

**SOCIO-CULTURAL INFLUENCES IN DECISION MAKING INVOLVING SEXUAL  
BEHAVIOUR AMONG ADOLESCENTS IN KHAYELITSHA, CAPE TOWN**

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts  
in Psychology, in the Department of Psychology, University of the Western Cape, Bellville.



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25 February 2011

## DECLARATION

I, the undersigned, Nolusindiso Ncetakalo, declare that this thesis ‘Socio-cultural influences in decision making involving sexual behaviour among adolescents in Khayelitsha, Cape Town’ is my own original work. Other work cited in this thesis has been fully referenced. This thesis has not been submitted, in full or part, for the award of any degree.

Signature: \_\_\_\_\_

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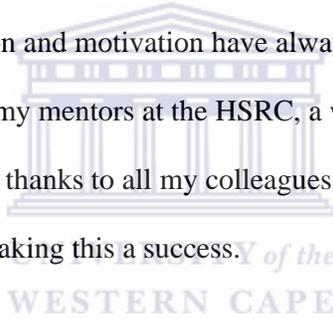


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## **KEYWORDS**

Adolescents

Risky sexual behaviour

Socio-cultural influences

Adolescent pregnancy

Social norms

Sexually transmitted infections

Cultural beliefs

Decision-making

HIV risk



## ABSTRACT

Risky sexual behaviour is one of the major concerns in South Africa today. This is because issues such as unplanned pregnancy and sexually transmitted infections (STIs) including HIV/AIDS are consequences of risky sexual behaviour. It is important to understand the socio-cultural, as well as behavioural factors that are associated with such sexual problems. The aim of the study was to explore the socio-cultural influences in decision making involving sexual behaviour among adolescents in Khayelitsha, Cape Town. Cultural beliefs associated with adolescents' decision to become sexually active were explored, as well as the social norms influences involved in adolescents' sexual behaviour. The theoretical framework used for the study was Bronfenbrenner's ecological systems theory of development. The results indicated that adolescent pregnancy was perceived as unacceptable behaviour although found widespread in communities. Social influences such as peer influence, low socio-economic status, alcohol use and lack of parental supervision were found to play a role in adolescents' risky sexual behaviour. Cultural beliefs, cultural myths and social norms were identified as socio-cultural influences that endorsed issues such as gender disparities, which made adolescent mothers vulnerable. Findings from this study suggest that female adolescents are faced with sexual behaviour complexities. This points out the need to prioritize adolescents in intervention programmes in environments such as school, church, at home and community at large. Such interventions should raise awareness and enrich adolescents' knowledge on prevention of both HIV/AIDS and unplanned pregnancies. Emphasis should be on changing cultural beliefs and norms that disapprovingly influence adolescents' sexual behaviour.

# CHAPTER 1

## INTRODUCTION

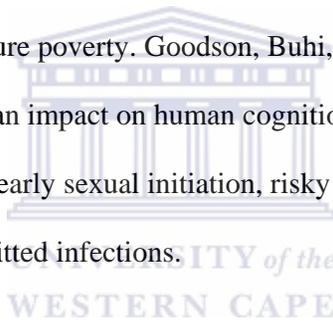
### 1.1 Background

Adolescent pregnancy and HIV/AIDS are regarded as both reproductive health and social concerns for adolescents in Sub-Saharan Africa. Cultural beliefs have been shown to influence sexual behaviour. Researchers have come up with different findings as to why adolescent pregnancy and HIV infection rates are both high in our communities. The main fact is that young South African adolescents engage in unprotected sex and that exposes them to unplanned pregnancy and risk for HIV infection.

Unplanned pregnancy, sexually transmitted infections (STIs), and human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) tend to be consequences of risky sexual behaviour especially by engaging in unprotected sexual intercourse. Several studies have suggested that adolescents perceive lower risk for STIs and HIV/AIDS than for unplanned pregnancy. For example, researchers have found that adolescents tend to report that they engage in safe sex behaviour (condom use) to prevent pregnancy rather than for disease prevention (Maticka-Tyndale, 1991). Condom use among young people in South Africa has increased (Maharaj & Cleland, 2006; Shisana et al., 2009). The increase in condom use has been positively associated with education as young people in school use condoms more than those out of school. Assuming that the issue of sex without birth control creates risk for pregnancy, research findings can also be interpreted as support for the notion that sexually active adolescents are more concerned about becoming pregnant than they are about

diseases as adverse sexual outcomes. This can therefore mean that adolescents feel more invulnerable to some risks than to others.

It is critical to understand how an individual's sexual behaviour is shaped by his/her surrounding environments. Research findings by Cleveland, Udry and Chantala (2001) demonstrate that socio-cultural contexts influence a person's behaviour, as well as their decision making. In addition, social norms and other societal processes are related to individual experiences and their sense of sexual behaviour (Smith et al., 2003). During adolescence, sexual activity is associated with risks including STIs and unplanned pregnancy (Dubhashi & Wani, 2008). For adolescents who are not emotionally mature, there are added risks of emotional distress or future poverty. Goodson, Buhi, and Dunsmore (2006) also pointed out that self-esteem has an impact on human cognition and emotion, including sexuality-related factors such as early sexual initiation, risky sexual behaviour, unplanned pregnancies and sexually transmitted infections.



## **1.2 Defining socio-cultural influences**

Social norms, as defined by Durlauf and Blume (2001), are customary rules of behaviour that coordinate interactions with others. Bryant and Jary (2001) define social norms as shared expectations of behaviour that are prescribed and considered acceptable by societies/communities. In addition, cultural beliefs are regarded as symbolic and learnt aspects of a society/community that in some way or the other prescribe behaviour. These beliefs are considered as the norms and values shared by a community. It is these social norms and cultural beliefs that influence the thinking, as well as the behaviour of an individual.

Adolescents are therefore pressured by social influences, which take many forms and can be perceived in peer groups, at home, and in the community. Socio-cultural influences could therefore be defined as the sum of all things that change or have some effect on an individual's behaviour. Such influences can be from one's family background, one's religious or cultural beliefs and norms/customs that exist in one's community.

### **1.3 Rationale of the study**

Estimates from the 2003 Demographic and Health Survey (DHS) show that South Africa has one of the lowest total fertility rates in sub-Saharan Africa (Panday et al., 2009). Teenage fertility in South Africa is also declining. However, the decline in teenage fertility is interrupted from time to time. Data from the 2003 Status of the Youth Survey (Richter et al., 2005) showed that young people between ages 15-35 years were at greatest risk for HIV infection. In addition, a study conducted by the Department of Health in 2006 estimated that almost a third (29.1%) of pregnant women were living with HIV in 2006 (Department of Health, 2002-2006). It is therefore important to understand the contextual issues related to sexual behaviour of young people in South Africa.

One of the areas that have not been well researched is the way teenage mothers think about their experiences of early pregnancy, as well as the cultural influences in decision making of adolescents. This research study investigates the importance of understanding the socio-cultural influences that affect adolescents when making decisions associated with sexual behaviour. In doing so, the researcher seeks to find out how cultural practices and social or community norms influence adolescents' decision making with regard to sexual behaviours

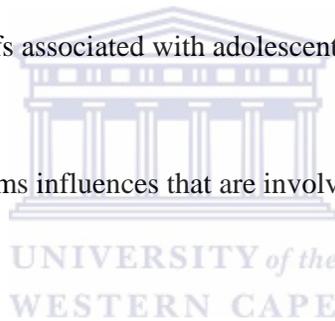
such as onset of sexual activity, use of contraceptives, and number of sexual partners. It is of importance to focus on understanding cultural practices and beliefs that influence decision making involving sexual behaviour among adolescents.

#### **1.4 Aim and objectives**

The aim of this study is to explore the socio-cultural influences in decision making involving sexual behaviours among adolescents in Khayelitsha, Cape Town.

The objectives of the study are:

- a) To explore cultural beliefs associated with adolescents' decision to become sexually active,
- b) To understand social norms influences that are involved in adolescents' sexual behaviour



#### **1.5 Overview of chapters**

**Chapter 1** provides the background and explains the study. The background briefly provides factors associated with risky sexual behaviour of adolescents. Following the background is the rationale of the study, which explains the importance and the focus of the study. The aim and objectives of the study follow the rationale. Lastly, the overview of the thesis is provided at the end of the chapter.

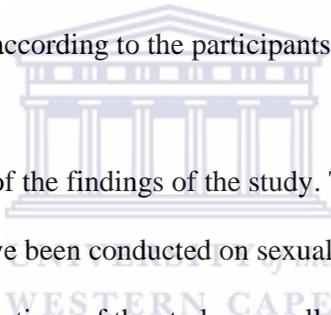
**Chapter 2** provides an overview of existing literature on the study particularly adolescent sexual behaviour. The chapter also provides literature from research studies that have been

conducted. The chapter outlines both the South African research as well as the global research on adolescent sexual behaviour. The chapter also includes a theoretical explanation that is relevant to that is relevant to the study. Lastly, the chapter concludes with a chapter summary.

**Chapter 3** focuses on the methodology of the study. The methods section includes participants in the study, description of the research design, data collection method and tool, data analysis, trustworthiness and credibility, ethical considerations and reflexivity. A comprehensive description of the above elements is provided in this chapter.

**Chapter 4** presents the findings of the study. These findings are categorized into different themes. Each theme is analysed according to the participants' responses.

**Chapter 5** provides a summary of the findings of the study. This summary also relates to previous relevant studies that have been conducted on sexual behaviour. The chapter includes a discussion of the findings, limitations of the study, as well as recommendations of the study. To finish, the chapter provides concluding remarks.



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter provides an overview of existing literature on adolescent sexual behaviour. It also provides literature from research studies that have been conducted, which focused on adolescent risk behaviours. The chapter begins with some literature on statistics of adolescent sexual behavior globally. Following this is some literature and research studies conducted in South Africa related to adolescent sexual behaviour. The literature and South African studies draw attention to a number of issues affecting adolescent sexual behaviour. Risk factors or influences of adolescent sexual behaviour are described in this chapter. These risk factors include issues such as the environmental factors, cultural or societal factors, psychological factors, and so forth that influence adolescent decision making related to sexual behaviour. This chapter also looks at factors influencing decision-making of adolescents regarding their sexual behaviour. Perceptions and beliefs of adolescents on risk behaviour are explored. The chapter also provides literature on cultural beliefs and social or community norms associated with adolescent sexual behaviour.

Finally, this chapter includes a review of a theoretical explanation that is the ecological systems theory of development. The chapter provides a detailed description of the relation of Bronfenbrenner's ecological theory to adolescent sexual behaviour. This describes how social contexts influence development as well as decision-making processes. Furthermore, the chapter presents a brief conclusion on the existing literature and research studies.

## 2.2 Global Research and statistics on risky sexual behaviour

There has been an increase in HIV prevalence globally over the past two decades. Not only has this increase occurred in South Africa, but in other countries as well. Globally, the percentage of women among people living with HIV has remained stable at 50% for several years, although women's share of infections is increasing in several countries in Sub-Saharan Africa (UNAIDS, 2008). Researchers' particular concern is the increasing health threat posed by HIV. Research has therefore begun measuring the impact of sexual risk behaviours in terms of number of deaths of young adults who are infected with HIV as adolescents.

On a global level, it has been shown that currently more than half of all people newly infected with HIV are between 15 and 24 years of age (UNAIDS, 2008). Young people aged 15–24 account for an estimated 45% of new HIV infections worldwide. Leclerc-Madlala's (2002) findings emphasize that in communities with high sero-prevalence rates, most new HIV infections occur during adolescence. An extensive international study of HIV/AIDS and youth maintains that “more than half of those newly infected with HIV today are between 15 and 24 years old” (UNICEF, UNAIDS, WHO, 2002). Southern Africa continues to bear a disproportionate share of the global burden of HIV. For instance, estimated 35% of HIV infections and 38% of AIDS deaths in 2007 occurred in that sub region (UNAIDS, 2008).

