

**Insights of urban and rural female youth regarding the nature and  
consequences of sexual risk behaviour**

by

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Supervisor: Dr C.L. Carbonatto

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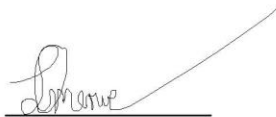
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## ABSTRACT

### Insights of urban and rural female youth regarding the nature and consequences of sexual risk behaviour

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**Department:** Social Work and Criminology  
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Like other developing countries in sub-Saharan Africa, South Africa is faced with the following social welfare issues: teenage pregnancies, high HIV rates, sexually transmitted diseases (STDs), and a high number of abortions. South Africa is dealing with the repercussions of risky sexual behaviour of female youth on a daily basis and these include: youth with STDs, teenage pregnancies, HIV infection, cervical cancer, abortion, and youth selling their bodies for money. All of these can lead to serious health risks. There are psychological and behavioural factors associated with the risk of STDs like Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (Gebregiorgis, 2000:15). Gebregiorgis reported that understanding sexual risk behaviours is one of the most important issues in preventing the spread of HIV and AIDS. Doing so will result in the design and implementation of health education programmes with the view of preventing these infections, or at least minimising their occurrence (Damtie, 2013:1). Very limited research has been done on this topic in South Africa and Africa. A need for a similar study was recommended in Ethiopia, where it was stated that no published empirical studies were available on factors relating to sexual risk behaviours in rural districts such as the Enemay District, East Gojjam Zone of Ethiopia (Anemaw, 2009:5). Hence, this study will explore and describe factors that may influence female youths to engage in unsafe sexual behaviours.

The focus of the study was on the risky sexual behaviour of female youth in rural and urban areas. The goal of the study was to explore and describe the nature and consequences of risky sexual behaviour of female youth in rural and urban areas. The research question of this study was: do female youth in urban and rural areas

have insight regarding the nature and consequences of their risky sexual behaviour?

A qualitative approach was followed with a case study research design, as the researcher wanted to compare cases in urban and rural areas. The population was school-going females aged between 18 and 20 years in Gauteng province. There were two targeted groups of population. The first one was in Kameeldrift Village, Hammanskraal in Tshwane Municipality, Gauteng province, classified as a rural area. The second population was in Tembisa, Ekurhuleni Municipality, Gauteng province, classified as an urban area. In this study non-probability, purposive sampling was used to generate a sample. The criteria for sampling participants were as follows:

- Female youth between the ages of 18 and 20 years old.
- Female youth who are sexually active, as they request contraceptives at the clinic.
- Female youth who are from Ivory Park in Tembisa and Kameeldrift Village in Hammanskraal, both in Gauteng.

Twelve participants, namely six female youth from a rural area and six from an urban area, who were at the above-mentioned clinics to access family planning within the above-mentioned age groups were chosen for the study. Semi-structured interviews were conducted with participants individually. Interviews were voice recorded with the permission of the participants and were transcribed by the researcher. The data was analysed by the researcher and themes and sub-themes were generated. The research findings were presented by providing a profile of the research participants and presenting a thematic analysis of the themes and sub-themes, including literature and verbatim quotes from the transcriptions to support the findings. The themes included the following: Theme 1 – Knowledge of female youth regarding reproductive health; Theme 2 – Knowledge of preventative measures and prevention of pregnancy; Theme 3 – Sexual risk behaviour and exploration of multiple sexual partners or concurrent partners; Theme 4 – Consequences of risky sexual behaviour; and Theme 5 – Attitudes experienced as a result of consequences of risky sexual behaviour.

The conclusions of this study reflect that that a limited understanding of reproductive health is a contributing factor to the sexual risk behaviour displayed by female youths in both rural and urban areas. It was further concluded that fear of dealing with the consequences of risky sexual behaviour does not prevent female youth from early sexual debut. Another conclusion is that early sexual debut is the biggest factor to risky sexual behaviour, as the majority of participants started engaging in sexual activities very early in life while they were not mature enough to negotiate safer sex practices.

Recommendations of this study can be used by professionals working with female youth in the health field in order to understand the dynamics involved, such as the biological, psychological, and social influences that result in the sexual behaviour of female youth. These will address the complex issues related to environmental influences that shape risky sexual behaviour of female youth.

**LIST OF KEY TERMS:**

Insights

Urban and rural

Female youth

Consequences

Sexual risk behaviour

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## **1. CHAPTER 1: GENERAL INTRODUCTION**

### **1.1 INTRODUCTION**

Like other developing countries in sub-Saharan Africa, South Africa is faced with the following social welfare issues: teenage pregnancies, high Human Immunodeficiency Virus (HIV) rates, sexually transmitted infections (STIs), and a high number of abortions. South Africa is dealing with the repercussions of risky sexual behaviour of female youth on a daily basis and these include: youth with sexually transmitted diseases (STDs), teenage pregnancies, HIV infection, cervical cancer, abortion, and youth selling their bodies for money. All of these can lead to serious health risks. There are psychological and behavioural factors associated with the risk of STDs, like HIV and Acquired Immune Deficiency Syndrome (AIDS) (Gebregiorgis, 2000:15). Gebregiorgis reported that understanding sexual risk behaviours is one of the most important issues in preventing the spread of HIV and AIDS. Doing so will result in the design and implementation of health education programmes with the view of preventing these infections, or at least minimising their occurrence (Damtie, 2013:1). Very limited research has been done on this topic in South Africa and Africa. A need for a similar study was recommended in Ethiopia, where it was stated that no published empirical studies were available on factors relating to sexual risk behaviours in rural districts such as the Enemay District, East Gojam Zone of Ethiopia (Anemaw, 2009:5). Hence, this study will explore and describe factors that may influence female youths to engage in unsafe sexual behaviours.

Thom (1992:396) describes adolescence or puberty as starting from ages 11 to 13, continuing up to 18 years, and during this stage youth goes through various developmental issues such as: many physical and emotional changes, sexual curiosity, sexual experimentation, social development, and peer pressure. The researcher is of the opinion that this developmental stage is very critical and deserves constant attention from professionals, as it may have an influence on the high pregnancy rates, high number of abortions, and STI rate amongst youth, because young girls do not have the maturity required in order to make these life-changing decisions. The researcher contacted the Chris Hani Baragwanath Hospital, which is the third largest hospital in the world, and spoke to the

Gynaecological Ward Matron, Sister Motshapi (2014), who reported that unsafe sex is a major challenge for the hospital and a minimum of 70 abortions are done every day, as made possible by the Choice on Termination of Pregnancy Act (No. 38 of 2004). The majority of age groups of their patients are between 13 and 20 years old.

In South Africa there are several organisations who work in partnership with Government in addressing the risky sexual behaviour exhibited by the youth. The South African based organisations include loveLife Trust, Planned Parenthood Association of South Africa, Solidarity Centre, and many others. The researcher contacted the loveLife Trust National Call Centre Director, Mrs Precious Magogodi (2013), who reported that the organisation was formed about 14 years ago specifically to address the sexual reproductive health issues of the youth of South Africa, in an effort to combat the alarmingly high spread of HIV and AIDS. Dr David Harrison, the founder of loveLife Trust, saw the gap within the culture, norms, behaviour and communities, and realised that youth could only change their risky sexual behaviour if they had access to relevant, professional and user-friendly services (loveLife, 2012:1). Magogodi (2013) confirmed that on a day to day basis the call centre handles call volumes on average of about 6000 calls and the category of issues discussed amongst others are abortion, pregnancy, STI, health and welfare resources in South Africa, peer pressure, and how to deal with the consequences of abusing alcohol, to mention a few. The organisation has recently launched its own research unit that deals with research on sexuality issues, including risky sexual behaviour in South Africa.

