FACTORS CONTRIBUTING TO UNSAFE SEX AMONG TEENAGERS IN THE SECONDARY SCHOOLS OF BOTSWANA

By

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Dedication

To my parents, Mr and Mrs DB Mwinga and my children Malala and Mainza for their unwavering support throughout the study.

Student number: 3676 – 474 – 4

DECLARATION

I declare that the study on FACTORS CONTRIBUTING TO UNSAFE SEX PRACTICES AMONG TEENAGERS IN THE SECONDARY SCHOOLS OF BOTSWANA, is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

…….. ……..

SIGNATURE DATE

Ms A M MWINGA

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FACTORS CONTRIBUTING TO UNSAFE SEX PRACTICES AMONG TEENAGERS IN THE SECONDARY SCHOOLS OF BOTSWANA.

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Abstract

Correct and consistent condom use is an effective strategy for the reduction of adolescent pregnancy and sexually transmitted diseases. The purpose of this study was to describe the factors that contribute to unsafe sex practices among adolescents and to compare male and female sexual practices. Quantitative, descriptive research, namely a survey was conducted to determine these practices. Convenience sampling was used to select a sample (n=324) of respondents who were willing to participate in the study. Data were collected by using a self-administered structured questionnaire.

The findings of the study revealed that adolescents indulged in unsafe sex practices for various reasons including the desire for self-satisfaction and the non-availability of condoms at the time. Based on the identified reasons, it is clear that strategies had to be developed to curb unsafe sex and its consequences. Formulating these strategies requires the concerted effort of all policy makers and stakeholders.

Key concepts

Adolescent, unsafe / unprotected sex, factors, teenage pregnancy.

TABLE OF CONTENTS

List of tables **Page**

List of figures **Page**

List of abbreviations

ABC	Abstinence, being faithful and condom use
AIDS	Acquired Immune deficiency syndrome
ARV	Antiretroviral
ASRH	Adolescent sexual and reproductive health
FP	Family planning
HIV	Human Immuno-deficiency virus
IEC	Information, education and counselling
MCH	Maternal/child health
MDG	Millennium development goals
PMTCT	Prevention of mother to child transmission
SADC	Southern African Development Community
SRH	Sexual reproductive health
STI	Sexually transmitted infection
VCT	Voluntary counselling and testing
UNISA	University of South Africa
UNFP	United Nations Population Fund
WHO	World Health Organisation

List of annexure

CHAPTER 1

INTRODUCTION AND BACKGROUND INFORMATION ABOUT THE STUDY

1.1 INTRODUCTION

Botswana is a landlocked country in the Southern Africa Development Community (SADC) region, with a total land area of 582 000 square kilometres (Botswana 2006:9). The population of Botswana is estimated at 2 038 million people, that is one of the smallest populations in Africa (Botswana, 2011:1). Over the past 40 years, this country has been one of the fastest growing economies in Africa due to sound macroeconomic policies and good governance. It has acquired upper middle-income status under its National Development Plan 9 of 2003 to 2009 (Botswana 2008 (a):153).

However, Botswana's economic gains are unfortunately being lost to the human immunodeficiency virus (HIV) pandemic. The country has one of the highest HIV infection prevalence rates (17.6%) as a consequence of unsafe /unprotected sex practices (Botswana 2008 (a):1). In 2007, new HIV infections in sub-Saharan Africa among young people aged between 15 and 24 accounted for 40% (Leclerc-Madlala. 2008:S18). Unsafe/unprotected sex with its consequences is a worldwide problem that affects adults as well as adolescents, as evidenced by adolescent pregnancy and sexually transmitted infections.

This study looked into factors that contributed to unsafe/unprotected sex among adolescents and was conducted in Molepolole, in Botswana.

1.2 BACKGROUND TO THE STUDY

Molepolole is one of the large villages in Botswana and is situated in the Kweneng - East district. According to the 2011 preliminary census results, Kweneng - East district has a population of 256 833 people. This district lies 50 kilometres to the west of Gaborone, the capital city of Botswana. Molepolole has

one senior secondary school and eight junior secondary schools as well as two privately owned secondary schools.

1.2.1 Secondary education system

The maximum age at entry to form 1(grade 8) is 19 years and all pupils seeking admission should have passed the national examination equivalent to standard 7 (grade 7). Pupils attend the junior secondary school for three years, after which they have to write form three (grade 10) examinations. The maximum age at entry to form four (grade 11) is 22 years. Girl pupils who drop out of school due to a pregnancy may be readmitted to any school six months after delivery of the baby. They have to produce a testimonial from the previous school, a birth certificate of the baby, and proof of their age upon readmission. Pupils who drop out due to desertion or illness may be readmitted if they are able to submit a testimonial from the previous school and proof of their age. Pupils who left school due to illness have to produce a medical fitness statement. (Botswana Secondary education)

Botswana is signatory to the development goals of the Millennium Declaration of 2000. These goals correspond with the Botswana government's policy on gender equality and empowerment (Botswana Millennium Development Goals Status report 2004:37).

1.2.2 Adolescence and sexual behaviour

Adolescence, between 13 and 19 years, is marked by the maturation of physical and psychological characteristics. During this period of transition from childhood to adulthood, physical maturity precedes psychological and social maturity. Adolescents consequently begin to indulge in risky sexual behaviour, often with adverse consequences for the individual as well as the family and the community (Botswana 2003(a):7).

Adolescents in Angola, for example, consider premarital sex the norm. Freitas (2007:160) reports that most adolescents believed that premarital sex was acceptable when the couple was in love or engaged.

Empirical evidence indicates that sexually active young people in Botswana experienced their first sexual encounter at the average age of 17 years. Most (90%) of the girls between 10 to 14 years stated that their first sexual experience was unplanned where as 50% of the boys indicated that they had planned the sex was in advance. More than 50% of older girls between 15 and 24years stated that their first sexual experience had been unplanned. Condom use at first intercourse was observed to be higher as the level of education increased. Unfortunately 50% of all sexually active teenage girls became pregnant. This figure was generally attributed to significant peer pressure to engage in sex (Botswana 2001(a):14-15).

Adolescent pregnancy is a major problem in Botswana and responsible for a large number of school drop-outs annually. The number of female adolescents who attended antenatal clinics to register their pregnancies is indicated in table 1.1 below. Please note, however, that although girls younger than 15 years become pregnant, this table only reflects the pregnancies of girls from 15 to 19 years old.

Table 1.1 Attendance of antenatal clinics of adolescent girls aged 15-19 years in all districts of Botswana

	2003	**2005**	**2006**
First visit to Antenatal clinic	7 932	7 830	10 757

Source: Botswana Health Statistics Reports of 2003, 2005 and 2006

Table 1.1 shows an increase of 2 825 in the number of pregnant adolescent girls who attended an antenatal clinic between 2003 and 2006.

The problem of adolescent pregnancy also exists in Kweneng - East District where the study was conducted. Table 1.2 reflects the number of adolescent pregnancies in 2008 and 2009.

Table 1.2 Attendance of antenatal clinic of adolescent girls aged 15-19 years in the Kweneng district of Botswana

Teenage pregnancy	**2008**	**2009**
Number of women attending ANC	4 485	4 658
Number of girls younger than 20 years	634	614
Percentage of teenage pregnancy	14,10	13,18

Source: Kweneng East District Health Profile

The table above shows a slight decrease in the number of adolescent pregnancies from 2008 to 2009. Nonetheless, the challenge remains as teenage mothers have to leave school and thus lose the opportunities to complete their education and to ensure a better future for themselves and their children.

1.2.3 National sexual and reproductive health

Since diagnosis of the first case of acquired immunodeficiency syndrome (Aids) in Botswana in 1985, the government has introduced programmes that address prevention of new infections and others to mitigate the impact of HIV/Aids on the country. The programmes include: Prevention of Mother to Child Transmission (PMTCT), routine HIV testing and the Antiretroviral (ARV) programme (Botswana

2006: 11). These programmes disseminate information that empowers citizens and residents to make informed choices and decisions regarding their sexual behaviour and to take appropriate measures when they have contracted HIV.

Botswana declared HIV/Aids a national emergency and developed a National Strategic Framework for HIV/Aids, 2003-2009. Within this framework, a strategic management approach to HIV/Aids was adopted. It calls for a national response that involves the management of all essential elements and complexities of the infection. Goals of this Strategic Framework include:

- Prevention of HIV infection;
- Provision of care and support;
- Effective management of the National Response to HIV and Aids

(Botswana 2003-2009:8-11).

In line with the above goals, the government of Botswana identified the following avenues to managing the spread of HIV infection:

- *Voluntary Counselling and Testing (VCT)*. The government encourages the population to establish their HIV status through VCT as it forms the basis of the national response to the pandemic;
- *Community Mobilisation and Empowerment*. For the National Response to HIV and Aids to be realised, the government considered it prudent for citizens to take ownership of their condition. This means that communities need to be made aware of the existence of the pandemic and which measures are being taken to redress the situation. Citizens should also appreciate that it is their right and responsibility to be included in this national response;
- *Behaviour Change*. The national response focuses on prevention. People's behaviour and social relations should be so that their actions help to prevent the spread of the infection (Botswana 2003-2009:31-32).

1.2.4 Adolescent sexual and reproductive Health

Botswana has a young population between the ages of 10 and 24 of about 38% of the total population. The sexual and reproductive health of adolescents has been neglected in the past as this group was not included under the national Maternal and Child Health/Family Planning (MCH/FP) Strategy. This fact significantly contributed to unsafe/unprotected sex and its consequences (e.g. adolescent parenting, sexually transmitted infections such as HIV, and interrupted formal education). It is against this background that the Botswana government decided to introduce a new approach to adolescent sexual and reproductive health (ASRH) to address the situation (Botswana 2003(a):5).

The government of Botswana also decided to change its MCH/FP approach to a sexual and reproductive health (SRH) approach. The MCH/FP approach concentrated mainly on child-bearing women, where as the new approach was expected to be all-encompassing. The SRH approach respects the rights and needs of individuals and couples with respect to their sexuality and reproduction. With access to quality SRH services, adolescents would be equipped with information and education that will enable them to change their sexual behaviour (Botswana 2002:13).

Note that the Botswana government developed its Adolescent Sexual and Reproductive Health Implementation Strategy in 2003 to improve existing services. The objectives of this strategy were to provide sufficient knowledge for adolescents to change their sexual behaviour, to improve their reproductive health and to increase their utilisation of the available sexual and reproductive health (SRH) services (Botswana 2003(a):13). It aimed at delaying first sexual intercourse, improve voluntary counselling and testing, promote their use of family planning services, prevent sexually transmitted diseases (e.g. HIV infection), to limit adolescent pregnancies and to ensure early treatment of sexually transmitted infections (Botswana 2003(a):15).

Through the Ministry of Education, SRH education is provided from standard seven until form five, the twelfth grade of schooling in the school curricula. The Ministry of Education has incorporated adolescent sexual and reproductive health in primary, secondary and teacher training schools and the subject is examinable. Counselling and guidance departments have also been established at primary and secondary schools. These units assist teachers in teaching sexual and reproductive health topics (Botswana 2003(a):11).

Adolescent friendly services were introduced in Botswana as part of the ASRH approach. One of the objectives of the ASRH programme was to promote adolescent friendly sexual services and to increase the utilisation of SRH services. To attain this objective there was need to train existing staff in provision of adolescent friendly services, to establish adolescent corners in health facilities and to provide SRH services during hours suitable for adolescents, among other activities (Botswana 2002:39).

However in spite of the introduction of SRH services, unsafe/unprotected sex continues to be a problem and cases of pregnancy, STI and HIV continues to be a major challenge and cases of pregnancy, STI and HIV continue to be reported among adolescents.

1.2.5 Adolescence and pregnancy

The teenage birth rate in the United States of America for 2002 was reported as 53 births per 1 000 women aged 15 -19. In the United Kingdom teenage birth rate for 2006 was reported as 26.4 births per 1 000 women aged 15-19 and in South Asia, fertility rates range from 71 to 119 births per 1000 women aged 15-19.

Africa has the highest rate of teenage pregnancy in the world with 143 per 1 000 girls aged 15 - 19 years getting pregnant in sub - Saharan Africa. In Kenya, approximately 13 000 girls drop out of school annually due to pregnancy (United

Nations 2008). In Botswana, in the year 2003, there were 7 932 teenage pregnancies of the 44 412 total births. This gives a calculated teenage pregnancy rate of 178 per 1000 total births for that year (Botswana 2003(b):43). These are very high birth rates which perpetuate the problems of adolescent mothers, school drop outs as well as labour and delivery complications.

1.3 RESEARCH PROBLEM:

An enabling environment has been created in Botswana by the government where adolescents are provided with quality sexual and reproductive health services (Botswana 2003(a):13). Health care workers have been trained and services have been provided all over the country. Despite these efforts, adolescents continue to indulge in unsafe/unprotected sex practices leading to consequences of adolescent pregnancy and parenting, school drop-outs, STI and HIV infection.

It is against this background that the researcher found it necessary to investigate the factors contributing to unsafe/unprotected sex practices among the adolescents in the secondary schools of Molepolole.

1.4. PURPOSE OF THE STUDY

The purpose of the study was to investigate factors that contribute to unsafe/unprotected sex practices among adolescents in the secondary schools of Molepolole.

1.5 OBJECTIVES

Objectives of the study were to:

- investigate the factors contributing to unsafe/unprotected sexual practices among adolescents
- determine if there are differences between selected sex practices of male and female respondents

- make recommendations for planners and implementers of SRH services that can contribute to improve the SRH services.

1.6 SIGNIFICANCE OF THE STUDY

Attainment of safe sex practices among adolescents in secondary schools is critical in promoting adolescent health and subsequent attainment of educational goals.

The study is considered significant for the following reasons:

- Literature reviewed did not reveal any previous study on factors contributing to unsafe/unprotected sex among adolescents in Botswana;
- Attainment of safe sex practices among adolescents could help reduce the cases of adolescent pregnancy, STI and HIV infection, thereby promoting adolescents to achieve their educational goals;
- The study will provide information to health care providers that could be used in improving the already existing adolescent friendly safe sex programmes;
- Findings of the study will assist in coming up with recommendations for improving the Adolescent Sexual and Reproductive Health services in the village.

1.7 DEFINITION OF KEY CONCEPTS

For the purpose of this study, the following terms will apply:

Adolescent

A young person who has undergone puberty but has not reached full maturity (The American Heritage Medical Dictionary).

Adolescent in this study refers to male and female pupils aged between thirteen and nineteen and are attending a government day secondary school.

Teenager

A young person (male or female) aged between thirteen and nineteen years old (Webster's New World College Dictionary).

In this study teenager and adolescent will be used interchangeably.

