moments of joy like one-night stands, which risk one's good relationship and health.
- Avoid multiple sexual partners as they predispose one to STIs and HIV.

7.12 STRATEGY 7: PROMOTE THE USE OF SRH SERVICES AMONG SCHOOL-GOING ADOLESCENTS

Rationale for the strategy

It is assumed that if SRH service providers could improve on health facility-related problems, school-going adolescents' use of SRH services would improve, thereby promoting responsible sexual behaviour.

Recommendations

- Affordable contraceptives at private health facilities will assist adolescents who do not want to go to public clinics for free SRH services.
- Adolescents are very sensitive to issues of SRH, and health professionals should thus avoid judgements and harassment.
- Afford privacy and confidentiality every step of the way, not only in consulting rooms.
- Avoid stigmatisation as it prevents the adolescent from seeking further SRH services.
- A good nurse-patient relationship should be maintained to build trust.

7.13 STAKEHOLDER SUPPORT IN SCHOOL-GOING ADOLESCENTS' SRH

It is envisaged that it takes a whole community to raise a child. Therefore, to achieve responsible sexual behaviour among adolescents, stakeholder cohesion is vital and requires a collaborative SRH approach with different stakeholders in the community where adolescents live. Parents as educators, promoters and supporters of adolescents' SRH, teachers as information disseminators of SRH knowledge, religious fraternities as promoters and disseminators of SRH information, and health professionals and NGOs as information disseminators and SRH providers are part of this community.

7.13.1 Strategy 8: Parents as educators, promoters and supporters of school-going adolescents' SRH

Rationale for the strategy

It is envisaged that the strategy's implementation will promote active parental involvement in school-going adolescents' sexual lives, promoting positive adolescent sexual behaviour.

Recommendations for parents

- Create a healthy and strong relationship between parents and adolescents. This helps establish a bond, and with a close bond, parents teach sexual responsibility easily, and children are free to share with their parents instead of keeping secrets.
- Impart SRH knowledge initially when the child starts puberty and consequently as the child grows; both positive and negative real-life messages.
- Communicate correct information about sex. Sex education should be morally appropriate, and parents should avoid telling lies to promote learning. Lies mislead the child, and learning does not take place.
- Use practical examples to reinforce SRH messages, consequently reinforcing positive knowledge.
- Correct a child with love and understanding instead of using threatening messages to create understanding and agreement between parent and child.
- Reinforce positive knowledge and correct negative interpretations. If the adolescent cannot avoid sex, it is not a crime, but stress that the adolescent should be responsible by using protection against STIs and contraceptives to prevent unplanned pregnancies.
- Break cultural and sexual boundaries that do not allow an exchange of SRH ideas between parents and children. Teach about premarital sex because most adolescents revealed that they do engage in premarital sex despite parents wishing sex during adolescence would not happen.
- Explain the consequences of having sex before marriage, especially unprotected sex.

- Set aside time with adolescents to teach them about the ways of life in terms of sexual responsibility, and emotional, physical and economic readiness so that they engage in sexual encounters prepared.
- Train adolescents spiritually and physically on managing sexual temptations and building self-control.
- Be there whenever adolescents need SRH information from parents so they do not learn incorrect SRH information from peers.
- Provide for adolescents' needs to prevent them looking for money from 'blessers'.
- Empower adolescents through self-sustaining methods like entrepreneurship, which is integral to meeting their needs. This will prevent adolescents from engaging in sex in return for money or gifts and fight poverty.
- Enrol for government child support grants and use these wisely to meet adolescents' needs.
- Parents should discourage adolescents from receiving gifts from the opposite sex because it might come with the condition of an exchange of money for unprotected sex.
- Do not promote transactional sex by accepting what the child brings home without knowing where the money came from.
- Offer advice on the advantages of maintaining virginity and engaging in sexual abstinence since it is the only sure way of avoiding adverse consequences.
- Continuously reinforce messages of sexual responsibility by regularly giving supportive information, and accompanying the child for SRH services at health facilities.
- Avoid the spirit of individualism where one parent stands by their family alone and turns a blind eye to a neighbour's child going astray sexually. Allow others to discipline the adolescent.
- Desensitise culture on SRH topics to allow for free discussions between responsible parents and adolescents in households and the community at large.
- Be open to accepting CTOP and use preventive methods among adolescents rather than seeing these as immoral and wrong. Parents should regard legal abortions and preventive methods as a way to give the adolescent a second chance at life to achieve their goals. However, parents should educate adolescents to be sexually

responsible and know that abortion is not a ticket to sleeping around without condoms.

- Sensitise children on the rules and regulations of the household related to sexual responsibility and avoid giving adolescents too much freedom without keeping them accountable and responsible for their actions. Parents should be authoritative when it comes to the rules of the house concerning moral aspects of sexual responsibility and sexual behaviours. A household without rules makes it difficult to control an adolescent.
- Practical, reasonable and supportive rules should be enforced in order for the child to achieve responsible sexual behaviour. Avoid too strict rules as they create rebellion among adolescents.
- Leave room for the child to practice responsible sexual behaviours freely, affording independence with accountability and responsibility.
- Encourage adolescents to verify and rectify all myths and misconceptions about contraceptives, condom use, HIV and other STIs – which are the causes of irresponsibility – before sharing wrong information with peers.
- Actively participate in the child's sexual life instead of feeling hopeless.

7.13.2 Strategy 9: Teachers as promoters and disseminators of SRH information among adolescents

Rationale for the strategy

Creating a positive SRH learning environment and effective school-based curriculum on SRH could facilitate desirable learning outcomes and consequent desirable adoption of SRH information. It is envisaged that sex education breaks the silence related to challenges school-going adolescents face in achieving sexually responsible behaviour.

Recommendations for the teachers and education policymakers

- Promote efficient and effective SRH education among adolescents in school.
- Avoid focusing on abstinence-only messages; rather, promote alternative ways of behaving responsibly.

- Encourage adolescents to remain in school and be resilient despite the SRH problems they face because adolescents will have higher prospects when they remain in school.
- Encourage adolescents to have clear and specific goals because the more years of schooling they obtain, the lower their chances of early adolescent pregnancies. Attention will be focused on future goals of having a better future through education.
- School-based sex education by teachers and school nurses should be supported by relevant authorities, researchers and policymakers.
- Expert SRH training at teaching colleges and universities specific for Life Orientation teachers are required.
- Reduce teachers' workload by training more teachers on Life Orientation.
- Provide teachers with equipment and sufficient resources to impart SRH knowledge comprehensively.
- Avoid ineffective messages of abstinence for adolescents having sex on a daily basis.
- Teach adolescents how to have safer sex, and do not promote abstinence-only messages.
- Integrate theory about safer sex with practical demonstrations. For instance, how to use condoms, from putting them on and removing them safely. This will promote safety by preventing tearing and slipping off, which predispose adolescents to pregnancy and STIs.
- Offer constant teaching about sexual responsibility to remind and reinforce what adolescents know because they easily forget what educators teach them.

7.13.3 Strategy 10: Religious fraternities as promoters and disseminators of SRH information

Rationale for the strategy

It was revealed that some religious authorities have conflicts of interest, namely promoting the gospel through abstinence-only messages instead of promoting sexual responsibility through contraceptives. Hence, the strategies are meant to promote responsible behaviour through an indoctrination of the gospel of God to adolescents,

as well as motivating school-going adolescents in the church to use contraceptives when the need arises.

Recommendations

- Re-enforce the importance of attending church services and church activities because Bible teachings promote abstinence and discourage adultery and premarital sex.
- Guide abstaining adolescents towards responsible sexual behaviour through the teachings of the Bible, which reviles adultery.
- Desist from threatening or stigmatising adolescents who are sexually active; rather, give advice on contraceptives and condom use, which promote sexual responsibility.
- Promote sexual responsibility by having workshops with adolescents and invite professionals who deal with adolescent SRH to provide alternative ways of embracing sexual responsibility because sex education from a religious leader might be too sensitive for some.
- Promote sex education in churches to desensitise congregants from normalising abstinence-only messages in the church.

7.13.4 Strategy 11: Reinforce the role of healthcare and NGO professionals as SRH care providers and information disseminators

Rationale for the strategy

It is envisaged that the developed strategies will promote effective healthcare practices and reinforce policies and programmes meant to improve school-going adolescents' SRH.

Recommendations

- Establish rapport with adolescents to promote good relationships and open, trustworthy communication.
- Create tailor-made reproductive and sexual health messages specifically for the millennial generation.

- Update policies, messages and programmes to meet the expectations of today's generation rather than imposing outdated policy programmes on them. Efficient programmes are ones made by adolescents for adolescents.
- Promote continuity in the SRH programmes targeting adolescents at health facilities.
- Promote adolescents' active participation in programmes that concern them. This allows adolescents to take action, ownership and responsibility for their own sexual behaviour.
- Ensure continuous training for healthcare providers/clinic staff about treatment, support, supervision and cultural sensitivity options according to new trends so that the adolescents' needs match their expertise.
- Disseminate correct information because knowledge has the power to transform sexual ignorance into sexual responsibility.
- Promote active dissemination of SRH information related to methods of pregnancy and STI prevention, and promote sexual responsibility to allow a saturation of information among adolescents. Disseminate contraceptive use to remove obstacles in accessing contraceptives.
- Involve parents and guardians in adolescent SRH programmes.
- Promote the acceptability of the role of nature, contraceptives and denounce stigmatisation when rendering SRH care.
- Provide free condoms and contraceptives through franchised clinics for adolescent networking.
- Subsidised sexual and reproductive services should be offered in private practices where adolescence feel safe and get the confidential care they need.
- Extensive community outreach, social marketing and mass media communication may increase clinic attendance among adolescents.
- Seek consent before any procedure to show respect for the adolescent's autonomy.
- Be compassionate, respectful and empathetic healthcare providers who provide confidential interactions.
- Health professionals should not bias health education with judgement and give effective information with confidence.
- Improve interpersonal communication styles to facilitate adolescents' engagement with healthcare professionals during SRH education.

- Health facilities should be replenished with contraceptives so that they are always available to cater for adolescents. This will promote the ongoing use of different contraceptives and prevent inconsistencies in their use, which affect sexual responsibility among adolescents.
- Create a positive environment where adolescents are free and comfortable to access condoms, within reach and privately to prevent embarrassment and stigmatisation.
- Offer health education to adolescents about the advantages of protecting oneself and demonstrate how to put on, remove and dispose of a condom, stressing the importance of consistent and correct condom use.
- Afford privacy, confidentiality, respect and openness when discussing preventive and protective methods.
- Avoid non-use of contraceptives due to embarrassment and fear of discrimination by respecting the adolescent's choice, their privacy and confidentiality.
- Promote safe, confidential, non-judgemental, and legal abortions so that adolescents feel free to use this service and have a chance to complete their schooling and gain better future prospects.
- Responsible health professionals should rectify all myths and misconceptions about contraceptives, condom use, HIV and other STIs, which are the causes of non-use.

7.14 SUMMARY

Chapter 7 presented a discussion on the developed and validated strategies to promote responsible sexual behaviour among school-going adolescents. These strategies were formulated based on concluding statements from the data obtained in the qualitative (phase I) and quantitative (phase II) phases, with supporting literature. The strategies were also validated by field experts for clarity, comprehensiveness, applicability, credibility and validity. Their suggestions were incorporated into the strategy document. These strategies are intended to be implemented to ensure the best possible promotion of responsible sexual behaviour among school-going adolescents. Chapter 8 discusses the conclusions, recommendations and limitations of the study.

CHAPTER 8
CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

8.1 INTRODUCTION

Chapter 8 briefly outlines the study, its limitations and recommendations for promoting responsible sexual behaviour among school-going adolescents. The study's contributions are also discussed.

8.2 PURPOSE OF THE STUDY

The purpose of the study was to develop strategies to promote responsible sexual behaviours among school-going adolescents in Mpumalanga Province, South Africa. The results generated from respondents' feedback in Phase I were used to develop an interview schedule for the qualitative phase (Phase II). The two approaches were mixed by merging the quantitative and qualitative data, generating integrated findings that were used to develop strategies to promote responsible sexual behaviours among school-going adolescents.

8.3 RESEARCH DESIGN

The study used a sequential explanatory mixed-method design.

8.3.1 Phase I

The quantitative phase sought to explore patterns of sexual behaviours among adolescents and their knowledge and attitudes towards responsible behaviour. A self-administered questionnaire was used to collect data from 252 school-going adolescents. The response rate was 96%.

8.3.2 Phase II

The qualitative phase was conducted using a nested sample of school-going adolescents who were part of the sample of respondents in Phase I. Two focus group discussions were conducted with 14 school-going adolescents. In addition, individual face-to-face interviews were held with parents, teachers, health professionals and NGO staff. This phase sought to explore participants' views on adolescents' responsible sexual behaviour, and the challenges adolescents face in achieving responsible sexual behaviour.

8.3.3 Development and validation of strategies

The final objective was to develop and validate strategies to promote responsible sexual behaviour among school-going adolescents. This objective was achieved after the quantitative and qualitative data were integrated. From the integrated data, concluding statements were grouped to form themes and categories that were formulated into strategies. A final set of strategies with recommendations for implementation were validated by field and guideline experts, health professionals, teachers, parents, NGO staff and policymakers.

8.4 CONCLUSIONS OF THE STUDY

Conclusions are presented based on the results of school-going adolescents' pattern of sexual behaviour, attitudes towards responsible sexual behaviour (Phase I) and the meaning they ascribed responsible sexual behaviour (Phase II). The challenges school-going adolescents face in achieving responsible sexual behaviour and key stakeholders' views on their sexual behaviour were also invaluable.

The health professionals in the field of the study, parents, teachers, adolescents and the researcher's supervisor critically evaluated the strategy document. Based on this critical evaluation of the document, some strategies were amended, and the final strategies were developed.

