Support of adolescents to resist peer pressure and coercion to sexual activity

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Abstract

Aim: The aim of this study was to explore and describe how peer pressure and coercion to sexual activity manifested among adolescents in a district in South African and how primary health care nurses could support them to resist it.

Background: Peer pressure and coercion are driving adolescents to engage in early sexual activity. Adolescent risk behaviour that involves unsafe sexual practices remains a major concern for primary health care nurses, because it negates all progressive efforts to prevent the incidence of amongst others, unplanned pregnancies, sexual transmitted infections. Emotional immaturity and vulnerability predisposes adolescents to making irresponsible decisions regarding sexual activity with dire consequences to their health and well-being. Despite various initiatives specifically implementing governmental targeted adolescent intervention programs aimed at

reducing the consequences of irresponsible sexual activity many South African adolescents are still having unprotected sex and even multiple sex partners.

Methods: A constructivist grounded theory study was done. The initial sample consisted of 10 adolescents and nine professional nurses who were selected from six primary healthcare clinics in the identified district. Constant comparative data collection and analysis was done to identify the initial codes that were theoretically saturated through another round of data collection and analysis involving five participants (four professional nurses and one health educator).

Findings: The findings of the study refer to the definition of peer pressure and coercion and the relationship between professional nurses and adolescents. Ways to optimize the relationship in order for nurses to substitute for parental shortcomings in guiding adolescents towards responsible sexual behaviour and to address the adolescents' vulnerability regarding peer pressure were identified.

Conclusion: Challenging adolescent-nurse interaction incidents were identified that warranted different approaches to build on existing initiatives to improve adolescent friendly health services. Adolescents need support from professional nurses to resist peer pressure and coercion to sexual activity.

Implications for nursing practice and policy: Primary healthcare nurses should perform complementary roles to substitute for parents who do not have the skills to guide their adolescent children towards responsible sexual behaviour. Programmes need to be developed to enable nurses to optimize their relationships with adolescents and to deliver services through mobile health care units to adolescents where they regular socialize. Management should provide budgets for nurses to use multimedia to interact with adolescents.

Key words: Adolescent Development, Coercion, Constructivist Grounded Theory, Peer pressure, Risk Behavior, Sexual Activity

Introduction

Irresponsible sex among adolescents and its consequences towards their health and wellbeing is a worldwide concern (De Vries et al. 2014). Adolescents engage in unplanned, unprotected and early sex as a result of peer pressure and coercion thus increasing their vulnerability to unplanned pregnancies and sexual transmitted infections (STIs) (Setswe et al. 2014). Peer pressure and coercion to sexual activity is a challenge to them despite the availability of adolescent health programmes (Widman et al. 2016).

Based on data from the United States of America (USA) National Health and Nutrition Examination Surveys 1999-2012, the median age for sexual debut is 17 years (Lui et al. 2015). In the same country five percent of 14 year olds, 19 percent of 15 year olds and 32 percent of 16 year olds were sexually active at the time of the survey (Finer & Philbin 2013). In SA, in 2011, 36% compared to 38% in 2008 adolescents were sexually active, while the sexual debut was 12 years in 2011 compared to 13 years in 2008 (Reddy et al 2013). It is thus clear that a significant number of adolescents are sexually active, whether it happens by choice or due to pressure and coercion.

Background

Despite health promotive initiatives spearheaded by non-governmental organizations to implement adolescent development programmes, the incidence of Human Immuno-deficiency Virus (HIV) infection and unplanned pregnancy among adolescents remain a concern (Salih et al.

2015). A study conducted by Bilal et al. (2015) stated that initiatives targeting adolescents and parents to raise awareness on the implications of unsafe sexual practices and its consequences do not always lead to healthy sexual behaviour. In South Africa, the National Youth Behaviour Survey conducted in 2002, 2008 and 2011 give a gloomy picture regarding the risk behavior of adolescents and the negative impact on their health and well-being (Reddy et al. 2013).

Using a comprehensive approach rather than imposing abstinence only initiatives to prevent the spread of STIs among adolescents and the occurrence of teenage pregnancies is encouraged. Individuals and thus also adolescents have a right to be respected for their choices however they are obliged to become responsible for decisions taken. Adolescents resist prescriptive guidance (Parkin & Kuczynski 2012). They do not want to be told what to do and what not to do (Burns & Porter 2007). They want to be involved in decision making and want to feel that they are respected as individuals. Therefore, it is essential to reach out to adolescents with additional initiatives to address peer pressure and coercion to unsafe sexual activity (Enah et al. 2015). It is important to get their perspective on what peer pressure to sexual activity is and how it manifests before any initiative could be developed to support them.