The focus of the study will be on the risky sexual behaviour of female youth in rural and urban areas. The researcher would like to fill a gap in research and make recommendations for practice to help reduce or prevent risky sexual practices among female youth. For the purpose of the study, the researcher will be focusing on the key concepts discussed below.

## **Youth**

The Children's Act of 2005 (Act No. 38 of 2005) sets out principles relating to the care and protection of children, defines parental responsibilities and rights, and makes provision for matters such as children's courts, adoption, child abduction,

and surrogate motherhood. The Act also clarifies the grey area that exists in relation to the age of adulthood, whereby the Age of Majority Act of 1972 stipulates the age of 21 as the age of majority, while a child was defined as someone under the age of 18. As stated in Govender and Masango (no date):

Between 18 and 21 you're neither a child nor an adult. The Children's Act of 2005 clarifies that grey area and brings in line with section 28 (3) of the Constitution. Now any person under 18, unless married or emancipated by order of court, is a child and any person over 18 is an adult.

It added that the Constitution and the African Charter on the Rights and Welfare of the Child defined a child as any person under the age of 18 years. Furthermore, youth refers to young people aged between 13 and 20 years (Getnet, Templeton & Barber, 2005:17). The term is also best understood as people in a period of transition from childhood to adulthood (Dessalegn, 2006:9). Youths in this study mean girls aged between 18 and 20 who visit Kameeldrift Clinic in Kameeldrift, Hammanskraal, a rural area in the Gauteng province, and Hikentsile Clinic in Tembisa, an urban area in the Gauteng province.

### **Risky sexual behaviour**

This refers to being sexually active (as opposed to abstaining from or postponing sexual activity), having many partners (either serially or concurrently), and practicing unprotected sex (which includes the irregular or incorrect use of condoms) (Eaton, Flisher & Aar, 2003:163).

### **Behaviour**

Behaviour is viewed as an integral part of the person and their environment. The unit of analysis is not just the person, but an integration of elements in the environment and the person, resulting in his or her behaviour (Maticka-Tyndale, Tiemoko & Makinwa-Adebusoye, 2007:67). Behaviour also refers to the actions and mannerisms exhibited by a person. It is a response of an individual to his or her environment (Anemaw, 2009:3).

### **Urban area**

An urban area is characterised by higher population density and vast human features in comparison to the areas surrounding it. Urban areas may be cities, towns or conurbations, but the term is not commonly extended to rural settlements such

as villages and hamlets. Urban areas are created and further developed by the process of urbanisation (*Oxford Dictionary of English*, 2010:430).

### **Rural area**

A rural area is a geographic area that is located outside the cities and towns. The *Oxford Dictionary of English* (2010:374) defines the word “rural” as encompassing all population, housing and territory not included within an urban area. Whatever is not urban is considered rural.

## **1.2 THEORETICAL FRAMEWORK**

The search for ways to characterise the relationship between person and environment took on new vigour in the 1950s and 1960s as social work theorists began to explore emerging ideas in systems theory. Much of modern systems theory evolved out of the work of North American sociologist Talcott Parsons’ (1951) Social Systems Theory and Austrian-born biologist Ludwig Von Bertalanffy’s (1968) General Systems Theory.

Von Bertalanffy began developing the General Systems Theory (GST) in the early 1920s. Building on a background in biology, over the next 50 years Von Bertalanffy attempted to define an alternative to conventional models of systemic organisation which tended to view system interchange as static, closed and resistant to change. He is credited with developing the concept of open systems, which for him was a far more accurate description of how interactions actually took place within and between living systems (Von Bertalanffy, 1968). Von Bertalanffy was especially interested in applying his theory to the intricacies of human systems. He was critical of conventional atomistic and reductionist models of system exchange which posited sealed, single-loop interactions, but which left little room for dynamic growth, differentiation, creativity and transformation over time. For Von Bertalanffy, conventional ideas have had a profound staying power and the influence of his General Systems Theory can be seen in almost every scientific discipline, including psychology, biology, physics, anthropology, engineering, sociology, economics, political science, and social work (Davidson, 1983).

Cassileth (2003:19), describes the background of the biopsychosocial model is as follows:

The biopsychosocial model of disease is best understood in juxtaposition to the traditional, dominant paradigm: the biomedical model. The biomedical model has long prevailed in Western society, its assumptions governing definitions of health and disease, patterns of clinical research and care, and parameters of the doctor-patient relationship. The biomedical view defines disease in terms of deviations from measurable biologic norms. Further, it attributes primary significance to physical variables, and incorporates a mind-body dualism. The underlying principle of the biomedical model is that disease ultimately can be explained in terms of discrete physiologic or biochemical aberrations. Illness is seen as a physical entity reducible to a single biomedical cause that can be located, studied, and understood using the conceptual and technical tools of the basic physical sciences.

Cassileth further listed the following shortcomings of the biomedical model:

The shortcomings of the biomedical construct are less theoretical than practical in nature. As a guiding principle in clinical care, the model simply fails to work. It does not recognise the individual as more than a biologic organism; it disembodies disease and takes no account of the reciprocal relationship between illness and the significance it holds for the patient. The model's exclusion of the personal "meaning" of illness for the patient is not criticised here on humanistic grounds. Rather, it is faulted in the view of compelling evidence that illness cannot be understood exclusively on the basis of physiological indicators, and in view of the fact that patients do not seek medical assistance solely or even primarily for physiological intervention. Disease can be present totally outside of the individual's awareness and, conversely, illness can occur in the absence of discernible biological disorder (Cassileth, 2003:20).

The researcher is of the view that biomedical model would not be appropriate for the study as explained above, because it focuses on limited areas and functions of the patient. The researcher is interested in the biological (female youth), psychological, environmental, and social attributes of the risky sexual behaviour of female youth in rural and urban areas. The researcher believes that a solution to the risky sexual behaviour of female youth would be reached if all avenues that attribute to this behaviour are explored thoroughly and a holistic approach is implemented to address it.

The biopsychosocial model will be used in this study. Models help to structure and organise how to approach a complicated situation (Payne, 2005:5). This model will assist the researcher to organise and have a better approach in order to reach the goal and objectives of the research topic. The purpose/goal of this research is to understand the risky sexual behaviour of female youth in rural and urban areas and determine whether the participants understand its impact on their future reproductive health.

The biopsychosocial model is defined as the psycho-socio-environmental model (sometimes referred to as the social model or the biopsychosocial model), and focuses on the promotion and maintenance of health through socio-environmental and behaviour changes. It emphasises the role of people's behaviour, what work they do, how they lead their lives, where they live, and their access to health services in determining their health status. For example, life expectancy and the chances of contracting a disease such as cancer, tuberculosis or HIV/AIDS are strongly influenced by socio-environmental factors (Ross & Devereil, 2004:12). Consideration is given to stabilising and destabilising influences in the person's environment and the effects of a person's illness on others. The lifespan perspective adds an important dimension to this model by taking into consideration the role of the person's development and life stage in health and illness (Ross & Devereil, 2004:12). Based on the explanation from the author above, the researcher will use this model in order to understand psychosocial, environmental and biological factors that contribute to the risky sexual behaviour of female youth in urban and rural areas. The psychological, environmental, and social impact of the risky sexual behaviour of female youth may be different due to the exposure to and availability of health resources in rural and urban settings. Severe health consequences could be perpetuated by lack or accessibility to primary health care in rural and urban areas.