8.4.1 Conclusion of Phase I

The conclusion of Phase I revealed that most school-going adolescents from the township are sexually active and do not consistently practice responsible sexual behaviours. There were some favourable and unfavourable attitudes towards responsible sexual behaviour, but adolescents' utilisation of health facilities for SRH was low.

The school-going adolescents who were sexually active showed concern about the challenges they faced in achieving sexual responsibility. The minority of adolescents who practised sexual abstinence faced challenges threatening their abstinence.

8.4.2 Conclusion of Phase II

School-going adolescents had a basic knowledge of the meaning of responsible sexual behaviour, which was expressed in terms of: preventing unplanned pregnancies, HIV and other STIs by using condoms, contraception, faithfulness, commitment, knowing their own and partner's HIV status and maintaining absolute sexual abstinence. These ideals also acted to uplift their moral values, abstinence and use of SRH services.

Stigmatisation is a common cause for school-going adolescents not using SRH health services. School-going adolescents are scared to be judged for being sexually active, fear their parents, and are lazy and ignorant about accessing SRH services. Some also do not have time to go to the clinic, where it takes time to be attended.

Conversely, some adolescents were concerned about the absence of parents in their sexual lives. They expected their parents to be there for them as educators, supporters and promoters of responsible sexual behaviour. Instead, the adolescents faced challenges in taking advice from friends because they were readily there for them when their parents were not.

Teachers were shown to contribute positively to SRH theory among school-going adolescents. However, they were concerned about a lack of expertise and resources

in dealing with other sex-related issues beyond them. It was evident that school-going adolescents used their SRH rights out of context when they did not listen to the advice of teachers and parents, predisposing them to risky sexual behaviours.

Other stakeholders, like health and NGO professionals, significantly contributed to school-going adolescents' sexual responsibility. However, adolescents were concerned about confidentiality, privacy, stigmatisation, and judgemental healthcare professionals.

8.4.3 Conclusions from Phase I and Phase II

The results of Phase I and findings from Phase II were integrated and formed the basis for the developed strategies to promote responsible sexual behaviour among school-going adolescents. The integrated findings were supported by related literature, culminating in 12 strategies, as presented in Table 8.1.

Table 8.1: Summary of validated strategies to promote responsible sexual behaviour among school-going adolescents

Theme	Category	Concluding statements	Strategies	Recommendations
THEME 1: SAFER SEXUAL PRACTICES AMONG SCHOOL-GOING ADOLESCENTS	**Prevention of HIV/AIDS, other STIs and unplanned pregnancy**	School-going adolescents do not use condoms or use them inconsistently. Most school-going adolescents do not use contraception. Faithfulness is lacking among adolescents, leading to multiple sexual partners. Adolescents lack a commitment to long-term relationships, leading to exposure to STIs and HIV infection from different partners. Many school-going adolescents indicated they are scared of knowing their own and their partner's HIV status. Most adolescents indicated that absolute sexual abstinence is impractical, though it is 100% safe.	Sexually safer, responsible adolescent as a promoter of responsible sexual behaviour Facilitate and support adolescents to become an example of a sexually responsible person to other adolescents	• Promote intentional and responsible sexual intercourse by always using condoms and contraceptives. • Have a good attitude towards practising responsible sexual behaviours, such as commitment, faithfulness and consistency. • Build resilience in the face of difficulties hindering the achievement of responsible sexual behaviour, such as self-control. • Promote the use of dual protection to prevent both unplanned pregnancies and STIs. Abstain from sex and wait for the right time, if possible. Abstinence is the 100% safe way of promoting responsible sexual behaviour. • Be resilient and have a pure determination to succeed to preserve purity and prevent STIs, HIV and unplanned pregnancy at least until late adolescence when a person is strong enough physically, mentally and economically. • Desist from pressures from peers, partners and hormones. • Participate in different activities like sports to prevent idleness. • Build resilience to help adolescents who commit to abstinence refrain from engaging in penetrative sex without planning and proper preparation for such behaviour to prevent regrets, unplanned pregnancies, infections with STIs and HIV. • Avoid multiple sexual relationships. • Be open and accepting of CTOP rather than seeing abortion as immoral and wrong. • Regard legal abortions as a way of giving an adolescent a second chance at life to achieve set life goals.

Theme	Category	Concluding statements	Strategies	Recommendations
	Protecting moral values and beliefs	Most adolescents understand SRH rights out of context. It was evident that adolescents do what they want with their bodies because it is rightfully theirs. Lack of responsibility jeopardised the rights of others in the process. Adolescents have a habit of disrespecting or not taking advice and discipline from others. Adolescents fall prey to peer pressure. Some adolescents have bad attitudes towards good morals and values.	The adolescent as a promoter of responsible sexual behaviour To raise an adolescent who abides by moral values of sex	• Learn to respect their rights and the rights of others. • Take responsibility for sexual needs by accepting guidance from professionals like teachers, elders, health professionals, and NGOs dealing with adolescent SRH. • Respect the community in which adolescents are living so that even when adolescents are sexually lost, the community can assist. • Intentionally set personal goals, values and beliefs and how to meet them to promote sexual responsibility. • Invest in a lasting relationship. • Stop looking down on good values and beliefs instilled by parents. • Be aware of own values and those of a partner to create mutual agreement. • Cultivate a culture of honesty in the sexual relationship. • Be morally responsible and know that abortion is not a ticket to sleeping around without condoms or not using contraceptives. • Erase the myths and misconceptions among adolescents that there are no longer virgins in this generation. • Be a good testimony of sexual purity for others to imitate. Refuse to be a statistic in adolescence pregnancy, STIs and HIV infections.
THEME 2: SRH KNOWLEDGE AND INFORMATION AMONG SCHOOL-GOING ADOLESCENTS	**Open partner communication**	Dishonesty Self-decision and lack of support from partners. Less knowledgeable partners.	The adolescent as good open communicator in a relationship Changing the bad communication skills some adolescents have about	• Adolescents should have honest communication with their partners about sex-related issues. • Adolescents should be confident of what they want from the relationship, and communicate about it. • Set individual sexual boundaries and communicate them so that there is an understanding of each other's comfort zone.

Theme	Category	Concluding statements	Strategies	Recommendations
		Doubtfulness with their relationship. Regrets with allegations of rape. Cultural barriers to sexual communication.	sex-related issues with their partners	• Choose together the best methods of prevention and gather information on where to get contraceptives and how to use them. • Get as much support as you can from the partner. • Partners should acquire SRH knowledge continuously so that SRH support is given accordingly. • Participate actively in functional youth-friendly services, programmes and activities designed to engage adolescents in sexuality education that equip them with knowledge that promotes responsible sexual behaviour. • Maintain continuous and consistent exposure to positive information on sexual and reproductive health to guard against media fallacies. • Engage in peer-to-peer sex-related discussions which are productive and informative.
		Adolescents do not make informed decisions about their sex life. Myths and misconceptions are prevalent among adolescents. They do not possess knowledge of the benefits and consequences of being sexually active. No knowledge of SRH services and places available to them.	An adolescent as an SRH knowledgeable stakeholder Adequate and accurate SRH knowledge has the power to change adolescents' irresponsible sexual behaviours	Adolescents and different stakeholders should: • Gather adequate and accurate SRH information by researching different sources of SRH knowledge. • Avoid spreading myths and misconceptions about SRH. • Regularly read and watch programmes on issues about SRH in the media to equip yourself with knowledge of the pros and cons of being sexually active. • Communicate regularly with significant others about SRH issues. • Learn to have a positive attitude towards SRH and avoid the negative influence of myths and misconceptions. • Be proactive on SRH issues and avoid laziness by seeking SRH services and information.

Theme	Category	Concluding statements	Strategies	Recommendations
		Some adolescents are just ignorant concerning SRH issues.		
THEME 3: Challenges school-going adolescents encounter in achieving responsible sexual behaviour	Excessive use of alcohol and drugs	Adolescents are drinking alcohol excessively. Adolescents use substances to remain high. Many drug dealers target adolescents. The majority of adolescents end up with alcoholism and drug addictions. Most adolescents like partying, where there is a risk of drug use.	Responsible alcohol drinking and non-use of substance abuse by the adolescent. Drinking alcohol responsibly or no alcohol at all and no substance use among adolescents promote responsible sexual behaviour.	• Stay away from bad company or youth with deviant behaviour. • Improve self-esteem and self-confidence to stand your ground no matter the circumstance. • Acknowledge good morals and practice them. • Stop drinking or drink responsibly since alcohol predisposes adolescents to sexual irresponsibility. • Stop substance use during adolescence since drugs permit a person to indulge in risky sexual behaviour like unprotected one-night stands. • Go to supervised parties or parties without alcohol. • Exercise restraint when drinking alcohol with or without a partner and drink in an open space where there are other people to prevent temptations. • Participate in programmes that divert adolescents from alcoholism and drugs. • Seek help promptly for any form of addiction. • Commit to rehabilitation and join support groups against substance and alcohol abuse.
	Overwhelming pressure among adolescents	Pressure from family and the community, and adolescent rebellion. Peer pressure to indulge in risky sexual behaviours.	A resilient, self-esteemed and self-confidant adolescent. A resilient adolescent conquers all the behavioural and sexual challenges despite all the obstacles the adolescent may face.	• Join support groups to encourage and build each other physically, emotionally, mentally and socially to build resilience. • Stay away from violent sex. • Avoid stigmatising each other's relationships or sexual choices. • Seek information on sex-related issues which are difficult to tackle. • Respect and uphold cultural differences in a relationship. • Communicate openly with a partner about your expectations in the relationship.

Theme	Category	Concluding statements	Strategies	Recommendations
		Pressure from partners to have unprotected sex and to bear children. Pressure to contain over-active hormones during adolescence. Adolescents become overwhelmed due to a lack of experience and maturity. Pressure from gender-based violence and sexual coercion.		• Be confident around peers, and do not be swayed. • Learn to say no and do not be forced to do what you do not believe in. • Seek help from important significant others if you feel overwhelmed.
	Lack of commitment to successful relationships	Adolescents easily get bored with each other. Adolescents experience unsatisfying relationships leading to cheating. Adolescents like short-term relationships, and this creates heartbreak. Lack of respect for relationships. One-night stands.	An adolescent as a committed partner in a relationship. Commitment to one faithful partner in a sexual relationship could change the bad attitudes adolescents have towards long-term relationships, build trust and love, minimising their risk of exposure to STIs, HIV and	• Create a fulfilling and trusting relationship among sexual partners. • Create a relationship that promotes high self-esteem, like appreciating a partner as they are. • Do things together in a relationship. • Present as a unity (united front) and avoid infiltration of the relationship by third parties. • Prevent heartbreak/trauma by being faithful in a relationship. • Promote a pleasurable relationship full of happiness and good memories. • Communicate problems in a relationship and solve them constructively.

Theme	Category	Concluding statements	Strategies	Recommendations
		Adolescents have multiple sexual partners.	unplanned pregnancy from different partners	
	Poor use of SRH services by adolescents	Most adolescents hate attending public clinics because of a lack of confidentiality and privacy. A majority of adolescents in townships cannot afford to go to private facilities for SRH services. The majority of adolescents lack a commitment to consistent use of SRH services. Lack of privacy and confidentiality at public health facilities. A majority of adolescents complain of rude nurse-patient relationships.	Promote the use of SRH services among adolescents	• Affordable contraceptives at private health institutions will assist adolescents who do not want to go to public clinics for free SRH services. • Adolescents are very sensitive to issues of SRH, and health professionals should avoid judgements and harassment. • Afford privacy and confidentiality every step of the way, not only in consulting rooms. • Avoid stigmatisation. • Good nurse-patient relationship should be maintained.

THEME 4: stakeholder support for adolescents' SRH	Parents as educators, promoters and supporters of adolescents' SRH	Parents do not have time to discuss sex-related issues with their adolescents. Parents regard dating as a very sensitive and private topic; hence, it is taboo to have such discussions. Parents do not have healthy and strong relationships with their adolescent children. Some parents feel the early adolescence stage is not yet the right time to impart SRH knowledge. Parents do give SRH knowledge in a threatening manner. There are cultural, sexual boundaries that do not allow exchanges of SRH ideas between parents and children.	Parents as promoters, supporters, and educators of SRH Parents as promoters, supporters, and educators of SRH will improve on active parental involvement in adolescents' sexual lives and promote adolescents' sexual behaviour.	• Create a healthy, strong relationship between parents and adolescents. A close bond helps parents teach sexual responsibility easily, and children will be free to share with their parents instead of keeping secrets. • Impart SRH knowledge initially when the child starts puberty and consequently as the child grows; share both positive and negative real-life messages. • Communicate correct information about sex. Sex education should be morally proper, and parents should avoid telling lies to promote learning. Lies mislead the child, and learning does not take place. • Use practical examples to reinforce the SRH messages and consequently reinforce positive knowledge. • Correct a child with love and understanding instead of using threatening messages to create understanding and agreement between parent and child. • Reinforce positive knowledge and correct negative knowledge. If the adolescent cannot avoid sex it is not a crime, but stress that the adolescent should be responsible sexually by using protection against sexually transmitted infections and contraceptives to prevent unplanned pregnancies. • Break cultural, sexual boundaries that do not allow exchanges of SRH ideas between parents and children. Teach about premarital sex because most adolescents revealed that they do engage in premarital sex despite parents wishing that sex during adolescents would not happen. • Explain the consequences of having sex before marriage, especially unprotected sex. • Set aside time with adolescents to teach them about sexual life. • Train adolescents spiritually and physically on managing sexual temptations and building self-control. Surely, a person cannot always sleep around to quench sexual desires.