Aim of the study

The aim of this study was to explore and describe how peer pressure and coercion to sexual activity manifested among adolescents in a district in South Africa and how primary healthcare nurses could support them to resist it.

Methods

Research Design

A constructivist grounded theory study was done as developed by Charmaz (2014) based on symbolic interactionism described by Mead (1934) and Blumer (1969). Constructivist grounded theory methodology and symbolic interactionism are compatible and difficult to separate as they both involve the construction of meanings of social reality (Flick, Von Kardorff & Steinke 2004). Adolescents understand the reality of peer pressure and coercion to sexual activity in interaction with others such as their peers, family members and significant others. At the same time nurses develop an understanding of how they can support adolescents to resist peer pressure and coercion during interaction with their colleagues. Both groups develop symbolic interpretations of these social processes in their social worlds (Blumer 1969) and it is thus appropriate that these processes be studied through constructivist grounded theory research as the approach is substantiated by symbolic interactionism (Charmaz 2014).

In this study meanings were constructed regarding the social processes of peer pressure and coercion to sexual activity as experienced by the adolescents and the ways in which nurses can support adolescents to resist pressure and coercion. Constant comparative analysis throughout the study enabled the researchers to construct the meaning of the studied processes (Charmaz 2014).

Sample and setting

The setting for the initial round of sampling and data collection of this study was six public primary health care clinics spread over urban, semi-urban, rural and semi-rural areas in a district in South Africa. The study population in the theoretical round of sampling were from youth and adolescent health services in the vicinity of the clinics.

The initial sample consisted of 10 adolescent (six females and four males) and nine female professional nurse participants. Open sampling was done to ensure that participants were selected who could provide the researchers with comprehensive data concerning the studied social processes (peer pressure and coercion to sexual activity and the support that nurses can render to help them to resist it). The inclusion criteria for the adolescent participants were male and female adolescents aged from 14 to 19 years old, visiting the clinics for treatment of minor ailments or attending to access sexual reproductive health services. Nurse participants were selected who have been exposed to working with adolescents at least for a year in the sexual reproductive health services or general adolescent health care services. Theoretical sampling was done to select participants that could elaborate a particular aspect of the studied processes. Four professional nurses and one health educator were involved.

Four of the female adolescent participants were attending school at the time of the study. Two of them were raised by single mothers and two by both parents. One participant left school and ran away from home because of conflict with her family. She stayed with friends and was not

planning to return to school. The participants regularly visited the selected clinics for contraception.

The male adolescent participants were all attending either schools or tertiary education institutions. Three of them stayed with their single mothers and one stayed with his maternal grandparents. They visited the selected clinics for minor general ailments.

The nurse participants of the initial sample have had experience varying from 2 to 17 years in adolescent healthcare. At the time of the study they worked in school health services, rural, township and suburb clinics.

In the theoretical sampling phase four nurses and one health educator were selected. The nurse participants were at the time of the study involved in the management of adolescent health programs at district, provincial and national levels in South Africa. The health educator was employed as a Health Education Specialist and had extensive experience of working in youth and adolescent health programs both locally and abroad.

Data Collection

Intensive individual interviews were done at venues of the participants' choice. Such interviews provide the researchers with opportunities to gain 'deep views' of the studied processes as it enhances interaction between researchers and participants (Charmaz 2014). As data collection and analysis happened simultaneously the ongoing data analysis informed the subsequent data

collection. The adolescent participants were asked to describe their perspectives regarding peer pressure and coercion to sexual activity and the nurse participants were asked to describe what their contribution could be to support adolescents to resist peer pressure and coercion to sexual activity. Questions were added as the data collection progressed and the ongoing data analysis informed the data collection (Charmaz 2014). The data collection in the second round was focused on the theoretical saturation of the codes that emerged during the initial round of data collection. The interviews were audio recorded with the permission of the participants.