As proposed by Engel (1977), the biopsychosocial model addresses the biological, social, environmental, psychological, and behavioural aspects of illness. This model expands the traditional medical model of health care that focuses primarily on the biological causes of disease. The biopsychosocial model considers the non-medical determinants of disease in collaboration with the purely biological components. For example, a biopsychosocial model of health service takes into account patients' ability to purchase recommended medicine for diabetes when creating a treatment plan for patients, rather than focusing only on laboratory results and physical status, as a medical-model approach would do (Gehlert & Browne, 2012:19). It is imperative for the study to determine whether female youth understand the biological impact of early sexual debut. The biopsychosocial model is used to indicate an approach to health service delivery that addresses the psychological and social aspects of health, and treatment that includes behavioural and

environmental factors (Gehlert & Browne, 2012:20). The same approach of this model would address the complex issues related to environmental influences that shape the risky sexual behaviour of female youth. For example, the researcher would like to look at biological effects (physical impact of the risky sexual behaviour of female youth), psychological (psychological impact of this behaviour), and social effects (society's contribution to the social life or even social expectations of female youth).

This model would be appropriate for this study, as sexuality addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from a cognitive domain (information), affective domain (feelings, values and attitudes), and the behavioural domain (communication and decision-making skills) (Kaviyvyva, 2003:13). The researcher has selected the biopsychosocial model as it also addresses the complex sexuality phenomenon defined above. This model deals with the same components that sex education deals with (the biological, psychological, and social components of individuals).

### **1.3 CONTEXTUALIZATION OF TOPIC**

The researcher views the risky sexual behaviour of female youth as self-destructive because it most often results in females dropping out of school due to pregnancy. The researcher's primary motivation is to assist to address the persisting challenge that South African female youth face. There are interventions that are in place at schools (such as Life Orientation and sexuality education subjects in the Department of Education's school curriculum) and these interventions are in place to address the high pregnancy rates amongst female youth. The teenage pregnancy rates are relatively high in South Africa, as mentioned by Matlane (2013), and existing interventions have to be enhanced in order to solve the sexual challenges of the community's female youth. The researcher is interested in determining how much knowledge the female youth in rural and urban areas have regarding the facts about early sex debut and the link to cervical cancer and the human papillomavirus (HPV). The researcher, therefore, is aiming to collect new knowledge regarding risky sexual behaviour practices that can be used within the social work profession to design or improve existing interventions. This study seeks to understand personal

behaviour experiences as well as the consequences of risky sexual behaviour in order to design or improve interventions.

#### **1.4 RATIONALE AND PROBLEM STATEMENT**

Female youth are constantly exposing themselves to risky behaviour, such as substance abuse, early sexual debut, high pregnancy rates amongst adolescent and teenage girls, missing school, no respect for teachers, violence in schools and in communities, and many others. It is a fact that youth of today are the leaders of tomorrow. It is important therefore to take the challenges seriously in order to remedy the problem and transform the behaviour of female youth so that they can lead healthy lives in a healthy country (South Africa). The researcher understands that some studies have been conducted under the same topic and measures are taken to address the problem, however it is still important to further investigate the subject until there are significant positive results when interventions are implemented. It is important to investigate whether the risky sexual behaviour challenge is as a result of lack of resources in rural areas or not, so that relevant structures are put in place to address the problem. The following statement confirms the researcher's opinion: research also validates that many young people participate in risky sexual activities, including early sexual debut, sex with many partners, and low and inconsistent use of condoms (Amazigo, Silva, Kaufman & Obikeze, 1998; Iwuagwu, Ademola & Ajuwon, 2000; Olaseha & Alao, 1991).

Delaying sexual activity until the age of 20 and restricting sexual activity to a monogamous relationship would significantly reduce the risk for cancer of the cervix (Spitz & Newell, 1992:43). Traditional risk factors include early age at first intercourse, multiple sexual partners, promiscuous behaviour, early child bearing, and high-risk behaviour of a male partner. With the availability of better methods of detection of HPV infection in patients with cervical cancer, it is now clear that the traditional risk factors and associations only serve as a surrogate marker for genital HPV infection (Schrijvers, Senn, Mellsteadt & Zakotnik, 2008:122). HPV infection is essentially a STDs, and hence safe sexual practices and barrier contraception can play a major role in prevention. The etiological link between HPV and cervical cancer has led to the development of several HPV vaccines. There is, however, evidence that the risk of pre-invasive disease Cervical Intra-epithelial Neoplasia

(CIN) is increased in the presence of HIV infection, and that this is confined to women who are infected with HPV (Parkin, Ferlay, Hamdi-Cherif, Sitas, Thomas, Wabinga & Whelan, 2003:274). Since 1993, cervix cancer has been considered to be an 'AIDS-defining' condition, meaning that when it occurs in someone who is positive for HIV, that person is deemed to have AIDS (Parkin et al., 2003:270). The researcher is interested in determining how much knowledge the female youth in rural and urban areas have regarding the facts about cervical cancer and HPV, as well as its link to HIV and early sexual debut.

Matlane (2013), a Department of Education spokesperson, reported that there were 4800 girls who became pregnant in 2010 and 4200 girls who became pregnant in 2011 in Gauteng, which means the current interventions are not effective. The researcher believes that the introduction of HPV inoculation in South African schools will effectively reduce the number of women who are diagnosed with cervical cancer later in life, but the question still remains whether the sexual behaviour of female youth will change as a result of once off vaccination. The above statement by Mr Charles Matlane clearly shows that South African youth are facing huge behaviour problems and understanding the reasons or causes of these challenges will allow the social work field to design programmes that will effectively address this social problem. The researcher would like to gather information on whether female youth understand the costs versus benefits of risky sexual behaviour, and what the perceived emotional and social consequences of health-related behaviours are (Fishbein & Azjen, 2010:24). According to the researcher, the current South African Government policies pertaining to the sexual behaviour of youth allow youth to access contraceptives at clinics from the age of 12 and decide whether they want to terminate a pregnancy or not without their parents' permission from the age of 14, which could contribute to risky sexual behaviour. Policies have got to be put in place to prevent youth from engaging in sex at an early age. The study has a possibility to enhance youth sexuality education programmes. Thus the research question:

Do female youth in urban and rural areas have insight regarding the nature and consequences of their risky sexual behaviour?

## 1.5 GOAL AND OBJECTIVES

The goal of the study is:

To explore and describe the nature and consequences of risky sexual behaviour of female youth in rural and urban areas.

The objectives of the study are:

- To explore the knowledge of female youth regarding reproductive health in rural and urban areas.
- To explore the nature of risky sexual activities of female youth in rural and urban areas.
- To contrast the nature of risky sexual behaviour of female youth in rural and urban areas.
- To explore the understanding of female youth regarding the nature and consequences of the risky sexual behaviour of youth in rural and urban areas.
- To make recommendations for improved sex education as a preventative measure for female youth against risky sexual behaviour.

## 1.6 RESEARCH METHODOLOGY

The researcher selected the qualitative approach, because the study seeks to understand the phenomenon of risky sexual behaviour of female youth. The purpose of this approach is to construct detailed descriptions of (social reality) the sexual behaviour of female youth in rural and urban areas. It seeks to understand personal behaviour experiences.