Adolescent pregnancy

Pregnancy occurring in girls aged between thirteen and nineteen years old (Botswana 2003(a):8).

Adolescent parent

An adolescent who mothers or fathers a child during teenage (Botswana 2003(a): 9).

Unsafe/unprotected sex

Penetrative sex between a male and female, without the use of either a male or female condom during sexual intercourse.

Safe/protected sex

The practice of non-penetrative sex or penetrative sex using either the male or female condom.

1.8 SUMMARY RESEARCH DESIGN AND METHODOLOGY

In this section the research methodology is summarised – it will be elaborated on in chapter 3.

1.8.1 RESEARCH DESIGN

A quantitative, explorative and non-experimental descriptive design was adopted for the study because there was no need for control or manipulation of study elements. The researcher conducted a survey. According to Polit and Beck (2008: 274), this design enables the researcher to observe, describe and document various aspects of a phenomenon that occur naturally. This strategy

was used to solicit accurate information from respondents on what drives them to practice unsafe/unprotected sex.

1.8.2 POPULATION AND SAMPLE

The study population was drawn from the target population and included male and female secondary school going pupils aged between 13 and 19 years old in Molepolole village. Owing to the sensitivity of the research topic, a non-probability convenience sampling approach was used. The researcher went to the respective schools and invited pupils who were available and willing to complete the questionnaire (Polit and Beck (2008: 341).

1.8.3 DATA COLLECTION AND ANALYSIS

Data were collected using a structured questionnaire. Respondents filled in the questionnaires, after which the researcher collected them. MS Excel spreadsheets were used to analyse the data with the assistance of a statistician.

1.9 ETHICAL CONSIDERATIONS

Ethics refers to acceptable moral principles developed by individuals or groups which govern the conduct of research with regard to experimental subjects and respondents and all stakeholders of the research process. In carrying out a survey, it is the responsibility of the researcher to protect the respondents from harm and to provide them with adequate information about the investigation to enable them to withdraw from the investigation, if necessary (De Vos, Strydom, Fouche and Delport 2010:114 and 115).

Written permission to conduct the survey was sought and obtained from the Botswana Health Research Unit as well as UNISA. Since the study would be carried out in the Secondary schools, written permission was also sought and granted by the Regional Director of Kweneng Region. Copies of the letter providing information on objectives of the study and assuring respondents of

confidentiality of data and information to be requested from respondents were made and given to all the school head teachers prior to the study.

Respondents were provided with a participant information leaflet which provided them with information on objectives of the study and assuring respondents of confidentiality of data and information to be requested from respondents. On the basis of this information they could decide to fill in the questionnaire or decline.

1.10 SCOPE AND LIMITATIONS OF THE STUDY

The study took place in Molepolole village in the government secondary schools and excluded the private schools. The results cannot therefore be generalised to other villages or the country as a whole.

A non-probability convenience sampling method was used to select the respondents. The limitation of this method is that not everyone from the source population can be included in the study.

1.11 STRUCTURE OF THE STUDY REPORT

This report is divided into five (5) main chapters as follows:

Chapter 1

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

Chapter 2

In this chapter related literature on factors influencing adolescents to indulge in unsafe/ unprotected sex is reviewed.

Chapter 3

The research methodology used in the study, the research design, study population, sampling method, data collection method, validity and reliability of the tool used, ethical considerations and data analysis method are reviewed.

Chapter 4

The research findings are presented.

Chapter 5

Conclusions from the study, limitations of the study, as well as the recommendations are stated in this chapter.

1.12 CONCLUSION

This first chapter focussed on the introduction and background of the problem statement under investigation, purpose and objectives of the study. The significance of the study, research design and methodology were discussed. The next chapter is a review of the literature related to factors that influence adolescent unsafe/unprotected sex.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

According to Polit and Beck (2008:105), a literature review is necessary to enable the researcher get acquainted with the already existing knowledge base of their topic of study. Wood and Ross-Kerr (2006:51) state that relevant literature reviewed should be included to substantiate the background for the problem being researched.

Burns and Grove (2005:93, 94) state that literature review takes place throughout the study, from the beginning to the end of the research study. They cite the purposes of literature review in Quantitative research as:

- Refining and clarifying the problem;
- Acquiring essential information from existing studies and theories;
- Clarifying definitions and relationships of concepts;
- Developing a framework of study;
- Formulation of objectives, questions or hypotheses;
- Identifying limitations and assumptions for a study;
- Developing a stronger and more effective design;
- Developing of effective methods of measurement, data collection and analysis;
- Forming a basis for comparison during interpretation of findings.

Literature related to factors contributing to unsafe/unprotected sex among adolescents is reviewed in this chapter. Related research studies, journals, books and Internet sources were reviewed in order to get a wide picture of what other researchers had found out about factors contributing to unsafe/unprotected sex among high school adolescents. Elements of importance in the construction of the questionnaire were also looked at.

2.2 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH (ASRH)

Adolescents are neither children nor adults and during the period of transition from childhood to adulthood, seek to establish their identity. Adolescents are not children because their bodies are physically developing into adult bodies and they begin to socialise more with their peers and rely on information obtained from their peers as opposed to that provided by parents. This is done in an effort to gain independence from parents and acceptance by their peers.

During adolescence, there is physical and psychological growth and usually the former precedes the latter leading to uneven growth and social pitfalls among adolescents (Botswana 2003(b):7).

Educating the adolescents on matters of sex is one strategy being used to delay the adolescents' first sexual intercourse. This is an attempt to equip them with the right information needed to enable them make informed choices.

Studies generally support the premise that parent – adolescent communication about sex and related topics is effective in protecting adolescents from sexual risk behaviours. Adolescents who communicate with their mothers were found to be less sexually experienced, less likely to indulge in penile-vaginal sex and more likely to use condoms and contraceptive methods (Lyon and D'angelo 2006:148).

Lyon and D'angelo (2006:149) further state that communication between parents and adolescents serves the following purposes:

- Fosters honest discussion on sex which is then translated into action in the adolescents' dating relationships
- Information discussed shields the adolescents from vices like peer influence

- Adolescents become aware of what their parents consider acceptable /not acceptable sex behaviour and this knowledge helps delay sexual debut.

In Botswana, education on sexual and reproductive health is offered in all formal government schools. Counselling and Guidance departments have been established in an effort to provide reliable information on sexual and reproductive health issues. To ensure effective implementation of the Sexual and Reproductive Health strategy, stakeholders such as the teacher trainers and school head-teachers are sensitised on the need to improve efforts in the programme (Botswana 2002:34).

Efforts have been made in Botswana to make SRH services youth friendly. According to the WHO, this means that services should be accessible, acceptable and appropriate for adolescents. They should be in the right place at the right price (free where necessary) and delivered in the right and acceptable style to adolescents. The services should be effective, safe and affordable. In addition they should meet the young people's individual needs to enable them return for more services and recommend them to their friends (Botswana 2008(b):11.

2.3 FACTORS LIKELY TO INFLUENCE SEX IN ADOLESCENTS

Children are initially socialised in the home environment but as they begin to attend school, other people, like teachers and peers, begin to have an influence on them and their behaviours as well. Cooper and Guthrie (2007:30) allude to the fact that the Ecological approach to adolescent Health Behaviour asserts that development in adolescence is influenced by factors such as family, peer and neighbourhood characteristics. The Ecological approach refers to social interactions of children with their parents and peers (Dishion 2007:7). There are multiple factors that are likely to influence unsafe/unprotected sexual behaviour among adolescents and some of those factors are highlighted in the discussion to follow:

2.3.1 Gender

According to international research, gender has a definite influence on adolescent sexuality. Gender and power differentials in most societies disadvantage female adolescents. Male partners control all decisions pertaining to sexual relations thus predisposing female adolescents to risky sexual behaviour (Lyon and D'angelo 2006:151).

More males than females of school going age have sex. In a study conducted on adolescent sexual and reproductive health behaviour by Afenyadu and Goparaju (2003:10 and 14) in Dodowa, Ghana, it is reported that among in-school students 65% of males and 44% of females had ever had sex.

2.3.2 Priorities in sexual relations

Male adolescents advance different reasons from their female counterparts for indulging in sex. In a study conducted among Croatian adolescents, a relatively high number of the boys (44%) reported physical pleasure as a priority in sexual relations. Girls, on the other hand reported the importance of emotional pleasure (32%) or a combination of emotional and physical pleasure (32%) as priorities in sexual relations (Hamprecht, Hodzic and Warriner 2004:2).

In a study carried out among adolescents in Angola, girls stated that their main reason for engaging in sex was for love (Freitas 2007:154). Silva (2007:115) had similar findings in a study conducted in another part of the same country. The main reason female adolescents (76 respondents) advanced for having sex was love for the partner. Other reasons were that they (20 respondents) wanted to find out what sex was all about and 18 respondents stated that they had sex due to peer pressure.

2.3.3 Gender and contraception

In many cultures, young girls and women are expected to submit to the desires of their boyfriends and spouses on sex matters. They therefore lack the ability to

discuss contraception and to negotiate safe sex (Panday, Makiwane, Ranchod & Letsoalo 2009:12).

In the Croatian study referred to earlier, more boys than girls reported the use of condoms during their first sexual encounter (Hamprecht et al 2004:2). The reason for this could be that since the boys' priority for sex is physical pleasure, they seek sex from whoever will give it to them and so may have sex with strangers, thus see the need to use a condom. Girls in contrast, attach emotion to sexual intercourse and are likely to only have sex with a partner they have had a relationship with and trust and therefore are not likely to use a condom.

Unfortunately, although condom use was reported by over half of the adolescents for first sex, this practice is not sustained because condom use becomes increasingly erratic as relationships continue (Hamprecht et al 2004:2).

In a study done in Ghana, one-third (33%) of the sexually-active female adolescents and 13 percent of the sexually-active males indicated that they had had sex for a financial reward (Afenyadu and Goparaju 2003:10 & 14). Qualitative as well as quantitative data in the same study indicated that unsafe/unprotected sex was common. Among the 190 sexually active adolescent respondents, 41% did not use a condom. It was also indicated that female students were least likely to use condoms. The study also revealed that 19% of the sexually active female adolescents already had a child.

The perception and experiences of condom use among adolescents may also influence their decisions on whether or not to use condoms. Reasons advanced by participants for non-use of condoms included decreased feeling and pleasure during the sexual act in males and allergy (skin irritability) in females (Hammer and Banegas 2010:292).

Chaibva (2007:93 and 106) reports in a study of pregnant adolescents in Zimbabwe, that they expressed fear of their partners and were unable to negotiate with them to use the female condom. She also states that adolescent girls did not have adequate contraceptive knowledge and did not know where contraceptives could be obtained.

In Swaziland, generally regarded as a polygamous society, adolescent boys acknowledged the fact that men are the heads of families and as such the sole decision makers on contraception. The adolescents did not approve of modern family planning methods, stating that this is against their culture and caused side effects. The female adolescents were observed to shun boys who used condoms and such relationships could not be sustained. Unsafe / unprotected sex in this community is encouraged because if a boy impregnated a girl his social status would then be higher (Ziyane and Ehlers 2007:8-9).

In a study conducted in Kenya among high school male respondents, less than one third of the respondents stated that they always used condoms. The study also revealed that consistent condom users were more likely to have had their initial sexual experience at an older age and with a romantic partner. Adolescents in steady relationships anticipated sexual intercourse and were therefore more likely to have condoms readily available (Kabiru and Orpinas 2009:429).

The studies cited above indicate that unsafe/unprotected sex is a problem among adolescents. Most of them are aware of safe sex but in practice they engage in unsafe/unprotected sex for reasons such as lack of condoms at time of sexual intercourse, misconceptions about condoms and inability to refuse unsafe/unprotected sex in a long term relationship.

2.3.4 Age

In a study conducted in South Africa, it was found that more than a third of adolescents were sexually active and that sexual activity started early at an average age of 15 with multiple partners (Hartell 2005:177).

However, it seems as if gender also plays a role here, because Hammer and Banegas (2010:290) state that male adolescents initiated sexual relations earlier, at the average age of 15, while females started at the average age of 18. Young female adolescents who are subjected to early marriages, usually to older men, are also predisposed to unsafe/unprotected sex (Hinden and Fatusi 2009:58).

2.3.5 Social and cultural factors

The social set up, especially in African countries puts adolescents at risk. Adolescents in Angola consider premarital sex a norm. Freitas (2007: 160), reports that the majority of adolescents felt that premarital sex was acceptable in cases where a couple were in love or engaged. Silva (2007:113), in a study carried out in a different setting in Angola, had similar findings with those of Freitas.

In a study carried out in Zomba, Malawi, Mwale (2008:295) reports that boys and girls are exposed to cultural practices when they become adolescents. Under these practices the initiates are instructed to cleanse themselves by engaging in unprotected sex with experienced persons of the opposite sex. This practice exposes the adolescents to sexually transmitted infections since these experienced persons carry out the ritual every initiation season and has other adult partners.

In a study done in Vietnam adolescents felt obliged to submit themselves to the expectations of their society. For adolescent females the expectation was that by the age of 17 or 18 years they should be married. Any adolescent aged 19 was regarded as being ‘left on the shelf’ and was considered a ‘girl’ if not married.

She could therefore not be accorded the respect given to her married colleagues. The study also revealed that some of the adolescents married against their wishes and were expected to conceive in their first year of marriage (Klingberg, Binh, Johansson and Berggren 2008: 340 and 342).

Nkazana, is a cultural practice among the Kalanga ethnic group of Botswana, in which a new husband is authorised to ask for sexual favours from one of his wife's younger sisters. This younger sister may be a teenager and is officially introduced to the husband's family. According to the Kalanga ethnic group, this practice serves to safeguard the health of the new husband by deterring him from having sexual relations with other women outside the family (Ntesane 2004:4-5).

Unsafe sex is also perpetuated in Botswana because women lack power in negotiating sexual relationships and because of the cultural belief that single women should prove their fertility and cleanse their womb by having a child (Scott 2009:89).

Maundeni (2004:48) reports that according to the social norms of Botswana, males are expected to have multiple sexual partners. This expectation is conveyed in Setswana expressions for example that '*a man like an axe goes around cutting*' and that '*a man like a bull cannot be confined to the kraal*'. These expressions suggest that a man may go around looking for women and have sex with many, even if married.

Among the Basarwa (bush men) ethnic group of Botswana, it is expected of women to have sex with any man. Culture requires that men protect every woman from the hostile environment of wild animals in exchange for sexual favours. They leave a spear at the entrance to the woman's hut and the presence of the spear is a means of communicating to other men that the woman in the hut is protected and they should not disturb (Ntesane 2004:9).