		Parents tell lies when communicating about sex. Parents wish that premarital sex during adolescence would not happen while adolescents are engaging in sex. Parents' sexual behaviour is exposed in front of adolescents and can negatively affect an adolescent's sexual behaviour. Some parents do not provide for their children's essential needs. Parents promote sexual transactions by accepting gifts and money when their child engages in sex for profit. Some parents do not accept that their adolescents be disciplined by anyone else.		• Be there whenever adolescents need SRH information so they do not learn from peers who offer the wrong information. • Provide for adolescents' needs. • Empower adolescents through self-sustaining methods like entrepreneurship, which is integral to meeting adolescents' needs. This will prevent adolescents from engaging in sex in return for money or gifts and fight poverty. • Enrol for the government child support grants and the grant wisely to meet adolescents' needs. • Parents should discourage adolescents from receiving gifts from the opposite sex because it comes with a condition of sex. Usually, nothing is free. • Do not promote transactional sex by accepting what the child brings home without knowing where the money came from. • Offer advice on the advantages of maintaining virginity and sexual abstinence since it is the only 100% sure way of sexual responsibility. • Promote continuous discussions about sexual responsibility by regularly giving support information, and accompanying the child for SRH services at health facilities. • Avoid a spirit of individualism where parents stand by their family alone and turn a blind eye to a neighbour's child going astray sexually. Allow others to discipline the adolescent. • De-sensitisation of culture on the SRH topics will allow for free discussions between responsible parents and adolescents in households and the community at large. • Be open to CTOP and preventive methods among adolescents rather than seeing these as immoral and wrong. Look at CTOP as a lens to a bright future. • Parents should regard legal abortions and preventive methods as a way to give adolescents a second chance at life to achieve life goals. However, parents should educate adolescents to be sexually

		Adolescents and the community's norms stigmatise CTOP and other methods of preventing unplanned pregnancy and STIs. This does not stop adolescents from having sexual intercourse or abortions. Parents are too liberal and do not enforce the rules of the house by allowing children not to take responsibility and accountability for their actions. Parents are too strict and rigid without providing alternative ways for adolescents to behave freely, and this creates rebellious adolescent behaviour. Parents are sinking in despair and hopelessness without doing anything about it.		responsible and know that abortion is not a ticket to sleeping around without condoms. • Sensitise children on the rules and regulations of the household about sexual responsibility and avoid giving them too much freedom without being accountable and responsible for their actions. • Parents should put their foot down when it comes to the rules of the house concerning moral aspects of sexual responsibility. A household without rules makes it difficult to control an adolescent. • Practical, reasonable and supportive rules should be enforced at home in order for the child to achieve responsible sexual behaviour. • Leave room for the child to practice responsible sexual behaviours freely, affording independence with accountability and responsibility. • Encourage adolescents to verify and rectify all myths and misconception about contraceptives, condom use, HIV and other STIs, which are the causes of their avoidance of these. • Discourage adolescents from sharing myths and misconceptions among themselves. • Actively participate in the child's sexual life instead of sinking in hopelessness.

	Teachers as information disseminators of SRH knowledge to adolescents	Adolescents felt that teachers are not comfortable teaching them about sex in a deeper sense. There is less time for teaching Life Orientation subjects on SRH, which is a broad topic requiring more time. Teachers focus more on abstinence-only messages when most adolescents have already had sex, proving that the message will not work for most adolescents. Teachers do not have expert SRH knowledge to promote correct SRH information. Life Orientation teachers felt overburdened with the subject, for which they were not trained.	Teachers as promoters and disseminators of SRH information among adolescents The creation of a positive SRH learning environment and effective school-based curriculum on sexual and reproductive health in schools could facilitate desirable learning outcomes and, consequently, the desirable adoption of SRH outcomes among adolescents.	• Promote efficient and effective SRH education among adolescents in school. • Encourage adolescents to remain in school and be resilient despite the SRH problems they face because adolescents will have higher future prospects when they remain in school. • Encourage adolescents to have clear and specific goals to achieve because the more years of schooling an adolescent have, the lower their chances of early pregnancies. Their focus will be on future goals, attainable through education. • Relevant authorities, researchers and policymakers should support school-based sex education by teachers and school nurses. • Expert SRH training at teaching colleges and universities must be specific for Life Orientation teachers. • Reduce teachers' workload by hiring adolescent health experts to supplement Life Orientation classes. • Provide teachers with equipment and sufficient resources to impart the SRH knowledge comprehensively. • Teach adolescents how to have safer sex, not promoting abstinence-only messages. • Integrate theory about safer sex with practical demonstrations. For instance, utilise school nurses to demonstrate how to use condoms; from putting them on and removing them safely. This will promote safety by preventing tearing and slipping off, which predispose an adolescent to pregnancy and STIs. • Constantly teach sexual responsibility to remind and reinforce what adolescents already know.
	Religious fraternities as promoters and	Adolescents and parents reported that religion is	Religious fraternities as promoters and	• Re-enforce the importance of attending church services and activities because Bible teachings promote abstinence and discourage adultery and premarital sex.

	disseminators of SRH information	very important in their lives. However, parents have an over-reliance on churches, which is fatal for maintaining sexual responsibility among adolescents. Church leaders mainly support abstinence-only messages. Adolescents listen in church and then engage in sex after the service. Religious people have conflicts of interest in promoting the gospel through abstinence messages against promoting sexual responsibility through contraceptives.	disseminators of SRH information Promoting responsible behaviour through indoctrination of the gospel of God to adolescents who are abstaining.	• Guide adolescents towards responsible sexual behaviour through the teachings of the Bible. • Desist from threatening adolescents who are sexually active; rather, give advice that promotes sexual responsibility. • Promote sexual responsibility by having workshops with adolescents and invite professionals who deal with adolescent SRH to provide alternative ways of sexual responsibility because sex education from a religious leader might be too sensitive for some. • Promote the adoption of sex education in churches to desensitise the congregants from normalising abstinence-only messages.
	Health and NGO professionals as information disseminators and SRH caregivers.	Adolescents do not feel comfortable around some healthcare providers. Health education policies and programmes by	Role of health care and NGO professionals.	• Establish rapport with adolescents to promote good relationships and open, trustworthy communication. • Tailor-make reproductive and sexual health messages specifically for the millennial generation. • Update policies, messages and programmes to meet the expectations of today's generation rather than imposing outdated

		some providers are outdated and lack continuity. Adolescents lack consistency when using condoms. Adolescents known to use contraceptives and who terminate an unplanned pregnancy are stigmatised. Reproductive and sexual health issues are dynamic and change constantly. There is a lack of continuity in the SRH programmes for adolescents. Adolescents face a large body of information from different sources, none of which are factual. Some healthcare professionals are judgemental and biased.		policies and programmes on them. Efficient programmes are ones made by adolescents for adolescents. • Promote continuity in the SRH programmes targeting adolescents at health facilities. • Adolescents' active participation in programmes that concern them allows adolescents to take action, ownership and responsibility for their own sexual health. • Continuously train healthcare providers/clinic staff on treatment options, support, supervision and cultural sensitivity according to new trends so that the needs of the adolescents match their expertise. • Disseminate correct information because knowledge has the power to translate sexual ignorance into sexual responsibility. • Promote active dissemination of SRH information through different channels to allow saturation of information among adolescents. • Disseminate contraceptives to remove failures to access contraceptives. • Encourage active participation from community members, parents and guardians in adolescent SRH programmes. • Promote acceptability of the role of nature, contraceptives and denounce stigmatisation when rendering SRH care. • Provide free condoms and contraceptives through franchised clinics. • Subsidised SRH services in private practices where adolescence feel safe, and get the confidentiality they need. • Extensive community outreach, social marketing and mass media communication may increase clinic attendance among males and females. • Seek consent before any procedure to show the healthcare provider respects the autonomy of the adolescent. • Be compassionate, respectful and empathetic health providers who provide confidential interactions. • Health professionals should not judge and should be able to give effective information in confidence.

		There is an inadequate supply of contraceptives at health facilities. The facilities are too small to accommodate adolescents with their own departments.		• Improve interpersonal communication styles to facilitate adolescents' engagement with healthcare professionals. • Health facilities should be replenished with contraceptives, so they are always available, promoting ongoing use of different contraceptives, which affect sexual responsibility among adolescents. • Create a positive environment where adolescents are free and comfortable to access condoms, within reach and private to prevent embarrassment and stigmatisation. • Educate adolescents about the advantages of protecting oneself and demonstrate how to put on, remove and dispose of a condom, stressing the importance of consistent and correct use of condoms. • Afford privacy, confidentiality, respect and openness when providing preventive and protective methods. • Invest in structures meant exclusively for adolescents. • Avoid the non-use of contraceptives due to embarrassment and fear of discrimination by respecting the adolescent's choice to preserve their privacy and confidentiality. • Promote safe, confidential, non-judgemental, and legal abortions so that adolescents feel free to use this service and have a chance to finish school and gain better future prospects. • Responsible health professionals should rectify all myths and misconceptions about contraceptives, condom use, HIV and other STIs, which are the causes of non-use. • Rectify any shortcomings and mistakes pointed out by adolescents to improve the role of healthcare professionals as promoters of SRH.

8.5 RECOMMENDATION FOR FURTHER STUDIES

Evaluating the developed strategies' effectiveness was not the aim of this study. Hence, a follow-up study to evaluate the strategies to promote responsible sexual behaviour among school-going adolescents is encouraged.

A comparative study should also be carried out in different townships in Mpumalanga and other provinces in South Africa.

8.6 SCOPE OF THE STUDY

The study was conducted with school-going adolescents aged 15-19 years, parents, teachers, health professionals and NGO staff in one township of Mpumalanga Province. Middle and late adolescents were chosen because this period is when most adolescents start to engage in sex and are deemed mature enough to give useful information.

8.7 CONTRIBUTIONS OF THE STUDY

Risky sexual behaviours among school-going adolescents were identified, revealing that adolescents are susceptible to HIV infections and other STIs, as well as unplanned pregnancies. Strategies to promote responsible sexual behaviours were developed, and school-going adolescents were part of the solution on matters that affect them.

This study contributed to the body of knowledge concerning school-going adolescents' SRH, particularly in promoting sexual responsibility. This research is also intended to assist policymakers, donors, NGO health professionals, parents and other stakeholders. It offers essential information for drafting new policies and reinforcing available ones to protect vulnerable school-going adolescents against irresponsible sexual behaviours that predispose them to unplanned pregnancies, HIV and other STIs.

The school-going adolescents showed some potential for positive behaviour change if they received the right support and resources from different stakeholders.

8.8 LIMITATIONS OF THE STUDY

The sensitive nature of SRH issues may have contributed to some school-going adolescents not feeling comfortable presenting all relevant information. The study's findings may limit generalisation and applicability of the developed strategies to the whole population of school-going adolescents in Mpumalanga, since the study was conducted in only one township of the province.

The study also excluded early school-going adolescents, but this does not necessarily mean that they are not affected. Hence, there is a need to conduct a similar study targeting early adolescents. However, despite the appealing nature of sequential explanatory mixed-method research, being the sole researcher, it was financially constraining and labor intensive. Nonetheless, the process was a learning curve that equipped the researcher with both qualitative and quantitative research skills.

8.9 CONCLUSION

The study illuminated the current state of adolescents' sexual behaviour patterns and the challenges hindering them from practising responsible sexual behaviour. They lack correct information, parental support, face stigmatisation, learn from ill-equipped teachers, experience peer and partner pressure, and report poor utilisation of SRH services at health facilities. Based on the study's findings, strategies to promote responsible sexual behaviours among adolescents were developed.

The meaningful contribution came from different stakeholders dealing with adolescents, namely parents, teachers, healthcare professionals and NGO staff with experience in adolescents' SRH well-being. These stakeholders' contributions reinforced the strategies to promote responsible sexual behaviour among school-going adolescents.

REFERENCES

Adegboyega, LO, Ayola, VA & Muhammed, S. 2019. Influence of peer pressure on sexual behavior of undergraduates in Kwara State. *Anatolian Journal of Education,* 4(1): 49-58.

Agdeve, AS, Fiaveh, DY & Anto-Ocrah. 2022. Parent-Adolescent Sexuality Communication in the African Context. A Scoping Review of the Literature. *Sexual Medical Review 1*0(4):554-566

Ahanhanzo, YG, Sossa-Jerome, C, Sopoh, G, Tchandana, M, Azandjeme, C & Tchandja, T. 2018. Factors associated with early sexual intercourse among teenagers and young adults in Benin. *Journal of Public Health in Africa* 9(681): 88-91.

Ahmed, T. 2015. Child marriage: A discussion paper. *Bangladesh Journal of Bioethics,* 6(2): 8-14.

Ajzen, I. 2012. The theory of planned behaviour. *In Handbook of theories of social psychology* edited by Van Lange, P.A, Kruglanski, A.W & Higgins, E.T. Sage: 438-459.

Ajzen, I. 1991. The theory of planned behaviour. *Organisational behaviour and human decision processes*. 50(2): 179-211.

Ali, M, Merdad, L & Bellizi, S. 2021. Socioeconomic variations in risky sexual behaviour among adolescents in 14 Sub-Saharan Africa countries who report ever having had sex. *International Journal for Equity in Health* 20:11 https//doi.org/10.1186/s12939-020-01352-8.