A qualitative approach was followed with a case study research design, as the researcher wanted to compare cases in urban and rural areas, namely a collective case study design. The population was school-going females aged between 18 and 20 years in the Gauteng province. There were two targeted groups of population, both in the Gauteng Province. The first one was in Kameeldrift Village, Hammanskraal, in the Tshwane Municipality, namely teenagers from a rural area. The second population was in Tembisa, Ekurhuleni Municipality which were teenagers from an urban area. In this study non-probability, purposive sampling was used to generate a sample. The criteria for sampling process were as follows:

- Female youth between the ages of 18 and 20 years.
- Female youth who are sexually active, as they request contraceptives at the clinic.
- Female youth who are from Ivory Park in Tembisa and Kameeldrift Village in Hammanskraal, both in Gauteng.

Twelve participants, namely six female youth from a rural area and six from an urban area, who were at the Kameeldrift and Ivory Park clinics to access family planning within the above-mentioned age groups were chosen for the study.

The data collection technique that was used was the semi-structured, one-to-one interview. According to Strydom in De Vos, Strydom, Fouche & Delpont (2011:352), researchers use semi-structured interviews in order to gain a detailed picture of participants' beliefs about, or perceptions or accounts of a particular topic. The method gives the researcher and participants much more flexibility. The researcher is able to follow up particular interesting avenues that emerge in the interview and the participants are able to give a fuller picture. Semi-structured interviews are especially suitable when one is particularly interested in complexity or process, or when an issue is controversial or personal.

Interviews were voice recorded with the permission of the participants and were transcribed by the researcher. The data was analysed by the researcher and themes and sub-themes were generated.

The research findings were presented by providing a profile of the research participants and presenting a thematic analysis of the themes and sub-themes, including literature and verbatim quotes from the transcriptions to support the findings.

Two prominent qualitative researchers, Lincoln and Guba (1999:76), propose the following four alternative constructs they believe reflect the assumptions of the qualitative paradigm more accurately. The first of these criteria, namely credibility, is considered to be the most important one (Strydom & Delpont, 2011:419). The others are transferability, conformability, and dependability. Strategies used were

member checking, peer debriefing, and reflexivity. Trustworthiness and the ethical considerations are discussed in detail in Chapter 3.

## **1.7 LIMITATIONS OF STUDY**

Although the study reached its aims, there were some unavoidable limitations.

Firstly, educational levels of the participants were not diverse. This means that only female youth who met the selection criteria were selected for the study. For this reason, some of the participants' communication was limited even though the study was conducted in their own language.

Secondly, it was difficult to recruit participants for the study, as the study was about a very sensitive topic which required participants to share their personal experience on risky sexual behaviour. This led to some of the female youth selected being reluctant to be participants in the study.

Lastly, there were a few interruptions during the process of interviews by some workers at the clinic, even when they were aware that interviews were in progress. In future, ways to avoid disruptions should be put in place.

## **1.8 CONTENTS OF THE MINI-DISSERTATION**

Chapter 1 will be the general introduction, definition of key concepts, theoretical framework, rationale and problem statement, and limitations of the study.

Chapter 2 will be a literature review of the young adult life stage, risky sexual behaviour of female youth, sexuality and sex education, STIs, HIV, cervical cancer, HPV, multiple partners, early sexual initiation, transactional sex, sexual violence against women, teenage and youth pregnancies, and the relationship between substance abuse and risky sexual behaviour. Organisations involved in sex education and what they focus on will be discussed.

Chapter 3 will include the research methodology and research findings.

Chapter 4 will include the summary, conclusions and recommendations.

Chapter 2 includes a review of the relevant literature and follows hereafter.

## **2. CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. It is broadly defined as the social construction of a biological drive (WHO/UNAIDS, 2002:23), which often deals with issues such as whom one has sex with, in what ways, why, under what circumstances, and with what outcomes a person engages in sex (Maticka-Tyndale et al., 2007:67).

Longitudinal studies on the factors promoting and perpetuating unsafe sexual behaviour in South African youth included studies between 1990 and 2000 which addressed the sexual behaviour of youth between the ages of 14 and 35 years (Eaton et al., 2003:165). The review concluded that at least 50 percent of young people are sexually active by the age of 16 years; the majority of school students who had ever experienced sexual intercourse reported at the most one partner in the previous year, with a persistent minority of between 1 percent and 5 percent of females and 10–25 percent of males having more than four partners per year; and between 50 percent and 60 percent of sexually active youth report never using condoms. In terms of explanations for unsafe sexual behaviour among South African youth, the findings illustrate the powerful impact of the proximal and distal contexts, and in particular, the pervasive effect of poverty and social norms that perpetuate women's subordination within sexual relationships. Personal factors and the proximal and distal contexts interact to encourage HIV risk behaviour (Eaton et al., 2003:149-165, 151).

The proposed study will focus on risky sexual behaviours and whether there is a difference in behaviours among rural and urban female youth. There are two important elements that will be explored, namely the examples of risky sexual behaviours, such as unprotected sex, multiple sexual partners and early sexual initiation, and the consequences of risky sexual behaviours amongst youth. The section that follows provides an overview of the available literature on factors relating to risky sexual behaviours, but does not contrast rural and urban areas

specifically, as the researcher discovered that there is no research that was done on this topic covering both rural and urban areas simultaneously. Related topics have been covered before in previous studies, however the studies were done in either a rural or urban area (Damtie, 2013:5).

The association of youth with risk is prominent in relation to young people's social activities and debates around youth welfare, criminal justice, employment, and sexuality. The expanding knowledge base about young people's personal and social risks is driven by research that gives increasing attention to young people as problems; sexual behaviour (Hoggart, 2007:20); substance misuse and binge drinking, with grand but contested claims about alcohol misuse (France, 2007:137-138); and the links between truancy and long-term social exclusion are just three examples. This concern with risky sexual behaviour drives a desire to predict it or stop it, using the idea of risk factors: literally determining what key determinants impact upon whether young people will grow up as integrated members of society, or as somehow deviant. This growing body of work seeks to understand protective factors and the idea of resilience to address the question: what capacities do young people need in order to ward off risk? Resilience is not simply located at the level of individual agency, but is increasingly seen as a cultural and structural concept. Particular approaches to building resilience through community youth development (Perkins, 2009:36) and the building of social capital (Boeck, 2009:17) demonstrate the importance of strategies which acknowledge and work with the social contexts in which young people are growing up, rather than viewing young people only as sites of individual incapacity (Curran, Harrison & Mackinnon, 2013:8).

Risk is a part of daily life for young people growing up in South Africa, and the environments they live in undoubtedly impact their risk taking perceptions and behaviour. The qualitative data from the study conducted by loveLife and the Human Sciences Research Council (HSRC) in 2011 indicate that many young people are aware of the consequences of certain risky activities, but that this knowledge does not always seem to change behaviour. While there are some young people who do not take risks or who reflect upon the risks they have taken, many others are not aware or feel unable to change their risk-taking behaviour. It is this latter group, generally ignored by most social and behaviour change

communication models, that loveLife programmes work with (Swartz, Peltzer, Naidoo, Bray, Sanger, Garzouzie, Sebklew-Sehume, Venables, Koen, Burnett & Matlhape, 2011:7).