2.3.6 Economic factors

Poverty is one factor that is regarded as fuelling the practice of unsafe/unprotected sex in Sub-Saharan Africa. Essex, Mboup, Kanki, Marlink and Tlou (2002: 518-519) state that, due to extreme levels of poverty in Africa, some parents persuade their female adolescents to engage in sex for money so that they can contribute to the family income. These adolescents are inexperienced and due to gender inequalities in African culture, do not have the necessary skills to negotiate for safer sex even when they are aware of the risks involved.

It has also been observed that economic barriers and poor performance in school are associated with young people dropping out of school early, predisposing them to increased risk of early pregnancy. This was also found to be true about children raised in informal and rural residential areas where poverty is entrenched (Panday et al 2009:12).

Leclerc-Madlala (2008) referred to Nkosana's unpublished PhD thesis. The findings in a study carried out in Botswana among Gaborone school girls were that 80% of the girls were motivated to engage in intergenerational partnerships for material gain. Others went into these relationships for fun that was associated with glamour and enjoyment of material goods. They also wanted to live a life that they perceived was commensurate with an urban setting and a status that their peers would envy.

2.3.7 Provider biases

Access to professional care is difficult for the adolescents because the environment at the health facilities is not adolescent-friendly and opening hours are not convenient. (Botswana 2003(b):8-9).

Importantly, health care providers sometimes have conflicting views between their professional responsibility and religious values, such that they fail to provide

services to the adolescents (Botswana 2008(b):12). Such attitudes deprive adolescents of safe sex services and predispose them to unsafe/unprotected sex practices.

Access to contraceptive services for adolescents in Swaziland is also a problem and service providers were observed to be unfriendly. Male adolescents reported that modern contraceptives were poorly distributed and thus not accessible. Service providers were observed to discuss only the use of the condom for contraception and did not mention the other methods. In some cases they refused to prescribe contraceptives for adolescents (Ziyane and Ehlers 2007:8).

2.3.8 Attitudes and practices of adolescents

The Ministry of Health in Botswana reported that most adolescents had heard about Acquired Immuno-deficiency Syndrome (AIDS) and methods of preventing pregnancy and sexually transmitted infections (STI). Adolescents further demonstrated that they had knowledge about condoms and where to obtain them. Despite this, 60-80% of adolescents thought it was not realistic to use a condom each time they had sex and believed that condoms made the sexual experience less enjoyable (Botswana 2001(a):3 and 8).

The Ministry of Health in Botswana, further reports that over a third of adolescents considered it impossible to refuse sex in a long-term relationship including unsafe/unprotected sex, even in instances where they feared that their partner might be having a STI. Moreover, more than half of the adolescents reported that their first sexual intercourse was not planned (Botswana 2001(a):10 and 14).

Mohtasham, Shamsaddin, Bazargan, Anosheravan, Elaheh and Fazlolah (2009:126-127) report that in a study conducted among male adolescents in Iran, a society which emphasises virginity until marriage, 23% of students rejected and 20% were uncertain about abstaining from sexual intercourse until marriage.

The same study revealed that adolescents from traditional families, whose mothers were unemployed or students who received lower daily allowances were more likely to practice abstinence.

Ntesane (2004:7-8) in a study conducted in Botswana, reports that it was culturally not acceptable to expect a man to use a condom during sexual intercourse. Women were expected to have children and therefore could not abstain from what is part of them. Besides, in marriage the two people are expected to be one in sickness and in health. Female youth were also socialised to believe that they could not contract HIV from a man of the Herero tribe. They therefore use condoms with men from the urban areas but enjoy real sex with Herero men who will not accept to use a condom.

Mwale (2008:296) states that there is some inconsistency between cultural practices and the attitudes and beliefs of adolescents in Malawi. In her study, 87% of the respondents indicated that they had an urge to abstain from sex but their sexual desires outweighed the urge to abstain. These studies show that much as the adolescents would like to abstain from sex until marriage, the concept of abstinence does not seem realistic and possible to them as they would rather give in to their feelings.

On the other hand, adolescents who have a positive attitude towards achieving their educational goals delay initiation of sexual intercourse. When they value being in school, attain good grades, aspire to complete high school and progress to college, adolescents, especially Whites, usually delay sexual debut (L'engle and Jackson 2008:372).

2.3.9 Alcohol abuse

A correlation between smoking, drugs and alcohol and unsafe/unprotected sex has been reported in some studies. Taylor, Dlamini, Kagoro, Jinabhai and de

Vries (2003) state that learners exposed to smoking and drinking are more likely to engage in risky sexual activities that place them at risk of HIV/AIDS infection.

Randy and Cougar (2009:374) also report that, the risk of having had sex with two or more partners was significant in adolescents who reported having experienced psychosocial distress and taking alcohol. Findings in another study also gave evidence of a correlation between alcohol and risky sexual activities. Any events of alcohol ingestion and any additional amount of alcohol taken thereafter were each associated with a greater likelihood of unprotected sex (Kiene, Barta, Teunnen and Armeli 2009:78).

2.3.10 Parent – adolescent relationships

Parent-adolescent relationships have been discussed briefly in section 2.2. Good relationships were found to influence adolescents' sexual activities positively. Nagamatsu, Saito and Sato (2008:605) report that open discussion by parents and their adolescents on issues of AIDS and monitoring of the female adolescents by the mother, delayed the first sexual experience in those adolescents. Cooper and Guthrie (2007: 38) also state that female adolescents with a close and supportive mother – daughter relationship are less likely to engage in substance abuse and risky sexual behaviours. Lyon and D'angelo (2006:148) state that frequent monitoring of adolescents by parents has also been found to reduce the likelihood of delinquency and reports of ever having sex among adolescents.

Parent-adolescent communication in matters of sex and sex-related topics has also been demonstrated to offer protection for adolescents from sexual risk behaviours (Lyon and D'angelo 2006:148). Communication between parents and their children on sexual matters is therefore encouraged as right messages will be passed on to the adolescents and will help them manage their sexual issues better.

2.3.11 Disparate sexual relationships

For a number of reasons, some female adolescents prefer to have sexual relationships with men that are much older than themselves. Age – disparate relationships refer to an age difference of five (5) years or more between a couple, the female being younger (Leclerc – Madlala 2008:S19).

Age – disparate sexual relations promote the practice of unsafe/ unprotected sex because young adolescents are intimidated and are unable to stand up against the older men. Young adolescent women often have sexual relations with older and more sexually experienced men. These men usually have multiple concurrent sexual partners and are likely to carry sexually transmitted infections.

They may subject the adolescents to traditional practices of dry sex which means sexual intercourse in which vaginal lubrication is removed by means of herbs, leaves or wiping. This makes them even more vulnerable to acquiring sexually transmitted infections (Botswana 2003:10).

An important reason why adolescents have sexual relations with older men is because they see them as financial providers of their basic needs and social status symbols like cell phones and cash. They do not however realise that they make themselves very vulnerable to these men. In her review of studies from Southern Africa on age disparate and intergenerational sex, Leclerc – Madlala (2008:S18-20) reports the following as factors likely to predispose female adolescents to unsafe/ unprotected sex:

- Adolescents view older men as ‘safe’ partners who are stable, responsible and are not risk-takers;
- Young women worry more about being ‘found out’ when dating married men than contracting STI/HIV;
- Failure to insist on safe sex practices exists because of fear of jeopardising their economic goals;

- When large gifts are given to young women by older men, safe sex (condom use) becomes very unlikely;
- Adolescents have a desire and perceived 'need' to acquire material goods to raise their social status.

The perspectives of older men according to the same study are as follows:

- Young women are perceived as 'clean' partners and are unlikely to be infected with STI/HIV;
- The belief exists that sex with a virgin cures STI/HIV;
- Older men need a young woman to rejuvenate them;
- Older men perceive a relationship like this as transactional where they exchange valuable gifts for services rendered, therefore do not see the need for condom use.

Maundeni (2004:49) in a study conducted in Botswana states that boys preferred love relationships with older women because they were less likely to demand for money from them as they had their own. They felt female peers were immature and insisted that the boys commit to the relationships and promise marriage, which they were not ready for. Importantly, these boys stated that it was difficult to negotiate for safe sex because the women were in control of the relationship. Older women preferred relationships with boys because they believed they were more energetic than older men.

2.3.12 Peer pressure

Peer pressure is another factor that influences adolescent sexual behaviour. As adolescents begin to socialise with their peers, they tend to shift from reliance on their parents and the lessons and values they learnt from home socialisation to reliance on their peers. In their study on Ecological Influences on Health-promoting and Health-compromising Behaviours, Cooper and Guthrie (2007: 38) discovered that there was a positive correlation between substance abuse due to

peer pressure and an increased risk of engaging in sexual activity and that these behaviours occur concurrently.

Hammer and Banegas (2010:290) state that a commonly cited reason for initiating sexual relations among adolescents was pressure from society and their peers. In their quest for a sense of belonging and to avoid rejection by the group the adolescents succumb to this pressure. Lyon and D'angelo (2006:149) report that when adolescents perceive that their friends of similar age are engaging in risky sex, this perception is likely to foster the same behaviour in them. Conversely, perceived peer norms that are supportive of sexual protective behaviours may influence adolescents to adopt and maintain safer sex practices (Lyon and D'angelo 2006:149).

2.3.13 Media

In this twenty – first century, technology has become a popular medium of transmission of sexual messages that influence adolescents' attitudes and sexual behaviours. Positive and negative messages are made available to adolescents through the media and may either build or destroy them.

Sometimes media messages have an opposite effect than the intended one. Mwale (2008:296) reports that adolescent discussants in a focus group discussion stated that the western media tended to exaggerate the dangers and implications of HIV/AIDS. The messages created a negative attitude such that the target groups responded in a contrary manner to the intentions of the messages.

L'engle, Brown and Kenneavy (2006:191) state that adolescents report more sexual activity and greater intentions to engage in sex when they have been exposed to sexual content through the media. They also report that the media does not depict risks associated with the sexual content and that media users are

likely to adopt the behaviours of characters they perceive to be attractive, regardless of the risks involved. In view of these findings, they suggest that the media be considered a significant factor in sexual socialisation of adolescents, along with the family, church, school and peers.

2.3.14 Force / Coercion

Adolescents are a vulnerable group especially when orphaned due to HIV/AIDS. Some lose their parents who should normally protect them and regarded as their role models. It is at this time that they become prone to sexual abuse. Adolescents are sometimes coerced and sexually abused by relatives and authority figures, under whose care they are entrusted (Botswana 2003: 13).

Forced/coerced sex is a common phenomenon in African developing countries and is a cause for unsafe/unprotected sex. Female adolescents are usually the victims especially before the age of 15 (UNFPA 2002:114). Literature reveals that older men have been responsible for some girls initiating sex and sometimes unsafe sex because sex was not anticipated. Hammer and Banegas (2010:291) report that males, usually under the influence of alcohol and drugs, force their female partners to have sex. In the study, participants also reported that stepfathers forced their stepdaughters to have sex with them and that is how some initiated sexual relations.

In Botswana it was discovered that half of the 3% of young adolescents (10 – 14 years) who were sexually active were forced to have sex. The perpetrators of forced sex (rape) were usually their peers or a family friend (Botswana 2001(a):16).

In a nationally representative study conducted in Swaziland, it was reported that 33% of females were subjected to sexual violence before the age of 18 (Hinden and Fatusi 2009:58).

2.4 SUMMARY

This chapter mainly discussed the documented factors in literature that influence and impact on adolescent sexual behaviour. The next chapter discusses the research methodology that was used in attempting to identify factors contributing to unsafe/unprotected sex among secondary school going adolescents in Molepolole, Botswana.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research methodology that was adopted for the study. It gives a detailed account of the data collection process employed in obtaining information from the secondary school adolescents in this research context.

Research design serves the purpose of providing a plan that will enable the researcher to answer the research question. The plan delineates the control mechanisms that are used in the study to come up with clear and valid answers to the research question (Wood and Ross-Kerr 2006:113-114).

3.2 STUDY CONTEXT

The study was conducted in Molepolole village which is situated about 50 kilometres west of Gaborone, the capital city of Botswana. The study targeted male and female school going teenagers from the eight (8) junior secondary schools and the one senior secondary school in the area. The study sought to identify the key factors that contribute to unsafe/unprotected sex among adolescents.

3.3 DESIGN OF THE STUDY

A research design provides the basic strategies that are necessary for the development of empirical evidence (Polit and Beck 2008:203). A research design can also be defined as a blueprint that guides the research process to ensure that there is maximum control over factors that could adversely affect the validity of the research results (Burns and Grove 2005:40). A quantitative, explorative, non-experimental and descriptive design was adopted for this study. Comparative descriptive studies describe variables and the differences/variations

between or among two or more groups with regard to the study variable(s) (Brink, Van der Walt and Van Rensburg 2006:104). In this study, responses from pupils with regard to their motivations for and practices of unsafe/unprotected sex among male adolescents were compared with those of female adolescents.

3.3.1 Quantitative research design

De Vos et al (2011:63) explain that the quantitative research paradigm endeavours to provide answers to questions about relationships among measurable variables. It is also possible to explain causation among variables, generalise research findings and predict relationships between variables. In a quantitative research approach, structured designs are used which are constant throughout the research period. Research variables are defined in advance of the study and data gathered can be quantified and subjected to the use of statistics in the analysis. Quantitative research usually requires large samples. The researcher remains detached from the subjects, thus ensuring well defined boundaries between him/her and the subjects. Analysis of data occurs after data gathering.

Quantitative studies are structured and provide detailed accounts of all activities at every stage of the study prior to data collection (Polit and Beck 2008:16). Quantitative research uses instrumentation, a component of measurement, which applies specific rules when developing a measurement device or instrument. The level of measurement of a specific variable will determine the statistical analysis to be used for the data collected (Burns and Grove 2005:41). In this study a structured questionnaire was developed and data were analysed using the MS Excel spreadsheets.

3.3.2 Non-experimental designs

These are studies conducted on naturally occurring phenomena. Non-experimental research purports to describe phenomena and not to determine cause and effect relationships between variables. These designs are useful in

generating knowledge in cases where it would be unethical or impossible to utilise experimental designs (Brink et al 2006:104).

The study was non-experimental because it involved a phenomenon that the researcher is aware of namely, unsafe/unprotected sex, and it merely sought to describe the factors that contribute to the practice (Polit and Beck 2008:63).

3.3.3 Descriptive research design

Descriptive studies do not manipulate variables or try to explain relationships between variables. They define and describe variables such as respondents' views, needs or other facts to provide a broader understanding of a phenomenon being studied in its natural setting (Brink et al 2006:104). The descriptive design was expected to give an accurate description of the factors that cause school going adolescents to engage in unsafe/unprotected sex in Molepolole village.