Data Analysis

Data analysis in grounded theory research is an iterative process that occurs concurrently with data collection. In this study data analysis started immediately after the first interview and continued until theoretical saturation of the categories was reached. Meanings of the social processes were co-created with the participants. Constructivist grounded theory researchers are not interested in descriptions of the processes, but rather on the conceptual understanding of it (Charmaz 2014).

Initially open line-by-line coding was done; followed by focused coding; and lastly theoretical coding to construct the categories (Charmaz 2014) that reflects descriptions of peer pressure and coercion to sexual activity and the contribution that nurses can make to support adolescents to resist it. Memos were written to enhance the move from a descriptive to a theoretical level and to raise the categories to an abstract level.

Ethical considerations

The study gained approval from the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria (Ethics Ref 365/13) and the healthcare authorities (Project 20/2014). The participants and parents of the adolescent participants provided the relevant assent and consent for their voluntary participation in the study. The privacy, confidentiality and voluntary participation clauses of the Belmont Report were explained to them.

Rigour in the study

The findings of a grounded theory study should be grounded in data. Researchers should thus prove how the data obtained from the participants respond with the categories. In the description of the findings of this study the researchers made use of excerpts from the transcribed interviews to prove that the categories are grounded in the data. As grounded theory researchers co-create the meaning of the studied processes (in this study the processes refer to peer pressure and coercion to sexual activity and the support that adolescents need to resist it) during intensive interviews with their participants, they have to use ongoing reflection to ensure that they remain aware of the possible effect that they could have on the data. Ongoing reflexive discussions were used in this study.

Charmaz (2014) prescribes specific key criteria for evaluating constructivist grounded theory research. The researchers adopted the criteria to ensure trustworthiness of the findings. The categories are credible as the data was collected from a diverse group of participants until theoretical saturation of the categories was obtained. The study provided new insights regarding

the challenge of negative peer pressure and thus met the criteria of originality of the findings. While much research has been done on the prevention of teenage pregnancy due to peer pressure to sexual activity, the researchers opted to focus the study on the guidance to help adolescents to resist negative peer pressure. The categories are original and were derived from data and not from previous research. Existing literature was not used prematurely to ensure that "fresh conceptual understandings" (Charmaz 2006:182) were reflected in the categories. The criteria of resonance was met as the findings of the study reflect the experiences of the participants. Probing questions were used to ensure that rich data was obtained. The findings of the study are useful to nurses who work with adolescents and who endeavor to support them to resist peer pressure to sexual activity.

Findings

In grounded theory research, findings are "presented in isolation of both extant theory and contemporary literature and then discussed in relation to each other" (Birks & Mills 2015:130). The findings will thus be described first and thereafter discussed. Six categories are presented.

Experiencing peer pressure and coercion

Peer pressure and coercion seem to refer to all acts that force persons to do something against their will. The adolescent participants were familiar with peer pressure and coercion and experienced it in different situations. One of them described it as follows:

> *"Maybe make you feel bad when you don't want and force you to do what you don't like."* (Adolescent participant 3)

It was made clear that it is often own friends that create the pressure and coercion. Adolescents want to impress their friends and also need their admiration in order to build an own self-image. They thus tend to easily give in to pressure from friends:

> *"It means that sometimes when you get forced to do things you don't want to do by your friends."* (Adolescent participant 8)

When adolescents seek admiration they may initiate daring activities. The peer pressure associated with the need to feel good about oneself becomes the driving force for behavior that adolescents will not try when they are not with their peers:

> *"It is something that you do just to impress other people."* (Adolescent participant 6)

Substituting for parental shortcoming

The nurse participants acknowledged that not all parents were capable of guiding their adolescent children towards resisting peer pressure and thus in adopting responsible sexual behavior. They also realized that they would have to substitute for parental shortcomings:

> *"I think we need…parenting programmes which will assist parents…in giving them the approaches or skills on how to communicate with their children…also give them…information on sexuality education…"* (Nurse participant 7)

The adolescent participants were cognizant of the limited adolescent-parental communication on reproductive health and sexual activity at home. They claimed that their parents could not advise them about the challenges that they experienced, especially regarding relationships. The adolescent participants blamed the limited sexual health information that they got at home for

their involvement in sexual risk behaviour. According to them it caused them to develop poor self-confidence and they relented to peer pressure and also manipulated others to relent to peer pressure tactics:

> *"I experienced peer pressure through friends…because they expect you to be this…person and sometimes you do not meet those requirements…then you end up doing things just to please them."* (Adolescent participant 6)