The most commonly discussed risks were related to sexual risk taking and alcohol consumption, but young people also discussed violence in their communities, walking home late at night, having older partners, and even being rude to elders as risky. There is no one definition of risky behaviour, and risks are often carefully calculated. Young people describe some risks as positive, such as taking a chance in applying for a job, whereas others such as having unprotected sex are viewed as negative. LoveLife's risk reduction model correctly acknowledges the roles of broader structural factors, social norms and individual histories in young people's abilities to reduce risk, but needs to consider young people's conceptualisation, internalisation, and multiple definitions of risk in more detail (Swartz et al., 2011:7).

## **2.2 RISKY SEXUAL BEHAVIOURS**

The researcher will discuss the following types of risky sexual behaviours: unprotected sex, multiple sexual partners, and early sexual initiation.

### **2.2.1 Unprotected sex**

Rising rates of premarital sexual activity, escalating numbers of unmarried women terminating unplanned pregnancies, and the increasing prevalence of HIV infection and other STIs among youths are critical, as they are related to risky sexual behaviours, such as unprotected sex (Mensch, Bruce & Greene, 1998:250). Unprotected sex is related to an increased potential of contracting STDs and unwanted pregnancies (Kost & Henshaw, 2012:2). Approximately 19 million STD cases were diagnosed in 2012, and 13 percent of these cases dealt with youth aged between 13 and 24 with HIV/AIDS (Kost & Henshaw, 2012:2). These infection cases were mainly attributed to unprotected sex. It is important to re-state that unprotected sex is a significant contributory factor to the rising rate of global youth pregnancy, (Damtie, 2013:14). This has huge implications relating to youths dropping out of school and subsequently having lowered levels of educational achievement. Unprotected sex is also closely associated with alcohol and substance use. Data obtained from a study conducted among youths in Southern Africa confirm this. The

data revealed that drunkenness tends to reduce the likelihood of men using condoms with their steady partners, as well increasing the potential of engaging in sexual relationships with multiple partners (Kiene & Subramanian, 2013:583).

The researcher would like to quote the fourth South African population-based survey of HIV prevalence amongst surveys that have investigated HIV prevalence and behaviour (Shisana et al., 2012:20).

Since 2002, the Human Sciences Research Council (HSRC) and its partners, supported by different international and local donors, have conducted several national surveys that have contributed to the country's understanding of the HIV epidemic over time. Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, and Onoya (2012:XXV), conducted the fourth South African population-based survey of HIV prevalence in the series of national HIV prevalence surveys that have investigated HIV prevalence and behaviour. In 2002, a consortium consisting of the Human Sciences Research Council (HSRC), Medical Research Council (MRC), Centre for AIDS Development, Research and Evaluation (CADRE) and Agence Nationale de Recherche sur le Sida (ANRS) constituted the first research team to conduct a national population-based survey of HIV prevalence in South Africa. In 2012, in South Africa it is estimated that 12.2 percent of the population (6.4 million persons) were HIV positive, which is 1.2 million more people living with HIV than in 2008 (10.6 percent, or 5.2 million). Geographical differences were found by locality, type and also by province. Rural informal area residents had a significantly higher HIV prevalence than did urban formal area residents. Provincial variation was evident, the top four high-prevalence provinces being Kwa-Zulu Natal, Mpumalanga, Free State and the North West, and the lowest the Western Cape, Northern Cape and Limpopo also have lower HIV prevalence than the other provinces.

The researcher would like to contrast risky sexual behaviours of one province that is not listed on the above-mentioned four high-prevalence provinces, which could help in understanding what keeps the province out of the high prevalence category.

According to the survey conducted by loveLife in 2011 (loveLife, 2012), when youth were asked about the frequency of condom use with their main partners, casual partners and transactional partners, the results show inconsistent use between genders and between different types of partner. Of those who had had sex, 94.2 percent of young people had ever used a condom, and this was slightly higher among men (96.6 percent) than women (91.8 percent). When asked about condom use with their latest regular partner, 85.3 percent of men and 80.4 percent of women used a condom during their most recent sexual encounter. Among those with non-regular or casual partners, this increased to 97.5 percent amongst men and 80.8 percent amongst women (Swartz et al., 2011:9).

Condom use with transactional partners is very low, with almost two thirds of young people (61 percent) reporting never using condoms when having transactional sex. More women (62 percent) than men (60 percent) report always using condoms with their transactional partners. This inconsistency is of great concern to loveLife. Programmes need to be targeted directly at young people who have transactional relationships. Further analysis needs to be done to understand what the characteristics of these relationships are and which people engage in them (Swartz et al., 2011:9).

### **2.2.2 Multiple concurrent partners**

Multiple sexual partnerships are a high-risk sexual behaviour because it increases the risk of HIV transmission through sexual networks (Berry & Hall, 2009:97). It is therefore important to know the extent to which youths are engaging in multiple sexual partnerships. STDs are often associated with sexually active youths with multiple sexual partners. In agreement, Astatke (2000:63-83) asserted that 9.2 percent of sexually active students in his study reported having STDs and this was attributed to students' frequent contact with commercial sex workers and the use of multiple sex partners. In a similar study in 2005 in South Africa among sexually experienced young people, nearly 25 percent of males and 45 percent of females reported having had one lifetime sexual partner. Among sexually experienced youth, 57 percent of men and 48 percent of women reported that they used a condom during their most recent sexual encounter, but the majority of both men and women reported that they did not always use a condom with their most recent sexual partner (61 versus 71 percent, respectively). The majority of males and females reported that their most recent sexual partner was a main partner, although more men reported casual partners than females (17.6 percent of males versus 1.5 percent of females reporting casual sexual partners) (Pettifora, Reesa, Kleinschmidt, Steffenson, MacPhail, Hlongwa-Madikizela, Vermaake & Padian, 2005:1528).

Shisana and Simbayi (2002:31), reported the following information which is important for the purpose of this study:

12.6 percent of the respondents aged 15 years and older reported that they had had more than one sexual partner in the last 12 months. Significant differences

were found across all five reporting domains, with five times more males (20.1 percent) than females having had multiple partners; younger people aged 15–24 years (22.4 percent) having had multiple partners more than the other age groups; black Africans (14.5 percent) than other race groups; other locality types (range: 12.8 percent –13.3 percent) than rural formal areas (6.0 percent); and other provinces (range: 10.1 percent –14.5 percent) than the Northern Cape (8.7 percent), which might explain the low HIV prevalence in this province. Among the key populations at higher risk of HIV exposure, recreational drug users aged 15 years and older (32.0 percent), high-risk (alcohol) drinkers aged 15 years and older (32.9 percent), black African males aged 25–49 years (21.1 percent), and the disabled aged 15 years and older (15.9 percent) reported that they had more than one sexual partner in the past 12 months than the other two high-risk groups. With respect to trend analyses over the four surveys conducted from 2002 to 2012, overall there was a steady increase in respondents who had had more than one sexual partner in the previous 12 months, from 11.5 percent in 2002 to 18.3 percent in 2012 presumably due to decline in HIV sexual transmission knowledge coupled with reduced communication campaigns. Rates of multiple sexual partnerships among the 25–49-year-old group were lower (11.2 percent) than those among the 15–24-year-old group which was true for both males and females.

Based on the above findings of the study it is clear that female youth are more exposed to infections and consequences of risky sexual behaviour.