To date, literature shows that adolescent pregnancy and HIV risk are not unique problems that only occur in South Africa but in other countries as well. For example, the majority of adolescents aged 15 to 19 years in Canada and the USA report having had sexual intercourse at least once (Hall & Holmqvist, 2004). In addition, 23.9% and 45.5% of adolescent females from Canada and the USA, respectively, report having had two or more sexual partners in the

past year. Similarly, 32.1% of Canadian males in this age group report having multiple sexual partners, while 50.8% of American males report the same. In addition to the risk of STIs, the risk of unplanned pregnancy increases with frequency of unprotected sexual intercourse. Estimates have suggested that approximately 40% of adolescent American women (aged 15 to 19 years) become pregnant before age 20 years and most of these pregnancies are unintended. Although more recent estimates suggest that rates have dropped to 35% the rates of teenage pregnancy are still significantly higher in Canada and the USA than in other Western industrialized countries like France, Germany, and Sweden (Hall & Holmqvist, 2004).

Furthermore, in a study conducted in rural Jamaica, research findings showed that adolescents initiate sexual intercourse early and do not consistently make use of protection. These behaviours are associated with increased risks of unplanned pregnancy and STIs, which have become significant health problems among adolescents (Smith et al., 2003). Sexual concerns that affect female adolescents include their lack of relationship control, fear of condom negotiation with their male partner, communicating less frequently with their partner about sex, and having older sexual partners; all of these issues have been associated with greater likelihood of teenage pregnancy and engaging in STI/HIV sexual risk behavior (DiClemente et al., 2008). Surveillance data indicated that African-American adolescent females are disproportionately affected by STI/HIV relative to other racial/ethnic groups and males (Smith et al., 2003).

In essence, there seems to be factors associated with adolescents' sexual behaviour, particularly females. Also, there are disparities between male and female adolescents' sexual behaviour, as well as risks that are related with their behaviours. It is therefore important to review sexual behaviour among these adolescents in South Africa.

### 2.3 South African research

South Africans are faced with the dual social problems of teenage pregnancy and HIV infections. The second national population-based survey conducted by the HSRC (Shisana et al., 2005) demonstrated an estimated 3.3% of children aged 2-14 years were infected with HIV, whereas for adolescents aged 15-19 years HIV prevalence was estimated at 6.3% (Gouws et al., 2008). Findings of the third national population-based survey in 2008 showed an estimated HIV prevalence of approximately 10.6% in all age groups (Shisana et al., 2009). Females were found to be more at risk of HIV infection than males. The survey also showed an HIV prevalence of 6.7% among females and 2.5% among males between the ages 15-19 years (Shisana et al., 2009). Surprisingly, research findings show a decline in teenage pregnancy rates over the past years. Whilst the overall fertility rate has been declining over the period, births to teenage women have been increasing (Makiwane & Udjo, 2006). Furthermore, it has been found that South Africa has the highest number of children living with HIV in the world with an estimated 280 000 children below the age of 15 years living with the infection (UNAIDS, 2008).

Risky sexual behaviours are of particular concern to South African communities in that they can lead to serious consequences both for the adolescent involved and other family members. Given that STIs and HIV have significant adverse health and social consequences for adolescents and society, preventing infection represents one of the most urgent public health priorities. Makiwane (1998) conducted a study in rural Transkei of South Africa and found that pre-marital childbearing and impregnation were socially accepted. The study also found that nearly two-thirds of adolescent mothers had partners older than 20 years of age. Furthermore, Makiwane and Udjo (2009) estimated that half of all young people between

ages 15-19 years of age report having had sex. It is also estimated that by age 19, close to 80% women in South Africa have had sex, and about 37% have been pregnant (Makiwane & Udjo, 2009).

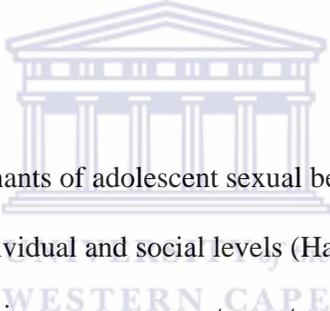
Alternative views of adolescent pregnancy are usually only voiced in more private settings, sometimes by the same people who at other times articulate the more familiar discourse. In-depth research has revealed that many teenagers are encouraged to become pregnant by their partners to prove their love, womanhood and fertility (Preston, Varga & Makubalo, 1996). This is often encouraged by grandmothers to produce a baby for the home, and mothers often indicate that teenage pregnancy is infinitely preferable to the possibility of infertility caused by contraceptive use (Wood et al., 1997). According to Wood et al. (1997), the baby is usually accepted into the mother's family, given the protection of her ancestors, looked after by elder women and the mother is often able to return to school. In some instances, children born out of wedlock become culturally accepted by the grandparents.

In South Africa, there has been an ongoing debate concerning whether or not the child support grant has an influence in adolescent pregnancy. Recently, Makiwane and Udjo (2009) compiled a report that outlined the relationship between child support grants and the increase in adolescent pregnancy. Based on national surveys conducted, they found that there was no relationship found between child support grants and adolescent pregnancy or fertility rates. Makiwane and Udjo also reported that only 20% of teenage mothers were beneficiaries of the child support grant. This analysis indicates that teenage mothers are not benefiting from the child support grant in the same proportion as older caregivers as was originally thought.

In general, it has been shown that in communities with high HIV prevalence rates, most new HIV infections occur during adolescence (Venier & Ross, 1997, cited by Leclerc-Madlala, 2002). Research evidence has illustrated estimates in 2001 that over 60% of HIV infections in South Africa occurred before the age of 25 years (Leclerc-Madlala, 2002). Additionally, an extensive international study of HIV/AIDS and youth confirmed that more than half of those newly infected with HIV were between 15 and 24 years (UNICEF, UNAIDS, WHO, 2002). This means that focus needs to be drawn on this particular age group, as it seems to be at higher risk than other people.

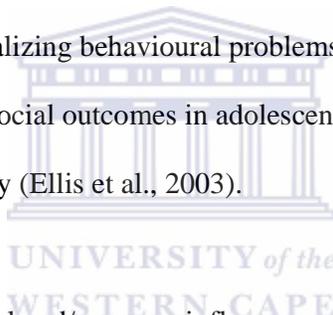
## **2.4 Factors influencing adolescent sexual behaviour**

### **2.4.1 Personal factors**



Influential factors or the determinants of adolescent sexual behaviour, including pregnancy, can be addressed on familial, individual and social levels (Haldre et al., 2009). In the context of adolescents, these include relations among parents, partners, peers, schoolmates, and other individual characteristics such as knowledge and self-esteem. Research evidence verifies that certain individual characteristics such as low level of knowledge, family characteristics such as alcohol abuse by family members, were associated with higher risk of unintended adolescent pregnancy (Haldre, et al., 2009). For example, adolescents with parents or siblings who abuse alcohol are probable to engage in risky behaviours due to lack of supervision and support from the family members. According to Panday et al. (2009), family structure characteristics such as single parenting and poor parental supervision due to work or alcohol use, play a role in determining adolescent sexual behaviour including pregnancy.

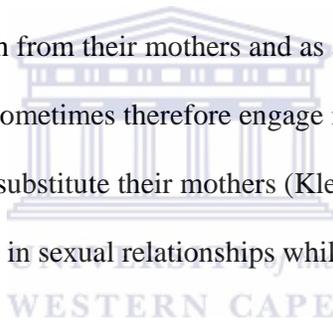
Additionally, when considering adolescent pregnancy and HIV infections in socio-cultural contexts, there are various psychosocial predictors of adolescents' risk behaviour. Adolescent sexual risk behaviour has been associated with the family structure (Ellis et al., 2003). Perceived family support, parental monitoring, and parent-adolescent communication about sex have each been shown to help prevent adolescents from engaging in risky sexual behaviour. Positive parental influence can buffer adolescents against the influence of negative peer norms that could lead to risky sexual behaviour, including delaying early sexual intercourse (Roche et al., 2005). In contrast, research studies have shown that adolescents with poor parental supervision are more likely to engage in early onset of sexual intercourse, that puts them at risk of teenage pregnancy and STI infections. Available evidence suggests that children who display externalizing behavioural problems early in life are at elevated risk for a variety of negative psychosocial outcomes in adolescence, including early sexual activity and adolescent pregnancy (Ellis et al., 2003).



Despite parental influences, social and/ or peers influences on adolescent sexual behaviour, there has been research evidence on the influence of siblings on adolescent sexual behaviour (Hearn et al., 2003). Younger siblings learn values, knowledge, roles, and skills from their older siblings. In a study that focused on sibling influence and sexual socialization of adolescent girls, it was found that girls with older brothers reported lower levels of interest in sexual activity than those with no older brothers. Living in a household with an older brother may have a protective influence so that girls are less likely to become intimately involved with boys (Hearn et al., 2003). For adolescents, good supervision from the parents or family members, as well as good communication and understanding are associated with delayed sexual activity. This means that an adolescents' sexual behaviour is somehow determined by his/her family background or structure.

### ***2.4.2 Psychological factors***

Additional individual characteristics, such as low self-esteem, psychological distress, sexual abuse, and depression, also place many adolescents at risk for engaging in risky sexual behaviours. Adolescents' risk behaviours seem to cluster with other risk behaviours, such as alcohol or drug use, antisocial behaviour and delinquency, and pregnancy (Tinsley, Lees, & Sumartojo, 2004). As stated by Klein (2001), adolescence seems to be a stage whereby loneliness emerges, and evidence indicates there is more loneliness during adolescence than any other developmental stage. This loneliness, with other personal attributes such as shyness, self-esteem may contribute to adolescent pregnancy (Klein, 2001). In early adolescence (12-14), girls are attempting to detach from their mothers and as a result, they search for mother substitutes. Female adolescents sometimes therefore engage in sexual relationships to overcome loneliness and also to substitute their mothers (Klein, 2001). To some extent, adolescent girls therefore engage in sexual relationships while they are in a confusion stage.



Adolescence is a developmental stage that is associated with identity confusion. Adolescents, whether male or female, have to make decisions that determine whether they are children or grown up individuals. This period is frustrating for them and they tend to make decisions that are not appropriate as they are overwhelmed by emotions. Adolescence is regarded as the time of experimentation and curiosity. Adolescents are especially vulnerable to STIs and HIV/AIDS as they live in a stage of emerging feelings and exploration of new behaviours and relationships. Sexual behaviour becomes an important part of this process and may involve risk.

During adolescence, decision-making becomes a difficult task. Piaget (1964) describes early adolescence as a stage whereby there is very little ability to understand perspectives of others. As stated by Piaget (1964), adolescents at this stage do not fully understand consequences of their thoughts and actions. On the other hand, Erickson (1968) characterises early and middle adolescence as a stage to establish identity. During this time, if the family does not support the adolescent, he/she may experience peer pressure to engage in unacceptable risk behaviours. This explanation confirms the fact that peers play a crucial role in an adolescent's behaviour. In most cases, adolescents then form identities by imitating their peers as well as adopting from the society (Duncan-Ricks, 1992). These adolescents may start to engage in sexual activities because of external forces which they have internalized.

#### ***2.4.3 Traditional or cultural factors***

Adolescent sexual behaviour can be influenced by a variety of social, cultural and/or relational factors. Studies of sexual behaviour have indicated gender differences where men were more sexually experienced and reported more sexual partners than do women. Such apparent sex differences occur due to the acceptability of men to have multiple sexual partners in certain communities. Research done on socio-cultural contexts indicates differences in gender norms for males and females. In a study conducted at a South African tertiary institution, findings showed that traditional constructions of gender were still operating and constraining women (Mantell et al., 2009). Women are still disadvantaged relative to men. Men are characterised as beating women if they feel like it, raping children, make decisions regarding sex, as well as use of condoms. Men maintain power over women and are regarded as heads of households (Mantell et al., 2009).

In addition to this, briefings on violence prevention compiled by World Health Organisation (WHO) also confirm cultural and social norms that encourage gender disparities (WHO, 2009). For example, there are cultural norms that tolerate or accept violence. An example is traditional beliefs that men have a right to control or discipline women through physical means. This type of behaviour makes women vulnerable to violence and places young girls at risk of sexual abuse. Available evidence demonstrates that sexual violence is an acceptable way of putting women in their places in South Africa (WHO, 2009). A study conducted in a township in Cape Town (Kalichman & Simbayi, 2004) found that women were sexually coerced due to gender-power imbalanced relationships. Furthermore, sexual activity including rape is considered a marker of masculinity (Kalichman et al., 2005).