Antonius, R. 2013. *Interpreting quantitative data with IBM SPSS Statistics*. 2nd edition. London: Sage

Babbie, E. 2013. *The practice of social research*. 13th Edition. California: Wadsworth Cengage Learning

Baron, P, Subedar, H, Letsoko, M, Makua, H & Pillay, M. 2022. Teenage births and pregnancies in South Africa, 2017-2021- a reflection of a troubled country: Analysis of public sector data. *South African Medical Journa*l, 112(4): 252-258

Beksisnka, M, Closson, K, Smit, J, Dietrich, J, Hornschuh, S, Smith, P, Nduna, M, Brockman, M, Ndung'u, T, Gray, G & Kaida, A. 2021. Adolescent pregnancy and current contraceptive use among adolescent and young women aged 16 to

24 years in Durban and Soweto, South Africa. Johannesburg: Research Square (https://doi.org/10.21203/rs.3.rs-514539/v1)

Beksinska, M, Pillay, L, Milford, C & Smit, J. 2014. The sexual and reproductive needs of youth of South Africa. *South African Medical Journal* 104(10): 676-678.

Bhushan, NL, Stoner, MCD, Groves, AK, Kahn, K & Pettifor, A. 2022. Partnership dynamics and HIV-related sexual behaviours among adolescent mothers in South Africa: A longitudinal analysis of HIV Prevention Trials Network 068 Data. *Journal of Adolescent Health* 71: 63-69

Bless, C, Higson- Smith, C & Sithole, SL. 2013. *Fundamentals of Social Research Methods: African perspective.* 5th edition. Juta: Cape Town.

Born, KM, Wolvaardt, L & Mcintosh, E. 2015. Risky sexual behaviour of university students: Perceptions and the effect of a sex education too. *African Journal for Physical, Health Education, recreation and dance (AJHERD)* 21: 502-518.

Borneskog, C, Haggstrom-Nordin, E, Stenhammar, C, Tyden, T & Iliadis, SI. 2021. *Changes in sexual behaviour among high school students 0ver a 40 year period.* Scientific reports. www.nature.com/scientificreports. Accessed 17/ 05/2017

Begun, S, Barman-Adhikari, A, Greenblatt, A, Sahajpal, P, Campbell, D, Cooke, K, & Rice, E. 2023. Social norms of pregnancy and pregnancy attitudes among youth experiencing homelessness. *Youth and safety* 55 (3): 524-551.

Brink, H, Van der Walt, C & Van Rensburg, G. 2018. 4th edition. *Fundamentals of research methodology for health care professionals.* Cape Town: Juta.

Cagney, AG. 2016. *Introduction to strategy.* Waterford Institute of Technology: Waterford.

Carella, M, García-Pereiro, T, Pace, R. & Paterno, A. 2020. 'The "dating game": age differences at first sex of college students in Italy', *Genus* 76(1)

Chawla, N & Sarkar, S. 2019. Defining high-risk sexual behaviour in the context of substance use. *Journal of Psychosexual Health.* 1(1):26-31

Creswell, JW & Plano Clark, VL. 2018. *Designing and conducting mixed methods research.* 3rd edition. Los Angeles: Sage

Creswell, JW & Poth, CH. 2018. *Qualitative inquiry and research design. Choosing among five approaches.* 4th Edition. United Kingdom: Sage

Creswell, JW & Plano Clark VL 2014. *Designing and conducting mixed methods research.* 2nd edition. Washington DC: Sage

Creswell. JW. 2014. *Research design: Qualitative, Quantitative and Mixed Methods Approaches*. 4th edition. Washington DC: Sage.

Creswell, JW. 2013. 3rd edition. *Qualitative inquiry research design: choosing among five approaches*. California: Sage.

Decker, MJ, Berglas, NF & Brindis, CD. 2015. A call to action: Developing and strengthening new strategies to promote adolescent sexual health. *Societies 5* (4): 686-712.

Denno, DM, Hoopes, AJ & Chandra-Mouli, V. 2015. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *Journal of Adolescent Health* 56: S22-S41.

Dessai SR. 2019*. High risk sexual behaviour among HIV- negative MSM in England: behaviour data to inform HIV prevention*. England: University College London.

Dube, S, Lavoie, F, Blais, M & Hebert, M. 2017. Consequences of casual sex relationships and experiences on adolescents' psychological well-being: A prospective study. *Journal of Sex Research* 54(8):1006-1017.

Duby, Z, Verwoerd, W, Isaksen, K, Jonas, K, Maruping, K, Dietrich, J, Lovette, A, Kuo, C & Mathews, C. 2022. 'I ca'nt go to her when I have a problem': sexuality communication between South African adolescent girls and young women and their mothers. *Journal Of Social Aspects Of HIV/AIDS* 19 (1):18-21.

Du Plooy- Cilliers, F, Davis, C & Bezuidenhout RM. (2014). *Research matters*. Cape Town: Juta

Durand MA & Chantler, T. 2014. (eds)*. Principles of social research.* 2nd edition. New York: Open University Press.

Kabiru, CW. 2019. Sexual and reproductive health and rights. What has been achieved in the 25 years since the 1994 International conference on population and development and what remains to be done? *Journal of Adolescent Health* 65 (S6): S1-S2

Embelton, L, Nyandat, J, Ayuku, D, Sang, E, Kamanda, A, Ayaya, S, Nyandiko, W, Gisore, P, Vreeman, R, Atwoli, L, Galarraga, O, Ott, MA & Braitstein. P. 2017. Sexual behaviour among orphaned adolescents in Western Kenya: A comparison of institutional and family-based care settings. *Journal of adolescent health* 60:417 -424.

Esan, DT & Bayajidda, KK. 2021. The perceptions of parents of high school students about adolescent sexual and reproductive needs in Nigeria: A qualitative study. *Public Health in Practice 2*:1-7.

Fasakin, OF. 2017. *Parent adolescent communication on risky sexual behaviour: Facilitators and barriers in KwaZulu Natal, South Africa.* Centre for communication, Media and Society Dissertation. Durban: University of KwaZulu Natal.

Fink, A. 2015. *How to conduct surveys. A step by step guide*. 6th edition . Los Angeles: Sage.

Fouche, CB, Strydom, H & Roestenburg, WJH. 2021. *Research at grassroots. For the social sciences and human services professions.* 5th edition. Pretoria: Van Schaik

Gillespie, B, Baleni, J, Allen, H, Soma-Pillay, P & Anumba, D. 2022. Shifting social norms and adolescent girls' access to sexual and reproductive health services and information in a South African community. *Qualitative health Research* 32 (6):1014-1026.

Gilliam, M, Woodhams, E, Sipsma H & Hill, B. 2017. Perceived dual method responsibility by relationship type among African-American male adolescents. *Journal of Adolescent health* 60 (3): 340-345.

Gray, DE. 2014. *Doing research in the real world*. Los Angeles: Sage

Gray, JR, Grove, SK & Sutherland, S. 2017. *The practice of research. Appraisal, synthesis and generation of evidence*. 8th Edition. St Louis: Elsevier.

Gresh, A & Maharaj, P. 2014. Termination of pregnancy: Perspectives of female students in Durban, South Africa*. African Population Studies* 28(1): 681-690

Gumindega, GC & Maharaj, P. 2022. Challenges with couples HIV counselling testing among black MSM students: perspectives of university students in Durban, South Africa. *Journal of Social Aspects of HIV / AIDS* 19 (1): 22-31

Haberland, N & Rogow, D. 2015. Sexuality education: emerging trends in evidence and practice. *Journal of Adolescent Health* 56(1): 15-21.

Hebert, AC, Ramirez, AM, Lee, G, North, SJ, Askari, M, West, RL & Sommer, M. 2017. Puberty experiences of low income girls in the United States: A systematic review of qualitative literature from 2000 to 2014. *Journal of Adolescent Health (*60): 363-379.

Houser, J. 2015. *Nursing research: Reading, using and creating evidence*. 3rd edition. Sudbury: Jones and Bartlett

James, S, Pisa, PT, Imrie, J, Beery, MP, Martin, C, Skhosana, C & Delany-Moretlwe, S. 2018. Assessment of adolescent and youth friendly services in primary healthcare facilities in two provinces in South Africa. *BMC Health Services Research* 18(809): 1-10

Jansen, S. 2021. *The moderator effect of socioeconomic status in the relationship between perceived social support, adolescent resilience and risk behaviour*. Master's dissertation. Bloemfontein: University of Free State.

Kara, R & Maharaj, JP. 2015. Child bearing among young people in South Africa; findings from the National Income Dynamics study. *South Africa Demography 2015*. 16(1):57- 85

Kembo, J. 2013. Changes in sexual behaviour and practice and HIV prevalence indicators among young people aged 15 to 24. *Sahara Journal of social aspects of HIV/AIDS* 10(3):150-162.

Khumalo, S, Taylor, M, Makusha, T & Mabaso, M. 2020. Intersectionality of cultural norms and sexual behaviours: a qualitative study of young Black male students at a university in Kwazulu- Natal, South Africa. Manuscript. *Reproductive health 17,188.* https://doi.org/10.1186/s12978-020-141-3

Kidman, R & Angelwicz, P. 2017. Why are orphaned adolescents more likely to be HIV positive? Distinguishing between maternal and sexual HIV transmission using 17 nationally representative data sets in Africa. *Journal of Adolescent Health xxx:* 1-8.

Kothari, CR & Garg, G. 2019. *Research methodology methods and techniques*. 4th edition: London: New age international.

Koto, M V & Maharaj, P. 2016. Difficulties facing healthcare workers in the era of AIDS treatment in Lesotho. *Sahara- J: Journal of Social Aspects of HIV/AIDS+qq* 13(1):53-59.

Kwasnicka, D, Dombrowski, S, White, M & Sniehotta, F. 2016. Theoretical explanations for maintenance of behaviour change: A systematic review of behaviour theories. *Health Psychology Review* 10(3):277-296.

Lam, CB & Lefkowitz, ES. 2013. Risk sexual behaviours in emerging adults: Longitudinal changes and within-person variations. *Archives of Sexual behaviour* 42(4): 523-532.

Larsson, FM, Bowers-Sword, R, Narvaez, G & Ugarte, WJ. 2022. Exploring sexual awareness and decision making among adolescent girls and boys in rural

Nicaragua: A socio-ecological approach. *Sexual & Reproductive Healthcare,* 31:1-6: 100676 https:// do.org/1016/j.srhc.2021. 100676.

Leedy, PD & Ormrod, J. 2019. *Practical research planning and design*. 12th edition. New York: Pearson.

Loew, N, Mackin, ML & Ayres, M. 2018. Collegiate women's definitions of responsible sexual behaviour. *Western Journal of Nursing Research* 40(8): 1148-1162

Lokubal, P, Corcuera, I, Balil, Frischer, JM, Kayemba, CN, Kurinczuk, JJ, Opondo, C, Nair, M. 2022. *Abortion decision-making process trajectories and determinants in low-middle-income countries: A mixed-methods systematic review and meta-analysis. eClinical Medicine* 54: 13-25

Lopez, LM, Bernhole, A, Chen, M & Tolley EE. 2018. School based interventions for improving contraceptive use in adolescents. *Cochrane Database System Review* 2016(6).

Lubinga, E, Maes, AA & Jansen, CJM. 2016. How peer conversations about HIV/AIDS media messages affect comprehension and beliefs of young South African women. *Sahara-J: Journal of social aspects of HIV/AIDS* 13(1):68-80.

Machimana, E.G. 2012. *Perceptions of the associations between alcohol misuse and the risk of HIV infection among male youths in Soshanguve, Gauteng*. Master's dissertation. Pretoria: University of South Africa

Machiyama, K, Casterline, JB, Mumah,JN, Huda, FZ, Obare, F, Odwe, G, Kabiru, CW, Yeasmin, S & Cleland, J. 2017. Reasons for unmet need for family planning, with attention to the measurement of fertility preferences: protocol for a multi-site cohort study. *Reproductive Health* 14(23): 1-11.

Marcell, AV, Morgan, AR, Sanders, R, Lunardi, N, Pilgrim, NA, Jennings, JM, Page, KR, Loosier, PS & Dittus, PJ. 2017. The socio-ecology of sexual and reproductive health care use among young urban minority males. *Journal of Reproductive Health* 60: 402-410.

Mayimbo, S, Musenge, E & Ngoma, CM. 2019. HIV infection risk awareness and sexual behaviour among young women: Observations from Mufulira urban district, Zambia. *Journal of Psychiatry and Behavioural Sciences* 2 (2):1024 -1032

Merriam-Webster.com dictionary. Sv"community". Https://www.merriam-webster.com/ dictionary/ community. Accessed 10 April 2017

Michielsen, K, Remes, P, Rugabo, J, Van Rossem R. & Temmerman, M. 2014. Rwandan young people's perceptions on sexuality and relationships: Results from qualitative study using the 'mailbox technique', *Sahara J: Journal of Social Aspects of HIV/AIDS* 11(1): 51-60.

Milimo, J, Zulu, JM, Svanemyr, J, Munsaka, E, Mweemba, O & Sandoy, IF. 2021. Economic support education and sexual decision making among female adolescents in Zambia: a quality study. *BMC Public Health* 21:1360. https://doi.org/10.1186/s12889-02-11373-w

Mokwena, K, & Morabe, M. 2016. Sexual abstinence: What is the understanding and views of secondary school learners in a semi-rural area of Northwest Province, South Africa? *Sahara-Journal: Journal of social aspects of HIV/AIDS* 13(1):81-87.

Moore, L, Beksinska, M, Rumphs, A, Festin, M & Gollub, EL. 2015. Knowledge, attitudes, practices and behaviours associated with female condoms in developing countries: a scoping review. Open Access. *Journal of contraception*. 6: 125-142.

Mpondo, F, Ruiter, RAC, Schaafsma, D, van den Borne, B & Reddy, P. 2018. Understanding the role played by parents, culture, and the school curriculum in socialising women on sexual health issues in rural South Africa. *Journal of Social Aspects of HIV/AIDS* 15(1): 41-49.

Mpumalanga Provincial Aids Council. 2017. Mpumalanga implementation plan for HIV, TB and STIs 2017-2022.