3.3.4 Research methodology: Survey

A survey was carried out in which a self administered questionnaire was administered. According to Polit and Beck (2008:324) a survey is used to gather information from a sample of the population by means of self-report. Advantages of a survey include:

- Flexibility and broad scope
- May be applied to many different populations
- Focuses on a wide range of topics
- Information obtained can be used for many purposes

The questionnaire developed for this study was administered to 324 adolescents and included sections soliciting for basic information on the respondents' demographic data, their previous sexual practices and condom use as well as their current sexual behaviours and practices.

Disadvantages of a survey are:

- Information obtained is superficial
- Respondents may not be able or willing to respond on the topic

In overcoming these disadvantages, the researcher carried out an extensive literature review that guided the content that was included in the questionnaire. Prior to selection of respondents, the researcher referred to the fact that some of their peers had dropped out of school due to pregnancy and that the survey would assist in coming up with strategies to reduce the cases of teenage pregnancy. Emphasis was also laid on the fact that the respondents would be anonymous and so could respond truthfully without being identified.

3.3.5 Population and Sampling

A study population comprises the entire aggregation of cases that a researcher is interested in (Polit and Beck 2008:337). In this study, the population was made up of all male and female adolescents attending the eight (8) government junior secondary schools and the only government senior secondary school in Molepolole village.

Sampling can be defined as the process of selecting elements, which are the basic units from which data and information would be collected to represent the entire population (Polit and Beck 2008:339). Quantitative research studies emphasise the need for representative samples. Larger samples are usually more representative of the population than smaller samples which produce less accurate estimates (Polit and Beck 2008:348). The sample size for this study was 330.

There are mainly two forms of sampling namely probability and non-probability sampling. Probability sampling has an advantage over non-probability sampling in that all elements in the population have an equal and independent chance of being selected and therefore more likely to provide accurate and representative samples (Polit and Beck 2008:340).

Despite the weaknesses of the non-probability sampling method such as lack of representativeness and sampling bias, the researcher had to use it owing to the sensitivity of the topic of study. Convenience sampling method was therefore used. In convenience sampling, the researcher selects elements that are readily available and willing to take part in the study to comprise the sample (Polit and Beck 2008:341).

A disadvantage of this method is that available elements may possess different characteristics from those of the population with regard to critical variables (Polit and Beck 2008:341). Another disadvantage of convenience sampling is that there is a possibility of sampling bias being introduced in a study as some elements may be over-represented or under-represented (Brink et al 2006:133). Its limitations include lack of representativeness in the sample and inability to generalise the findings.

This study also presented some challenges related to ethical issues. Unsafe/unprotected sex is a sensitive topic and the researcher aimed at obtaining factual information regarding the topic from the respondents without outside influence. Ethical considerations with regard to sampling emphasise the principles of respect, beneficence and justice, all of which are explained in section 3.6

A sample size of 330 male and female adolescents was decided upon for the nine (9) secondary schools. As was indicated previously, in quantitative studies large samples are advised. The larger the sample, the more representative of the population it will be and the smaller the chance of producing less accurate estimates (Polit and Beck 2008:348). In this case the study context as well as the sensitivity of the topic had a limiting effect on the sample size. In Molepolole, each junior secondary school had an average of 4 classes per form (grade) with

40 - 45 pupils per class giving a total range of 3840 - 4320 pupils for the 8 junior secondary school combined together.

The senior secondary school had 30 classes per form (grade) with 30 - 35 pupils on average per class. At the time of data collection there was a double session system in operation i.e. 15 classes each of forms four (4) (grade 11) and five (5) (grade 12) attended school in the morning and the remaining 15 classes per form came to school in the afternoon. The total number of pupils at the senior secondary school was estimated to be between 900 – 1 050. The overall total target population was more than 4 500 pupils.

In order to get a sample as representative as possible of all the schools involved in this study and given the limited financial resources, the researcher, with the assistance of a statistician, aimed to include 30 pupils from each of the eight (8) junior secondary schools and ninety (90) from the senior secondary school, making a total of 330 respondents. This sample, using the statistical formula $1/\sqrt{N}$ (Niles), would give a calculated margin of error of 0.05, suggesting that the results from the survey would be reliable. During data collection however, more adolescents were willing to participate in the study. A total of 341 questionnaires were distributed and returned. During data cleaning, it was discovered that some of the questionnaires were grossly incomplete and could not be used in the study for analysis purposes. Eventually the sample size was 324. Data analysis was therefore based on 324 questionnaires which gave a percentage in the region of 7% of the target population (4 500).

Inclusion criteria for the study were as follows:

- Male and female adolescents aged between 13 -19.
- Male and female adolescents attending government secondary schools in Molepolole village
- Willing to participate

3.4 DATA COLLECTION AND DATA COLLECTION INSTRUMENT

Data collection involves selecting subjects and gathering information from them. The process delineates the steps involved in data collection with regard to a specific study and depending on the research design and method of measurement (Burns and Grove 2005:430).

3.4.1 Data collection approach and method

Data were collected from the respondents by using a self-administered questionnaire. A questionnaire can be used to determine a variety of aspects from respondents including beliefs, thoughts, knowledge, and motives. Well designed questionnaires should be easy for literate people to complete and the researcher to administer and analyse (Brink et al 2006:146).

The respondents were school-going in advanced grades and therefore considered or deemed literate. They were able to read and understand the questions on the questionnaire. This method was chosen because it enabled the researcher to obtain a lot of information in a small space of time. The instrument also ensured anonymity of respondents as their identities were not requested for.

According to Brink et al (2006:147) questionnaires have strengths and weaknesses.

Notable strengths include the following:

- Data can quickly be obtained from a large group;
- They are less costly and require less time to administer;
- Testing for reliability and validity is fairly simple;
- They offer respondents a great sense of anonymity that enables them to provide factual responses, which the researcher considered beneficial due to the sensitive nature of the survey;
- The questionnaire format is standard for all respondents and is not subject to the mood of the interviewer.

Despite these strengths, questionnaires have the following weaknesses:

- Not all respondents will fill in and return the questionnaires;
- Respondents may provide responses that they feel are socially acceptable;
- Some items may not be answered by the respondents as was the case in this study;
- The researcher is unable to clarify items that respondents may misunderstand;
- The sample selected may not be representative of the population.

A structured questionnaire was developed based on the literature review and reference was also made to the problem identified and objectives set. Assistance in development of the instrument was sought from the research supervisor and a statistician. Questions developed were mainly close-ended.

Refinement of the data collection instrument was achieved by pre-testing it at a government secondary school in Thamaga, a neighbouring village. Ten pupils with similar characteristics as the study population volunteered to complete the questionnaire. The instrument was tested for clarity of the questions, after which corrections were made. Following the pre-test, it became necessary to rearrange the questions and provide clearer instructions for each section.

3.4.2 Layout of the data collection instrument

According to Brink et al (2006:147), a well-designed questionnaire should have the following characteristics:

- Meet the objectives of the enquiry;
- Demonstrate a fit between its contents and the research problem and objectives;
- Obtain the most complete and accurate information possible and do so within reasonable limits of time and resources.

The questionnaire comprised of 21 questions divided into demographic data, condom use and sexual practices.

On the front page of the questionnaire was an information leaflet followed by three (3) sections. Section A required respondents to provide their basic demographic data while section B measured their knowledge and feelings concerning condoms and section C elicited their sexual experiences and practices. The contents of the questionnaire are discussed and presented in the form of a table (Refer to Table 3.1). A copy of the information leaflet and questionnaire is attached as annexure C and D.

Information leaflet

The information leaflet introduced the respondent to the researcher, whose aim was to provide information on stakeholder institutions supporting the research, the purpose of the study and to seek for support for the research. Information was provided regarding the principles of voluntary participation and informed consent and respondents were assured of anonymity and confidentiality of the data and information to be supplied.

Section A

This section elicited for basic demographic data pertaining to the respondents and assisted in identifying the characteristics of the study sample. Demographic data refers to statistics of births, deaths, disease etc. (The Concise Oxford Dictionary). The data provided could be used as a basis to investigate relationships between basic demographic data and some of the respondents' practices and experiences with regard to unsafe/unprotected sex.

Section B

The second section of the questionnaire tested respondents on issues surrounding condom use.

Section C

The last section of the questionnaire tested issues surrounding the sexual experiences and practices of the respondents.

Table 3.1: Layout description of questions on the questionnaire

SECTIONS:	**QUESTIONS:** ***DESCRIPTION AND MOTIVATION***
SECTION A: DEMOGRAPHIC DATA	Questions 1 - 4: Information was requested about the respondents' gender (1) age (2) and level of education (3) and who respondents live with (4). The data obtained were used to describe the sample characteristics and to establish whether there is a relationship between the people they live with and their sexual behaviour and practices.
SECTION B: ISSUES ON CONDOM USE	Questions 5 - 13: Respondents were requested to indicate whether they had a previous sexual encounter (5), the age (6) and the reasons why (7). They were also asked about the use of condoms during sex (8). Their knowledge on protection obtained from condoms (9) was tested. The provision of condoms (10-12) was investigated as well as their attitudes regarding condom use (13).

SECTION C: SEXUAL EXPERIENCES AND PRACTICES	Questions (14 - 21) Current sexual activity was determined (14). The sexually active respondents were then required to indicate their sexual current experiences and practices (15-18). Reasons for having unprotected sex were investigated (19). The respondents were also asked how they felt about unprotected sex (20). The final question (21) investigated remuneration for sex. This is important because it provides information on the actual practices adolescents are involved in and the reasons why. It also forms the basis for any corrective measures to be recommended to address the problem of unsafe sex practices among adolescents.

3.4.3 Data collection process

During the data collection process, the researcher visited each school and made appointments for data collection through the deputy head-teachers and Counselling and Guidance department teachers. Each school was coded with different unique code numbers. Classrooms or school halls were used for the data collection process. Due to the sensitive nature of the research topic, respondent's desks were separated to provide privacy and enable factual information to be obtained. The researcher personally distributed the questionnaires and collected them. No teacher was allowed in the room during

completion of questionnaires. This was done to ensure that respondents were free to express themselves without any outside influence. Would be respondents were informed of the purpose of the study and were given an information leaflet which was on the front page of the questionnaire. They read the contents on the leaflet and decided whether or not to participate.

3.4.4 Validity and reliability

Validity

Validity is the ability of an instrument to measure a concept under study and to be able to measure it accurately so that any observed differences are true and not the result of random or constant errors (De Vos et al 2010:173). Instrument validity determines whether an instrument accurately measures that which it is supposed to measure (Brink et al 2006:159).

Content Validity

This refers to how well an instrument represents all the components of the variables being measured (Brink et al 2006:160). The study was conducted to determine the factors contributing to unsafe sex among teenagers. Content validity was ensured by doing a thorough literature review study on which the content of the questionnaire was based.

Face Validity

Face validity is an intuitive judgement to determine whether an instrument appears to measure what it is supposed to measure. It considers whether the tool is readable and checks for clarity of the content. (Brink et al 2006:160). Face validity was ensured by:

- Scrutiny of the instrument by the research supervisor and the statistician
- Pre-testing of the data collection tool

Construct Validity

Construct validity measures the relationship between the instrument and the related theory using a 'known-groups approach' to test if scores obtained from two groups differ significantly. It can be used to measure traits within a given population e.g. anxiety, satisfaction and happiness (Brink et al 2006:162). In this study, construct validity was not determined.

Other forms of validity e.g. Criterion-related validity, Predictive validity and Concurrent validity were not addressed because they were considered not applicable in the current study. (Brink et al 2006:161).

External validity

External validity of a study is said to exist when the results obtained in a study can be generalised to other people and other settings. Generalisation is made considering the degree of confidence with which the sample findings can be conferred on the population and whether similar findings would be obtained at other times and places. External validity may be affected in cases where subjects behave in an unnatural way due to the fact that they are aware that they are being observed by the researcher (Brink et al 2006:101).

The researcher met the respondents for the first time during data collection and merely explained the purpose of the study to the respondents. The relationship was strictly formal; therefore researcher effect was very minimal. This was important because if respondents are familiar with the researcher, they may not provide truthful information and results may not be valid. The variable of interest was also very sensitive and researcher effect needed to be minimal in order for accurate information to be obtained.

External validity was influenced by the sampling method, namely convenience sampling: findings cannot be generalised to other settings because of this sampling method.

Internal validity

Internal validity refers to the extent to which the results of an experiment can be said to be wholly due to the manipulated independent variable as opposed to any other factor that has not been controlled for (Brink et al 2006:99).

As experimentation was not part of this study and a survey was done, issues of internal validity did not influence the outcome of this study.

Reliability

Reliability refers to the extent to which an instrument yields similar results each time it is administered by independent persons under comparable conditions. De Vos et al (2010:177). The researcher took much care to ensure that the research procedure was the same at each of the schools included in the study population. The respondents could for example complete the questionnaire in the presence of the researcher only – without any of the teachers present. An environment was created where they could honestly complete the questionnaire (Brink et al 2006:164).

The data collection instrument was pre-tested on male and female adolescents at a government school in Thamaga, a neighbouring village. Changes were then made.

Stability – This refers to the ability of a research instrument to maintain its consistency over time (Brink et al 2006:164). Stability was not addressed in this study but can be addressed in a future study. However, it should be done in a short span of time because phenomena under investigation are subject to change.

Internal consistency – The extent to which all items on a data collection instrument measure the same variable is referred to as internal consistency

(Brink et al 2006:164). This was evaluated when experts looked at the questionnaire prior to it being administered.

3.5 DATA ANALYSIS

The services of a statistician were sought during this phase of the research process. As pointed out in 1.7.3, MS Excel spreadsheets were used to analyse the data as the sample size was appropriate for the purpose and the researcher is familiar with the functionalities of MS Excel spreadsheets. The researcher attempted to establish differences between male and female responses. Graphs and tables were used to present summaries of the data findings.

3.6 ETHICAL CONSIDERATIONS

3.6.1 Permission for the study

Permission to conduct the research was sought from the Botswana Health Research Unit, University of South Africa (UNISA) and the Kweneng Region Education Office (see annexures A and B) where Molepolole village is located. Permission was also sought from each of the secondary school head teachers after presenting the letter of permission from the regional office. In view of the sensitive nature of the study, permission was only sought from pupils who met the inclusion criteria. They were handed an information leaflet concerning the study, and they could then chose to participate or not (see annexure C). Respondents were encouraged to exercise the right to withdraw from the study if they so wished and no penalties were attached to such withdrawal.

The variable of study was a sensitive one and was bound to have an emotional effect on the respondents. The researcher explained the importance of the study, in that it would provide essential information which would be used to curb adolescent pregnancy and its consequences.

3.6.2 Respect for Self determination/Autonomy and Human Dignity

Respect refers to an individual's right to voluntarily take part in a study. Study subjects should be given full disclosure of the nature of the study to enable them make informed choices to participate in the study or not. In addition their decisions should not be coerced or influenced by other people or factors. Only when these conditions are satisfied should informed consent be obtained from them (Polit and Beck 2008:171,172).