Likewise, in most communities of South Africa, families are still defined with males being identified as primary wage earners and decision-makers (Mantell et al., 2009). For example, a study that examined influence of men's right to control their wives' behaviour also demonstrated existence of patriarchal societies (Adegoke & Oladeji, 2008). In such communities people hold a variety of cultural beliefs that oppress women. This means that women are often less likely to make decisions, and that includes sex-related decisions. Men are therefore considered heads of households and are expected to rule. These gender imbalances have been associated with unprotected sex and increased risk for HIV infection among females (Harrison et al., 2001; Mantell et al., 2009). Females are at risk because they are less likely to negotiate safe sex practices with their male counterparts. Men are the ones who decide whether to use a condom or not.

The gender inequalities not only place women at risk for sexual oppression but emotional disturbance. Leclerc-Madlala, Simbayi and Cloete (2009) also stated that the patriarchal social arrangements enhance power and advantage for men while restraining the independence of women. In communities that condone men authority, females are praised for sexual abstinence but labeled as loose and promiscuous when having multiple sexual partners. This means that females are expected to be loyal and must submit to their male counterparts. In contrast, loss of virginity for males may be an indication of manhood, and having multiple sexual partners may be an indication of sexual competence among their peers (Cleveland, Udry & Chantala, 2001). For example, men therefore perceive themselves to be naturally superior to women and having multiple partners is culturally acceptable (Leclerc-Madlala et al., 2009).



#### ***2.4.4 Societal factors***

The environment in which a child grows has an influence on his/her development as well as behaviour. One of the most powerful psychosocial influences on an adolescent's sexual risk behaviour is the perception about the behaviour of their peers in their social environment (Pettifor et al., 2004). Evident peer norms surrounding sexual behaviour and condom use have been shown to be key influencers of risky sexual behaviour. If adolescents and young adults perceive that their friends are having unprotected sex or engage in risky sex, they may be more likely to adopt their friends' behaviours. In addition, East, Khoo and Reyes (2006) highlighted that it was found that in a national survey of American adolescents, for every high-risk friend, girls' risk of pregnancy increased. Similarly, general perceptions of low levels of social support among peers have also been associated with the likelihood of participating in risky sexual behaviour. Gibbons, Helweg-Larsen and Gerrard, (1995) found that peer pressure plays a critical role in teenage girls who are still attending school. Girls

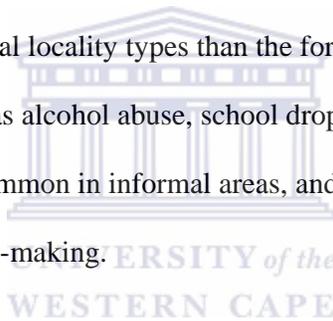
became pregnant to confirm with the norm of being sexually active. For them, it is part of their social norms or values to fall pregnant in order to fit in the community. For some of teenage girls in schools, having a baby while still at school was found to be fashionable.

The society at large plays a vital role in shaping an individual's behaviour. Societal influences, such as inadequate community resources, poor community supervision, and extreme poverty, are each likely to influence risky sexual behaviour (Smith et al., 2003). A study that was conducted in KwaZulu-Natal, one of the South African provinces with high HIV prevalence (Shisana et al., 2009), focused on sexual behaviours that adolescents adopt. The study findings demonstrated that poverty, as one of the environmental factors, was a drive for young women to engage in sexual activities for financial assistance. These young women engaged in transactional sex in exchange for food, rent/services, essential clothing, school fees, and/or basic transportation (Leclerc-Madlala, 2004). For some reason, these sexual practices are socially accepted for women who have limited means of providing for themselves or their children. Therefore, these young women engage in sexual relationships with older partners, which in turn put them at risk for HIV infection.

For adolescents, poverty may contribute and even influence risky sexual behaviour. Communities that are considered as poverty-stricken areas have high rate of unemployment. Mostly, socio-economic status of women increases vulnerability. A national household HIV survey conducted by the HSRC in 2008 showed evidence that younger girls engage in sexual relationships for material gains (Shisana et al., 2009). It is evident that poverty continues to motivate younger girls to seek older sexual partners for financial assistance. In addition to this, some adolescent girls continue to engage in these sexual relationships with older men so that they provide food for their families. Due to this reason, some parents know about such

relationships but they turn a blind eye on them as they fear losing the provider (HSRC, unpublished data). This leaves these adolescent girls at risk of HIV infection as these older sexual partners are less likely to use condoms.

Research has shown that environmental influences make consistent and substantial contributions to disparity in personality behaviour (Cleveland et al., 2001). The area in which an individual lives, whether urban, rural and/or informal settlement, impacts on one's behaviour. Research confirms that adolescents who grow up and reside in informal environments are more likely to engage in risky sexual behaviours than those in urban formal areas. Evidence from the national HIV population survey conducted by the HSRC showed a higher HIV prevalence in informal locality types than the formal areas (Shisana et al., 2005). For example, social issues such as alcohol abuse, school drop-outs, child sexual abuse, adolescent pregnancy, etc are common in informal areas, and they are expected to influence someone's behaviour or decision-making.



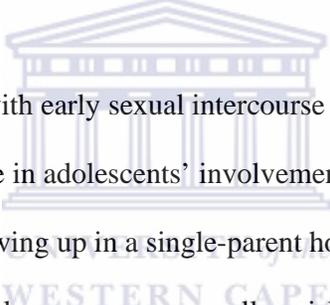
## **2.5 Risky sexual behaviours**

### ***2.5.1 Sexual debut***

Sexual debut is recognised as a behavioural determinant of HIV transmission, and also increases chances of adolescent pregnancy. The South African National HIV Survey conducted in 2008 estimated that only 15% young people between ages 15-19 reported to have had sex before the age of 15 years (Shisana et al., 2009). At such an age, most adolescents are too young to think wisely about HIV and pregnancy prevention or protection. Furthermore, some adolescents experiment with alcohol and drugs, which leads to practicing unsafe sex. Early sexual activity is linked to adolescents being less likely to use

contraceptives at first sexual intercourse (Shisana et al., 2009), and that remains a crucial factor of vulnerability to HIV infection and pregnancy.

The developmental stage during adolescence is a time of risk-taking and experimentation, and this includes an adoption of certain behaviours affecting an individual's health (Willa et al., 2003). Early sexual intercourse is one of these behaviours. The consequences of engaging in early sexual intercourse include both teenage pregnancy and STIs, particularly the greater risk of HIV/AIDS (Willa et al., 2003). Research done by Koniak-Griffin (1995) also highlighted the importance of studying sexual behaviour in early adolescence, and the findings confirmed that adolescents had unprotected sex and multiple sex partners (Willa et al., 2003).



A number of factors associated with early sexual intercourse are given and parenting characteristics seem to play a role in adolescents' involvement in sexual risk behaviours. Studies have discovered that growing up in a single-parent home or without any parent places adolescents at elevated risk of early pregnancy, as well as risk for HIV infection. Roche et al.'s (2005) findings confirm that adolescent girls are less likely to become sexually active when parents show stricter supervision. In addition to this, parent-adolescent communication was also found to play an essential role in delaying early sexual intercourse. For example, talking openly with children about sex-related issues reduces the likelihood of early sexual intercourse.

Sexual violence among children is also related with early sexual intercourse. Adolescent pregnancy continues being a major public health problem worldwide due to sexual violence such a sexual coercion or rape (Baumgartner et al., 2009). Therefore there is a relation between sexual violence and unwanted pregnancies. A review by Francisco et al., (2008)

highlights poverty in the family as a risk factor for sexual abuse. For example, in poverty-stricken households there is shared living space with sexual perpetrators living in the victim's home. In addition to this, it is common in low socioeconomic status communities to have stepfathers, who sexually abuse their stepdaughters. In such unpleasant incidents, the abuser is regarded as the head and the provider of the household.

### ***2.5.2 Sexual abuse***

South Africa has a serious problem of child abuse and sexual violence. South Africa is reported to have one of the highest rates of sexual violence in the world (Peterson, Bhana & McKay, 2005). Coerced sexual practices are considered to play a role in vulnerability to HIV infection as well as unplanned pregnancy. Research suggests that girls experiencing sexual abuse are more likely to engage in riskier sexual behaviours than their peers (Shisana et al., 2009). Sexually-abused adolescents often feel confused about their condition, and they feel betrayed by their partners and the uneven support they receive from family members (Kaufman, de Wet & Stadler, 2001).

In some communities sexual social norms have been recognized as norms that encourage patriarchal societies. Such societies put women and children at risk as men are expected to be in charge when making decisions about sex. In these communities, culturally, boys are socialized from an early age into traditional patriarchal notions of masculinity (Peterson et al., 2005). This promotes unequal gendered power relations where men have power over women. Sexual coerciveness has been linked with peer groups where masculinity is perceived as normative. Rape myths are also linked to these patriarchal ideological beliefs. For an example, if a girl is seen wearing a short skirt or dress, it means the girl is asking for rape or seducing men. Such social sexual norms and beliefs put teenage girls at risk of sexual

violence, which results in pregnancy and likelihood of HIV infection. In addition to these traditional beliefs of masculinity are the research findings that girls are controlled through sexual violence (Peterson et al., 2005). Also, patriarchal rape myths are used to rationalize and legitimate sexual violence (Wood & Jewkes, 2001). Therefore, violence against women and girls is a common method for enforcing discipline and control over women in South Africa.

Another factor that seems to be common in sexual abuse incidents is the notion of poverty. To some extent, in some communities sexual abuse is condoned because of economic gain from the sexual perpetrators (Wood & Jewkes, 2001). This means that the perpetrators continue abusing the victims as they are providing financial assistance to them. Also contributing to rape supportive attitudes is the cultural belief that having sexual intercourse with a virgin can cure HIV/AIDS (Leclerc-Madlala, 1997; Madu & Peltzer, 2000). Although there is no direct evidence for it, this belief has widely spread and has put children at risk for rape and HIV infection.

### ***2.5.3 Alcohol and drug use***

Substance abuse has become a persistent problem among adolescents in South Africa. Additional to that, alcohol use has implications for HIV risk (Shisana et al., 2005). Excessive alcohol abuse has been identified as one of the primary behaviours that increase an individual's probability of engaging in risky sexual behaviours (Wong et al., 2007; Simbayi et al., 2004). Some of the severe consequences of substance use include injury and illness such as liver disease, cancer, tuberculosis, HIV infection, child/spouse abuse including aggressiveness, rape, social isolation, exclusion, homelessness, conflict and erosion of values/norms which includes school drop-out.

Research evidence demonstrates a relation between substance abuse and risky sexual behaviour (Morojele et al., 2006). In a study conducted among adolescents in Cape Town, results from the focus groups discussions confirmed that adolescents use drugs for sexual arousal (Morojele et al., 2006). Adolescents, when under the influence of substance, engage in unsafe sexual activity for satisfaction and that increases chances of HIV infection (Wong et al., 2007). Additionally, when these adolescents have taken drugs, they easily become aggressive to their sexual partners, forcing them to have unprotected sex.

Regardless of sexual stimulation, adolescents end up using drugs because of their peers and sometimes their parents. For instance, if a parent/guardian of a child abuses a substance that enhances the child's likelihood to experiment with his/her peers. The child is often left unsupervised by the parent/guardian because of their dependence on substances which make them incapable of providing care for the child (Barth, 2009; Wulczyn, 2009). On the subject of their peers, adolescent boys, when under the influence of alcohol or other drugs, feel motivated to have multiple sexual partners (Morojele et al., 2006). The risk for HIV infection therefore expands extensively among substance users.

#### ***2.5.4 Condom use***

Correct and consistent use of condoms is an appropriate way to prevent unwanted pregnancy and HIV infection (Shisana et al., 2009). Some of the factors identified above such as sexual abuse as well as substance abuse are associated with condom use. For example, when one is having sexual intercourse under the influence of alcohol or drugs, chances are that the person will not use a condom. Engaging in unsafe sexual intercourse therefore increases risk of HIV infection and unplanned pregnancy.