### **2.2.3 Early sexual initiation**

Research confirms that many young people participate in risky sexual activities, including early sexual debut, sex with many partners, and low and inconsistent use of condoms (Amazigo et al., 1998; Iwuagwu et al., 2000; Olaseha & Alao, 1991). The data from the National HIV/AIDS and Reproductive Health Survey (NARHS) in Nigeria reveals that among the sexually active 15 to 19 year olds, only 34.4 percent used condoms during their most recent sexual encounter (Federal Ministry of Health, 2003). The survey found that by age 13, over a quarter of a sample of secondary school students in Plateau State in Nigeria had sexual intercourse (Federal Ministry of Health, 2003). The explanations for these behaviours include earlier menarche, effect of media that glamorise sex, and the increasing weakness of traditional control of the family system in Nigeria (Adekunle & Ladipo, 1992; Brieger, Afolabi, Oladepo, Delano, Lane & Oyadrian, 2001). Similar explanations are appropriate in SA.

The 2012 study indicates that one tenth (10.7 percent) of respondents aged 15–24 years reported having had sex for the first time before the age of 15 years. Significant differences were found between sex and race, with higher percentages amongst males (16.7 percent higher) and black Africans (11.1 percent higher)

reporting that they had done so in comparison with their counterparts. However, no significant differences were found by locality type and province. Overall, the rates of sexual debut before the age of 15 years were stable from 2002 until 2008 at about 10 percent, and then increased slightly in 2012 to about 11 percent. More importantly, differences were found between sexes with males also consistently reporting significantly higher rates of sexual debut before 15 years of age as compared to females in the 2002 to 2012 period (Shisana et al., 2012:20).

Different interventions have been offered by a number of organisations, including government departments, namely loveLife Trust, the Planned Parenthood Association of South Africa, Soul City, and the Department of Education through life skills or life orientation programmes in the past years. There remains a gap which is the unstructured lifestyle in rural (e.g. inaccessible resources) as compared to urban areas and is evident in the challenges faced by the Department of Education regarding the sexual behaviour of youth, as reported by the department's spokesperson Mr Charles Matlane (2013). In the researcher's opinion there are components that influence the social behaviour of youth in urban and rural areas. The researcher seeks to understand and to investigate these sexual behaviours in South Africa in order to enhance the social work field and enhance existing sexual education programmes to delay sexual debut as far as possible, and in so doing allow female youth to mature physically and cognitively, and to be financially independent, so that they are able to deal with the consequences of having sex. The definition of sexual behaviour reported by SIECUS (2003) and the findings of studies conducted in Nigeria by Amazigo et al. (1998) and Iwuagwu et al. (2000), and in Ghana by Olaseha and Alao (1991) on sexual behaviour, illustrate that behaviour trends can be resolved appropriately with the right measures.

#### **2.2.4 Transactional Sex**

Sex workers have long been considered a high-risk group for HIV infection, but to date little quantitative research has explored the association between HIV risk and the exchange of sex for material gain by women in the general population. The objective of a study by the authors below was to estimate the prevalence of such transactional sex among women attending antenatal clinics in Soweto, South Africa, to identify demographic and social variables associated with reporting transactional

sex, and to determine the association between transactional sex and HIV sero status (Jewks, Dunkle, Brown, Gray, Mcinrayre & Harlow 2004:1581–1592).

In defining transactional sex for the purposes of this article, researchers did not attempt to disentangle the complex motivations for sexual intercourse within primary partnerships, but instead focused on transactions only within relationships with a 'roll-on' or once-off sexual partners on the presumption that such liaisons would be more likely than main partnerships to be primarily motivated by material or financial considerations. Transactional sex was thus defined as sex with a roll-on or once-off partner who was motivated by material gain. It was assessed by asking the following: "Have you ever become involved with a roll-on/*nyatsi/makwapheni* because he provided you with or you expected that he would provide you with" any of a list of commodities: food; cosmetics; clothes; transportation, tickets or money for transport; items for children or family, such as clothes, food or school fees; your own school or residence fees; somewhere to sleep; or cash? A similar question was asked in relation to once-offs, although the items regarding children and school fees were omitted from the list, as these items are generally only transacted in on-going relationships. About 27.5 percent of the population admitted to having transactional sex (Jewks et al., 2004:1581–1592).

Victims of prostitution are described as women and (occasionally) children who are forced, coerced, or trapped in prostitution. They are individuals who are distinguished from other ordinary, non-prostitute citizens because their need for affection and/or complex personal problems, including drug problems, homelessness, school exclusions, and so on, make them vulnerable to the predatory, exploitative and abusive behaviour of others. Victims of prostitution are also distinguished from others involved in prostitution. These include: abusers who purchase sex from children, exploitative partners who force women and children into prostitution and keep them there for their own pecuniary gain, drug dealers who control women in prostitution through their control of the drug market, and the organised criminals who traffic people across national borders, including the UK, for the purposes of sexual commercial exploitation (Phoenix & Oerton, 2005:89-90).

There has been a growing trend of young people dating older people in order to get money from them. Based on a study conducted by loveLife in 2008, in which young

people were asked whether or not they had sex with a transactional partner in the past 12 months (this was defined as someone they had sex with in return for money, gifts, favours, good grades, or other material and non-material goods), 7 percent of the sexually active youth said yes. In the 2003 loveLife survey only 3 percent of young people reported ever having had a transactional sexual partner. When young people were asked about condom use with their transactional partners in the loveLife 2011 study (loveLife, 2012), 23.5 percent responded that they had transactional partners, indicating that more than one out of every five sexually active young people had transactional partners. Qualitative interviews also revealed that in addition to young women having sugar daddies (relationships with intergenerational partners), young men are also having relationships with sugar mommies (Swartz et al., 2011:10).

The profession of social work has a dual focus on enhancing the social functioning of individuals and the responses of social institutions to human needs (Dhooper, 1994:14 in Gehlert & Browne 2012:33). A biopsychosocial approach to health requires the perspectives of a number of professionals to most effectively deliver health services (Gehlert & Browne, 2012:33). Social Workers handling rape and sexual violence cases need to follow protocol and involve other professionals like a district surgeon to assess the severity of harm/tearing/scars during these incidents, and this information is recorded in J88 forms that are used during court proceedings as evidence.

The researcher strongly agrees with Gehlert and Browne's (2012:20) statement that "health social workers operate in a variety of environments and assume numerous roles in the design, delivery, and evaluation of care. Social workers facilitate linkages across organizational systems and professions to improve health care for both individuals and populations."

### **2.3 THE CONSEQUENCES OF RISKY SEXUAL BEHAVIOURS AMONGST YOUTH**

The consequences of risky sexual behaviours include: STDs/STIs, teenage pregnancies, HIV infections, cervical cancer on the long-term, and suicide.

### **2.3.1 Sexually transmitted infections (STIs)**

STIs represent a major public health problem, and are among the most common causes of illness, and even death, in the world and have far-reaching health, social and economic consequences. Failure to diagnose and treat traditional infections such as gonorrhoea, chlamydia and syphilis can have a deleterious effect on pregnancy and the new-born, for example miscarriage, premature birth, congenital and neonatal infections, and blindness. Other complications, particularly in women, such as pelvic inflammatory disease, ectopic pregnancy, infertility, and cervical cancer, are serious health and social problems (Adler, 2002:1).

Stanberry and Rosenthal (2013:4) confirm that many infections are sexually transmitted although some, including HIV and Hepatitis B and C, are also transmitted by blood or blood products. Others, like HPV and the herpes simplex virus (HSV), can also be transmitted by close bodily contact. Stanberry and Rosenthal (2013:4) and Adler (2002:1) concur that STIs are a major cause of morbidity and mortality, with HIV causing over one million deaths per year worldwide.