As was indicated, a participation information leaflet was availed on the front page of the questionnaire. The purpose and benefits of the study were clearly stated for would be respondents to read. The information provided would provide a basis for would be respondents to either agree to participate in the study or decline. In addition the researcher verbally explained the reason why the study had to be carried out. This was done in an effort for the respondents to appreciate the need for the study. Those that agreed to participate were then given questionnaires to complete.

At all times the respondents were treated in a way that their dignity was respected.

3.6.3 Beneficence/ Freedom from harm

Research carried out on humans may in some cases cause physical, psychological, social and economic harm. A researcher conducting such research should ensure that any risk of harm to study subjects is reduced to a minimum and that there is a balance between risks and benefits (Polit and Beck 2008:170). Studies affecting personal views, weaknesses and fear may affect respondents psychologically. Researchers therefore need to be sensitive to the effects of invading respondents' psyche. Respondents should also be assured that the information they provide will not be used to exploit them or for the researcher's benefit (Polit and Beck 2008:170).

The researcher anticipated that the topic of study would cause some discomfort to the respondents since it involved an invasion into their sexual behaviour. In view of this, the researcher informed the respondents that the results of the study would assist in understanding why adolescents indulged in unsafe/unprotected sex, based on which interventions for addressing adolescent pregnancies and school dropouts could be developed. It was envisaged that respondents would benefit from participating in the study by knowing that their contributions would assist in coming up with solutions to unsafe / unprotected sex.

3.6.4 Anonymity and Confidentiality

Anonymity refers to a situation where even the researcher cannot link the data collected to the respondents. Their privacy, especially with regard to their personal lives should be respected and their identities kept anonymous (Polit and Beck 2008:180).

Questionnaire numbers were used and no names of schools or respondents were required. This was done to ensure anonymity and confidentiality of information and respondents. They were also verbally advised not to indicate their names or any other form of identity on the questionnaire. The results were therefore confidential with no possibility of names being detected. At no time during the study were any of the teachers allowed access to the questionnaires.

3.6.5 Justice

Justice refers to fair treatment of respondents i.e. whether respondents choose to participate in the study or not, there should be no distinction in their treatment (Polit and Beck 2008:173). The principle of justice ensures that vulnerable people e.g. slaves, the poor or prisoners and individuals who are unable to protect themselves (the dying) are not exploited and subjected to research for the sake of knowledge advancement. In addition benefits of research results should be equitably distributed to all individuals without discrimination (Polit & Beck

2008:173). All researchers are obliged to observe this principle in the selection of their sample.

No participant was exploited in the study: participation was voluntary as earlier indicated. After completion of this study, the researcher will write a research report that will be availed to the Kweneng Region Education office.

3.7 SUMMARY

This chapter discussed the methodology employed in the data collection process. A quantitative, non-experimental and comparative research design was used. Data collection was done using a structured self report questionnaire. The next chapter is a detailed presentation and discussion of the findings from the research study.

CHAPTER 4

RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter discusses the data analysis and the research findings from the completed questionnaires from male and female respondents who attended government secondary schools in Molepolole village during 2010. The schools represented in this study from which data were collected included one senior secondary school and eight junior secondary schools. There is usually only one senior secondary school in each village, but quite a number of junior secondary schools.

The purpose of the survey was explained to the adolescents by the researcher. A participant information leaflet was also available and was attached to the questionnaire as well. Adolescents who were willing to fill in the questionnaire were issued with the questionnaire.

Initially the researcher planned to obtain data from 330 respondents i.e. 30 from each of the junior secondary schools and 90 from the senior secondary school. However during data collection, more respondents than expected offered to participate in the questionnaires. The reason could be that the researcher was a foreigner in the country and they felt free to participate. A total of 341 questionnaires were completed. During data cleaning, it was observed that some questionnaires were incomplete to the extent that they could not be used. Others provided contradictory answers and it seemed as if some aspects in the questionnaire were not fully understood and thus could also not be used in the study.

The findings provided in this chapter were therefore derived from a convenience sample of 324 respondents, which comprise 98% of the targeted sample size.
The questionnaire comprised of three sections namely:

- Demographic data (section A)
- Condom use (section B)
- Sexual practices (section C)

4.2 DATA MANAGEMENT AND ANALYSIS

All completed questionnaires were subjected to data cleaning, a process carried out to determine quality of the data provided and to determine if there were questionnaires that had to be excluded from the study.

Analysis of data was done using MS Excel spreadsheets with the assistance of a statistician. All data from individual respondents per school was entered in order to make sure that the schools were represented as planned. Summary sheets were then made comprising of variables in the questionnaire with frequencies or counts of particular responses. These summaries were then aggregated to provide the results for the entire sample which are illustrated frequency tables and graphs.

4.3 RESEARCH RESULTS

The results presented in this study are derived from a sample of 324 respondents' questionnaires. For anonymity and confidentiality reasons the names of the schools are coded and not mentioned.

Table 4.1 reflects the distribution of the respondents as they were distributed across the different schools. From this table is clear that the researcher came very close to the initial planned number of having 30 respondents per junior secondary school and 90 respondents from the senior secondary school. The frequency of male and female respondents is also depicted in table 4.1 below.

Table 4.1 Frequency of respondents (n=324)

School and code number	Number of Males participants	Number of Females participants	Total
Senior secondary school – 1	30	59	89
Junior Secondary school – 1	12	18	30
Junior Secondary school – 2	9	20	29
Junior Secondary school – 3	9	21	30
Junior Secondary school – 4	11	17	28
Junior Secondary school – 5	13	16	29
Junior Secondary school – 6	11	19	30
Junior Secondary school – 7	10	19	29
Junior Secondary school - 8	11	19	30
Total	116	208	324

4.3.1 Section A: Demographic data

The demographic data discussed here includes gender, age of respondents, highest educational level attained and who the respondents lived with.

4.3.1.1 Gender of respondents

Figure 4.1 below shows from the total sample the majority, 64.2%, (n=208) of the respondents were female and the rest, 35.8% (n= 116) were male.

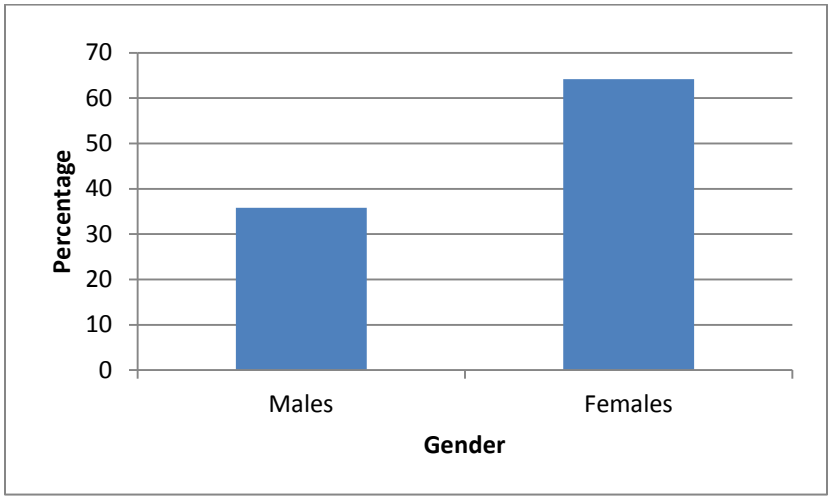

Figure 4.1: Gender of respondents (n=324).

According to the 2006 Botswana Demographic survey (Botswana 2009:7) the general population consists of 52% females and 48% males. It could be possible that in this study more girls chose to participate in the study, because the investigator was female and the girls therefore felt more comfortable to participate.

4.3.1.2 Age of respondents

The age of respondents ranged between 13 and 19 years, the average age of those who stated their ages being 16.6 years. The mode was 16 years. Figure 4.2 below shows the age distribution of the respondents.

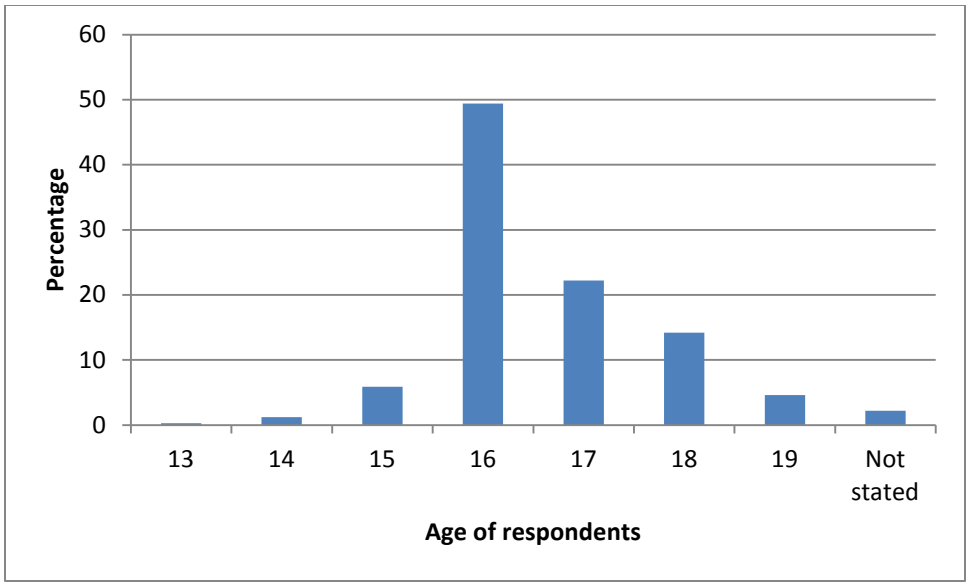

Fig 4.2 Age distribution of respondents (n=324)

It is interesting to note that the majority of respondents were aged between 16 – 17 years, because 49.4% of the respondents (n=160) were 16 and 22.2% of the respondents (n=72) were17 years old.

4.3.1.3 Highest level of education attained

When asked about their highest level of education, 51.9% (n=168) of respondents were in form three (3), the tenth grade, 16.4% (n=53) were in form two (2), the ninth grade, 15.7% (n=51) were in form five (5), the twelfth grade, 11.7% (n=38) in form four (4), the eleventh grade, 3.7% (n=12) were in form one (1) the eighth grade, and 0.6% (n=2) did not state their form (grade). These findings are depicted in the figure 4.3 below.

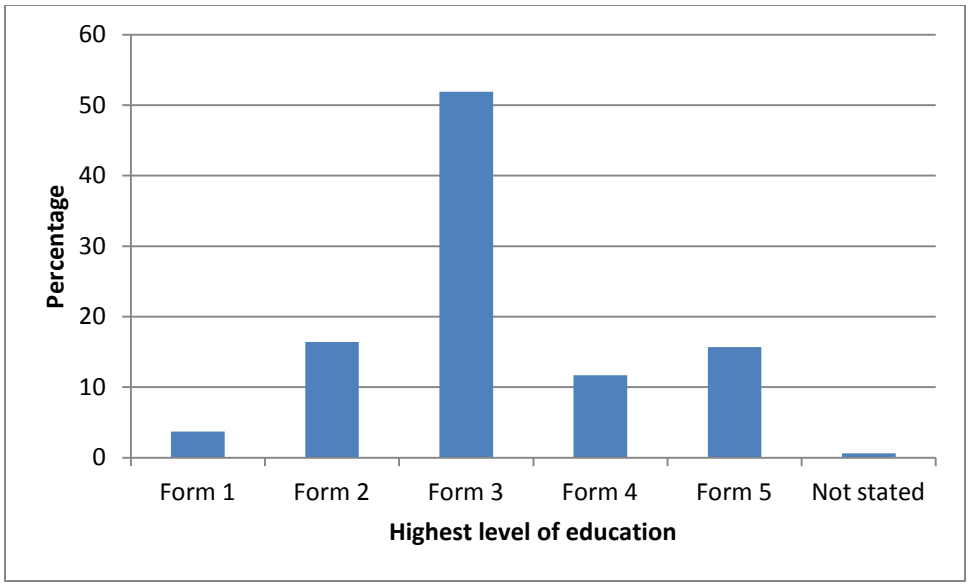

Figure 4.3 Highest level of education (n=324)

4.3.1.4 Who the respondents live with

The graph in figure 4.4 illustrates that 40.1% (n=130) of the respondents live with both their parents, 21.9% (n=71) with their mother only, 16.4% (n=53) with their relatives, 9% (n=29) with their grandparents, another 9% (n=29) with only their brothers and sisters and 2.5% (n=8) with their father only. Of the remaining respondents 0.3% stay/s alone and 0.9% did not answer the question.

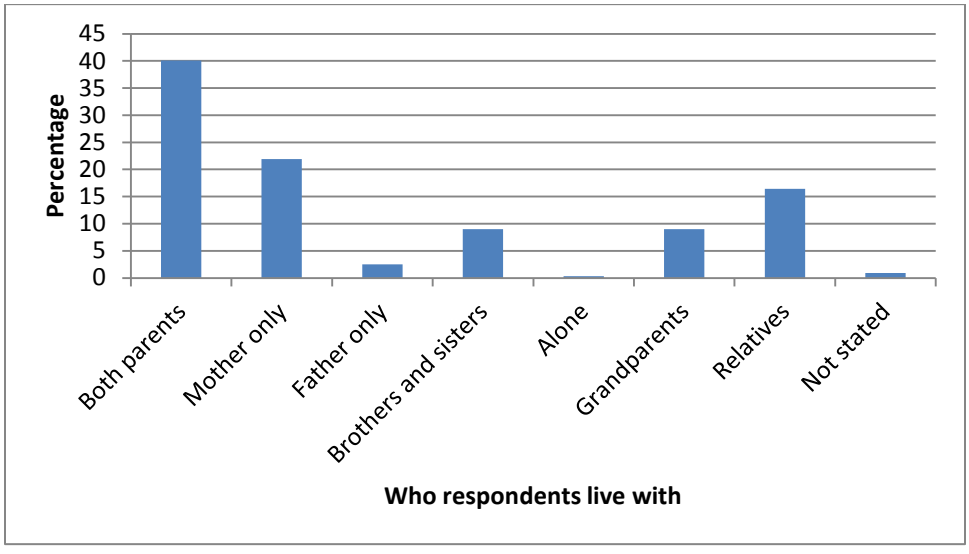

Figure 4.4 Who respondents live with (n=324)

The majority of respondents (64.5%) live with either both parents or at least one of the parents.

4.3.2 Section B: Aspects regarding condom use

Responses to all questions in Section B of the questionnaire, dealing with sexual activity, condom use and knowledge around these issues in this section are presented below.