There have been concerns associated with lack of condom use among adolescents. Some of these include issues such as myths around condoms. For example, an ethnographic study of adolescent sexuality in Manenberg, in the Cape Flats, illustrated the relationship between adolescent sexual practices and knowledge about sex. One of the perceptions of adolescents regarding condom use was that condoms are only used with spare girlfriends (Salo, 2002). These adolescents engage in sexual practices with different sets of sexual norms and beliefs associated with misleading perceptions, and that places them at risk of HIV infection.

### ***2.5.5 Intergenerational sex***

Similarly to condom use, intergenerational sex, also referred to as age mixing, is one of the behavioural determinants of HIV infection (Shisana et al., 2009). Although it hasn't been one of the focus areas for researchers, age mixing has an impact on sexual behaviour, especially young girls. Shisana et al. (2009) emphasizes the importance of age differential concerning HIV risk. For example, adolescents or youth who have sexual partners five or more years older than themselves are more likely to be exposed to HIV infection. This is because their older partners are expected to make decisions, which in turn puts women at risk of HIV infection.

Adolescent girls who tend to have older sexual partners are placed at an elevated risk for HIV or STIs than girls with partners of their same age. For example, they are more likely to fall pregnant as their older male counterparts refuse to use condoms (Leclerc-Madlala, 2008). The older partners, especially males, are the ones who decide on whether to use a condom or not. Due to male dominance in such relationships, young girls agree to what the boyfriend wants. Moreover, Leclerc-Madlala (2008) also emphasizes that throughout sub-Saharan Africa,

studies have revealed that young women's power to negotiate condom use is often compromised by age disparities and economic dependence. These young women cannot insist on safe sex practices, as doing so will risk their economic goals in the relationship.

### ***2.5.6 Multiple sexual partnerships***

Multiple sexual partners are one of the behaviours that increase probability for HIV risk, STI infections, as well as unplanned pregnancies. Shisana et al. (2009) point out that when an individual has multiple sexual partnerships, he/she creates sexual networks, which allow for HIV transmission to occur. Additionally, Mah and Halperin (2010) reveal that concurrent sexual partnerships can increase the size of an HIV epidemic, the speed at which it infects a population and its persistence within a population. The people in such sexual networks are at high risk, as a new infection has the probability to spread rapidly between them.

The situation for South Africa, the national HIV population survey conducted by the HSRC in 2008 demonstrated that among young people between ages 15-24 years, males reported having more sexual partners than females. Among the age group 15-24 years, 30.8% males reported having more than one sexual partner whereas only 6.0% females reported having more than one sexual partner (Shisana et al., 2009). When interpreting this behaviour, one can tell that young females are therefore put at high risk for HIV infection by their male counterparts. It is interesting to discover that multiple sexual partnerships are somehow acceptable among males in other cultures (Leclerc-Madlala, 2008). This therefore encourages males to continue having more than one sexual partner.

Multiple sexual partnerships are also associated with intergenerational relationships, where young women engage in sexual relationships with older men for financial dependence

(Shisana et al., 2009). Some qualitative data drawn from in-depth interviews and focus groups in Zambia confirm that young women have multiple sexual partnerships for financial reasons, which allows them to satisfy their material needs while young men have multiple sexual partners for gaining status and sense of belonging (Nshindano & Maharaj, 2008). The behaviour then becomes acceptable and regarded positively. These older sexual partners, also referred to as 'sugar daddies', provide young women with gifts and money (Dunkle et al., 2007). The risk for HIV infection among these young girls increases as their older partners are less likely to use condoms (Eaton et al., 2003; Leclerc-Madlala, 2008). In essence, young women engage in transactional sex with older partners to suit their survival needs.

Moreover, multiple sexual partnerships are somehow endorsed by cultural beliefs held by individuals. For some reason, in other African cultures, it is acceptable of a man to have more than one sexual partner. Culturally, it is acceptable for males to have multiple sexual partners as an indication of sexual competence among their peers (Cleveland et al, 2001). In contrast, females are expected to have one sexual partner or abstain from sexual practices. Females are labeled loose and promiscuous when they have more than one sexual partner. Due to patriarchal systems that promote the subordination of women, social norms tend to disproportionately endorse practices and behaviours that are advantageous towards the needs of men, which indirectly put women at risk for HIV infection.

### ***2.5.7 Orphans and vulnerable children***

UNAIDS define an orphan as a child under 18 years of age who has lost their mother (maternal orphan) or both parents (double orphan) to AIDS. Vulnerable children, in South African context, are children who are neglected, abandoned, living with terminally ill parents, those born to single mothers, those with unemployed caretakers and those who are abused by

caretakers or are disabled (Skinner et al., 2006). Orphaned and vulnerable children are at higher risk for HIV infection and unwanted pregnancy than other children. They are therefore regarded as children who have little or no access to basic needs or rights, which places them at risk.

The HSRC's second national population-based survey also confirmed that orphanhood has become a problem in South Africa. The number of orphans and vulnerable children is increasing due to the increase in HIV/AIDS epidemic in South Africa. Skinner et al. (2006) identified community contexts that influence vulnerability of children. For example, unsafe environments such as informal settlements, without adequate housing, exposure to crime, gangs and drug use. Such environments are external threats that can impact negatively on the child's behaviour. Salaam (2005) also pointed out that orphaned children may be forced to leave school, engage in labour or prostitution or engage in high-risk behaviour that makes them vulnerable to contracting HIV. Overall, compared to non-orphans, risk for unwanted/unplanned pregnancies, sexual abuse, and drug/alcohol use are more likely to occur among orphaned and vulnerable children, as they often do not have parental supervision, and this puts them at risk for HIV infection.

Street children are also categorized as vulnerable children. The estimated number of children living on the streets was recorded by the census data in 2001 was 2 189 2001, with their ages ranging between 10 and 17 years (Stats-SA, 2001). According to Salaam (2005), an estimated five percent of children affected by HIV/AIDS worldwide have no support and are living on the street. These street children, who are mostly adolescents, are at increased risk of HIV infection. Their vulnerability is increased due to early initiation of sexual intercourse than other adolescents who live with both parents. Richter et al. (1995) also pointed out that street

children are vulnerable to rape and they have been found to use condoms less frequently and more inconsistently than other adolescents. In general, a number of risk factors are associated with the sexual behaviour of orphaned and vulnerable children, which in turn increase their likelihood of both HIV infection and unplanned pregnancy.

## **2.6 Theoretical framework**

The study is framed around Bronfenbrenner's *ecological systems theory* of development. Bronfenbrenner (1979) developed this theory to explain how everything in a child and the child's environment affects the development of the child. He identified five different levels of social contexts that are influential in development, including the individual level. These ecological levels are named follows: individuals, microsystems, organizations, localities and macrosystems. The development of a child or an individual can be influenced by these ecological levels in different ways (Dalton, Elias & Wandersman, 2007). Bronfenbrenner relates these levels to an individual's behaviour. Microsystems are environments in which the person engages in personal interaction with others, for example families, friends, classrooms, work groups. Organisations are parts of larger social units and they include schools, work places, religious congregations, local businesses, etc. Localities include neighbourhoods, cities, towns, rural areas, etc. Localities may be understood as sets of organisations or microsystems. A locality is important in an individual's life and its history, cultural traditions and qualities as a whole community surrounds the individuals. Macrosystems represent the largest ecological level. Macrosystems include societies, cultures, political parties, social movements, mass media, internet, etc. All these ecological levels influence behaviour through policies and specific decisions (Dalton et al., 2007).

The above-mentioned ecological levels play an essential role in the development of a person's behavior. Adolescents' sexual behaviour can be understood by looking at how these different environmental settings affect their decision-making with regard to teenage pregnancy and HIV risk. These environmental settings, as highlighted by Bronfenbrenner (1979), will assist in terms of understanding how adolescents' ways of thinking are shaped by the environments in which they live. Understanding the factors that influence an adolescent's decision to have sexual intercourse has important implications for theory. These risk factors have been defined as individual or environmental hazards that increase an individual's vulnerability to negative developmental outcomes (Small & Luster, 1994).

Bronfenbrenner's ecological perspective provides a useful conceptual framework for understanding adolescent sexual activity by looking at risk factors at the individual level, family risk factors, peer risk factors and cultural context (Small & Luster, 1994). The theory is appropriate for understanding the extent to which these factors influence adolescents' decision of being sexually active. It is assumed that behaviour is the result of the interaction between individuals and the contexts they are exposed to. Changes in human behaviour may be possible when patterns of social and organizational relationships change or the physical environment changes (Visser, 2007). Decision making of adolescents regarding sexual behaviour can be understood by looking at the individuals and their environments.

## 2.7 CONCLUSION

This chapter includes a review of different studies and literature that have focused on adolescent sexual behaviour. The chapter has briefly provided an overview of adolescent sexual behaviour in South Africa as well as other countries. Additionally, this chapter highlighted the influential factors affecting adolescent sexual behaviour, including risky sexual behaviours. A theoretical perspective that explains the development of an individual is also provided in this chapter.



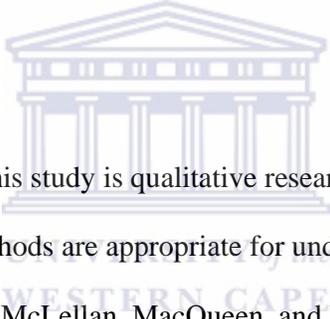
## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 Introduction**

This chapter highlights the methods utilized in conducting the study. It starts with a discussion of the research design of the study. This is followed by data collection methods, the participants of the study, data collection tool, and data analysis. Trustworthiness and credibility are also discussed, followed by reflexivity.

#### **3.2 Research design**



The research design chosen for this study is qualitative research design. According to Durrheim (1999), qualitative methods are appropriate for understanding new issues and to make preliminary investigations. McLellan, MacQueen, and Neidig (2003) state that qualitative research is concerned with discovering meaning, in other words, how people interpret their experience, and how they use those interpretations to guide the way they live. This method is therefore designed to provide empirical findings in which the phenomenon under investigation is linked to the social context in which it occurs, and in which these links are made explicit as participants of the data analysis process.

Semi-structured interviews were used for data collection with first time adolescent mothers. The aim of conducting individual interviews was to get a richness or depth of the data. Individual interviews were found appropriate for adolescents to speak freely about their sexual experiences.

### 3.3 Procedure

Ethics approval to conduct the study was requested and obtained from the Senate Higher Degrees Research Ethics Committee at the University of the Western Cape. The study supervisor and the Faculty of Community and Health Sciences also gave approval for the study. In addition, permission to conduct the study in Khayelitsha Clinic was given by Dr Strini Govender, the Clinical Manager, SR F Notshe, the Facility Manager and the Provincial Department of Health.

Once the researcher had acquired the approval from all different sources, the researcher went to the study site (Khayelitsha clinic) and held a meeting with sister-in charge of the clinic. The aim of the meeting was to explain the study to the sister-in charge, and to ask for her assistance for recruiting the participants and arranging an appropriate venue. The researcher and the sister-in charge agreed on a date to commence with the study. One of the consultation rooms was given to the researcher to use for the interviews.

To begin with, the researcher recruited the participants with assistance from the nurses. The participants were approached by nurses at the clinic as they went for their post natal visits at the clinic. The nurses introduced the study to the participants and referred them to the researcher. The researcher provided the selected participants with details about the study. An information sheet was made available to the participants, as well as the informed assent forms prior to their participation. Each selected participant was asked whether they agreed to participate or not before the researcher could start with the interviews.

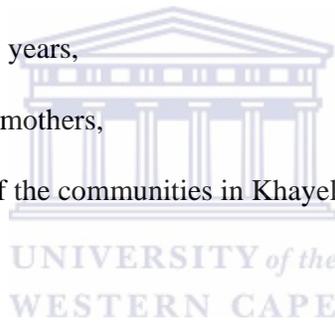
### **3.4 Participants**

Participants were female adolescent first time mothers. A non-probability sampling was used for selecting the participants. The participants of the study were from different areas in Khayelitsha, Cape Town. Most of them were from informal settlements in Khayelitsha. The participants were selected on a voluntary basis at the clinic. A total of 12 participants were interviewed for the study.