Muanda, FM, Gahungu, NP, Wood, F & Bertrand, JT. 2018. Attitudes towards sexual and reproductive health among adolescents and young adults in Urban and rural DR Congo. *Reproductive Health* 15(74): 1-14. https://doi.org/10.1186/s12978-018-0517-4

National Development Plan. Voluntary National Review Report. 2019. *South Africa's implementation of the 2030 Agenda for sustainable development. "Solving complex challenges together"*. Pretoria: National Development Plan.

Netshikweta, ML, Olaniyi, CO & Tshitangano, TG. 2018. Reproductive health choices among adolescents in secondary schools: A case study of selected schools in Limpopo, South Africa. *The Open Public Health Journal* 11(1): 319-329.

Ngabaza, S & Shefer, T. 2019. Sexuality education in South African schools: Deconstructing the dominant response to young people's sexualities in

contemporary schooling contexts. *Sex, Sexuality, Society and Learning* 19(4):422-435.

Nkani, ND & Bhana, D. 2016. Sexual and reproductive well-being of teenage mothers in a South African Township School, South Africa. *Journal of Education* 36: 1-10.

Ngidi, ND, Moyo, S, Zulu, T, Adam, JK & Krishna, SBN. 2016. Qualitative evaluation of selected social factors that impact sexual risk-taking behaviour among African students in Kwazulu-Natal, South Africa. *Sahara-J: Journal of Social aspects of HIV/Aids* 13(1): 96-10

Ninsiima, LR, Chiumia, IK & Ndejjo, R. 2021. Factors influencing access to and utilisation of youth friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. *Reproductive health.* 18135. https://doi.org/10.1186/s12978-01183-y

Nkhwashu T & Mafukata, MA. 2015. The didactics and pedagogy of sexuality and reproductive health of adolescents in Mpumalanga Province, South Africa. *International Journal of Information Research and Review* 2 (9):1077-1086

Nkosi, NN & Pretorius, E. 2018. The influence of teenage pregnancy on education: Perceptions of educators at a secondary school in Thembisa, Gauteng. *Social Work Journals*. Doi:http://dx.doi.org/10.15270/55-1-698.

Ntsepe, Y, Simbayi, LC, Shisana,O, Mabaso, M, Rehle,T, Ncitakalo, N, Davids A & Naidoo, YD. 2014. Perceptions about the acceptability and prevalence of HIV testing and factors influencing them in different communities in South Africa. *Sahara-J: Journal of Social Aspects of HIV/AIDS* 11(1): 138-146

Obare, F, Kabiru, CW, Chandra-Mouli, V. 2018. *Reducing early and unintended pregnancies among adolescents. Family Planning evidence brief.* Geneva: Wold Health Organisation

Odigwebu, CO, Amoo, EO & De Wet, N. 2018. Teenage pregnancy in South Africa: Where are the young man involved? *South African Journal child health* 12 (2 Supplement 1):S44-S50.

Oxford English dictionary. 2019. Sv "*Strategy"*. 4th Edition. Oxford Press: United Kingdom

Patsani, P, Parida, J, Panda, A, Jena, S, Behera, SS & Pradhan, A, Patra, PK, Pati, S, Kaur, H. & Acharya, SK. 2023. *Knowledge, beliefs and practices towards HIV/AIDS among adolescents in India: A scoping review protocol. PlosONR* 18(2): e0280985.https://doi.org/1371/journal.pone.0280985

Polit, DF & Beck CT. 2017. *Nursing research generating and assessing evidence for nursing practice*. 10th edition. China: Walters Kluwer

Powell, TW, Weeks, FH, Illangasekare, S, Rice, E, Wilson, J, Hickman, D & Blum, RW. 2017. Facilitators and barriers to implementing church based adolescent sexual health programs in Baltimore city. *Journal of Adolescent Health* (60): 169-175.

Pringle, J, Mills, KL, McAteer, J, Jepson, R, Hogg, E, Anand, N & Blakemore, SJ. 2017. The physiology of adolescent sexual behaviour: A systematic review. *Cogent Social Sciences* 3:1-14.

Pulerwitz, J, Blum, R, Cislaghi, B, Costenbader, E, Harper, C, Heise, L, Kohli, A & Lundgren, R. 2019. Proposing a conceptual framework to address social norms that influence adolescent sexual and reproductive health. *Journal of adolescent Health* 64(4): 7- 9.

Pugh, S. 2019. Politics, power, and sexual and reproductive health and rights : impacts and opportunities. *Sexual and Reproductive Health Matters* 27(2):1-5.

Rubin, A & Babbie, ER. 2017. *Research methods for social work*. 8th edition. California: Cengage Learning

SABC. 2018. News online. 16 August 2018, 9:39pm news. Teenage pregnancy on the rise in Mpumalanga, www.sabcnews.com.@SABCNEWSONLINE. Accessed 19 August 2018.

Santos, JLG, Erdmann, AL, Meirelles, BHS, Lanzoni, GMML, Cunha, VP & Ross, R. 2017. Integrating quantitative and qualitative data in Mixed method research. *Texto Contexto Enferm* 26(3): 1-9

Sarantakos, S. 2013. *Social research*. 4th edition. United Kingdom: Red Globe.

Sedgh, G, Lawrence, E, Finer, LB, Bankole, A, Eilers, MA & Singh, S. (2015). Adolescent pregnancy, birth, and abortion rates across countries. Levels and recent trends. *Journal of Adolescent Health* 56: 223-230.

Shisana, O, Rehle, T, Simbayi, L.C, Zuma, K, Jooste, S, Zungu, N, Labadarios, D, Davids, A, Ramlagan, S, Mbelle, N, Zuma, K, Van Zyl, J, Onoya, D. & Wabiri N. 2014. *South African National HIV Prevalence, incidence and Behaviour Survey*. 2012. Cape Town: HSRC Press

Smith, L Jacob, L, Lopez-Sanchez, GF, Grabovac, I, Yang, L, Pizzol, Sigman, A, McDermott, D & Koyanagi, A. 2022. A multi-country study of the violence-related

risk factors for early sexual debut and risky sexual behaviour in adolescents. *Journal of Interpersonal Violence* 37 (3) 1275-1297

Solomons, N & Gihwala, H. 2021. *The right to sexual and reproductive health: challenges and possibilities during Covid-19.*Cape Town: The Gender Health justice: University of Cape Town.

South Africa. 2007. *Sexual offences and related matters Amendment Act 32 of 2007.* Pretoria: Government Printers

South African Labour and Development Research Unit (SALDRU). 2016. South Africa Demography Survey.www.samrc.ac.za> reports<sadhs. Accessed 5/04/2018.

Statistics South Africa (STATS SA) 2019. *Statistical release P0302. Mid-year population estimates 2019.* Pretoria: Department of Statistics.

Statistics South Africa. 2018. *Mid-year population estimates*. Pretoria: Department of statistics.

Statistics South Africa. 2016. *Media release: South Africa demographic and health Survey, key indicators report*. Pretoria. Accessed 21/02/2020

Sunarsih, T, Astuti, EP, Shanti, EFA & Ambbarwati, ER. 2020. Health promotion model for adolescent reproductive health. *Electronic Journal of general Medicine.* httpd://doi.org/10.29333/ejgm/7873

Tagwirei, L. 2014. *An exploration of adolescents' knowledge of HIV/AIDS and its influence on sexual behaviour: A case of a high school in Johannesburg, South Africa.* Pretoria: University of South Africa

Taukeni, S & Ferreira, R. 2016. HIV and or AIDS awareness among adolescents in a South African at risk rural community. *Southern African Journal of HIV medicine* 17 (1): 1-7.

Tesfaye, G, Dessie, Y, Berhane, Y, Assefa, N, Semahegn, A, Canavan, CR & Fawzi, WW. 2020. HIV/AIDS awareness and testing practices among adolescents in eastern Ethiopia. *Tropical medicine and International Health* 25(1):111-118.

Todhunter, L, Hogan-Roy, M. & Pressman, EK. 2022. Complications of pregnancy in adolescence. *Seminars in Reproductive Medicine* 40: 98-106.

Tuyiseng, G, Hategeka, C & Aguilera, RA. 2018. Should condoms be available in secondary schools? Discourse and policy dilemma for safeguarding adolescent reproductive and sexual health in Rwanda. *Pan African Medical Journal.* 31 (1): 1-12 173.doi:10.11604/pamj.2018.31.173.1549

Twinomugisha, B, Ottemoller, FG & Daniel, M. 2020. Exploring HIV related stigma and discrimination at the workplace in Southwestern Uganda: Challenges and solutions. *Advances in Public Health:1-10 https://doi/10.1155/2020/8833166 *j*

Underwood, JM, Jones, SE, Demissie, Z, Rasberry, CN. 2021. School level poverty and rurality associated with differences in sexual risk behaviours among US public high school students. *Journal of Adolescent health* 69(6): 94-969.

United Population Fund (UNFPA) Report. 2015b *Incorporating comprehensive sexuality education within Basi and Higher Institutions of Learning in KwaZulu Natal.* KwaZulu Natal: United Population Fund

United Population Fund (UNFPA). 2015a *Girlhood not motherhood: Preventing adolescent pregnancy*. New York: United Population Fund.

United Population Fund (UNFPA). 2015b. *Assessing adolescent and youth friendly health service delivery in the East and Southern Africa Region.* New York: United Population Fund

United Children's Fund (UNICEF). 2022. Strategic plan 2022-2025. *Renewed ambition towards 2030*. New York: United Children's Fund.

United Children's Fund (UNICEF) Annual Report. 2021.Protecting child's rights in times of crises. New York: United Children's Fund

United Children's Fund (UNICEF). 2017. *Turning the tide against AIDS will require more concentrated focus on adolescents and young people. United Nations Department of Economic and Social Affairs, Population Division. World Population Prospects: The Revision*. New York: United Children's Fund.

United Nations. 2021. Department of Economic and Social Affairs Population Division. *Fertility among young adolescents aged 10 to 14 years.* United Nations: New York University of Minnesota. Late adolescent stage. Https://sahrc.umn.edu/sites/sahrc.umn.edu/files/2021-01/late_stage-eng.

Vetten. L. 2014. Policy brief 72. *Rape and other forms of sexual violence in South Africa*. Pretoria: Institute for Security Studies.

Vhembo, T. 2013. *Sexual behaviour among adolescents living with HIV in Zimbabwe. Master's* Dissertation. Pretoria: University of South Africa.

Wakjira, DB & Habedi, DSK. 2022. Perception, knowledge of sexual and reproductive health rights and associated factors among adolescents in East Arsi Zone, Ethiopia: a sequential explanatory mixed method study. *African Journal of Reproductive Health* 26(1):67-78.

Wakjira, DB. 2021. *Training guidelines for promoting adolescents' knowledge and perceptions on sexual and reproductive health rights and services in rural Arsi zone, Ethiopia.* Ethiopia: UNISA.

Widman, L, Chouka-Bradley, S. Helms, SW & Prinstein, J. 2016. Adolescent susceptibility to peer influence in sexual situations. *Journal of Adolescent Health* 58(3):323-329

Wilson, KN, Jensen, J, Ballard, S & Taylor, A. 2022. Tell more: Parent-child sexual talk and young adult sexual communication satisfaction with romantic partners. *Journal of Social, Behavioural and Health Sciences,* 16(1):19-39.

World Education Network. 2023. *South Africa education guide: schooling, higher education and funding.* SouthAfricaEducation.info. Accessed 17 April 2017

World Health Organisation (WHO). 2014a. *Adolescent pregnancy.* Department of Reproductive Health and Research. Geneva: World Health Organisation

World Health Organisation (WHO). 2016. *Global health estimates, Deaths by cause, age, sex, by country and by region.* Geneva: World Health Organisation.

World Health Organisation (WHO). 2018. *World Health Statistics. Monitoring health for the SDGs.* Geneva: World Health Organisation.

World Health Organisation (WHO). 2022. WHO fact sheet of the 15 September 2022. Geneva: World Health Organisation

Yarger, J, Decker, MJ, Campa, MI & Brindis, CD. 2017. Rural-Urban differences in awareness and use of family planning services among adolescent women in California. *Journal of Adolescent Health* 60(4): 395-401.

Yu, C, Kagesten, AE, De Meyer, S, Moreau, C, Van Reeuwijk, M & Lou, C. 2021. Pornography use and perceived gender norms among young adolescents in Urban poor environments: A cross site study. *Journal of Adolescent Health* 69: S31-S38.

Yussof, F, Sahril, N, Rasidi, NM, Zaki, NAM, Muhamad, N, Ahmad, N. 2014. Drug use among school-going adolescents in Malaysia. *Asia Pacific Journal of Public Health 26(5):supplementary: 100S-107S.doi:10.1177/1010539514542425.*

Zhao, Y, Qiu, P, Yan, L, Li, S, Yang, Z, Zhang, H, He, J & Zhou, C. 2022. *Epidemiological trends of female breast gynaecologic cancers in adolescents and young adults in China from 1990-2019: results from the Global burden of disease study 2019*. Frontiers in Oncology,1-1.12:1003710. doi 10:1003710

ANNEXURE A: LETTERS SEEKING APPROVAL

45357390 MUDZANA

APPROVAL SEEKING LETTER TO CONDUCT RESEARCH IN CLINICS

House Number 103

Matsulu C, Mbombela

P O Box 1103, Malelane, 1320

31 October 2017

The Director

Department of Health, Province of Mpumalanga

Mbombela

Ref: PERMISSION TO CONDUCT RESEARCH WITH HEALTH PROFESSIONALS AND NGOs

Dear Sir/ madam

I am Pricilla Mudzana, and I am a Doctoral student in Nursing Science at the University of South Africa. I request permission to carry out a study titled 'Strategies to promote responsible sexual behaviour among school going adolescents in Mpumalanga Province'. I request the participation of health professionals in clinics of the proposed Township and I am seeking the approval of your office as the Director to conduct a series of interviews with the participants in the academic year 2018.