4.3.2.1 Sexual activity of respondents

The first question in this section (Question 5) was asked to determine the number of respondents that ever had sex. This question was answered by all the respondents (n=324). The results are reflected in table 4.2.

Table 4.2 Respondents who had sex (n=324)

Variable	Number	Percentage
Respondents who had sex	115	35.5%
Respondents who never had sex	209	64.5%
Total	324	100%

Of the total respondents, 35.5% (n=115) reported that they had had a sexual experience while 64.5% (n=209) denied ever having sex.

4.3.2.2 Age at first sex

Those respondents that answered positively in the previous question (n=115) were asked to indicate how old they were the first time they had sex (Question 6). A number of the respondents, 22.6%; (n=26) did not indicate how old they were when they first had sex – this question was answered by only 89 respondents. Table 4.3 depicts these results.

Table 4.3 Age at first sex (n=89)

Age at first sex	Number	Percentage
Less than 10	8	8.9%
10	5	5.6%
11	2	2.2%
12	2	2.2%
13	3	3.4%
14	7	7.9%
15	17	19.1%
16	24	27%
17	9	10.1%
18	9	10.1%
19	3	3.4%
Total	89	100%

Of those that did indicate their age, 27% (n=24) had their first sexual experience at the age of 16, 19.1% (n=17) at the age of 15, 10.1% (n=9) at the age of 17 and another 10.1% (n=9) at the age of 18. There were 8.9% (n=8) respondents who reported having their first sexual experience at less than ten years old and 5.6% (n=5) at ten years old.

4.3.2.3 Reasons for having sex the first time

Question 7 was intended to establish the respondents' reasons for having sex the first time. Reasons from the115 respondents are reflected in table 4.4.

Table 4.4 Reasons for having sex the first time (n=115)

Reason	Number of respondents	Percentage
Curiosity	40	34.8
Encouraged by friends	16	13.9
Persuaded by boy/girlfriend	24	20.9
Forced/ raped	1	0.9
Expected by culture	5	4.3
Influence of alcohol	7	6.1
Not stated	22	19.1
Total	115	100

Curiosity was cited as the commonest reason by 34.8% (n=40) for having sex and persuasion by the boyfriend/girlfriend by 20.9% (n=24) was the next commonest. Cultural expectations accounted for 4.3% (n=5) and 0.9% (n=1) indicated forced/rape.

Though in this study curiosity was cited as the commonest reason for having sex the first time, Silva (2007:115) found that the main reason for having sex was love for the partner in her study. In this study a small percentage, namely 6.1% (n=7) stated alcohol as a reason for initiating sex in this study. Other authors like Randy and Cougar (2009:374) also reported that alcohol was associated with having sex.

4.3.2.4 Use of condom during sex

Respondents were asked if they use a condom during sex. This question was answered by only 93 of the 115 respondents. Results are reflected in table 4.5.

Table 4.5 Use of condom during sex (n=93)

Condom use during sex	Number of respondents	Percentage
Always	58	62.3%
Sometimes	15	16.1%
Never	20	21.5%
Total	93	100%

This study revealed that the majority, 62.3% (n=58) of respondents always used a condom during sex while 16.1% (n=15) sometimes used a condom and 21.5% (n=20) never at all.

These findings are different from the study by Abdulraheem and Fawole (2009: 505), who reported that the minority (38.1%) of adolescents in their study always used condoms during sex while the rest did not. In another study in South Africa different findings were also obtained. It was reported that more than 50% of the sexually active students never used a condom (Hartell 2005:174).

4.3.2.5 Respondents' feelings about condoms

Respondents were asked in question 9 to indicate how they felt about condoms in relation to protection against pregnancy, HIV/AIDS and STI's. This question actually tested their knowledge on these issues to an extent and all the respondents were requested to answer this question. The results are presented below in three sub-sections.

- *Pregnancy* - The question on pregnancy was answered by 266 respondents and 58 did not state their answer. Results are reflected in table 4.6.

Table 4.6 Condoms protect against pregnancy (n=266)

Opinion	Number of respondents	Percentage
Agree	236	88.7
Disagree	30	11.3
Total	266	100

Most, namely 88.7% (n=236) of the respondents indicated that condoms were effective in preventing pregnancy and 11.3% (n=30) disagreed.

- *HIV/AIDS* - The question on HIV/AIDS was answered by 255 respondents and 69 did not state an answer. Results are reflected in table 4.7.

Table 4.7 Condoms protect against HIV/AIDS (n=255)

Opinion	Number of respondents	Percentage
Agree	217	85.0
Disagree	38	14.9
Total	255	100

The majority of respondents, in this case 85% (n=217) indicated that condoms protect against HIV/AIDS while 14.9% (n=38) disagreed.

- *Sexually transmitted infections* - The question on sexually transmitted infections was answered by 261 respondents and 63 did not state an answer. The results are reflected in table 4.8.

Table 4.8 Condoms protect against sexually transmitted infections (n=261)

Opinion	Number of respondents	Percentage
Agree	223	85.4
Disagree	38	14.6
Total	261	100

Most of the respondents, 85.4% (n=223) indicated that condoms protect against sexually transmitted infections and 14.5% (n=38) disagreed.

For the three subsections above then, it seems as if the majority of the respondents do acknowledge the importance of using condoms in preventing pregnancy, HIV/AIDS and STI's.

4.3.2.6 Provision of condoms in schools

Respondents were requested in questions 10 and 11 to indicate whether or not their schools provided them with condoms and if it was enough. All respondents were requested to answer this question. All the respondents, 100%, stated that schools did not provide condoms for the pupils.

However, it was the researcher's perception that schools provided condoms to pupils through the Counselling and Guidance departments in each school. These departments at schools provide sexual and reproductive health care services, among other services, to pupils. The researcher's impression was that, for those who requested, condoms would be provided.

4.3.2.7 Where to obtain condoms

Because condoms may be obtained from various places, this item (Question 12) asked respondents to state the places that they knew of where condoms could be obtained. The number of respondents that answered this question was 285 and therefore 26 questionnaires had no responses. Results are reflected in table 4.9.

Table 4.9 Where condoms can be obtained (n=285)

Place	Number of responses	%
Clinic	144	50.9
Hospital	63	22.1
Clinic and hospital	47	16.5
Shops, bars chemists and toilets	20	7.0
Clinic, hospital, shops, bars, chemists and toilets	11	3.9
Total responses	285	100

Most of the respondents, 50.5% (n= 144) only stated that condoms could be obtained from clinics and 22.1% (n=63) only indicated from the hospital. The rest of the respondents' indicated the following combinations of places namely, 16.5% (n=47) from the clinic and hospital, 7.0% (n=20) from shops, bars, chemists and toilets and 3.9% (n=11) from the clinic, hospital, shops, bars, chemists and toilets.

Responses indicated that respondents were knowledgeable to an extent about the places where condoms could be obtained. A combination of places where it could be obtained was mentioned by 49.5% of the respondents. This knowledge unfortunately does not automatically translate into safe sex practices.

4.3.2.8 Who to use condoms with

Respondents were asked, in question 13, to indicate who they felt they should use condoms with during sex. This question also determined the knowledge of the respondents regarding condom use to an extent. The respondents had to indicate if they agreed or disagreed with five statements and each will be discussed separately.

- *Condom use with every partner* – The question was answered by 305 respondents and 19 did not state an answer. The results are reflected in table 4.10.

Table 4.10 Condoms to be used with every partner (n=305)

Opinion	Number of respondents	Percentage
Agree	279	91.5
Disagree	26	8.5
Total	305	100

- *Condom use with strangers only* – The question was answered by 282 respondents and 42 did not state an answer. The results are stated in table 4.11.

Table 4.11 Condom use with strangers only (n=282)

Opinion	Number of respondents	Percentage
Agree	40	14.2
Disagree	242	85.8
Total	282	100

- *Condom use with regular (steady) partner* – The question was answered by 283 respondents and 41 did not state an answer. The results are reflected in table 4.12.

Table 4.12 Condoms not to be used with regular partner (n=283)

Opinion	Number of respondents	Percentage
Agree	40	14.1
Disagree	243	85.9
Total	283	100

- *Condoms should never be used* – The question was answered by 290 respondents and 34 did not state a response. The results are reflected in table 4.13.

Table 4.13 Condoms should never be used (n=290)

Opinion	Number of responses	Percentage
Agree	7	2.4
Disagree	283	97.6
Total	290	100

- *Other remarks regarding condom use* - The fifth item required respondents to provide any other response regarding condom use. This was not a well formulated question because respondents had to either agree or disagree with the statements provided. This error was not however evident in the pre-test. It is suggested that in future research this item be excluded from the questionnaire.

The trend that is evident from the four questions above is that there was consensus that condoms should be used always and in all circumstances. Of the respondents, 91.5% (n=297) agreed that condoms should be used with every partner; 85.8% (n=242) of the respondents disagreed that condoms should only be used when having sex with strangers; 85.9% (n=243) of the respondents disagreed with the premise that condoms should not be used with a regular or steady partner while 97.6% (n=283) disagreed that condoms should never be used during sexual intercourse.

According to Kabiru and Orpinas (2009:429) condom use is advocated as one of the most effective preventive measures against STI's if used correctly and consistently.

4.3.3 Section C: Sexual experiences and practices

Section C had to be answered by the respondents that indicated that they had sex before, even if the respondent was not sexually active at the time of completing the questionnaire.

4.3.3.1 Currently sexually active

It was determined in question 5 (4.3.2.1) that 115 respondents did have sex. These respondents had to indicate if they were currently sexually active. Results are reflected in table 4.14

Table 4.14 Currently sexually active respondents of group that had sex Previously (n=115)

Variable	Number	Percentage
Sexually active	100	87.0
Not sexually active	15	13.0
Total	115	100

From this data it is clear that by far the majority of respondents who ever started/initiated sexual activity, are sexually active - only 13% (n=15) of the respondents were not sexually active.

If calculated as percentages of the entire sample, the majority of respondents, namely 69.1% (n=224) are currently not sexually active. It seems from this finding that once sexual activity is commenced, it continues.

4.3.3.2 Number of sexual partners per respondent

Respondents were asked in question 15 to indicate how many sexual partners they had. Results are reflected in table 4.15.

Table 4.15 Number of sexual partners per sexually active respondent (n=100).

Number of sexual partners	Number of respondents	Percentage
1	61	61.0
2	15	15.0
3	3	3.0
4	11	11.0
5	1	1.0
5+	2	2.0
Not stated	7	7.0
Total	100	100

The respondents that indicated that they had only one partner each were 61% while 32% indicated that they had multiple partners ranging from two to more than five and seven did not state how many partners they had.

These findings are in contrast with the study by Abdulraheem and Fawole (2009:505) in Nigeria. They found that 66.4% of the respondents in their study group have multiple sexual partners.

4.3.3.3 Partners status related to attending school

Respondents were asked to state whether their sexual partners were in school or not in school in question 16. This question was answered by 94 of the respondents. Results are reflected in table 4.16.

Table 4.16 Sexual partners status related to school attendance (n=94)

Variable	Number of respondents	Percentage
In school	61	64.9
Not in school	19	20.2
Some in school others not	14	14.9
Total	94	100

The majority 64.9% (n=61) of the respondents' sexual partners were school going, 20.2% (n=19) were not in school and 14.9% (n=14) were either in school or not in school (it could be assumed that these respondents had multiple partners).

4.3.3.4 Age of sexual partners

Respondents had to indicate in question 17 the age of their partners, choosing between given age brackets. Only one respondent did not answer this question. Due to the fact that one pupil had three (3) sexual partners with different age groups and one more did not answer the question, the total number of responses for this question was 101. The results are reflected in table 4.17

Table 4.17 Age range of sexual partners (n=101)

Age range	Number of responses	Percentage
15 – 19	75	74.2%
20 – 24	13	12.9%
25 – 29	5	5.0%
30 – 39	4	4.0%
40 – 49	3	3.0%
50+	1	1.0%
Total	101	100%

Most of the respondents' sexual partners, namely 74.2% (n=75), were between 15 and 19 years old and 8% (8) in total had partners older than 30 years. Intergenerational sex is not an uncommon phenomenon among secondary school going adolescents in Molepolole.

4.3.3.5 Respondents having unsafe/unprotected sex

The 100 sexually active respondents were asked in question 18 if they currently were having unsafe or unprotected sex. All respondents answered this question and results are reflected in table 4.18.

Table 4.18 Respondents having unprotected sex (n=100)

Variable	Number	Percentage
Having unprotected sex	45	45.0
Not having unprotected sex	55	55.0
Total	100	100

One hundred respondents reported that they were sexually active at the time of data collection. Of these, 45% (n=45) of the respondents stated that they were having unprotected sex while 55 % (n=55) denied having unprotected sex.

4.3.3.6 Reasons for having unsafe / unprotected sex

Respondents were required to indicate the reasons for having unsafe or unprotected sex in question 19. They were at liberty to state more than one reason and therefore 194 responses are reflected. The reasons for having unsafe/unprotected sex is reflected in table 4.19.

Table 4.19 Reasons for unsafe / unprotected sex (n=194)

Statement	No. of responses	%
It makes me feel very good	22	11.3
I want to satisfy my own sexual needs better	15	7.7
I want to please my partner and that is why I have sex without a condom	11	5.7
Condoms are not 100% safe anyway	20	10.3
It makes me feel like a real man/woman when I have unprotected sex	12	6.2
I have a long and steady relationship so there is no need for condoms	9	4.6
Partner refuses to use a condom and I don't want to lose her/him	16	8.2
There was no condom available at the time	12	6.2
Sex was not planned	16	8.2
Partner refused to use a condom	4	2.1
Was offered money for unsafe/unprotected (skin to skin sex)	10	5.2
It is more enjoyable	18	9.3
Partner is faithful and will not cheat on me	15	7.7
Wanted a pregnancy	2	1.0
Was under the influence of alcohol / drugs	12	6.2
Other (specify)	0	0.0
Total responses	194	100.0

The three responses that ranked highest were that they had unsafe/unprotected sex because it made them feel good, 11.3% (n=22), that condoms were not safe, 10.3% (20) and that sex was more enjoyable without protection, 9.3% (18). Percentages of between 8.2% and 2.1% were recorded for the rest of the responses and only 1.0% (n=2) said they wanted a pregnancy.

The Ministry of Health, Botswana, reports that despite adolescents knowing and having knowledge about AIDS, methods of preventing STI's and where to obtain condoms, most adolescents thought it is not realistic to use condoms each time they had sex. It was also stated that condoms made the sexual experience less enjoyable (Botswana 2001:3 and 8). These findings are consistent with those in the current study.

4.3.3.7 Opinion of sex without a condom

This question (20) required all of the respondents to react positively (yes) or negatively (no) to four sub-questions. Each of these sub-sections is now discussed.