Not all parents who refrain from educating their adolescent children about sexual health do that due to inadequate knowledge about the issue. Some experienced cultural barriers that hindered open communication with their children about peer pressure and sexual activities. According to the nurse participants, some parents were well informed, but found it difficult to divulge it to their adolescent children:

> *"I think parents have enough information…just that some will feel somehow because of culture and whatever..."* (Nurse participant 5)

When parents of adolescents try to guide their children in the way that their parents guided them, inappropriate actions can be taken. Although parents may not communicate their need to be trained to assist their adolescent children to resist peer pressure, the need may exist:

> *"…to be able to see what do young people require these days…most parents the way their parents parented…that is why they need training on parenting…"* (Theoretical sample participant 1)

Addressing negative peer pressure vulnerability

Some of the nurse participants had experiences of identifying the vulnerability of adolescents during their interaction with adolescents at primary healthcare clinics. It should, however, not be limited to healthcare facilities as many adolescents will not benefit from their endeavours as healthcare should be rendered where the adolescents meet regularly:

> *"I think when we go and do primary healthcare services at schools…that is where we are going to get them…"* (Theoretical sample participant 3)

Unfortunately the adolescent participants reported that they were hesitant to speak out about their concerns because of the nurses' attitudes towards them. Some of them perceived the primary healthcare nurses as hostile towards them:

> *"Some nurses must learn to talk to people well…like they don't have to take advantage…"* (Adolescent participant 5)

Nurses' ability to communicate with adolescents and to create an enabling environment is a prerequisite for identifying and addressing their peer pressure vulnerability. When nurses treat adolescents as valued healthcare users, they contribute to an open discussion of the healthcare needs that include the needs that they develop due to peer pressure and their vulnerability to it:

> *"I think communication is priority, the way that adults communicate with young people…it is very important…"* (Theoretical sample participant 2)

Addressing risk behaviour vulnerability

Adolescents should be enabled to resist risk behaviour. Building their skills can be done in on-the-spot teaching as well as through formal programmes. Interactive teaching and learning methodologies are preferred and learning should be reinforced by doing:

> *"It requires time so that you can give them practical experience of really doing role play…practicing the skills and not only theoretical learning…"* (Theoretical sample participant 1)

Nurses can also develop dedicated spaces to enable adolescents to develop skills to avoid risk behavior. In such spaces, adolescents can interact without fear that other may overhear them and entertainment can be mixed with health education:

> *"…life skills training and dealing with issues in a real way…the activities were meant to entertain and educate at the same time."* (Theoretical sample participant 2)

Adolescents require guidance and the adolescent participants voiced their needs to be warned against risk behavior that can lead to sexual promiscuity. They prefer events for teenagers only:

> "*Maybe by creating an event for us young people…"* (Adolescent participant 7)

Technology and social media could be used to educate adolescents in dedicated spaces while they wait for consultations:

> *"…use technology…there are so many ways to communicate to the youth…media can be used in clinics…"* (Nurse participant 2)

Optimizing adolescent-nurse interaction

Adolescent-nurse interaction should take place where adolescents feel comfortable. The adolescents suggested that nurses could use school venues for health education:

> *"…maybe visit schools every month…they should share vital information and give guidance…"* (Adolescent participant 7)

The nurses should be willing to give adolescents advice they require wherever they encounter them be it during school health visits or at the clinic during nurse-adolescent interaction.

> *"Giving adolescents advice on peer pressure…. even when we are coming to the clinic."* (Adolescent participant 3)

Unfortunately nurses according to the adolescent participants make decisions on behalf of their adolescent patients and are judgmental when contraceptives are requested with detrimental effect on their relationships with their patients:

> *"…most nurses…they are thinking of their own children…coming here looking for contraceptives…that is when the relationships gets sour."* (Nurse participant 7)

The adolescent participants advised that nurses should adopt positive attitudes towards them to optimize adolescent-nurse interaction:

> *"…some take advantage because they are nurses…even when one goes to the…clinics…for one to get help it is difficult…"* (Adolescent Participant 7)

The nurse participants admitted that they should show more understanding of the challenges that adolescents face. They should communicate with adolescents on their level instead of patronising them and preaching to them about involvement in sexual activities:

> "*nurses should overcome their judgemental attitudes…should be able to communicate effectively…when one opens up and become honest to an adolescent…"* (Theoretical sample participant 2)

Enabling responsible decision making

Enabling responsible decision making entails a process of helping individuals to make choices based on the current circumstances and conditions they find themselves in. Nurses should help adolescents to become self-reliant and to gain confidence in themselves in order to distinguish between right and wrong decisions as well as stand firm on the choices they have made irrespective of other people's opinions. When parents are not capable of supporting their children to take decisions in a responsible manner, nurses should intervene:

> *"Some parents…are not very involved in their children's lives…and are not going to teach their children values…that is why their children are doing as they wish…it has to start from home…*" (Nurse participant 9)

During adolescence the development of self-esteem is dependent on the reaction of others towards the individual. Should the pressure from peers be that adolescents take part in risk behavior and they do not have a well-developed self-esteem to stand up against such pressure, they are vulnerable and take part in activities that they know are not acceptable:

> "*They feel like if I do not look like this I will not be accepted…they have a sense of not belonging…image is such an important thing…"* (Nurse participant 3)

Adolescents want to receive accurate health information. Being educated was commended as a way they can gain insight in peer pressure and how to resist it when it can lead to negative consequences. Being knowledgeable and having insight could boost their confidence and encourage self-discovery and self-reliance:

> *"I think you need to be educated…find information…in school…clinics, libraries … then find yourself and stay true to yourself in order to resist peer pressure."* (Adolescent participant 6)

Discussion

Adolescents interact with others and form social relationships at home, school and in the community through symbolic and non-symbolic means. Should there be parental shortcomings, others can act as substitutes. Nurses can thus be substitutes for the parents of adolescents; not to replace them, but rather to complement their parental endeavours. At times, the substitution can be aimed at rectifying mistakes and not only on complementing parenting. It can also imply that nurses could teach adolescents the skills that their parents are not capable of teaching them. As social circumstances, according to Mead (1967), prescribe the behavior of people, it is appropriate for nurses to compensate for a lack of parenting (in the case of adolescent orphans) and limited parenting (in the case of parents who are available, but not capable to guide their children) in ways to resist peer pressure and coercion to sexual activity. Adolescents cannot be forced to accept the attempts from nurses to compensate for the lack of skills of their parents. A requirement is that nurses and adolescents should attach the same meaning to the intervention and both groups should accept the intentions of the other for them to interact effectively (Blumer 1966).

When adolescents are influenced by negative peer pressure, they tend to engage in risk behavior and ignore the related negative consequences. Risk behavior includes early sexual activity, binge drinking, smoking and using illicit drugs. Adolescence is often associated with risk behaviour (Rowe et al. 2016) and it takes place as adolescents learn to establish their own identity. Adolescents are invited to cooperate in risk behaviour to obtain affirmation of their status in the group of peers (Kreager et al. 2016). They often require support from adults such as their parents or nurses at clinics to develop the courage to resist risk behaviour and to take responsibility for their own actions. When adolescents develop their self-esteem and no longer depend on their peers to approve their behaviour, their vulnerability decreases. Trusting relationships between adolescents and significant others enables adolescents to learn how to resist risk behaviour (Haggerty et al. 2013). Should parents not be able to fulfil supportive roles, others such as nurses can intervene to give adolescents the needed support (Malacane & Beckmeyer 2016).

The vulnerability of adolescents regarding negative peer pressure needs to be identified early and managed properly to minimize the negative effect on them and their relationship with others (Oza et al. 2015). Such interventions require a multi-disciplinary approach and the involvement of their parents (Cooper et al. 2015).

Whenever nurses interact with adolescents, they should be alert to circumstances that could cause negative peer pressure vulnerability. One example is poorly functional families that cannot support adolescents through their development into responsible adults. A study conducted by

Rowe et al. (2016) revealed that adolescents who come from dysfunctional families are more vulnerable and prone to early onset of intimate relationships.

Interviews to address peer pressure vulnerability of adolescents should be conducted in private venues (Reddy et al. 2013). Adolescents want to be treated with respect and need to be reassured that confidential matters would not be divulged to external parties (Nair et al 2015). Healthcare should be accessible to them and delivered by nurses who are sensitive to their needs at venues where they feel comfortable such as schools and recreation facilities (Cooper et al. 2015).