Purpose of the study

Adolescence is a period when most adolescents engage in all sorts of sexual behaviour, most of which are risky resulting in teen pregnancies, HIV and other sexually transmitted infections. Hence, turning the tide against these consequences will require more concentrated focus on adolescents' promotion of responsible sexual behaviour from different spheres. The purpose of the study is to develop strategies which promote responsible sexual behaviour among adolescents in Mpumalanga Province. This is in partial fulfilment of the requirement for the Doctoral degree in Nursing Science.

Procedure

I would like to meet with health professionals dealing with adolescents in relation to sexual behaviour for a 45-60 minutes' interview. We will talk about adolescents'

sexual behaviour pattern, knowledge of responsible sexual behaviour, challenges faced in promoting responsible sexual behaviour and what can be done to promote responsible sexual behaviour.

Risks

There will be no risks associated with participating in this study.

Benefits

It is possible that the health professional will not benefit directly by participating in this study. However, this study should provide the health professional with valuable opportunity to think and talk about their experiences with adolescents in relation to adolescents' sexual behaviour. The information gathered will be presented to different stakeholders and adolescents. This will be vital to their efforts to continually improve programmes targeted at improving responsible sexual behaviour in adolescents.

Confidentiality

Absolute confidentiality cannot be guaranteed since research documents are not protected from subpoena. However, the study records confidentiality will be maintained to the fullest extent possible through coded responses, concealment of identity and no linkages will be made to name or responses.

Costs

No cost to health professionals beyond their time and effort required to participate in the study. I will schedule interviews agreeable to the participants.

Right to refuse

The health professional may refuse to participate in the study. No one is forced.

Questions

If you have questions, contact Pricilla Mudzana on 0718802553. I look forward to hearing from you soon. Thank you,

Yours faithfully

Pricilla Shupikayi Mudzana

THE DIRECTOR: APPROVAL SEEKING LETTER TO CONDUCT RESEARCH IN SCHOOLS

House Number 103

Matsulu C, Mbombela

P O Box 1103, Malelane, 1320

16 October 2019

The Director

Department of education

Mpumalanga Province

Mbombela

Ref: APPLICATION TO CONDUCT RESEARCH WITH ADOLESCENTS IN SCHOOLS

Dear Sir/ madam

Adolescence is a period when most adolescents engage in all sorts of sexual behaviour, most of which are risky, resulting in teen pregnancies, HIV and other sexually transmitted infections. Hence, turning the tide against these consequences will require more concentrated focus on adolescents' promotion of responsible sexual behaviour.

In view of this, I Pricilla Mudzana, the Doctoral student in Nursing Science at the University of South Africa, request to carry out a study on strategies to promote responsible sexual behaviour among school going adolescents at your schools. I would like to seek the approval of your office to conduct a cross-sectional study with school going adolescents aged between 15-19 years in academic year 2019-2020. Questionnaires and interviews will be used to collect information.

This is in partial fulfilment of the requirement for the Doctoral degree in Nursing Science. Rest assured that any information given by participants are treated confidentially. I look forward to hearing from you soon. Thank you,

Yours sincerely

Pricilla Shupikayi Mudzana

THE COUNSILLOR: APPROVAL SEEKING LETTER TO CONDUCT RESEARCH

House Number 103

Matsulu C, Mbombela

P O Box 1103, Malelane, 1320

16 October 2019

The COUNSILLOR

Mbombela

Ref: APPLICATION TO CONDUCT RESEARCH IN HOUSEHOLDS WITH PARENTS

Dear Sir/ madam

Adolescence is a period when most adolescents engage in all sorts of sexual behaviour, most of which are risky resulting in teen pregnancies, HIV and other sexually transmitted infections. Hence, turning the tide against these consequences will require more concentrated focus on adolescents' promotion of responsible sexual behaviour.

In view of this, I Pricilla Mudzana, the Doctoral student in Nursing Science at the University of South Africa, request to carry out a study on strategies to promote responsible sexual behaviour among school-going adolescents in households in your jurisdiction. I would like to seek the approval of your office to conduct a cross-sectional study parents in academic year 2019-2020. Face to face interviews will be conducted.

This is in partial fulfilment of the requirement for the Doctoral degree in Nursing Science. Rest assured that any information given by participants are treated confidentially. I look forward to hearing from you soon. Thank you,

Yours sincerely

Pricilla Shupikayi Mudzana

ANNEXURE B: MPUMALANGA DEPARTMENT OF EDUCATION PERMISSION

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Indwe Building, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo Departement van Gesondheid UmNyango WezeMaphilo

Enq: 013 766 3766/3511
Ref: MP_201812_001

Provincial Research Approval Letter

TO: **Ms Pricilla Mudzana**
P.O Box 1104
Malelane
Malelane
1201

TITLE: STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL GOING ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA

The provincial health research committee has approved your research proposal in the latest format you sent.

- Approval Reference Number: MP_201812_001
- Data Collection Period: February 2019 – March 2020
- Approved Data Collection Facilities:

Kaapmuiden Clinic	Matsulu Clinic	Nkwalini Clinic

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with a soft or hard copy of the report once your research project has been completed.

Kind regards

MR. JERRY SIGUDLA
MPUMALANGA PHRC

MPUMALANGA PROVINCE
DEPARTMENT OF HEALTH
01 -02- 2019
PRIVATE BAG X11285
NELSPRUIT 1200

01/02/2019
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE C: MPUMALANGA DEPARTMENT OF HEALTH PERMISSION

health
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

MPUMALANGA
THE PLACE OF THE RISING SUN

No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo | Departement van Gesondheid | UmNyango WezeMaphilo

Letter of Support Signed by Chief Director (CD)/CEO/District Manager (DM)/Programme Manager (PM)

1. Name & contact no. of Applicant	MUDZANA PRICILLA SHUPIKATI 071 880 2553		
2. Title of Study:	STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA		
3. Aim and population target:	The study is aimed at developing strategies that will help promote responsible sexual behaviour among adolesce		
4. Period to undertake the study	**From:** 2018	**to:** 2022	
5. Resources Required from Facility/Sub-district/Community			
5.1: Facility Staff Required to assist with the Study	**Yes** ✓ **How many:** Nurses: 15 Doctors: 3 Other, please specify:		**NO**
5.2: Patient Records/Files	**Yes**		**NO** X
5.3: Interviewing Patient at Facilities	**Yes** ✓		**NO**
5.4: Interviewing Patients at Home	**Yes** ✓		**NO**
5.5: Resource Flow (Are there benefits to Patients/community)	**Yes** ✓ Please list: Reduction in risky sexual behaviour, Reduced unintended pregnancies, STIs, HIV		**NO**
5.6: Resource Flow (Are there benefits to Facility/District)	**Yes** Reduced burden of diseases Please list: Improved quality care, less work overload		**NO**
6. Availability of Required Clearance			
6.1: Ethical Clearance	**Yes** ✓ HSHDS/830/2018 Clearance Number: REC 012714-039 (AHREC)	**Pending**	**NO**
6.2: Clinical Trial	**Yes** Clearance Number:	**Pending**	**NO** X
6.3: Vaccine Trial	**Yes** Clearance Number:	**Pending**	**NO** X
6.4: Budget	**Yes** YES Source of fund: DOCTORAL NSFAS BURSARY		**NO**

Declaration by Applicant:
I Mr/Ms/Dr/Prof/Adv. Pricilla Shupikayi Mudzana agree to submit/present the result of this study back to the CEO/Institution/District.

Comment by CEO/CD/DM/PM: Support the ~~implementation~~ of the Study. The results to be shared ~~to~~ DOH.

Supported / Not Supported

MPUMALANGA PROVINCIAL GOVERNMENT
EHLANZENI DISTRICT OFFICE
66 ANDERSON STREET NELSPRUIT 1200
Date Received: 2018 -10- 16
DISTRICT MANAGER'S OFFICE
DEPARTMENT OF HEALTH

Signature of CEO/CD/DM/PM
Name: D MDLULI

Stamp/Date:

Please email completed form to: JerryS@mpuhealth.gov.za or ThembaM@mpuhealth.gov.za

MPUMALANGA
THE PLACE OF THE RISING SUN

education
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Building No 5, Government Boulevard, Riverside Park, Mpumalanga Province
Private Bag X11341 Mbombela, 1200
Tel 013 766 5552/5115, Toll Free Line 0800 203 116

Litiko le Temfundvo Umnyango we Fundo Departement van Onderwys Ndzawulo ya Dyondzo

Pricilla Shupikayi Mudzana
House Number 103, Matsulu
PO Box 1103
Malelane, 1320
Email: pmudzana@gmail.com
Cell: 078 033 8863

RE: APPLICATION TO CONDUCT RESEARCH: PRICILLA SHUPIKAYI MUDZANA

Your application to conduct research study was received and is therefore acknowledged. The tittle of your research project reads: **"Strategies to promote responsible sexual behaviours among school going adolescents"**. I trust that the aims and the objectives of the study will benefit the whole department especially the beneficiaries. Your request is approved subject to you observing the provisions of the departmental research policy which is available in the department website. You are requested to adhere to your university's research ethics as spelt out in your research ethics.

In terms of the research policy, data or any research activity can be conducted after school hours as per appointment with affected participants. You are also requested to share your findings with the relevant sections of the department so that we may consider implementing your findings if that will be in the best interest of the department. To this effect, your final approved research report (both soft and hard copy) should be submitted to the department so that your recommendations could be implemented. You may be required to prepare a presentation and present at the departments' annual research dialogue.

For more information kindly liaise with the department's research unit @ 013 766 5476/5148 0r a.baloyi@education.mpu.gov.za

The department wishes you well in this important project and pledges to give you the necessary support you may need.

MRS MOC MHLABANE
HEAD: EDUCATION

24/9/18
DATE

MPUMALANGA
THE PLACE OF THE RISING SUN

ANNEXURE D: UNISA ETHICAL CLEARANCE LETTER

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

7 February 2018

Dear Priscilla Shupikayi Mudzana

Decision: Ethics Approval

HSHDC/830/2018

Priscilla Shupikayi Mudzana

Student No.4535-739-0
Supervisor: Dr FH Mfidi
Qualification: D Litt et Phil
Joint Supervisor: -

Name: Priscilla Shupikayi Mudzana

Proposal: Strategies to promote responsible sexual behaviour among adolescents of Mpumalanga Province, South Africa

Qualification: **DPCHS04**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 7 February 2018 to 7 February 2023.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on7 February 2018.

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

RECEIVED
2018 -02- 14
Executive Dean
College of Human Sciences

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Open Rubric

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

pp

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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ANNEXURE E: COUNCILLOR'S PERMISSION LETTER

Civic Centre
1 Nel Street
Mbombela 1201
Republic of South Africa

CITY OF MBOMBELA
THE ULTIMATE DESTINATION

P O Box 45
Mbombela 1200
Republic of South Africa
Tel: +27 (0) 13 759-9111
Fax: +27 (0) 13 759-2070

Your ref: ward 28
Enq : Clr Sabelo Masuku ☎082 755 4252
Ref :

Date : 06 February 2019

CONFIRMATION LETTER

To Whom It May Concern

The matter in the above regard refers.

I S. R. Masuku in my capacity as ward Councilor within the boundaries of ward 28, hereby confirm that I give permission to Ms Priscilla Mudzana passport number EN 546223 to conduct a research in my ward covering the following:

- School households
- Clinics
- NGO's in Matsulu dealing with adolescents

She will be conducting the research from 02/02/ 2019 to 02/02/2023.

Trust you find this in order.

Yours faithfully

CLR SR MASUKU
WARD COUNCILOR 28
S.R Masuku

ANNEXURE F: CONSENT FORM

CONSENT FORM OVER 18 YEARS. Doc

My name is Pricilla Mudzana and I am a doctoral student at the University of South Africa, Department of health studies. I am inviting you to participate in the research titled "***Strategies to promote responsible sexual behaviour among adolescents in Mpumalanga Province of South Africa***". I am conducting the study in order to gain understanding into the knowledge, practices and attitudes of adolescents regarding sexuality and to explore challenges that they encounter in ensuring responsible sexual behaviours. The reason behind being to design strategies that would assist adolescents to practice responsible sexual behaviours. You are therefore recruited to participate in the study because we regard you as a valuable source of this information.

Should you agree to participate, you will be requested to complete a questionnaire with questions based on your own experience or view. They don't require any prior preparation. You will not take more than one hour to complete the questionnaire. Thereafter you will again be invited to join group discussions on the study topic with other fellow students. These will be audio tapped as per your permission.

The information you will share with the researcher will be kept confidential as much as possible. Your name or address is not required. The completed questionnaires will be locked away by the researcher for a period of three years. No individual names or identity will be used in the report. Should an article be written about this research project, your identity will be protected to the maximum extent possible. There are no known risks associated with your participation in this research. However, you have the right to refuse to answer any question that makes you feel uncomfortable. Should you feel very uncomfortable, you or the researcher will excuse you from participating and a debriefing session and/or referral for further counselling will be arranged for you in the nearby health care centre.

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide not to participate in the research and you will not be penalized or lose any benefits which you otherwise qualify for. This research will not have any monetary benefit to you as a participant. However, your views and experiences will assist the researcher to develop strategies that will promote responsible sexual behaviours among adolescents and thus improve adolescent reproductive health. Your participation will contribute to the learning process of the researcher

This research has been approved by the Department of Health Studies' Ethics Committees, University of South Africa. If you have any questions about the study itself, please contact me (Priscilla Mudzana) on telephone: 0718802553 or Email: pmudzana@gmail.com OR Dr FH Mfidi, the Research Supervisor on Tel number: 012 429 6731 or email: mfidifh@unisa.ac.za. Thank you for taking time to read this information sheet please sign the consent form below.