- *Sex without a condom is more enjoyable* - This question was answered by 208 respondents and 116 did not state an answer. The results are reflected in table 4.20.

Table 4.20 Sex is more enjoyable without a condom (n=208)

Sex more enjoyable without condom	Number	Percentage
Yes	53	25.5
No	155	74.5
Total	208	100

Of the respondents 25.5% (n=53), stated that sex without a condom is more enjoyable and 74.5% (n=155) did not agree that sex without a condom is more enjoyable.

- *Sex without a condom is risky* – This question was answered by 256 respondents and 68 did not state an answer. The results are reflected in table 4.21.

Table 4.21Sex without a condom is risky (n=256)

Sex without a condom is risky	Number	Percentage
Yes	218	85.2
No	38	14.8
Total	256	100

The majority of respondents 85.2% (n=218) stated that sex without a condom is risky, while 14.8% (n=38) stated that sex without a condom is not risky.

- *Sex without a condom should be encouraged* – This question was answered by 194 respondents and 130 did not state an answer. The results are reflected in table 4.22.

Table 4.22 Sex without a condom to be encouraged (n=194)

Unsafe sex to be encouraged	Number	Percentage
Yes	39	20.1
No	155	79.9
Total	194	100

The majority of respondents 79.9% (n=155) disagreed that sex without a condom should be encouraged and 20.1% (n=39) agreed that sex without a condom should be encouraged.

- *Sex without a condom should be discouraged* – This question was answered by 216 respondents and 108 did not state an answer. The results are reflected in table 4.22.

Table 4.23 Sex without a condom to be discouraged (n=216)

Unsafe sex to be discouraged	Number	Percentage
Yes	157	72.7
No	59	27.3
Total	216	100

The majority of respondents 72.7% (n =157) stated that sex without a condom should be discouraged and 27.3% (n=59) said that sex without a condom should not be discouraged.

The responses to this sub-section indicate that the respondents have positive attitudes and appreciate the advantages of condom use. Such attitudes, if translated into responsible behaviour, would go a long way in preventing unsafe sex and adolescent pregnancy.

4.3.3.8 Would accept money for unsafe sex

The last question (21) required the respondents to indicate if they would accept money for unprotected sex. This question was answered by 289 respondents and 35 did not answer the question. The results are reflected in Table 4.23.

Table 4.24 Would accept money for unsafe / unprotected sex (n=289)

Opinion	Number of respondents	Percentage
Yes	23	8.0
No	266	92.0
Total	289	100

The majority (92%; n=266) indicated that they would not accept money for unsafe sex, while 8% (n=23) indicated that they would. This is a positive finding from the data.

4.4 COMPARISON BETWEEN MALE AND FEMALE RESPONDENTS

For selected aspects of the study, male and female responses with regard to their sexual experiences and practices were compared. The information presented here is derived from the 115 respondents who reported having had a sexual experience. It is merely a comparison and significance is not determined.

4.4.1 Gender of respondents who have ever had sex

Of the adolescents that reported having had a sexual experience, 53.9% (n=62) were female and 46.1% (n=53) were male in the study as a whole. However, there were more female than male respondents and if this is then expressed as a portion of all the female participants, the percentage would be 29.8% (68 out of 208 participants) compared to a percentage of 45.6% (53 out of 116 participants) for the male group.

4.4.2 Age at first sex

Respondents were asked to indicate their age at first sexual experience. Twenty four (24) did not state an answer.

Table 4.25 Age at first sex (n=115)

	YEARS											
	<10	10	11	12	13	14	15	16	17	18	19	Not Stated
Male	6	4	1	0	3	2	8	9	2	4	2	12
Female	2	3	1	2	0	5	9	15	6	5	1	12
Total	8	7	2	2	3	7	17	24	9	9	3	24

The table above shows that most of the respondents, both male and female had their first sexual experience at the age of 16. Noteworthy too is the fact that more male than female respondents reported sexual debut before the age of ten. This finding is similar to that of March and Atav (2010:10) in which male adolescents were reported to be younger at sexual debut than female adolescents.

One of the objectives of the Botswana National Sexual and Reproductive Health Programme Framework is to assist children aged below ten years to improve their understanding of sexual and reproductive health (Botswana 2002:21). Sexual and reproductive health lessons provided to this age group need to be intensified if they are to be effective.

4.4.3 Use of condom

Respondents were asked to indicate whether or not they used a condom during sex. Results for male and female respondents are depicted in table 4.19.

Table 4.26 Use of condom (n=93)

Use of condom	Males (% of males)	Females (% of females)
Always	26 (56.2%)	32 (68.0%)
Sometimes	7 (15.2%)	8 (17.0%)
Never	13 (28.2%)	7 (14.9%)
Total	46	47

There is a slight difference between the males and females who indicated that they always used condoms because 56.2% (n=26) of the males and 68% (n=32) of the females reported that they used condoms always while 28.2% (n=13) males and 14.9% (n=7) females did not use a condom at all. Chi-square test revealed that there is a relationship between gender and unsafe sex ($p = 0.24$ $p > 0.05$).

Afenyadu and Goparaju (2003:14) reported in their study of the 190 sexually active adolescent respondents, 41% indicated that they did not use a condom and therefore were having unsafe/unprotected sex.

4.4.4 Currently sexually active

Of the 100 respondents who reported that they were sexually active at the time of data collection, 45% were male and 55% were female. It needs to be mentioned

however that 64.2% of the respondents, therefore the majority of the study group, were female.

4.4.5 Accepting money for unsafe / unprotected sex

Of the 7.1% (n=23) respondents who indicated that they would accept money in exchange for unsafe / unprotected sex, 47.8% (n=11) were males and 52.2% (n=12) were females. It seems as if there was no major difference between the males and females who reported that they would accept money in exchange for unsafe / unprotected sex but this finding needs to be refined in order to make a conclusion.

4.5 OVERVIEW OF RESEARCH FINDINGS

Chapter 4 provided a summary of the presentation of the findings of the study. Findings from the analysis of the data revealed that unsafe / unprotected sex is a fairly common phenomenon among some male and female secondary school going pupils. However, a large percentage is aware of the benefits of using condoms. The next chapter comprises a discussion of conclusions, limitations and recommendations.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The purpose of the study was to investigate factors that contribute to unsafe sex practices among adolescents in the secondary schools of Molepolole, Botswana. The target population included male and female adolescents from the eight government junior secondary schools and the only senior secondary school

The objectives of this study were to:

- Determine factors that contribute to unsafe sex among secondary school going adolescents;
- Determine if there are differences between selected sex practices of male and female respondents
- Make recommendations for planners and implementers of SRH services.

5.2 RESEARCH DESIGN AND METHOD

A quantitative non-experimental descriptive design in the form of a survey was applied in this study. A questionnaire was developed, pre-tested and administered to the respondents. The sampling method that was used was convenience sampling because of the sensitivity of the study topic.

5.3 SUMMARY AND DISCUSSION OF THE RESEARCH FINDINGS

5.3.1 Section A: Demographic data

Respondents for this survey were male and female secondary school going adolescents, the majority being females (64.2%). Respondents were aged between 13 and 19 years, the average age being 16.6 years. Study results indicated that most (40.1%) of the respondents lived in two – parent households.

Demographic factors such as age, sex and who adolescents live with could have an influence on whether they engage in unsafe sexual practices. Younger female adolescents may not have the skill to negotiate for safe sex especially if their sexual partners are older, such that partners have the final say in what happens during sex (Lyon and D'angelo (2006:151). Adolescents living in two – parent households are likely to be monitored more often than those in single – parent households or living with their siblings or extended families. Close monitoring, supervision and discussions on sexual matters have been found to delay initiation of sex among female adolescents (Nagamatsu, Saito and Sato 2008:605). The finding in this study was not consistent with previous research findings as adolescents living in two-parent households were more sexually active than those living in single – parent households or relations.

5.3.2 Section B Aspects regarding condom use

The survey demonstrated that some school going adolescents are sexually active as evidenced by 35% who indicated that they had had a sexual encounter and 30.9% of the study sample who were sexually active at the time of data collection. Sexual activity for some (7.0%) commenced as early as before the age of 10 years and before the age of 17 for most of them. Some respondents did not indicate their age at their first sexual encounter and this could imply that they could not recall when it happened. It was encouraging to note that the majority (64.5%) of respondents had never been involved in any sexual relations.

In the sample, adolescents engaged in first sexual intercourse out of curiosity (34.8%), persuasion by the boyfriend / girlfriend (20.9%) and encouragement by friends (13.9%). Other reasons included alcohol influence, cultural expectations and coercion.

About half of the sexually active respondents practiced safe sex because 50.4% used condoms during each sexual experience. This finding explains the ever increasing adolescent pregnancies that have subsequently led to pupils dropping

out of school. It also highlights possible contributory factors which adolescents could be facing in acquiring Sexual and Reproductive Health services such as poor access to condoms. Silva (2007:109), states that one of the reasons for adolescent pregnancies, with regard to provision of services, includes lack of access to family planning services (including male and female condoms).
Adolescents appeared to be knowledgeable about the conditions for which condoms provide protection to users: see section 4.3.2.5.

With regard to places where condoms could be obtained, the majority of respondents knew where to get condoms i. e. clinics, hospitals, shops, toilets, chemists and bars. Knowing where to obtain condoms does not unfortunately guarantee their use as the study demonstrated. It became clear from the study that the majority of adolescents approved the use of condoms at every sexual act with every sexual partner, whether regular or not. These are positive findings of the study and could be beneficial if put into practice by all sexually active adolescents.

5.3.3 Section C Sexual experiences and practices

The results confirmed that of those adolescents (30.9% of the sample) who indulged in pre – marital sex, the majority (61%) have one sexual partner. Some adolescents had multiple concurrent partners ranging from 2 to 5 partners and ages ranging from 20 to above 50 years.

Of the adolescents that were sexually active, 32.8% were practicing unsafe sex. The main reasons why adolescents in this study engaged in unsafe sex was because it made them feel very good (11.3%), they did not want to lose their partners (8.2%) and unsafe sex or not using a condom was more enjoyable (9.3%). In addressing the problem of unsafe sex it becomes important to inculcate into the minds of adolescents the value of self so as to discourage them from taking risks that will jeopardise their health and life. Hopkins, McBride, Marshak, Freier, Stevens, Kannenberg, Weaver, Weaver, Landless and Duffy

state that one element worth considering in the prevention of high risk behaviour is determining adolescents' ability to understand who they are and what their purpose in society is, through self appraisals (2007:S70).

More importantly, some (10.3%) sexually active adolescents believed that condoms were not 100% safe, suggesting that they may not use condoms during sexual intercourse even when available. This belief or misconception is retrogressive to the efforts being made to curb HIV / AIDS infection as correct and consistent condom use is the only available method, after abstinence and being faithful to one uninfected partner, for preventing HIV/AIDS infection. Such misconceptions need to be corrected and addressed holistically through integrated educational campaigns in schools and society in general.

It was evident from the study that respondents had other varied reasons for having unsafe sex (see section 4.4.6) It is critical therefore that these reasons are considered in coming up with solutions to the problem of unsafe sex among adolescents.

5.3.4 Comparisons between male and female responses

Of the 115 respondents who reported having had sex, the majority (53.9%) were female and the rest (46.1%) were male. 22.6% of the male respondents who were sexually active lived in a two – parent household compared with 20.9% female respondents who also lived in a two-parent household. There were slightly more sexually active females (9.6%) compared to males (6.1%) living with mother only and slightly more females (13.9%) compared with males (6.1%) living with relatives.

More male (5.2%) than female (1.7%) respondents initiated sex before the age of 10. Condom use was reported by 27.8% (n=32) females compared to 22.6% (n=26) males. Sexual activity at the time of data collection was reported by 45% males and 55% females. There were more (53%) females having unprotected

sex compared to males (47%) and 47.8% males stated that they would accept a financial reward for unsafe sex compared to 52.2% females.

An interesting finding of the study was that the majority of sexually active male respondents (80%; n=8) indicated that they had unsafe sex for a financial reward compared to 20% (n=2) sexually active females. These findings point to the possibility of sexual activities between financially stable older women or men (homosexuals) and male adolescents. This may not necessarily be a new phenomenon but may probably be one that has not yet received due attention of researchers. Maundeni (2004) reports that the boy child is neglected and socialised to be strong and not express his emotions despite being vulnerable. Due to this expectation from society sexually abused boy children do not disclose such sexual experiences such that their psychosocial problems are unknown and under-researched.

5.4 RECOMMENDATIONS FOR THE EDUCATIONAL AND HEALTH SECTORS

Unsafe sex among adolescents if left unchecked could result in consequences that adversely affect the educational aspirations, psycho-social aspects and the general health of adolescents. It is the corporate responsibility of the community and every nation to put in place measures that will help curb such practices, especially among the youth.

The findings of the study revealed that abstinence, being faithful to one sexual partner and use of condoms (ABC) as strategies of preventing adolescent unsafe sex and pregnancy have failed in some of the respondents in the study population. Based on the study findings, recommendations will be provided for addressing the factors identified in this study.

5.4.1 Promotion of abstinence

The majority of respondents had never had a sexual experience and were not sexually active. This was a positive finding of the study which could be used in coming up with solutions to the problem of unsafe sex. Great effort should be taken to promote the idea of abstinence and the value and importance of abstinence should be constantly emphasised in educational and other programmes.

5.4.2 Improving parent – child communication

There is empirical evidence from previous researchers which point to the fact that effective communication between parents and their adolescent children can significantly contribute to delaying sexual debut and protects against risky behaviour. Lyon and D'angelo (2008:149) state that initiation of sexual intercourse was delayed in adolescents whose parents honestly discussed sex. This strategy informs adolescents of parents' disapproval about sex and acts as a vaccine that protects teens from unhealthy peer influences.

Since the home is the first agent of socialisation, adolescents trust their parents in most cases for counsel and are likely to heed that counsel. It is thus recommended that:

- Parents and leaders of the community discuss ways of addressing adolescent sexual behaviour with adolescents during Kgotla meetings (these are meetings where issues concerning the welfare of community members are discussed. The Kgotla also serves as a customary / traditional court).
- Parents are encouraged to move away from the belief that discussions on sexual behaviour, with their children are taboo.
- Parents should openly discuss adolescence and sexual behaviour and point out the consequences of risky sexual behaviour to their children.

5.4.3 Education on valuing self

The concept of valuing of self means that adolescents should give first priority to issues concerning self above all else. This is important as empirical evidence has demonstrated in some studies that girls with high self esteem have positive attitudes towards condom use and are less fearful making it easier for them to negotiate condom use. They also communicate more frequently with their sex partners and parents (Salazar, Crosby, Diclemente, Wingood, Lescano, Brown, Harrington and Davies 2005).