Nurses should take the responsibility for creating adolescent-friendly interaction in order to guide them to resist peer pressure and coercion to sexual activities (Lince-Deroche et al. 2015). When dealing with adolescents, nurses should improvise strategies to keep them interested in health issues (Schriver et al. 2014). They require a special way of interaction when sexual matters are addressed (Alli et al. 2012) and when one requires their interaction during health education. However, if fun and games are engaged in, they are likely to become interested, especially if the health activities are aligned to recreational events to entice them to consistently participate (Motuma et al. 2016). Interaction between nurses and adolescents can take place through social media (Francis et al. 2013). They enjoy innovative ways of communication such as digital media (Perry et al. 2012).

Continuous professional development programmes for nurses who work with adolescent patients should focus on ways to enhance interaction between them and their adolescent

patients). Nurses should be trained in the special needs of adolescents and also how to show respect for their dignity and not to alienate them from clinics and as a result deprive them from opportunities to learn how to resist peer pressure and coercion to sexual activity (Chilinda et al. 2014). They need to develop skills regarding responsible decision making to resist peer pressure and risk behaviour (Kerpelman et al. 2016). It can happen at schools and be reinforced during clinic visits (Moksnes & Espnes 2013). Nurses can also serve as role models for adolescents as not all adolescents grow up with adults who have the ability to be positive role models (Kerpelman et al. 2016).

Conclusion

The adolescent participants experienced peer pressure to sexual activity and voiced their need to get support from adults to resist such coercion. The nurse participants shared their ideas regarding the support that they can render to adults at primary healthcare clinics. They were willing to be 'substitute parents' to their adolescent patients and to help them to develop means to counteract negative peer pressure; to acquire skills in responsible decision making in order to resist risk behaviour associated with irresponsible sexual activity. A prerequisite is that the adolescents-nurses relationships be improved. Adolescents want to be respected and not patronized by adults.

Limitation of the study

The research was done in one country, namely South Africa. The authors thus do not claim that the findings can be generalized to all adolescents globally. The readers will have to study the

context of the study to determine whether the findings could be applied to the adolescents in their clinical practice.

Implications for nursing practice and policy

Dedicated spaces in adolescent-only primary healthcare clinics should be equipped with digital and electronic media to enhance the effectivity of health education aimed at resistance of peer pressure and coercion to sexual activity. Adolescents need to be enabled to make responsible decisions regarding their sexual debut and health.

Clinic authorities should recruit nurses who prefer to work with adolescents; are capable to develop good relationships with adolescents; are willing to perform roles as 'substitute parents'; can utilize venues outside clinics for health education; to create conducive environments for adolescent-friendly healthcare. Adolescents need to feel welcome in primary healthcare clinics and comfortable to share their needs in order to get appropriate care.

Programs need to be developed to enable nurses to optimize their relationships with adolescents and to deliver services through mobile health care units to adolescents where they regular socialize. Management should provide budgets for nurses to use multimedia to interact with adolescents.

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REFERENCES

Bilal, S.M., et al. (2015) Utilization of sexual and reproductive health services in Ethiopia – Does it affect sexual activity among high school students? *Sexual and Reproductive Healthcare*, **6**, 14 - 18.

Birks, M. & Mills, J. (2015) *Grounded Theory: Practical Guide*. 2nd Edition. Sage Publication. London, UK.

Blumer, H. (1966) Sociological implications of the thought of George Mead. *American Journal of Sociology*, **71**(5), 535-544.

Blumer, H. (1969) *Symbolic interactionism: Perspective and method*. Prentice Hall, New Jersey, USA.

Burns, V.E. & Porter, E.J. (2007) The experience of having become sexually active for teen mothers. *Journal of Community Health Nursing*, 24(4), 215-236.

Charmaz, K. (2006) Constructing grounded theory. A practical guide through qualitative analysis, Sage Publication, London, UK.

Charmaz, K. (2014) *Constructing grounded theory*, 2nd Edition. Sage Publication, London, UK.

Chilinda, I., et al. (2014) Attitude of health care providers towards adolescent sexual and reproductive health services in developing countries: A systematic review. *Health*, 6, 1706-1713.

Cooper, D., et al. (2015) Youth health and well-being: Why it matters. Part 2. Youth and the intergenerational transmission of poverty. *South African Child Gauge*, 60-68.