#### *3.4.1 Criteria for selection*

Criteria for inclusion of participants in the study were:

- Ages ranging from 15-17 years,
- They had to be first time mothers,
- They had to live in one of the communities in Khayelitsha



### **3.5 Data collection**

For this study, in-depth interviews were chosen as a method for data collection. As highlighted by Mack et al. (2005), in-depth interviews are intended to extract a clear understanding of the participant's perspective on the research topic. In-depth interviews are therefore an effective qualitative method for getting the participants talk about their personal feelings, giving their opinions and experiences. They are also appropriate for addressing sensitive subjects that participants might be reluctant to discuss in a group setting.

During the interviews, the researcher used a tape recorder to collect data from the participants. For participants, in-depth interviews offered them opportunity to express themselves in a

comfortable way. During the interviews, the researcher used the participants' native language, which was IsiXhosa. They found it pleasing and even healing to discuss their opinions and life experiences and to have someone listen with interest. While interviewing the participants, the researcher also wrote down notes. These notes served as a backup when recording failed and to capture nonverbal information. The researcher also found the notes valuable when a participant asked her to turn off the tape recorder during discussion of particularly confidential information. The interviews were conducted until saturation was reached.

An interview guide was used during the interviews. The interview guide contained open-ended questions that had to be asked, but it also allowed for probing of the responses by the participants where necessary. Unlike single word or yes/no questions, the open-ended questions helped in getting in-depth answers that indicated 'why' and 'how'. As stated by Mack et al. (2005), open-ended questions set no limits on the range or length of responses; rather they provide participants with the opportunity to explain their position, feelings and/or experiences.

The interview guide excluded leading questions, which Mack et al (2005) define as questions that are worded in such a way as to influence participants' responses and lead participants along a particular line of thinking. The researcher avoided leading questions to lower risk of conveying her own judgments and biases and imposing a perspective on participants. The questions in the interview guide were neutral and free of preconceptions. In addition, the interview guide contained probes, which encouraged participants to elaborate on their answers. Probes were used when participants' responses to questions were brief or unclear.

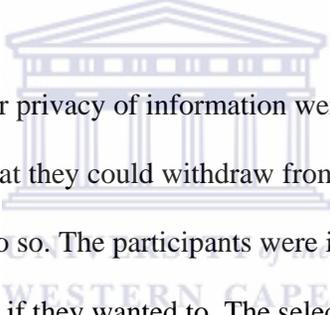
### 3.6 Data analysis

Data was analysed using thematic analysis. Thematic analysis is a widely used qualitative analytic method within and beyond psychology (Braun & Clarke, 2006). Thematic analysis is defined as a coherent way of organizing or reading some interview material in relation to specific research questions. The readings are organized under thematic headings in ways that attempt to justify both to the elements of the research question and the concerns of the study (Banister, Burman, Parker, Taylor & Tindall, 1994). In this study, the researcher analysed data according to themes that emerged, which was an appropriate way of analyzing data in a qualitative study. The researcher presented each extract separately and elaborated connections and contrasts between them, in relation to the themes in the study.

Since the interviews were conducted in IsiXhosa, all the transcripts were translated into English by the researcher before analysis of data commenced. Accuracy of translations was checked by another Xhosa-speaking person who translated the translations back into Xhosa and then the original and new Xhosa versions were compared to each other. During the analysis, initially the researcher expanded the notes by hand into rich descriptions. The raw notes were then transformed into a narrative and elaborated on her initial observations. Eventually, all expanded notes were written down in a note book. The researcher wrote a descriptive narrative describing what happened and what she learned. This served as the expanded notes. The researcher created separate, clearly labeled sections to report her observations versus her interpretations and personal comments.

### **3.7 Ethical considerations**

Interviews were conducted in a private room at the clinic to maintain confidentiality and privacy for the participants. Firstly, the researcher provided an information sheet to all participants to inform them about the study. The information sheet consisted of the aim and objectives of the study. This helped the participants know why they were being asked to participate in the study. The information sheet helped the participants understand the significance of their participation. Secondly, a participant's informed assent form was made available for participants before they started with interviews. The participant's assent form served as agreement to participate in the study.



Confidentiality, anonymity and/or privacy of information were taken into consideration. The researcher told the participants that they could withdraw from the study at any time without penalty, if they feel the need to do so. The participants were informed that they could refuse to answer any sensitive questions if they wanted to. The selected participants were also informed that the researcher would be the only person with access to the information they gave. The researcher told the participants that their names would not appear in any documents of the study during the writing of the final report. The participants remained anonymous in that the researcher did not address them by their names; instead, alphabets were used. The participants were promised that data would be kept in a safe place during and after the study was completed.

### 3.8 Trustworthiness and credibility

According to Lincoln and Guba (1985), the aim of trustworthiness in qualitative research is to support the argument that the researcher's findings are worth paying attention to.

Trustworthiness is a crucial aspect in qualitative research with emphasis on In qualitative research the concepts *credibility*, *dependability*, *transferability* and *confirmability* have been used to assess and/or ensure various aspects of trustworthiness (Graneheim & Lundman, 2003). These are described below:

- *Credibility* is an evaluation of whether or not the research findings represent a convincing conceptual interpretation of the data drawn from the participants' original data. The credibility criterion involves establishing from the perspective of the participant in the research that the results of qualitative research are credible or believable (Cutcliffe & McKenna, 1999)
- *Dependability* is an assessment of the quality of the integrated process of data collection and data analysis (Guba & Lincoln, 2005). Dependability therefore pertains to the importance of the researcher describing the changing contexts that are fundamental to the research and how these changes affected the way the researcher approached the study.
- *Transferability* refers to the degree that findings can be generalized to other settings, contexts, or populations (Rolfe, 2006). The researcher can enhance transferability by describing the research methods, contexts and assumptions underlying the study.
- *Confirmability* is a measure of how well the researcher's findings are supported by the data collected or by others (Guba & Lincoln, 2005).

While collecting data, the researcher made notes, in addition to the tape recorder. These notes were checked against the transcripts. This was helpful in ensuring credibility of the data.

### **3.9 Reflexivity**

Banister et al. (1994) state that the ways we theorize a problem will affect the ways we examine it, and the ways we explore the problem will affect the explanation we give. According to Patton (2002), reflexivity is an important component of any research project that emphasizes the significance of self-awareness, cultural consciousness and possession of one's perspective. It is therefore important to be aware of the researcher's bias throughout the study. The researcher's assumptions in mind regarding risky sexual behaviours may have impacted the results. The researcher may have expected the participants to give answers that she had anticipated and not their experiences and perceptions. Also, personally knowing people who had unplanned pregnancies might have impacted the lens through which the researcher looked at adolescents' sexual behaviours. Lastly, the researcher felt that language could have impacted one way or another. Data had to be translated into English as the interviews were conducted in IsiXhosa. This must have increased probability for some phrases and expressions to be left out during translation and cause ambiguous meanings. This is because some of the words or phrases in IsiXhosa cannot be directly translated into English and continue to have the same meaning.

## CHAPTER 4

### RESULTS

#### 4.1 Introduction

This chapter provides the key findings of the study. These findings are categorized into different themes, which are presented in detail. The key themes include: ‘the general perceptions and understanding of adolescent mothers’, ‘the social influences of adolescent sexual behaviour’, ‘relating adolescent stage to immature reasoning’ and ‘the relationship between adolescent pregnancy and HIV risk’. These key themes are discussed using quotes from the participants to evidently demonstrate the findings of the study.

#### 4.2 General perceptions and understanding of adolescent mothers

During the interviews, the participants were provided sufficient time to first express their perceptions of risky sexual behaviour among adolescents, particularly adolescent pregnancy. Participants therefore gave their perceptions on experiences of being mothers throughout early ages. They provided their opinions on how the community and their families recognize adolescent sexual behaviour. In addition to this, the participants expressed their opinions on how they perceived risk for HIV infection. The major themes are discussed in detail below:

##### 4.2.1 Participants’ perceptions of adolescent pregnancy

To start the discussion during the interviews, participants were asked to talk about the general perceptions of adolescent pregnancy. In general, participants perceived adolescent pregnancy

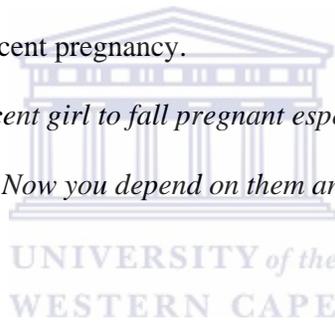
as bad behaviour. They frequently mentioned that they, themselves viewed the behaviour as unacceptable.

*'...I think the behaviour is unacceptable but very common.'* (Participant B)

*'Adolescent pregnancy is wrong but it happens all the time in my community. I can say that most young girls of my age also fell pregnant in my community. At the same time it is still regarded as a wrong behaviour...'* (Participant D)

Some of the participants' perceptions were concerns that focused on or were based on the negative consequences of adolescent pregnancy.

*'I think it's wrong for an adolescent girl to fall pregnant especially when your parents must still take care of you financially. Now you depend on them and they must provide money for your child'* (Participant D)



*'I think being pregnant at early age is wrong especially before marriage. It is wrong because I fell pregnant when I was still at school and not working...'* (Participant L)

#### **4.2.2 How family or parents perceive adolescent pregnancy**

In addition to the participants' perceptions, they were asked to speak about their parents' feelings. Most of the participants mentioned that their parents perceived adolescent pregnancy as unacceptable behaviour.

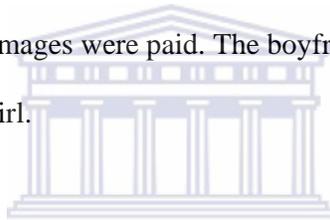
*'Culturally, it's unacceptable but very common'* (Participant B)

*'...your dreams fail due to punishment from parents. Opportunities go away because of being a mother. My family is very cultural and religious so for them adolescent pregnancy is not acceptable before marriage'* (Participant G)

*'My family is very religious and they respect cultural traditions. For them, pregnancy before marriage is not right'* (Participant H)

*'...my parents say childbirth before marriage is wrong behaviour'* (Participant J)

In contrast, few other participants pointed out that adolescent pregnancy was culturally found acceptable by their families if damages were paid. The boyfriend is expected to *'pay damages'* for impregnating the girl.



*...culturally, it's acceptable if the boyfriend agrees that he impregnated you. He must pay for damages then the parents will look after the baby'* (Participant E)

Although the behaviour was generally regarded as unacceptable, it was surprising to find out that some families perceived it normal. However, none of the adolescents themselves found it acceptable.

#### **4.2.3 How community members perceive adolescent pregnancy**

Similar to the question that was asked about family members, participants were also asked to speak about perceptions of their community members. Generally, participants reported that community members perceived the behaviour as unacceptable.

*'...uh, in my community young girls who fall pregnant are seen as doing something wrong. Adolescent pregnancy is totally unacceptable'* (Participant C)

*'...although my peers see the behaviour as normal, in my community they still regard it as unacceptable and wrong'* (Participant E)

Some participants revealed that in other communities, people tend to tease these adolescent mothers and spread rumors about them.

*'...it is wrong for a young girl to fall pregnant in my community. People laugh at you and call you names. This behaviour is still not acceptable especially by our parents and other older people in the community but it's very common'* (Participant G)

Furthermore, participants highlighted that community members felt that adolescent girls fell pregnant for other wrong reasons particularly financial gain.

*'...community members think that adolescent girls fall pregnant deliberately to get child support grant'* (Participant A)

#### **4.2.4 Participants' perceptions of HIV risk and perceived risk of self**

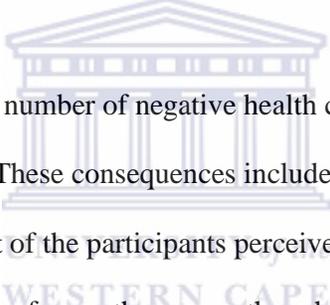
Concluding questions on participants' perceptions were based on whether they were aware of HIV risk or not. Majority of the participants were aware of the risk that resulted from unsafe sexual practices. Some of the participants gave reasons why they placed themselves at risk, that is not using condoms for protection.