I ..... voluntarily consent to participate in the above mentioned research project. The background, purpose, risks and benefits of the study have

been explained to me. I also understand that I may withdraw from the study at any time without consequences. I understand that my participation in the study will be acknowledged, although my identity and the identity of health facility will be withheld.I agree to be audiotaped during my participation in this study. I understand that my participation in the study is voluntary…….

……..Participants' signature ….....Date ……..

INFORMED CONSENT FORM FOR PARENTS AND GUARDIANS OF ADOLESCENTS.

My name is Pricilla Mudzana and I am a doctoral student in Nursing Science at University of South Africa. I am inviting your child to participate in the research titled **"STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG ADOLESCENTS OF MPUMALANGA PROVINCE".** I assure you that your child will be as comfortable as possible and all information shared will be treated as strictly confidential. The purpose of the study is to explore adolescents' sexual behaviour, attitudes, and challenges they face so that effective strategies to promote sexual behaviour will be developed.

The child will be required to complete the questionnaire, which will not take more than one hour. Your child will again be invited to partake in focus group discussions with other children on the research topic as a follow-up and these discussions will be audio recorded. Your child has been selected to participate because he/she is an adolescent between 15 and 19 years and may provide important information about the intended study.

Participation of your child in this study is entirely voluntary. You or your child can withdraw consent at any time without penalty and your child will be removed from the study and his/her research records will be destroyed. The researcher may stop the study or take your child out of the study at any time they can judge that it is in the best interest of your child for example when the child experiences excessive discomfort due to participation.

The questions which will be asked will be structured and unstructured in nature, they will allow the participants to express views fully and freely. Due to the sensitive nature of the topic, the child may feel uncomfortable with the questions asked, may be embarrassed or suffer emotional discomfort. In such cases, de-briefing and/or referral for further counselling in the local primary health care will be done. No real names will be published with the results and only code names will be used, therefore no one will link the findings to the participant. All personal information will be locked away and a password will be needed to access personal information on the computer. Confidentiality will be maintained by not releasing any identifiable form of information without prior consent of child and parent or guardian. By participating in the research, your child's views and experiences will assist the researcher in developing strategies that will promote responsible sexual behaviour among adolescents. Thus contributing to reduction of the problems of teen pregnancy, sexual transmitted infections including HIV/AIDS in adolescents.

The researcher will answer any further questions about the research, now or during the course of the study and can be reached by phone at 0718802553 or email at pmudzana@gmail.com. For more information contact, kindly contact my supervisor, Dr FH Mfidi, Contact detail: mfidifh@unisa.ac.za; or 012 429 6731. Thank you for taking time to read this information sheet please sign the consent form below.

INFORMED PARENTAL CONSENT

I confirm that the person asking my consent to take part in this study told me about the nature, process, risk, discomforts and benefits of the study. I have also received, read and understood the above written information regarding the study. I am aware that the results of the study, including personal details will be anonymously processed into research reports. I am allowing my child to participate willingly. I have had time to ask questions and have no objections to his/her participation in the study. I understand that there is no penalty should I wish she/he discontinue with the study and my withdrawal will not affect him/her in any way.

Parent's/ Guardian name..... (Please print)

Parents/ Guardian Signature.....Date.....

Investigator's name..... SIGNATURE……..DATE…….

Witness signature.....Date.....

ASSENT CONSENT/ CONSENT TO PARTICIPATE IN RESEARCH FOR MINOR ADOLESCENTS

TITLE OF THE STUDY: STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG ADOLESCENTS IN MPUMALANGA PROVINCE OF SOUTH AFRICA

You are being asked to take part in a research study about promotion of responsible sexual behaviour in adolescents. You are asked to participate in this research because you are in the age group 15 to 19 years and you live in the proposed township. You may be able to give us your views we can develop strategies that promote responsible sexual behaviour.

If you take part in this study you will be one of the participants at this school participating in this study. The person carrying out this study is Pricilla Mudzana under the supervision of Doctor FH Mfidi.

The purpose of this research is to explore the sexual behaviour of teenagers so that we develop strategies which promote responsible sexual behaviour. These strategies will hopefully help teenagers to prevent pregnancies, and sexually transmitted infections. The study will take place at the school you attend and you will be asked to participate in a series of sessions in academic years 2019 to 2020. Each questionnaire will take at most 30minutes of your time.

If it happens that you will be chosen for follow up interview session, it will take at most 20minutes of your time. You will be asked questions on a one to one session in a comfortable environment. You are asked to respond to the questions freely and honestly. If you feel that you do not want to speak about the question, you have the right not to or to end the interview. You are asked to give honest responses. The conversation will be tape recorded and if you do not want to be recorded, you will not be able to participate in the study.

To the best of researcher's knowledge, your participation will not harm you. However, you may experience embarrassment, fear, anger or any other psychological discomfort while participating. You may find some of the questions uncomfortable, upsetting, hurtful or bad that the researcher does not know at this moment, you are allowed to say so.

The expected benefits of this to you may be a sense of achievement in contributing to solutions that will promote responsible sexual behaviour and that suits adolescents' needs. The researcher cannot promise you that you will receive these benefits from taking part in this study. However, the community at large will benefit from your participation in this study.

You are not forced to participate in this study, you have an alternative not to participate in this study. You should talk first with your parents or guardians and others about taking part in the study and taking part in the study is your decision. You should take part in this study because you want to.

Your information will be added to the information from other participants so no one will know who you are. We will take steps like locking personal information and records in a cabinet and computer used needing password to access the system.

If you decide to take part in the research, you still have the right to change your mind later. No one will think badly of you if you decide to stop participating. On the other hand, the researcher may need you to stop participating. If this happens, you will be told when to stop and why.

You can ask questions about this study at any time, however you are strictly asked not to discuss anything with anyone except with the researcher in order to maintain the confidentiality of the study.

I understand what the researcher conducting this study is asking me to do and I have thought about this. I agree to take part in this study

Name of person agreeing to part in the study **Date ……..**
Signature **Date……**
Name of person providing information **Date**
Signature **Date**

ANNEXURE G: INTERVIEW SCHEDULES AND INFORMATINO SHEET

45357390 MUDZANA INTERVIEW SCHEDULE (FOCUS GROUP DISCUSSIONS WITH

ADOLESCENTS)

1. Introduce Study and read contents of the information sheet to discussants.
2. Outline what study is about.
3. Share Primary aim and Objectives.
4. Re-assure participants that their identity will be protected & confidentiality will be maintained.
5. Re-iterate that responses will be audio recorded and anonymity will be ensured for all. Provide guidance on how to speak audibly to ensure that responses are clearly recorded and general group etiquette.
6. Advise participants that my role will be as a passive facilitator.
7. Facilitators will be asking open questions but discussion will occur between discussants
8. Discussions will not last longer than 1hr.

School-aged adolescents are persons in, the age group 15-19 years, which is highly sexually active. What is your understanding of responsible sexual behaviour among adolescents?

What are the challenges you encounter to achieve responsible sexual behaviour? Probing: So in other words, do you just give him (sex) so that you maintain the relationship? After sex, then what? What is this, is it just sex explain deeper. Therefore, in other words, do you mean boys are abusing girls (by leaving them after having sex with them).

What do you think, what could be done to promote responsible sexual behaviour among adolescents? Probing: At what stage do you think school teaching about sexual related issues can start? Parents are saying adolescents as young as grade 7 are sexually active, what do you think? Oh, it (sex) starts mainly at Grade 10. Parents said that it is better to start as early as possible from grade 7, teaching sexual related issues, what is opinion?

To what extent, are parents playing their role in adolescent's life? What else can you say about this, what is the role of parents in this? Are they doing much in this case? Where did you learn about sexual related issues?

Who do you prefer to be your source of information for example, teachers or health professionals? If sexual and reproductive health education comes from schoolteachers rather health professionals, will this not be too much of a burden to department of education? Then the suggestion by adolescents is that Life orientation should be the main subject for teaching sexual related matters and taken seriously. Please, explain deeper.

45357390 MUDZANA FACE TO FACE INTERVIEWS FOR STAKEHOLDERS

INTERVIEW SCHEDULE FOR PARENTS

Interviewees were asked to consider/discuss the following broad topic areas:

What is the meaning of “responsible sexual behaviour” among adolescents in your community?

What role does the community/family/parents play in sexuality education?

What are the societal/community beliefs, attitude with regard to responsible sexual behaviours among adolescents?

What challenges prevail in ensuring that responsible sexual behaviour is attained among adolescents?

What can be done to promote responsible sexual behaviour among adolescents in the community?

Follow-up probing and clarity-seeking questions used intermittently.

Researcher: What role does a parent play to promote sexuality education?

Follow-up probing and clarity-seeking questions will be used intermittently.

*45357390 MUDZANA INTERVIEW SCHEDULE FOR **TEACHERS***

1. What is your understanding of responsible sexual behaviour among adolescents?
2. What role is played by teachers in ensuring responsible sexual behaviour among adolescents
3. Adolescents are taught about sexuality and sexual behaviours in school. In your opinion how effective is this process/programme in achieving responsible sexual behaviour?
4. How can the school ensure that processes and programmes in place are effective for adolescents to achieve responsible sexual behaviour?

*45357390 MUDZANA INTERVIEW SCHEDULE FOR **HEALTH AND NGO PROFESSIONALS***

1. What is your understanding of responsible sexual behaviour among adolescents?
2. What are health professionals/NGOs doing to promote responsible sexual behaviour among adolescents?
3. What challenges are you facing in the promotion of responsible sexual behaviour among adolescents?
4. What are the challenges encountered by adolescents at health facilities to achieve responsible sexual behaviour?

ANNEXURE H: STATISTICIAN CERTIFICATE

School of Natural Sciences
Department of Mathematics and Computer Science

Off Great Zimbabwe Road
P. O. Box 1235
MASVINGO

Tel: +263 39 266645/60/63
Fax: 039 - 253504
Email: *tmakoni@gzu.ac.zw*
Statistics Coordinator
Cell: **+263773425518**

GREAT ZIMBABWE UNIVERSITY

21 October 2022

TO WHOM IT MAY CONCERN

Ref: Letter of acknowledging involvement in Statistical Data Analysis

This serves to confirm that, I Tendai Makoni have assisted **Pricilla Mudzana (45357390)** with Statistical Data Analysis services on her project. The Statistical Package for Social Sciences (SPSS) was used in the analysis.

I hold of a PhD in Statistics from the University of the Free State (UFS) and currently employed as a senior lecturer at Great Zimbabwe University, Zimbabwe.

For more information about my profile, please do not hesitate to contact me on my email tmakoni@gzu.ac.zw or +263773425518.

With kind regards,

Tendai Makoni (PhD)

ANNEXURE I: LANGUAGE EDITING CERTIFICATE

Between the lines editing

Leatitia Romero
Professional Copy Editor and Proofreader
(BA HONS)

Cell: 083 236 4536
leatitiaromero@gmail.com
www.betweenthelinesediting.co.za

26 January 2023

To whom it may concern:

I hereby confirm that I edited the thesis entitled: "STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE IN SOUTH AFRICA". Any amendments introduced by the author hereafter are not covered by this confirmation. Participants' verbatim quotes were not edited. The author ultimately decided whether to accept or decline any recommendations I made, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work. The author is responsible for ensuring the accuracy of the references and its consistency based on the department's style guidelines.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001) – Accredited Text Editor
SATI: South African Translators' Institute (1003002)
REASA: Research Ethics Committee Association of Southern Africa (104)

ANNEXURE J: SELF-ADMNISTERED QUESTIONNAIRE

Purpose of the Study
This study seeks to explore the knowledge, attitudes and sexual behaviours among school going adolescents in order to develop strategies that would promote responsible sexual behaviours. Through filling in this questionnaire you would contribute to a clearer picture of adolescent sexual behaviours that could be ameliorated through strategies for responsible sexual behaviours thus improving sexual health for young people.

Accuracy: You may feel that some questions are hard to answer. Other questions may even not apply to you at all. However, it is important that you answer all those questions that are relevant to you as honestly and accurately as possible. So please take your time and ask your interviewer for assistance if you need any.

Confidentiality: All your answers will be treated in strict confidence. They cannot be linked to any of your personal data like your name, your address, the school you attended, etc. You may feel that some questions are hard to answer; other questions may not even apply to you. However, it is important that you answer all questions that are relevant to you as honestly and accurately as possible. When giving answers where a No/ Yes answer is needed, just provide one answer because if you choose both of them the information will be of no use and it will be thrown away. If you are in doubt, choose the answer that your think is nearest to what you think.

If you have any questions, please contact, Pricilla Mudzana (Principal researcher) on 0718802553.

SECTION 1: SOCIOECONOMIC AND FAMILY CHARACTERISTICS

Use a ✓ in the appropriate box/answer.