STIs pose a serious public health problem for South Africa (James, Reddy, Taylor & Jinabhai, 2004:264), with about 11 million episodes being treated annually. In the past decade there has been an increase in the consequences of unsafe sexual behaviour. In South Africa the National HIV zero-prevalence study focusing on women attending antenatal clinics at public health facilities indicated a prevalence rate of 22.4 percent. The age group most affected was women in their 20s; HIV prevalence in the 20 to 24 age group was 25.6 percent and 26.4 percent in the 25 to 29 age group. The HIV prevalence rate for women under 20 years of age was 16.5 percent. Developing protective sexual behaviour is dependent on the development, implementation, and adoption of effective primary prevention programmes that address the behaviours that curb the increase of STIs, including HIV and AIDS. To date, several prevention programmes concerning safer sexual behaviour in South Africa have been implemented, but their level of success is uncertain, as they have not been effectively evaluated. It is clear to the researcher that the sexual behaviour of youth is a social problem that has long-term effects on the future of female youth health status, including their reproductive health. It is

important for social work to continuously adapt, design and implement effective intervention programmes that focus on behaviour change.

### **2.3.2 Herpes simplex virus**

Although whole viruses of herpes simplex type 2 (HSV-2) have not been demonstrated in tumour cells, in situ hybridisation techniques have documented portions of HSV-specific Ribonucleic Acid (RNA) in tissue samples of women with cervical dysplasia. Deoxyribonucleic Acid (DNA) sequences have also been identified in tumour cells by the use of recombinant DNA techniques. It is estimated that 90 percent of patients with invasive cervical intraepithelial neoplasia have antibodies to the virus. Trichomonas infections, syphilis, and gonococcal infections have been found in association with cervical cancer, but they are believed to reflect promiscuous sexual activity and are not considered direct risk factors (Spitz & Newell, 1992:40).

### **2.3.3 Teenage and youth pregnancies**

The consequences of young people's sexual behaviour when not using contraception have become a global issue, mainly because it is associated with pregnancy and STIs (Turnbull, 2010:78). The Department of Education's spokesperson, Mr Charles Matlane (2013), reported that 4800 female learners became pregnant in 2010 and 4200 learners became pregnant in 2011 in Gauteng, South Africa. According to Bayley (2003:832), youths are twice as likely to die from pregnancy-related health complications, such as excessive bleeding and uterine infections like myometritis, as compared to adult women. It is critical to mention that pregnancy among youths could be a function of sexual risk behaviours, such as unprotected sex and early sexual initiation (Damtie, 2013:5). The researcher's focus will be on establishing whether there is a difference in behaviour amongst rural and urban girls, what the factors influencing that difference are, and their understanding of the impact of risky sexual behaviour in future.

The proportion of women who give birth in their teens has remained higher in rural areas over time. While rural teen births increased slightly between 1984 and 2008, the increase was driven by births to older teen mothers and the proportion of younger teen births almost halved between 1984 and 2008. Urban teen births

decreased over the same period for both younger and older teen mothers. The proportion of younger teens' birth declined from 8 percent to 5 percent (Ardington, Banson & Leibbrandt, 2011:2).

Reports in the South African media consistently describe an explosion of teenage pregnancies. Yet studies by the South African Labour and Development Research Unit (SALDRU) at the University of Cape Town show that teen childbearing in the country has decreased from 30 percent in 1984 to 23 percent in 2008. The proportion of young teens giving birth has also been decreased, with young women aged 18 and 19 accounting for the majority of teen births. However, SALDRU's research shows that teenage childbearing has a significant impact on the education of teenage mothers, and on the health and education of their children. Young mothers under 17 are particularly at risk. It is therefore essential to delay the age at which young women first give birth, and to strengthen support services for teenage mothers and their children (SALDRU, 2008:2).

The view of teenage pregnancy and motherhood as something that is problematic also lies at the heart of much mainstream social policy research. These studies often rely on statistical evidence to highlight the link between teenage pregnancy and consequent poor outcomes for both mother and child. For instance, it has been found that teenage parents are more likely not to finish their education and more likely to bring up their children alone in poverty (Dennison, 2004:78; Hobcraft & Kiernan, 2001:42). Teenage mothers and their children are also believed to be at an increased risk of poor health outcomes, including a 60 percent higher rate of infant mortality, a 25 percent increased rate of low-birth weight babies, and three times the rate of postnatal depression, as compared to older mothers (Social Exclusion Unit, 1999:103). There is also evidence that daughters of teenage mothers have a higher chance of becoming teenage mothers themselves (Ermisch & Pevalin, 2003:29; Hobcraft & Kiernan, 2001:12), leading, it is argued, to a cycle of disadvantage where social exclusion is passed down from one generation to another. Overall this research data has been used to support the argument that teenage pregnancy not only requires policy intervention, but preventative measures to stop it occurring in the first place (Social Exclusion Unit, 1999:63).

Pregnancy is an indicator that young people are having unprotected sex and is a strong predictor of HIV infection among young women. In the 2011 loveLife survey (loveLife, 2012) women were asked about their own pregnancy histories, and men were asked if they ever made their partner pregnant. Women are more likely to recall their own experiences of pregnancy, whereas men may not know if they have made someone pregnant, meaning that some data may be under-reported. Of the women in the survey, 42.7 percent had been pregnant before and one fifth of men reported that they had made someone pregnant before. When asked if they or their partners were currently pregnant, it was surprising that 8.1 percent of women and 27.3 percent of men reported that they were (Swartz et al., 2011:14).

The majority of first-time pregnancies were unintended. Of those that had ever been pregnant, 79.7 percent of women and 64.1 percent of men reported that they did not intend to get pregnant, or get their partner pregnant, at that time. Termination rates remained low, with 6.8 percent of the sample reporting aborting pregnancies, or persuading someone to abort a pregnancy. When asked about reasons for falling pregnant for the first time, 71.2 percent said they did not understand the risks involved in what they were doing or did not understand how pregnancy happens. While overall levels of coercive sex were low, 3 percent of the women who had ever been pregnant had been forced to have sex. Issues around pregnancy were explored in the 2011 study. Qualitative interviews revealed that men did not see themselves as being responsible for preventing pregnancy, or for providing support if their partner did become pregnant unintentionally (Swartz et al., 2011:14). The researcher agrees with the Social Exclusion Unit (SEU, 1999:63) when stating that pregnancy among youths could be a function of sexual risk behaviours, such as unprotected sex and early sexual initiation. The above-mentioned authors also concluded that teenage pregnancies has serious health risks, therefore the researcher is of the opinion that policies and preventative programmes should be reviewed in order to deal with teenage pregnancies as they need to be prevented from occurring in the first place.

#### **2.3.4 Consequences of teen/youth births**

SALDRU undertook several studies to provide empirical evidence of the consequences of early childbearing for young mothers and their children. Drawing

on international best practice, longitudinal data were used to control for pre-pregnancy characteristics that may contribute to poor educational outcomes such as household income and assets, parents' education, and children's educational progress and sexual behaviour before falling pregnant. This made it possible to compare teenage mothers with young women from similar backgrounds and to distinguish the impact of early childbearing from other contributing factors (SALDRU, 2008:3). The researcher believes that a joint or collective effort from parents, youth organisations and government institutions, including the Department of Education, would provide an answer to the national challenge of youth pregnancy by educating teenagers in order to empower them to make informed decisions.