*'I know that if you sleep with your boyfriend without a condom then you can get HIV or STI and maybe fall pregnant...'* (Participant B)

*'I understand the risk of having unprotected sex but sometimes my friends use injection (form of contraceptive) for protection and don't use condoms... \*not clear, noise\*'* (Participant C)

*'... yes I know that maybe when I'm drunk I don't remember to use condoms, so I may be at risk to get STIs'* (Participant D)

*'I was aware of HIV risk...'* (Participant F & H)



Adolescents are at high risk for a number of negative health consequences associated with early and unsafe sexual activity. These consequences include infection with HIV, other STIs and unplanned pregnancies. Most of the participants perceived low or no risk for themselves. Although they were practicing unsafe sex, they never thought that they were at risk for HIV or STI infections.

Contrary to what the majority said, a few participants mentioned that they never felt that they were at risk of HIV infection.

*'...I used to think that I was not at risk for HIV infection or STIs. I thought that STIs were for certain people until I fell pregnant'* (Participant A)

*'...no I'm not at risk of HIV infection...'* (Participant E)

*'...I didn't have much information on things like sex education. I don't go to youth clubs such as Love life...'* (Participant L)

A number of participants also pointed out their sources of information regarding HIV risk and sex related issues. It was common that they heard the information from their peers or school, and not from their parents.

*'I had enough knowledge about sex before I fell pregnant. I used to get the information from my friends and from school. I stayed with my big sister and we never talked about sex or HIV...'* (Participant F)

*'...I was aware of the consequences. I got the information from the clinic and from school. I also went to a youth group in my community'* (Participant G)

*'...my parents are very strict so we don't talk about sex-related issues. I get information from my friends and from school'* (Participant I)

### **4.3 Social influences of adolescent sexual behaviour**

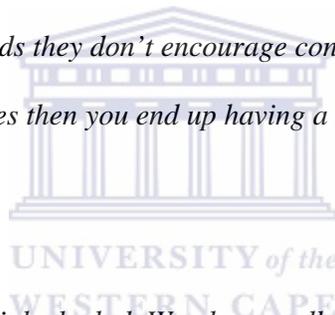
It is believed that our contextual surroundings as well as people around us influence the way we behave. In addition to the general perceptions, participants were asked to speak about the influences they experienced in their communities. They had an opportunity to mention all sorts of influences and pressures that existed in their lives, which they felt had an impact on their decision making processes. These social influences somehow played a role in the way these adolescents behave.

### 4.3.1 Peer influence

Surprisingly, the majority of the participants pointed out that they felt a lot of pressure from their friends. The participants revealed that they engaged in such behaviour to fit into their peer norms. Therefore, some of the behaviours they engaged in were somehow fashionable in their peer groups.

*'I saw my friends having boyfriends then I started dating...'* (Participant A)

*'...my friends had an influence in some of the things I did. For example I have many friends and when we talk about boyfriends they don't encourage condom use. When you don't have a boyfriend they will call you names then you end up having a boyfriend even if you are not ready'* (Participant B)



*'I have many friends and they drink alcohol. We always talk about our boyfriends and when you have a new boyfriend you tell your friends. I was drunk when I had sex with my boyfriend, and he was also drunk so we didn't use a condom...'* (Participant C)

*'...we have useless conversations with my friends. I have a lot of friends from my community and from school. We always talk about boyfriends. Many of my friends from my community left school for no reason...'* (Participant D)

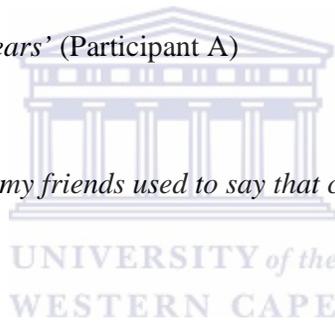
*'...my friends have more than one sexual partner and we often talk about the number of boyfriends one has. I think that such conversations influenced my behaviour...'* (Participant F)

*'...some of my friends just fell pregnant because they want to be like their friends who have babies. Some of them don't listen to their parents'* (Participant G)

Of note, it was shocking to find out that peers were giving one another incorrect information when talking about sex-related issues. Some of the participants highlighted that they only listened to the information and advice they received from their friends. Unfortunately, some of the information was incorrect.

*'...my friends told me that when you use contraceptives, especially the injection then your body shakes. My friends also blame condoms. \*not clear\* ... One of my friends also fell pregnant when she was fifteen years'* (Participant A)

*'I never used a condom because my friends used to say that condoms burst so there's no need to use them...'* (Participant I)



*'I told my friends that my boyfriend doesn't want to use a condom and they said that I shouldn't worry because their boyfriends also don't like condoms'* (Participant J)

#### **4.3.2 Socio-economic status**

Khayelitsha is one of the townships with high unemployment rate. It has numerous informal areas where poverty is relatively high, and adolescents engage in behaviours that put them at risk. During the interviews participants were asked about their economic status, whether they had financial difficulties. They were also asked whether their financial status was a determinant of their actions or behaviour. In other words, they had to tell how their economic status affected their sexual behaviour.

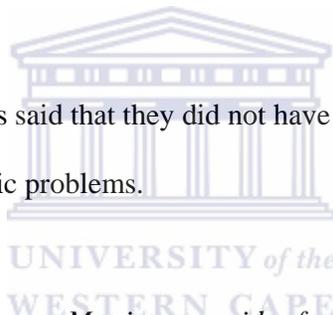
*'I don't have a problem with money. I don't need financial assistance from my boyfriend...'*

(Participants B)

*'I did not fall pregnant for financial gain. My boyfriend is taking care of the child and supports me financially. We made the decision to have a baby because we have dreams about our future. My boyfriend is mature...'* (Participant H)

*'I don't have finance problems at home... I think I fell pregnant because my boyfriend hated using a condom'* (Participant J)

Although most of the participants said that they did not have economic difficulties, very few mentioned that they had economic problems.



*'...I have financial problems at home. My sister provides for the family and I get money from my boyfriend. My mother drinks alcohol and she doesn't give us money with my sister. I think she has an impact on my pregnancy \*not clear\*...'* (Participant G)

#### **4.3.3 Lack of parental supervision**

One of the questions asked to participants focused on the parental supervision. Some parents work very long shifts and end up having little time to spend with their children. Some are either too strict or too loose. The discussion focused on whether the adolescents felt that the absence or presence of their parents or guardians had an impact on their behaviour. They explained how the supervision of their parents shaped their behaviour.

Participants felt that communication about sex-related issues with parents was important.

*'...my mother is very strict and in our culture we don't talk about sex-related topics with our parents. I think that's why we only discuss these things with friends'* (Participant B)

*'We never talked about boyfriends with my mother. Sometimes I wanted to ask her about things but I couldn't. Maybe I fell pregnant because she didn't want to discuss such things with me...'* (Participant H)

*'I never talked about sex or boyfriends with my parents. They are very strict, but I don't blame them for falling pregnant...'* (Participant L)

Also, participants believed that it was necessary of parents to show care and give advice to their children. Lack of parental care or supervision was associated with loose behaviour of adolescents, particularly pregnancy.

*'...my mother does not care for us. She sometimes throws us out of her house then we go and sleep anywhere. My sister also fell pregnant when she was 18 years old. My mother works at a restaurant and she buys alcohol not food. My sister provides for us and I get money from my boyfriend. I think my mother had a negative impact on my pregnancy...'* (Participant G)

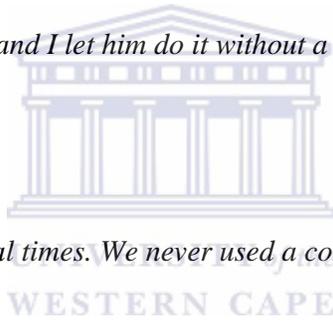
*'...my mother is not too strict. I sometimes go and stay with friends or my boyfriend. My mother is not always looking after me, and that's why I started having sex at early age...'*

(Participant K)

#### 4.3.4 Pressure from sexual partner: male domination in relationship

Even though we live in a post-apartheid era and regard ourselves as ‘the free generation’, male domination hasn’t disappeared completely. In most relationships, men still have power over women. The following quotes give the idea that these female adolescents engaged in unsafe sexual practices because their male counterparts refused to use protection. This shows that these female adolescents were afraid of their sexual partners and could not negotiate safe sex.

*‘I started being sexually active when I was 13 or 14 years old. I never understood the risk or consequences of unsafe sex until we were taught life orientation at school. My boyfriend always refused to use a condom and I let him do it without a condom. He was older than me...’* (Participant A)



*‘...there were no condoms several times. We never used a condom because he didn’t want to use it’* (Participant B)

*‘...we never used a condom every time we had sex. My boyfriend used to refuse and I had to obey what he said...’* (Participant C)

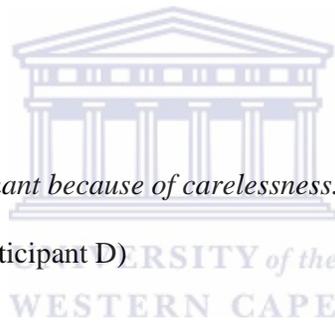
*‘We stopped using a condom because my boyfriend said that he couldn’t eat a sweet wrapped by a plastic. He also accused me of dating someone else. He said that there was no need for condom use. We then had unprotected sex to make him happy...’* (Participant E)

#### 4.3.5 Alcohol use

Alcohol use has been associated with risky sexual behaviour. One of the questions asked to the participant focused on alcohol use. Participants had to say whether they drank alcohol and whether they had engaged in sexual intercourse after drinking alcohol. They elaborated on their sexual behaviour under the influence of alcohol. This includes giving details on whether they used protection (condoms) when engaging in sex after drinking alcohol.

When discussing their general perceptions on adolescent sexual behaviour, some of the participants pointed out the causes of risky sexual behaviour. They mentioned alcohol use as one of the risky behaviours adolescents engage in, which in turn puts them at risk of having unprotected sex.

*'I think that most of us fall pregnant because of carelessness. Alcohol use is one of the reasons we fall pregnant...'* (Participant D)



Most of the participants mentioned that alcohol use caused disagreements on condom use. Particularly, their male counterparts refused condom use after drinking alcohol.

*'I think most boyfriends don't like to use condoms when they are drunk...'* (Participant E)

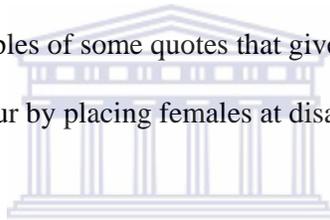
*'My boyfriend drinks alcohol and we have sex afterwards...'* (Participant G)

*'I was drunk when I had sex, and my boyfriend was drunk too. We didn't use a condom because he doesn't like using a condom when he's drunk...'* (Participant C)

*'I drink alcohol maybe on weekends. Most of the time we had sex under the influence of alcohol and we never used a condom. My boyfriend doesn't like using a condom. I also forget whether we used it or not...'* (Participant D)

#### **4.3.6 Cultural beliefs and/or social norms**

Beliefs that people hold in communities or households seemed to play a role in the sexual behaviour of adolescents. Participants spoke about the influence of culture in their behaviour. They explained how female adolescents were expected to behave in their cultural settings. Interestingly, supporting the existing research findings on sexual behaviour, participants highlighted how their traditions somehow privileged males and put females under men control. The following are examples of some quotes that give an idea of how cultural beliefs shape adolescent sexual behaviour by placing females at disadvantage.