Social workers should be involved in sensitising youth about their value as individuals and as members of the community to discourage them from for example accepting financial rewards for unsafe sex. They should be taught on:

- Self esteem and loving self as values that needs to be instilled in them. They should be told that their happiness should not be dependent on another person and that they are the sole determinants of their future life and what they want to be in life.
- Being responsible for everything they do and made to realise that there are adverse consequences for every wrong decision they make, such as indulging in unsafe sex.

5.4.4 Educational initiatives

Experienced personnel such as social workers trained in the education of children and health care workers, should be invited to teach children in primary school about sexuality. The following is proposed:

- SRH lessons should be taught as early as the first year in primary school.
- Efforts should be made to educate the young boys and girls about their sexuality and sensitise their innocent minds to the potential risk of sexual abuse. Such lessons will help them realise when they are being held inappropriately and will give them the impetus to report or seek help for any inappropriate behaviour.

- Empower them to be able to refuse gifts from members of the opposite sex or be found alone in their company.

5.4.5 Condom use

It was established in the study that the majority of respondents believed that condoms protect against pregnancy, HIV/AIDS and STI's. Most respondents also stated that condoms needed to be used with both regular partners and strangers. These are positive attitudes that need to be promoted and enforced in practice.

This study also provided evidence that unsafe sex is practiced by school going adolescents and is a challenge that needs to be addressed by school authorities working together with other stakeholders such as health institutions and community leaders. The community needs to acknowledge the fact that unsafe sex is a reality and should devise strategies that will work in addressing the problem. It is recommended that:

- Controversial and difficult as it may be for parents and teachers, there is need to consider making condoms available to pupils in secondary schools through the Counselling and Guidance departments in mitigating the problems of adolescent unsafe sex, pregnancy and school drop outs. This issue can be discussed during Parent-Teacher Association meetings.

Among reasons given for having unsafe sex was further the lack of condoms at the time of sex, unplanned sex and alcohol influence. The following are therefore recommended:

- Adolescents in sexual relations should be encouraged to always have condoms readily available.
- Clubs for adolescents should be formed in the community and in schools for the aim of discouraging drug abuse.
- Adolescents should be taught about the adverse effects of alcohol consumption and abuse as a means of deterring them from the practice.

5.4.6 Aspects that health authorities should attend to

The national SRH programme framework and the ASRH implementation strategy have been in use in Botswana for almost ten (10) years and yet adolescent pregnancies continue to rise. It is then recommended that:

- Evaluation of these policies needs to be undertaken to determine efficacy, challenges and flaws.
- Based on the evaluation new strategies will have to be developed.
- Health education, communication and promotion related to the broader topic of sexuality should be emphasised.
- Any health education to be embarked on should consider the various cultures of the people as these are instrumental to successful intervention.

5.5 RECOMMENDATIONS FOR ADDITIONAL RESEARCH

The study was not exhaustive and it was observed that additional research is required:

- Based on the study results, it is important to determine how prevalent unsafe sex for a financial reward is between male adolescents and older women, but also between female adolescents and any others.
- A survey could be conducted to compare the sexual practices of adolescents in government schools with those of adolescents in private schools.
- Questionnaires should be administered to adolescents to determine reasons why they engage in sex with multiple partners in this HIV/AIDS era.
- Experiences of adolescents involved in age-disparate sex also need to be determined.
- A study on why adolescents are motivated to use condoms is recommended and the findings should be rolled out.
- The questionnaire could be revisited and refined and similar studies could be done in other villages countrywide.

- Difficult as it might be, a qualitative study could be done to determine why children become sexually active at a very young age in order to address this problem.
- It is recommended that a qualitative study to interview respondents who are not sexually active as individuals or in focus group discussions be carried out, to determine how they manage to remain celibate as adolescents. The methods they use can then be shared with other adolescents during peer education.

5.6 CONTRIBUTIONS OF THE STUDY

The study revealed, like previous research studies, that some adolescents are sexually active and indulge in unsafe sex for various reasons, most of which have to do with individual attitudes and perceptions. This study was valuable because the situation as it is was in the specific study context could be presented and recommendations that would address identified problems could be formulated. This study can further serve as a basis for further similar studies in Botswana.

5.7 LIMITATIONS OF THE STUDY

Several limitations were identified during the course of the study and are listed as follows:

- Botswana lacks documented reference sources pertaining to the topic of study.
- Convenience sampling was used thus results cannot be generalised to adolescents in Molepolole or the rest of Botswana.
- Supervision of the dissertation was through distance tuition which proved a challenge sometimes.

5.8 IMPLICATIONS OF THE STUDY

This study revealed that young boys are involved in unsafe sex for a financial gain. It was evident from the study that adolescents engage in age-disparate

relationships with multiple concurrent partners. Sexual activity at very young ages (9-10 years) was also reported. These study findings indicate some gaps in the provision of adolescent sexual and reproductive health. They also raise serious implications for research.

5.9 CONCLUSION

Empowering youth and their parents with information, education and counselling (IEC) may be beneficial in discouraging the practice of unsafe sex.

It has been suggested that a comprehensive approach emphasising both abstinence and safe sex practices should be adopted in sex education and that the focus of the programme should depend on the stage of development of the learner (Panday et al).

The findings attested to the fact that secondary school going adolescents engaged in unsafe sex with partners who are mainly their colleagues though some of them had several sexual partners older than themselves. Reasons identified in the study for this practice were mainly self gratification, non-availability of condoms, alcohol influence and unplanned sex.

Recommendations were made in the light of the study findings to sensitise adolescents to the reality and consequences of unsafe sex, in an effort to enable them make informed and better decisions regarding their sexuality in future.

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ANNEXURE A:

Letter requesting permission to conduct the study on factors contributing to unsafe sex among teenagers in the secondary schools of Molepolole.

Molepolole Institute of Health Sciences
P. O. Box 684
Molepolole

The Director
Kweneng Region
P. O. Box 1293
Molepolole
Botswana

10/06/2010

Dear Sir,

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

I am hereby requesting for permission to carryout a research study in the secondary schools of Molepolole entitled 'Factors contributing to unsafe sex practices among teenagers in the secondary schools of Molepolole'.

I am a nurse lecturer working at the Institute of Health Sciences and reading for my Master of Public Health with the University of South Africa (UNISA). As part of the requirements for the degree, I am required to conduct a research study.

I look forward to your favourable response.

Yours truly,

Alvella Mwinga (Ms)

ANNEXURE B:

Letters granting permission to conduct research on factors contributing to unsafe sex among teenagers in the secondary schools of Molepolole.

TELEPHONE: 5920361
TELEGRAM: SABAOKI
REFERENCE: S. N
FAX: 5920369

INSTITUTE OF HEALTH SCIENCES
P. O. BOX – 684
MOLEPOLOLE
BOTSWANA

I.H.S PF II 1 (92)

14 June 2010

The Director
Molepolole Education Center
P O Box 1293
Molepolole

Attention: Mr Sethapelo

Dear Sir/Madam

FACTORS RESPONSIBLE FOR UNSAFE PRACTICE AMOUNG TEENAGERS IN SECONDARY SCHOOLS: MOLEPOLOLE

This is to inform your esteemed office that Ms Alvella Mwinga is an employee with the Ministry of Health at Institute of Health Sciences Molepolole. The officer is currently engaged in research whose title is Factors Responsible for Unsafe Sex Practice Amoung Teenagers in Secondary Schools – Molepolole. She is requesting for permission to collect data from the secondary schools.

Hope this information will assist you.

Yours faithfully

B. Chalashika
PRINCIPAL

(267) 5920378

FAX: (267) 5920460

Republic of Botswana

KWENENG REGION
MOLEPOLOLE EDU
PO BOX 1293

BOTSWANA

REF: KWR 1/3 I (62)

16 June 2010

Ms Alvella Mwinga
M I Health Sciences
Molepolole

Dear Ms Mwinga

FACTORS RESPONSIBLE FOR UNSAFE SEX PRACTICE AMOUNG TEENAGERS IN SECONDARY SCHOOLS: MOLEPOLOLE

Please refer to your correspondence on the above captioned subject dated 14 June 2010.

Permission granted. However, please contact each School Head to facilitate their assistance to you.

Yours faithfully

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B.E. Sethapelo
For Regional Director

/rm

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: 8 January 2010 Project No: 3656 474 4

Project Title: FACTORS CONTRIBUTING TO UNSAFE SEX PRACTICES AMONG ADOLESCENTS IN THE SECONDARY SCHOOLS IN MOLEPOLOLE (BOTSWANA)

Researcher: Ms AM Mwinga

Supervisor/Promoter: Dr ADH Botha

Joint Supervisor/Joint Promoter:

Department: Health Studies

Degree: MPH

DECISION OF COMMITTEE

Approved [√] Conditionally Approved [ ]

Date: 19 November 2009

Prof VJ EHLERS
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURES C AND D:

Information leaflet for adolescents and following Self-administered questionnaire for adolescents

PARTICIPANT INFORMATION LEAFLET

P.O. Box 684
Molepolole I.H.S.

Dear Respondent

RESEARCH: FACTORS CONTRIBUTING TO UNSAFE/UNPROTECTED SEX PRACTICES AMONG ADOLESCENTS

As part of the requirements for the MPH degree programme that I am undertaking with the UNISA, a research study on a selected topic needs to be undertaken. My selected topic is as stated above.

Currently I am a nurse lecturer as well as a clinical practitioner at Molepolole Institute of Health Sciences.

The purpose of my study is to determine the factors that contribute to unsafe/ unprotected sex practices among adolescents in Molepolole. This information will enable me to come up with strategies that will help improve safe sex education and help prevent school going pupils from adolescent pregnancy, sexually transmitted infections and HIV infection.

This letter requests your participation in this study. You will be asked to complete a questionnaire containing multiple choice questions. Completion of the questionnaire may take up to 30 minutes. Completed questionnaires have to be placed in the box provided by the researcher. In order to maintain anonymity and confidentiality, you will not be asked to complete a consent form. **The implication of completing the questionnaire is that informed consent has been obtained from you. The information to be collected will be used strictly for statistical inferences and no information pertaining to individuals will be divulged. Your participation in this study is voluntary and you can refuse to participate, or withdraw at anytime without stating a reason.**

Pease do not hesitate to ask the researcher any questions you may have.

Thank you for deciding to participate in the study

Kind regards
Alvella Mwinga

QUESTIONNAIRE

SECTION A

Please answer all the following questions to the best of your ability, by marking an X next to the appropriate answer.

DEMOGRAPHIC DATA (this is the information needed to tell the researcher about the ages, gender and more of the study participants)

1. What is your gender (sex)?

Male	
Female	

2. How old are you?

16	17	18	19	Other(specify)

3. What is your highest level of education attained?

Form 3	Form 4	Form 5	Other(specify)

4. Who do you live with?

Both parents	
Mother only	
Father only	
Brothers and/or sisters	
Staying alone	
Grandparent / s	
Relatives (Aunt etc)	
Friends	
Other (specify)	

SECTION B

This section contains very sensitive information, but you are requested to please answer it very honestly. Remember, nobody will see these questionnaires, except the researcher. Also: you have not written your name on this, so it will not be possible to know who answered which questionnaire.

In this section, the researcher looks at issues around condom use. Please indicate your answer again by making a (cross) X next to your answer. Take note: there are some questions where you may want to make more than one X: please do so if more than one possibility is applicable.

5. Have you ever had sex?

Yes	
No	

If you answered yes above, then answer questions 6, 7 and 8.

All continue from question 9.

6. How old were you the first time you had sex?

<10	10	11	12	13	14	15	16	17	18	19

7. What made you decide to have sex the very first time?

Wanted to experiment (curiosity)	
Was encouraged by my friends	
Boyfriend/girlfriend persuaded me	
Was raped/forced	
Culture expects me to have sex at my age	
Was under the influence of alcohol (drugs)	
Other (please specify)	

8. Do you use a condom during sex ?

Always	
Sometimes	
Never	

9. Please indicate how you feel about all the statements below by marking an X against the appropriate response.

Statement	Agree	Disagree
Condoms protect against pregnancy		
Condoms protect against HIV/AIDS		
Condoms protect against sexually transmitted infections		

10. Does your school provide condoms?

Yes	
No	

If Yes, please answer question 11

All: please continue from question 12.

11. Are there always enough condoms available at your school?

Yes	
No	

12. Where can you obtain condoms other than at school?

Clinic	
Hospital	
Other (specify)	

13. Please indicate how you feel about all the statements below by marking an X against the appropriate response:

Statement	Agree	Disagree
Condoms should always be used with every partner		
Condoms should only be used with strangers e.g. prostitute		
Condoms should not be used with a regular (steady) partner		
Condoms should never be used during sex		
Other (specify)		

SECTION C: THIS SECTION SHOULD ONLY BE ANSWERED BY ALL THAT MARKED *YES* IN SECTION B, QUESTION 5 (in other words, those who already had sex before; even if you are not sexually active at the moment**)**

In this section, the researcher looks at issues around sexual experiences and practices. Please indicate your answer again by making a X next to your answer. Take note: there are some questions where you may want to make more than one X: please do so if more than one possibility is applicable.

14. Are you sexually active at the moment?

Yes	
No	

If yes, please do questions 15 to 19. All continue with question 20.

15. How many sexual partners do you have?

1	2	3	4	Other (specify)

16. Your sexual partner(s)' are:

All attending school	
All not in school	
Some attending school & some not	

17. How old is/are your sexual partner(s)?

15 - 19	
20 -24	
25 -29	
30 -39	
40 – 49	
50+	

18. Are you having unsafe/unprotected (skin to skin) sex currently?

Yes	
No	

If Yes, Go to question 19

All continue with question 20

19. Why are you having or did you have unsafe/unprotected (skin to skin) sex? (you can mark more than one)

Statement	Yes	No
It makes me feel very good		
I want to satisfy my own sexual needs better		
I want to please my partner and that is why I have sex without a condom		
Condoms are not 100% safe anyway		
It makes me feel like a real man/woman when I have unprotected sex		
I have a long and steady relationship so there is no need for condoms		
Partner refuses to use a condom and I don't want to lose her/him		
There was no condom available at the time		
Sex was not planned		
Partner refused to use a condom		
Was offered money for unsafe/unprotected (skin to skin sex?)		
It is more enjoyable		
Partner is faithful and cannot cheat on me		
Wanted a pregnancy		
Was under the influence of alcohol / drugs		
Other (specify)		

All please continue from here:

20. In your opinion, is sex without a condom:

	Yes	No
more enjoyable		
risky		
to be encouraged		
to be discouraged		

21. If you needed money for school or to buy something you really liked, would you agree/accept to have unsafe/unprotected (skin to skin) sex?

Yes	
No	

THANK YOU FOR THE TIME SPENT COMPLETING THE QUESTIONNAIRE!