De Vries, H., et al. (2014) Adolescents' beliefs about forced sex in KwaZulu Natal, South Africa. *Archives Sexual Behaviour,* **43**, 1087–1095.

Enah, C., et al. (2015) Rural adolescents' perspectives on contextual influences of sexual risk behaviour. *Journal of Nursing and Health Care,* **2**(2), 5-13.

Finer, L.B. & Philbin, J.M. (2013) Sexual initiation, contraceptive use and pregnancy among adolescents, *Paediatrics,* **131**(5), 886–891.

Flick, U., et al. (2004) *A Companion to Qualitative Research*. Sage Publication, London, UK.

Francis, S.A., et al. (2013) An analysis of key stakeholders' attitudes and beliefs about barriers and facilitating factors in the development of cervical cancer prevention program in South Africa. *African Journal of Reproductive Health*, **17**(1), 158-168.

Haggerty, K.P., et al. (2013) Promising parenting programs for reducing adolescent problem behaviours. *Journal of Child Services,* **8**(4), 229 - 243.

Kerpelman, J.L., et al. (2016) Engagement in risky sexual behaviour: Adolescents' perceptions of self and the parent-child relationship matter. *Youth and Society*, **48**(1), 101-125.

Kreager, D.A., et al. (2016) The double standard at sexual debut: Gender, sexual behavior and adolescent peer acceptance. *Sex Roles*, **75**, 377-392.

Lince-Deroche, N., et al. (2015) Accessing sexual and reproductive health information and services: A mixed methods study of young women's needs and experiences in Soweto, South Africa. *African Journal of Reproductive Health*, **19**(1), 73-81.

Lui, G., et al. (2015) Trends and patterns of sexual behaviours among adolescent and adults aged 14 to 59 years. United States. *Sexually Transmitted Diseases,* **42**(1), 20–26.

Malacane, M., & Beckmeyer, J.J. (2016) A review of parent-based barriers to parent-adolescent communication about sex and sexuality: Implications for sex and family educators. *American Journal of Sexuality Education,* **11**(1), 27 – 40.

Mead, G.H. (1934) *Mind, self, and society*. University of Chicago Press, Chicago, USA.

Moksnes, U.K. & Espnes, G.A. (2013) Self-esteem and life satisfaction in adolescents: Gender and age as potential moderators. Quality Life Research, 1-8.

Motuma, A., et al. (2016) Utilization of youth friendly services and associated factors among youth in Harar town, east Ethiopia: Mixed method study. *British Medical Council Health Services Research*, **16**(272), 1-10.

Nair, M., et al. (2015) Improving the quality of services for adolescents, globally: A standards-driven approach. *Journal of Adolescent Health,* **57**: 288 – 298.

Oza, K.K., et al. (2015) Examining negative effects of early life experience on reproductive and sexual health among female sex workers in Tijuana, Mexico. *International Journal of Gynaecology and Obstetrics*, **128**, 169-173.

Parkin, S.M. & Kuczynski, L. (2012) Adolescent perspectives on rules and resistance within the parent-child relationship. *Journal of Adolescent Research,* **27**(5), 632-658.

Perry, C.W., et al. (2012) Adolescents' perspectives on the use of a text messaging service for preventive sexual health promotion. *Journal of Adolescent Health*, **51**, 220-225.

Reddy, S.P., et al. (2013) *Umthente uhlaba usamila. The 3rd South African National Youth Risk Behaviour Survey 2011.* South African Medical Research Council, Cape Town, SA.

Rowe, S.L., et al. (2016) Community, family and individual factors associated with adolescents' vulnerability, daily stress, and well-being following separation. *Journal of Divorce and Remarriage,* **57**(2), 87-111.

Salih, N.A., et al. (2015) Premarital sexual activity among unmarried adolescents in northern Ethopia: a cross-sectional study. *Sexual & Reproductive Healthcar,* **6**, 9-13.

Setswe, G., et al. (2014) The role of parents and peers in young people initiating sexual debut in South Africa. *Health Behaviour & Public Health,* **4**(1): 1 -8.

Schriver, B., et al. (2014) Young peoples' perceptions of youth-oriented health services in urban Soweto, South Africa: A qualitative investigation. *BMC Health Services Research*, **14**(625), 1-7.

Widman, L., et al. (2016) Adolescent susceptibility to peer influence in sexual situations. *Journal of Adolescent Health*, **58**, 323-329.