*'...my sisters used to tell me that we as females should listen to what men say. I never wanted to argue with my boyfriend, even when he had more than one sexual partner I couldn't confront him'* (Participant F)

*'I was too scared to argue with him to use a condom because he is older than me. He is 27 years old and I'm 17 years old so I thought he'd beat me. It's because we were told that in our African culture women are expected to respect their men...'* (Participant G)

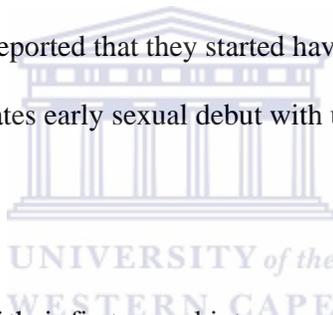
*'...the decision to fall pregnant was based on the maturity of my boyfriend. He is working and can take care of the child financially. It is supposed to be like that in our culture. A man should work and support his woman'* (Participant H)

#### **4.4 Linking adolescence stage to immature reasoning**

When conducting the interviews, the researcher observed that adolescents make decisions that lack sensible thoughts. Their way of thinking appeared to be shaped by how their peers feel. The participants therefore demonstrated undeveloped thinking when making decisions.

##### **4.4.1 Early sexual experience**

As highlighted by Shisana et al. (2009), sexual debut is one of the issues that play a role in vulnerability of youth to HIV infection. Adolescents tend to initiate sexual intercourse at an early age. Shisana et al. (2009) pointed out that over the last three population-based surveys conducted by the HSRC, youth reported that they started having sex before the age of 15 years. Geary et al. (2008) associates early sexual debut with unplanned pregnancies and little or no use of contraceptives.



The participants gave the ages of their first sexual intercourse. Most of them started having sexual intercourse before age of 15.

*“I think I was 13 or 14 years when I had sex for the first time”* (Participant A)

*“I started having sex when I was 14 years old...”* (Participant B)

*“I was 14 years old when I sex for the first time, and my boyfriend was 17 years old...”*  
(Participant C)

*“I started having sex when I was 15 years old”* (Participant E, H, & J)

Early sexual debut is linked with unprotected sex. This was affirmed by some of the participants who mentioned that they never used condoms during their first sexual intercourse. This lack of condom use therefore puts them at risk for unplanned pregnancies.

*“My boyfriend never liked condoms.”* (Participant A)

*“There were no condoms available several times. We never used a condom because my boyfriend did not want to use it.”* (Participant B)

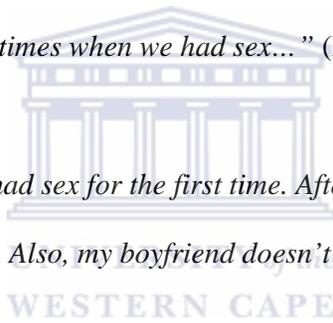
*“We never used a condom at all times when we had sex...”* (Participant C)

*“I never used a condom when I had sex for the first time. After drinking alcohol, sometimes I don’t remember using a condom. Also, my boyfriend doesn’t like using condoms...”*

(Participant D)

*“I was 16years old when I had sexual intercourse for the first time. We did not use a condom the first time and we never used a condom whenever we had sex. My boyfriend refused and said that he had one sexual partner. I did not have a right to make a decision for condom use...”* (Participant G)

*“I started having a boyfriend at 14 years. I had sex for the first time when I was 15 years. I had sex because I was scared of losing him...”* (Participant L)

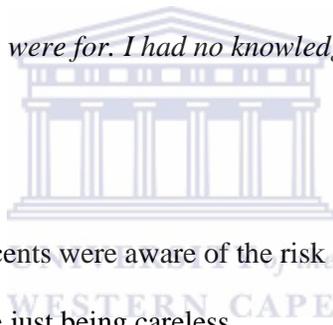


#### 4.4.2 Undeveloped reasoning

It was shocking to observe that most of these adolescents could not give specific reasons to why they fell pregnant or initiated sexual intercourse at early age. Most of them did not know why they were sexually active, and others started engaging in sexual intercourse because their friends were doing it.

*“...I think I fell pregnant during my first sexual intercourse. I blame my boyfriend for this because he should have controlled himself... I didn't know I was at risk until we were taught at school last year.”* (Participant A)

*“...I did not know what condoms were for. I had no knowledge about sexual issues”*  
(Participant I)



On the other hand, some adolescents were aware of the risk and consequences of not using a condom. They felt that they were just being careless.

*“It was just a mistake. I never used a condom when I had sex... maybe it's because I was young”* (Participant C)

*“We, young people, are careless. Adolescent pregnancy is common in our communities because we talk about useless conversations with our friends. Before I fell pregnant I was aware of HIV infection and STIs but sometimes I don't remember condom after drinking alcohol”* (Participant D)

*“I know that you get diseases if you don’t use condoms and you can also fall pregnant. I had sufficient knowledge before I fell pregnant. I used contraceptives then I stopped when I was in the Eastern Cape. I was lazy to go to the clinic and I fell pregnant”* (Participant F)

#### **4.4.3 Peers as ‘reliable sources of information’**

The issue of peer influence often came up during the interviews. It was discovered that these adolescents listened to their peers more than they did to their parents. Adolescents felt uncomfortable discussing sex-related issues with their parents. Additionally, some of their parents did not allow sex-related conversations with their children. Adolescents therefore spoke about sex-related issues with their peers

*“My mother doesn’t want to talk about sex-related subjects. She is very strict so I see my boyfriend during the day”* (Participant B)

*“My mother doesn’t care about us. We don’t talk \*not clear\* ...she sometimes throws us out of her house”* (Participant G)

*“I don’t talk about boyfriends with my mother”* (Participant H)

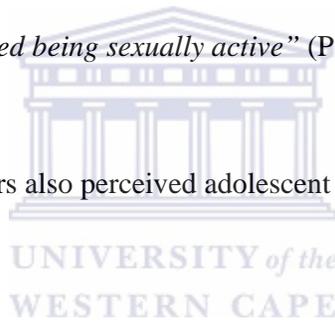
In addition to this, some adolescents felt that they were expected to behave the same way their peers behaved. It became a norm for them to try out their peers’ behaviours so that they fit in their peer groups.

*“I saw my friends having boyfriends then I also started to have a boyfriend. People in my community also condone adolescent pregnancy. For an example, you get those ladies older than us who say you can fall pregnant and have an abortion...”* (Participant A)

*“I think I was influenced by my friends and I thought that sex was good so I had sex at an early age. All my friends had boyfriends and they teased you if you didn’t have a boyfriend...”* (Participant C)

*“I have friends in my community and school. But with my friends from my community we only talk about boyfriends... some of them left school for no reason. I wanted to try something that I was told by my friend so I started being sexually active”* (Participant D)

Surprisingly, unlike parents, peers also perceived adolescent behaviour as normal and acceptable in the community.



*“My peers see nothing wrong when an adolescent is pregnant. They see it as a normal thing”*  
(Participant E)

*“Some adolescents have fallen pregnant because they don’t listen to their parents. Some want the child support grant and some just want to be like others, that’s why they don’t see anything wrong with it...”* (Participant G)

#### **4.5 The association between adolescent pregnancy and HIV risk**

The participants were asked to talk about their understanding of the relationship between adolescent pregnancy and HIV risk. They were given time to give their opinions on whether they understood how the two were related. Participants were asked to share their understanding of sexual behaviour, as well as distinguishing between healthy and unhealthy sexual behaviour. Furthermore, participants were provided an opportunity to explain their understanding of the consequences of sexual behaviours, for example their understanding of the impact of sexual intercourse. Lastly, participants were also asked about their perceptions on contraceptives and the risk of inconsistent use of contraceptives.

##### **4.5.1 Condom use at first sexual intercourse**

It was discovered that most of the participants did not use condoms at first sexual intercourse. Participants mentioned some gender dimensions that are linked with contraceptives. It was found out that there were different needs and expectations in terms of choosing a contraceptive method that was mutually beneficial to both parties. Condom use, specifically, predominantly depended on their male counterparts.

*“My boyfriend never liked condoms” (Participant A)*

*“We never used a condom every time we had sex” (Participant C)*

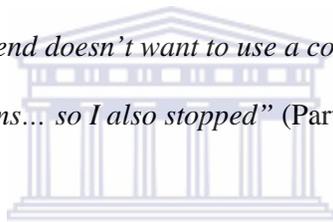
*I didn't use a condom in my first sexual intercourse. My boyfriend doesn't like using a condom” (Participant D)*

*“We stopped using condoms because my boyfriend said that he can’t eat a sweet wrapped by a plastic. My boyfriend accused me of having another boyfriend when I suggested that we use a condom so we had unprotected sex to make him happy” (Participant E)*

*“I was scared to argue with my boyfriend to use a condom because he is older than me. I thought he’d want to hit me because he is working” (Participant H)*

Very few participants mentioned that they stopped using condoms because they were advised by their friends to do so.

*“I told my friends that my boyfriend doesn’t want to use a condom and they told me that their boyfriends also don’t use condoms... so I also stopped” (Participant J)*



#### **4.5.2 Myths related to the use of contraceptives**

It was surprising to find out that adolescents held some myths on use of contraceptives. They shared these myths amongst their peers, influencing one another to stop using contraceptives.

*“My friends told me that using the injection is wrong because your body shakes when using it and you lose your shape. My friends also blamed condoms; they say it irritated one’s genital organs” (Participant A)*

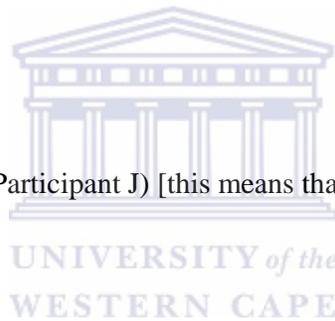
*“...contraceptives are bad for your body. Also, having sex at older ages is wrong maybe after you’ve reached 20. My friends believe that you must be sexually active during your teen years or else your sperm cells will go up to your head” (Participant B)*

It was discovered that adolescents spend much more time with their peers than they usually do with their parents or guardians. They speak freely with one another and share their experiences. It was shocking to find out that some of the information they shared with one another was misleading.

*“I was using contraceptives for two years from 2003 to 2004 and then my friends told me that my sexual performance will be less active with my boyfriend so I stopped...”* (Participant A)

*“I used a condom sometimes but it was inconsistent. My friends told me that condoms explode so there was no need to use it. I was not encouraged to use a condom and my boyfriend never like it too”* (Participant I)

*“...bathi iyatyabula icondom”* (Participant J) [this means that condom use causes skin irritation]



#### **4.5.3 Knowledge and awareness of HIV and/or sexual risk behaviours**

Of note, it was quite unexpected to find out that adolescents residing in urban settlements were not much knowledgeable about sexual risk behaviours. Most of these adolescents did not have sufficient information regarding HIV risk for example. They only obtained information from their peers, which they used for their benefit.

*“...I used to think that things like STIs were for other people. I started studying life orientation at school after I was already sexually active. I had no knowledge about sexual behaviours before I started having sex”* (Participant A)

*“...I have many friends and they drink alcohol. We used to think that we are safe when we use the injection instead of condoms sometimes. But I also never used condoms when I was drunk and no one tells us these things”* (Participant C)

*“...we talk about how many boyfriends one has. Most of my friends have more than one sexual partner. We don't think it's a big deal because no one tells us the right information”* (Participant E)

In contrast to the majority of the participants who lacked knowledge about sexual risk behaviours, it was also shocking to find out that there were few participants who understood the risk very well but still engaged in unsafe sex and fell pregnant.

*“I was a member of the youth club, the peer educating program. I sometimes went to workshops and conferences to learn more about issues that young people deal with, things such as pregnancy and STIs”* (Participants H)

#### **4.6 Summary of the chapter**

This chapter provided the findings of the study. It gave details about adolescents' common perceptions and acceptance of adolescent pregnancy in their communities. The chapter also presented results on the societal influences of adolescent sexual behaviour. Additionally, the chapter drew attention to the connection between adolescent pregnancy and HIV risk, looking at how the decision making process of adolescents determine their level of risk.

## **CHAPTER 5**

### **DISCUSSION AND CONCLUSION**

#### **5.1 Introduction**

This chapter provides detailed discussion of the main findings of the study. It focuses on the main themes that had emerged when analyzing the study data. The themes to be discussed below are the crucial issues that the researcher had focused on when conducting the interviews. These are the subjects that participants felt were of concern and played a vital role in the concept of adolescents' sexual behaviour. This chapter presents comprehensive discussion on the a) general perceptions and understanding of adolescent mothers, b) the social influences of adolescent sexual behaviour, c) the connection between adolescence stage and undeveloped reasoning and d) the relationship between adolescent pregnancy and HIV risk. These are presented separately with the intention that connections and contrasts between them are clarified, in relation to the core focus of the study. The limitations, implications and recommendations of the study are included in this chapter.