1.1 SEX OF RESPONDENT	MALE FEMALE	☐ ☐
1.2 What day, month and year were you born?	Day ☐☐ Month ☐☐ ☐	☐
1.3 How old were you at your last birthday?	Years ☐ ☐	
1.4 What is the school grade are you attending?	Grade 10 Grade 11 Grade 12	☐ ☐ ☐
1.5 How important is religion in your life?	Very important ☐ Important ☐ Not important ☐	
1.6 Is your father alive?	Yes ☐ No ☐→	
1.7 Have you ever discussed sex-related matters with your father? If YES Often or occasionally?	Often ☐ Occasionally ☐ ☐	

1.8 What is your father's level of education	Never Primary school ☐ Secondary ☐ Tertiary ☐	
1.9 Is your mother alive?	Yes ☐ No ☐ →	
1.10 Have you ever discussed sex-related matters with your mother? If YES Often or occasionally? 1.11 What is your mother's level of education?	Often ☐ Occasionally ☐ Never ☐ Primary school ☐ Secondary ☐ Tertiary ☐	
1.12Do you have any older siblings?	Yes ☐ No ☐ →	
1.13 Did any of them had unplanned child during adolescents	Yes ☐ No ☐	
1.14 Do you ever go to clubs or parties? IF YES. How many times in the last month?	Number of times ☐☐ Never ☐	
1.15 Do you ever drink alcohol? IF YES. On how many days in the last seven days have you drink alcohol? 1.16Do you get too drunk when you drink alcohol 1.17Did you ever had casual sex whilst you were drunk	Number of days ☐☐ Never ☐ Yes ☐ No ☐ Yes a ☐ No ☐	
1.18 Do you use drugs? IF YES. How many times have you been drugged in the last 7 days?	Number of times ☐☐ Never ☐ Always ☐	

Section 2: INFORMATION/ KNOWLEDGE OF REPRODUCTIVE HEALTH

Now we would like to ask you some questions about how you learned about sexuality from various sources and about your own views on sexual relationships. Again, it is important that all questions are answered honestly and to the best of your knowledge. You can ask for assistance if you need any

Reproductive Health Information **(Write the number of the source of information in the appropriate column)** 2.1 Information with regard to **puberty**- that is how boys and girls bodies change during the teenage years 2.2 From whom, or where, would you prefer to have received **more** information about the above-mentioned topic? 2.3 Information on the **sexual and reproductive systems of men and women (such as** where eggs and sperm are made and how pregnancy occurs) 2.4 From whom, or where, would you prefer to have received **more** information about the above-mentioned topic? 2.5 Information on **relationships** (how boys should treat girls and vice versa) 2.6 From whom, or where, would you prefer to have received **more** information about the above-mentioned topic?	**Sources** 1. School teacher 2. Mother 3. Father 4. Brother 5. Sister 6. Other family members 7. Friends 8. Doctors 9. Books/magazines 10. Films/Videos 11. Other (Specify ……) **Most Important/preferred**			
2.7 Did you ever attend school classes on any of the ABOVE topics?	Yes No Not sure			
2.8 Do you think that there should be (more) classes on these topics, fewer classes or were the number about right?	More Less About right			
2.9 A woman can get pregnant on the very first time that she has sexual intercourse 2.10 A woman stops growing after she has had sexual intercourse for the first time 2.11 Masturbation causes serious damage to health 2.12 A woman is most likely to get pregnant if she has sexual intercourse half way between her periods	True	False	Do not know Not sure	

Section 3A: CURRENT/MOST RECENT PATTERNS OF SEXUAL BEHAVIOUR AMONG ADOLESCENTS

Now we would like you to answer the following questions about your own sexual experience and relationship. Again, it is important that all questions are answered honestly and to the best of your knowledge. You can ask for assistance if you need any.

3.1 Have you ever had a girl/ boyfriend? By girl/boyfriend, I mean someone to whom you were sexually or emotionally attracted and whom you 'dated'	Yes No ((IF NO, MOVE TO 3C →	
3.2 How many girl / boy-friends do you have?	Number ☐☐	
3.4 How old is she/he/are they	Age ☐☐ Specify if more than one partner……..	
3.5 How would you describe your relationship with your current partner (s)? is it ……	(a) Casual (b) Serious with no intention of marriage (c) Important/might lead to marriage (d) Engaged to be married (Specify if you have more than one partner) Partner 1…… Partner 2…… Partner 3 etc……	
3.6 The person (s) you are in a relationship with is he/she a full time student, working or neither?	Full time student Working Neither (Specify if you have more than one partner)……	
3.7 How many months or years are you in a relationship with the partner you are with?	Months ☐☐ or Years ☐☐	
3.8 Do you have any penetrative sexual intercourse?	Yes No	

3.B. FOLLOWING QUESTION ARE ONLY FOR THOSE WHO HAVE EXPERIENCED SEXUAL INTERCOURSE

3.9 Think back to the first time you had sex with your partner - Would you say you or your parter (a) I forced partner to have intercourse against her/his will (b) I persuaded partner to have intercourse (c) Partner persuaded me to have intercourse (d) partner forced me to have intercourse (e) We were both equally willing	(a) I forced (b) I persuaded (c) NAME persuaded (d) NAME forced e) Both willing	
3.10 And would you say it was planned or unexpected?	Planned1 Unexpected	
3.11 How old were you at the time you first had sex?	AGE ☐☐	
3.12 Did you regret having intercourse on that first time?	Yes, regretted No, not regretted	
3.13 On that first time did you or NAME do anything to avoid a pregnancy?	Yes No →	
3.14 What method did you use?	Condom Pill Injection Withdrawal Safe period Other……	
3.15 Did you ever discuss contraception with partner (s)? IF YES Did you discuss contraception before or after you first had intercourse?	Before first intercourse After first intercourse Never	
3.16 How many times did you and NAME have full intercourse? (*estimate*)	No. ☐☐☐ Once only →	
3.17 Apart from the first time, did you and partner ever use a method to avoid pregnancy? IF YES Always or sometimes?	Always Sometimes Never →	
3.18 What method do you and partner mostly use? (MULTIPE RESPONSES PERMITTED)	Condom Pill Injection Withdrawal → Safe period Other……	
3.19 Where did you or NAME get this method? (CIRCLE ONLY ONE)	Shop Pharmacy	

	Govt. Clinic/Health Centre/Hospital Private Doctor/Nurse/Clinic Friend Other…….. Don't know	
3.20 SEE Q. 3.31 Whose decision was it to use a method always/sometimes/never? Was it mainly your decision, partner's decision or a joint decision?	My decision Partner's decision Joint decision	
3.21 MALES: Did your partner ever become pregnant by you? FEMALES: Did you ever become pregnant for your partner?	Yes No →	
3.22 What happened to the pregnancy?	Currently pregnant Abortion Miscarriage Live-birth No sure	
3.23 Were you ever concerned that you might catch AIDS or another sexually transmitted disease (STD) from partner? IF YES Very concerned or somewhat concerned?	Very concerned1 Somewhat concerned Not concerned →	
3.24 Were you able to do anything to reduce the risk of STDs	Yes No →	
3.25 What did you do? *Probe*	Use condoms Take medicines Other (……..) → 3	
3.26 Some young people are forced to have sexual intercourse against their will by a stranger, a relative or an older person. Has this ever happened to you?	Yes No	→
3.27 How many different strangers, relatives or older persons have forced you to have sex against your will?	☐☐	
3.28 Would you say this has happened often, sometimes, or rarely?	Often Sometimes Rarely	
3.29 Some young people have 'one night stands' (*use local terms*), perhaps after a party or after drinking? Has this ever happened to you?	Yes No →	

3.30 How many 'one night stands' have you had?	No. ☐☐ Many	
3.31 Did you or the sexual partner do anything to avoid a pregnancy on these occasions of one night stands? IF YES Always or sometimes?	Always Sometimes Never	
3.32 Some adolescents pay money or gifts in exchange for sexual intercourse. Has this ever happened to you? 3.33 Some adolescents receive money or gifts in exchange for sexual intercourse. Has this ever happened to you?	Yes No → Yes No →	
3.34 How many women/men have you had sex with for money or gifts?	No. ☐☐	
3.35 Did you or the sexual partner do anything to avoid a pregancy occasions when you pay or receive money? IF YES Always or sometimes?	Always Sometimes Never	

3.C. THIS PAGE IS ONLY FOR THOSE WHO HAVE NEVER EXPERIENCED SEXUAL INTERCOURSE

People may have mixed reasons for not having intercourse. Please indicate for each reason whether it applies to you or not.	Applies	Not apply	Don't Know/ Not Sure	
3.36 I don't feel ready to have sex.				
3.37 I have not had the opportunity.				
3.38 I think that sex before marriage is wrong				
3.39 I am afraid of getting pregnant				
3.40 I am afraid of getting HIV/AIDS or another sexually transmitted infection.				

3.41 And now I have a question about your future plans about sexual intercourse. Which of these statement best describes your plans. READ OUT (a) I plan to wait until marriage (b) I plan to wait until I am engaged to be married (c) I plan to wait until I find someone I love (d) I plan to have sexual intercourse when an opportunity comes along	(a) Marriage (b) Engagement (c) Love (d) Opportunity	
3.42 Do you feel any pressure from others to have sexual intercourse? IF YES A great deal or a little?	A great deal A little None →	
3.43 From whom do you feel pressure? PROBE CIRCLE ALL THAT APPLY	Friends Relatives Work colleagues Partner/special friend Other …… ……	

SECTION 4: ATTITUDES TOWARDS RESPONSIBLE SEXUAL BEHAVIOUR

Finally, we would like to ask you about your own attitudes towards the given adolescent sexual behaviour below. Again, it is important that all questions are answered honestly and to the best of your knowledge. You can ask for assistance if you need any.

4.1 I believe it's all right for unmarried adolescent boys and girls to have dates	Agree Don't know/not sure Disagree	
4.2 I believe it's all right for adolescent boys and girls to kiss, hug and touch each other.	Agree Don't know/not sure Disagree	
4.3 I believe there is nothing wrong with unmarried adolescent boys and girls having sexual intercourse if they love each other.	Agree Don't know/not sure Disagree	
4.4 I think that sometimes a boy has to force a girl to have sex if he loves her.	Agree Don't know/not sure Disagree	

4.5	A boy will not respect a girl who agrees to have sex with him.	Agree Don't know/not sure Disagree	
4.6	A boy and a girl should have sex before they become engaged (USE LOCAL TERM) to see whether they are suited to each other.	Agree Don't know/not sure Disagree	
4.7	I believe that girls should remain virgins until they marry.	Agree Don't know/not sure Disagree	
4.8	I believe that boys should remain virgins until they marry.	Agree Don't know/not sure Disagree	

4.9	I think that one-night stands are OK.	Agree Don't know/not sure Disagree	
4.10	It's all right for boys and girls to have sex with each other provided that they use methods to stop pregnancy.	Agree Don't know/not sure Disagree	
4.11	I am confident that I can insist on condom use every time I have sex.	Agree Don't know/not sure Disagree	
4.12	I would <u>never</u> contemplate having an abortion my self or for my partner.	Agree Don't know/not sure Disagree	
4.13	It is mainly the woman's responsibility to ensure that contraception is used regularly.	Agree Don't know/not sure Disagree	
4.14	I think that you should be in love with someone before having sex with them.	Agree Don't know/not sure Disagree	
4.15	I would refuse to have sex with someone who is not prepared to use a condom.	Agree Don't know/not sure Disagree	

Section 5: Knowledge, Use and evaluation of sexual and reproductive health services

5.1 Have you ever visited a health facility or doctor of any kind to receive services or information on contraception, pregnancy, abortion or sexually transmitted dieases?	Yes No →	END
5.2 How many times have you sought services or information from a doctor or a nurse for these services in the last twelve months?	Number of times ☐☐ Did not seek care in last 12 months →	END
5.3 Thinking about your last visit, did you go to a government clinic, health centre or hospital or a private doctor or clinic?	Government Private Other……	
5.4 4When you last saw a doctor or a nurse, what was your reason for going?	Contraception STD Gynaecological exam Pregnancy test Pregnancy termination MCH Other……	
5.5 At this facility Did you see any posters on contraception?	YES NO	
5.6 Were you given brochures on contraception?		
5.7 Did you attend a talk on contraception?		
5.8 Did you request contraceptive services during the consultation?		
5.9 Did the doctor or nurse talk to you about: (a) Contraception? (b) Sexually transmitted diseases? (c) Pregnancy?	YES NO	
5.10Did you feel comfortable enough to ask questions?	→	5.12
5.11 Were the questions you asked during the consultation answered adequately?		
5.12 Was there enough confidentiality?		

(adapted and modified from the WHO Illustrative Questionnaire for interview-surveys with young people;

http://www.who.int/reproductivehealth/topics/adolescence/questionnaire.pdf

accessed 30/09/2017

Thank you again for your co-operation

If there is anything you would like to add or comment about the survey or the questions, you can do so in the space provided below

ANNEXURE K: CONFIDENTIALITY BINDING FORM

Confidentiality agreement

I, _____ hereby agree to maintain the confidentiality of information disclosed during focus group as follows:

1. I will hold in confidence any and all information disclosed during the discussions.
2. I understand that any ideas, developments, inventions conceived or suggestions contributed by others and myself during the discussion, shall be solely used for this research.
3. I shall at all times hold in trust, keep confidential and not disclose to any third party or make any use of the confidential information beyond the Focus Group.
4. I shall at all times hold in trust, keep confidential and not disclose to any third party or make any use of personally identifiable information of any participant involved in the Focus Group.
5. I acknowledge that I will not be compensated for my participation in this Focus Group and that all information and opinions I provide are solely my own and are in no way reflective of my employer or institution whatsoever.
6. I hereby give permission to the researcher for an audio recording to be made of this session.
7. I understand transcription of the taped recordings will be used by the researcher for research purposes only.
8. I understand that because of this study there could be violations of my privacy. To prevent violations of my own or others' privacy, I have been asked not to talk about any of my own or other private experiences that I would consider too personal or revealing.
9. I also understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
10. I understand that all information I give will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher and the University of study.

By submitting this form I will be entering a Non-Disclosure agreement with the researcher.

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Participant Signature_____

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STRATEGIES TO PROMOTE RESPONSIBLE SEXUAL BEHAVIOUR AMONG SCHOOL-GOING ADOLESCENTS IN MPUMALANGA PROVINCE IN SOUTH AFRICA

By

PRICILLA SHUPIKAYI MUDZANA

Submitted in accordance with the requirements

for the degree of

PhD in Nursing

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR F.H. MFIDI

January 2023

ANNEXURE M: TURNITIN REPORT

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