#### **5.2 Discussion of the main findings**

##### **5.2.1 General perceptions and understanding of adolescent mothers**

Pettifor et al. (2004) classify adolescent pregnancy as an indicator that young people are having unprotected sex. A number of factors such as one's background and the environment in which they live play part in Pettifor et al.'s (2004) statement. Adolescent mothers had an opportunity to talk about their experiences, as well as sharing their viewpoints and understanding of adolescent pregnancy. Adolescent mothers perceived pregnancy before

marriage as a morally wrong behaviour. Their parents, families and community members in general also perceived adolescent pregnancy as immoral behaviour. Even though the behaviour is regarded as unacceptable, many adolescents continue to fall pregnant in their communities and therefore it remains a common behaviour.

The participants pointed out that families observe adolescent pregnancy using both cultural and religious viewpoints. Culturally, adolescents should not fall pregnant before marriage. Also from a religious perspective, falling pregnant before marriage is regarded as a sin. Surprisingly, the participants mentioned all the possible reasons that made the behaviour unacceptable but they kept highlighting that it is a common behaviour in their communities. Adolescents themselves perceived the behaviour as morally wrong and unacceptable.

### **5.2.2 Social influences of adolescent sexual behaviour**

Adolescent sexual behaviour has been changing over time. Major social and demographic influences have shaped and changed adolescents' behaviour, including their sexual attitudes and understanding (Wells & Twenge, 2005). Adolescents' sexual behaviour has changed due to shifts in their environments. They are also maturing much earlier than before. For example topics such as abortion, rape, teenage pregnancy, and so forth used to be taboo but they are now used in everyday conversations (Wells & Twenge, 2005). This shift to more liberal sexual attitudes and behaviours has altered adolescents' sexual culture.

Peer pressure stands out to be one of the major influences in adolescents' sexual behaviour. Pettifor et al. (2004) argued that peer norms influence adolescents' sexual behaviour. For example, young people tend copy behaviour of their peers. The findings of this study, to a large degree reflect the reality of Pettifor et al.'s (2004) statement. Generally, the participants

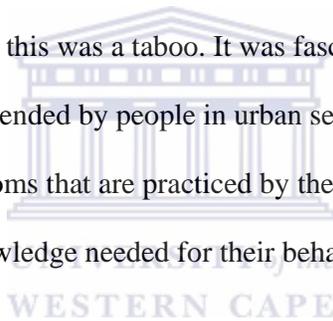
felt that their peers, one way or another, had had an impact on their behaviour. This includes making decisions regarding issues and/or risky behaviours such as engaging in sexual activity, condom or contraceptive use and alcohol use. More specifically, the study revealed that some of the behaviours that adolescents engage in are fashionable in their peer groups. Many adolescents, for example, started having sex at early ages because their peers were already sexually active and therefore they felt pressured to initiate the behaviour.

In addition to this, it was found that adolescents not only feel pressure from their peers but they also obtained information about sex-related subjects from them. It was shocking to find out that these peers were providing one another with incorrect information. Some of this information involved myths on prevention of adolescent pregnancy and protection against STIs and HIV infection. These findings are in line with those made by other researchers that have focused on young people's sexual behaviour. Findings of the status of the youth survey by Richter et al. (2005) revealed that peer pressure was a major factor that influenced youth to participate in high risk behaviours. Females reported that they were pressured by their peers to have sex more than males, and that put them at risk of unplanned pregnancies.

Amongst their peers, alcohol use was found to be one of the factors that impacted on some of the sexual behaviours they engaged in. The participants spoke about their sexual behaviours under the influence of alcohol. In general, alcohol use was identified as one of the risky behaviours that put adolescents at risk. Most participants highlighted that alcohol use caused carelessness. It was often mentioned that the participants engaged in unprotected sexual activities when under the influence of alcohol. Moreover, some of the participants pointed out their male counterparts refused to use condoms when they were drunk. Some of them mentioned that they could not remember using condoms due to alcohol intake. These findings

demonstrate that alcohol use is one of the risky behaviours that adolescents engage in, which puts them at risk for unplanned pregnancies, HIV/ STI infection as they practice unsafe sex.

One of the issues that the participants mostly mentioned was the concept of lack of communication with their parents. Most of the participants pointed out that they do not discuss sexual matters with their parents. This created difficulties for them as they ended up acquiring knowledge from their peers. Parents find it unusual to discuss HIV/AIDS-related issues with their children. Similar findings have been reported by Brookes, Shisana and Richter (2004) and by Shisana et al. (2005). This study found that it was culturally unacceptable and disrespectful for so-called African parents to discuss topics such as pregnancy with their children, as this was a taboo. It was fascinating to discover that traditions were still being apprehended by people in urban settings. It was alarming to realize that these cultural norms or customs that are practiced by the parents restrict their children from obtaining the essential knowledge needed for their behaviour.



In addition to cultural norms and beliefs held in communities, the participants revealed how their sexual behaviour was influenced by traditions. In the so-called 'Xhosa' communities, there are cultural beliefs associated with sexual behaviour particularly for males. The participants highlighted how their culture and traditions privileged males. Regarding sexual behaviour, males are expected to take control over females. For instance, the participants mentioned that it was normal for males to have more than one sexual partner. Also, it was a male's preference to decide on condom use. This means that in communities that still hold cultural beliefs, males are regarded as the heads of the households and they make decisions. It was alarming to discover that patriarchal societies still exist even though we are now in a democratic country.

More specifically, these patriarchal societies put females at disadvantaged situations in terms of decision making. The participants often emphasized that male domination still occurred in many relationships. For example, some of the participants mentioned that they could not negotiate condom use with their male sexual partners. Female adolescents therefore engaged in unsafe sexual activities due to the refusal of condom use by their sexual partners. Another factor that endorsed male domination was the socio-economic status of the male sexual partner. Some of the participants pointed out that they were pressured by their partners to start being sexually active at young ages. Because they depended on their male counterparts financially, they were scared to question their decisions as they feared losing financial assistance.



### **5.2.3 Linking adolescence stage to immature reasoning**

Developmental theorists in psychology refer adolescence as a developmental stage that is associated with identity confusion. For adolescents, it gets difficult to deal with issues that require decision making, for example initiation of sexual activity. At this stage, adolescents are overwhelmed by curiosity and they need to experiment, and sexual behaviour becomes part of the process. Adolescents' thinking and/or decision making is somehow influenced by their immaturity and lack of responsibility.

The participants spoke about their experiences and how their decision making processes were influenced by their undeveloped reasoning. The core factor that was identified as the cause of vulnerability was the age at first sexual activity. Most of the participants mentioned that they started engaging in sexual activity before age of 15 years. Those participants who started being sexually active before age 15 explained that they did not know or have a specific reason

for doing so. They associated their childish behaviours with carelessness, which resulted in unplanned pregnancies.

Again, peers were identified as influence on initiation of engaging in sexual activities at an early age. This study revealed that adolescents trust their peers more than their parents as they feel comfortable discussing sexual related issues with them. In order for them to fit in their communities, they had to copy their peers' behaviour. It was observed that due to the adolescents' immaturity, they were likely to consult their peers for affirmation of the decisions they had to make. A disturbing observation was that most these adolescents were not aware of the long-term consequences of unprotected sex. As young as they were, it was difficult for them to interact with their parents to get helpful information.

#### **5.2.4 The relationship between adolescent pregnancy and HIV risk**

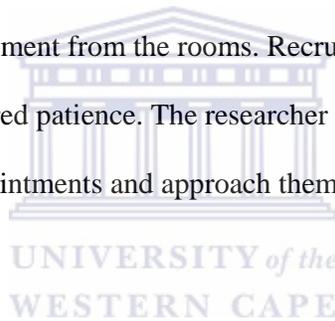
Practicing unsafe sex remains the crucial factor in vulnerability of adolescents to both HIV infection and unplanned pregnancies. One of the key worrying findings of the study was that adolescents engaged in unsafe sexual activities without considering the outcomes or the risk they're putting themselves in. Most of them rely on birth control methods such as the hormone injection, ignoring that it only prevents pregnancy and not STIs.

Furthermore, although there was a small number of participants who reported having more than one sexual partner, it is important to note that adolescent males were identified as those who engaged in such behaviour. The engagement of multiple sexual partnerships put their female sexual partners at risk of STIs. Of note, it was mentioned by the participants that in some occasions it is acceptable for a male to have more than one sexual partner. This mostly occurred in females with significantly older sexual partners who are in authority in the

relationship. Some of the participants pointed out that having a male sexual partner who has more than one sexual partner in their communities is not an unusual scenario. Females engage in sexual relationships with such males and they increase their likelihood of HIV risk.

### **5.3 Limitations of the study**

As the study was conducted in a clinic setting, noise was one of the challenges that the researcher had to tolerate during the interviews. There was often noise of children crying in the background, which made it hard for recording purposes. In addition to this, the interviews were conducted in consultation rooms and the researcher was being disrupted at times when nursing staff wanted to get equipment from the rooms. Recruiting the participants was also a frustrating experience that required patience. The researcher had to wait for the participants to first see the nurses for their appointments and approach them after they were done with everything.



Noteworthy, the fact that the participants were young mothers rather than merely sexually active young girls may have impacted on their response during the interview. Their attitudes and perceptions could have been different. Lastly, during data analysis, it was tricky to translate some of the phrases from isiXhosa into English as some of the phrases could not directly be translated. This might have caused biased meaning.

#### **5.4 Implications for future research**

The main finding from this study is that adolescents are faced with a variety of dynamics that impact on their thinking and reasoning. These factors negatively alter their decision making processes. The researcher has identified the factors associated with risky behaviour, which in turn influence adolescents' decision making. This suggests that research focusing on community-based intervention programs is required. Fieldwork needs to be conducted to find out the best way these adolescents can change their thinking, for example, eliminate the societal norms or myths that exist around sexual behaviour. Find out from the adolescents what prevention methods or interventions could be more acceptable and what could work best for them. Identifying adolescents' needs to change their behaviour could provide better prospect of how to intervene. Noteworthy, these adolescents need informative intervention programmes that bring awareness to them regarding STIs and/or HIV risk. It was discovered that the knowledge they have is insufficient. Because they are culturally not encouraged to discuss sex-related issues with their parents, they end up obtaining information from people who are not experts, which are their peers.

#### **5.5 Conclusion and recommendations**

Findings of the study reveal that socio-cultural influences, societal environments and communities somehow influence adolescents' sexual behaviour. One of the fundamental reasons for this is that adolescents' behaviour is mostly shaped by what is happening around them. Interventions that focus on community traditions are needed. Focus should be on changing some of the societal norms and cultural beliefs that exist, which influence the way adolescents make decisions. Also, parents should start communicating with their children and

provide them with advice on sexual behaviour. It was found out that many parents still hold on to cultural beliefs that it is disrespectful to discuss sexual matters with your children. This is a concern as adolescents acquire knowledge and information from unreliable source, and that puts them at risk. Awareness programs are needed to enrich adolescents' knowledge regarding sexual related issues as they seem to hold incorrect information, which in turn make them vulnerable and puts them at risk for sexual dilemmas such as unplanned pregnancies and HIV or STI infections. By attempting to identify such factors that influence adolescent sexual risk behavior, meaningful prevention and intervention programs may be developed.

In addition, as part of cultural beliefs, one of the main findings of the study was the issue of gender disparities in relationships, which led to adolescent vulnerability. Gender empowerment interventions particularly for women are needed to address this concern. There needs to be change in masculinity patterns in communities to improve women's inferiority. Moreover, such interventions should also focus on discouraging intergenerational sex, which stands out to put young females at risk. There is serious need for interventions at schools, at church, at home, and community at large. Lastly, cultural approaches to address both HIV and adolescent pregnancy should be placed in communities.

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