#### **2.3.4.1 Impact on teenage mothers' education**

Research from developed countries has shown that most of teenage mothers' poor educational outcomes can be attributed to their socio-economic background, rather than having a child at a young age. However, in South Africa there seems to be different factors at play. SALDRU's research showed that while socio-economic background did explain some of the difference in educational attainment between teenage mothers and their peers (especially in urban settings), the majority of the shortfall was due to the teenage birth. Overall, the data showed that even when controlling for pre-birth characteristics, teen mothers had poorer educational outcomes than girls who did not give birth in their teens. Analysis of data from the National Income Dynamic Study in 2008 (a study conducted in South Africa) shows that teen childbearing clearly contributes to school drop-out, but that it is not the only reason girls leave school prematurely (Ranchhod, Lam, Leibbrandt, & Marteleto, 2011:13). The researcher is of the opinion that factors that have been reported by the above authors, such as poverty and school drop-out, need to be addressed as they will assist in dealing with the current problems. When poverty is addressed in South Africa, some of the factors may be eliminated. The Department of Education may need to come up with an intervention plan that caters for teenage mothers in order to encourage them to continue with their schooling. Proactive intervention strategies will be more effective than reactive strategies.

#### **2.3.4.2 Teenage pregnancy in rural KwaZulu-Natal**

Drawing on 2001-2009 data from the African Centre Demographic Surveillance Area, SALDRU's research found that the prevalence of teen childbearing in rural KwaZulu-Natal was higher (46 percent) than the national average (25 percent). There were no differences between teenage mothers and their peers in terms of household characteristics or educational performance before the births. But teenage childbearing had a significant impact on educational outcomes. Teenage mothers were two thirds of a grade behind their peers, 20 percent less likely to matriculate, and 20 percent more likely to drop out (SALDRU, 2008:4). According to the researcher, cultural background and belief systems have a direct influence on how people behave and what choices they make. In KwaZulu-Natal, specifically in the rural areas, women have no say in decision-making regarding sexual intercourse and preferences, and the province largely consists of rural, underdeveloped areas. Education needs to be directed or provided for youth or teenagers' parents in order for them to understand the importance of education for their children.

#### **2.3.4.3 Teenage pregnancy in the Western Cape Metropole**

An analysis of Cape Area Panel Study data (SALDRU, 2008) found that the prevalence of teenage childbearing in the Western Cape metropole was similar (22 percent) to the national average (25 percent), and lower than in the rural sample. In contrast to the rural sample, teenage mothers in the Western Cape metro had different pre-birth characteristics to their peers and were likely to have had poor educational outcomes even if they had not given birth. However, teenage childbearing still had a significant impact on their performance at school. Teenage mothers in the Western Cape metro were one third of a grade behind their peers by age 20, 6 percent less likely to matriculate by age 20, and 16 percent more likely to drop out (SALDRU, 2008:4).

Similar to the rural study, younger teenage mothers were found to be particularly at risk of poorer educational attainment, although they were no more likely to drop out than older teen mothers. Younger teenage mothers were two grades behind, 12 percent less likely to matriculate, and 11 percent more likely to drop out (Leibbrandt, Woolard & De Villiers, 2008:4). The availability of resources in urban areas in the

Western Cape metropole could be the reason why there is a significant difference in education of teenage youth when comparing with other metropolises in predominantly rural areas. These could be used to design and implement strategies to address teenage pregnancies in rural areas.

#### **2.3.4.4 Impact on the health and education of teenagers' children**

The national and urban studies have shown that children born to teen mothers have poorer health and education outcomes than their peers. The urban survey showed that teen childbearing had a negative impact on the nutritional status of children, who were 10 percent more likely to be underweight at birth, and 18 percent more likely to be stunted (SALDRU, 2008:5).

The national survey data showed that children of teenage mothers in both rural and urban areas had poorer educational outcomes than their peers. Children born to younger teenagers were most at risk, especially in rural areas. The younger the mother the higher the child's schooling deficit. Children born to older teenagers in urban areas were not lagging behind in grade attainment compared to peers born to older mothers. In the national and urban studies, mothers' lower education and socio-economic status before the birth partly explained the poorer health and education outcomes of their children. Teen mothers' educational deficit due to the birth also partly contributed to these poorer outcomes for children.

#### **2.3.4.5 Implications for policy and practice**

Teenage pregnancy and parenthood has received a huge amount of policy interest across the world, most notably through the United States Department of Homeland Security Temporary Protected Status, or TPS program, to help Haitians living in the United States (Labour's TPS in the USA) that spanned a 10-year period (Congressional Research Service, 2016). Looking at the impact of this policy, real tensions become apparent. On the other hand, when policy is based on assumptions that teenage parents are a problem it can lead to them feeling stigmatised, which is harmful. On the other hand it can be argued that, delivered in the right way (non-judgementally and respectfully), targeted provision can provide critical support at times of need (Smithbattle, 2003:369; Wenham, 2011:55). A tension exists between policies that can be seen as empowering or disempowering.

According to Curran et al. (2013:43) policy that has been developed in response to a problem can be received as positive and even life-changing, and that society can learn from policy implementation that has successfully supported young parents.

The discourse of early childbearing as problematic continues to hold strong. When youth are paid more not to work than to work, when a mother is better off leaving her children rather than nurturing them, when the welfare system tells young girls that having children before finding the security of work and a loving relationship means home and cash now, is it any wonder that society is broken (Cameron, 2009:6)?

South Africa is no exception, as there exists the following conflicting laws: Teenagers are allowed to make decisions to abort their unborn babies from the age of 13 years. Statutory rape is said to be any sexual act between an under aged child (under the age of 17 years) with an adult. The approval and implementation of the Child Support Grant in 1994 could be a contributing factor to youth having children at an early age.

### **2.3.5 Human Immunodeficiency Virus (HIV)**

HIV risk behaviour is influenced by factors at three levels: within the person, within the proximal context (interpersonal relationships and physical and organisational environment), and within the distal context (culture and structural factors) (Eaton et al., 2003:149-165). Young people in sub-Saharan Africa continue to be one of the populations at greatest risk for HIV infection, particularly young women. Based on the 2003 South African antenatal clinic survey, HIV prevalence among 15 to 19 year old girls appears to be stabilising at around 15 percent, whereas in the 20 to 24 age group the prevalence increased from 2002 levels to 30 percent. Given the urgency of preventing new HIV infections, the determination of whether changes in the HIV epidemic are occurring and whether these can be attributed to HIV prevention programmes is a very high priority (Pettifora et al., 2005:1526).

An understanding of the HIV epidemic and its key drivers are fundamental in guiding the National Strategic Plan. The HIV interventions proposed in the 2012-2016 National Strategic Plan (SANAC, 2011) are guided by the findings of the “Know Your Epidemic” (KYE) reports and other analyses, which identified the key determinants

of the HIV epidemic in South Africa. These include behavioural, social and biological factors, as well as underlying structural and societal factors, such as poverty, gender inequalities, human rights abuses, and migrant labour. A review of evidence shows that the HIV prevalence in pregnant women attending public sector clinics is stabilising, albeit at a very high level of around 30 percent. However, there is a marked heterogeneity in HIV prevalence by key epidemiological variables, such as age, race, gender, geographical location, and socio-economic status, which reflect differentials in exposure to risk of infection (SANAC, 2011:22).

For the purposes of this study the researcher will only report on the statistics for youth and young adults. South Africa has a generalised HIV epidemic driven largely by sexual transmission. Using the spectrum model, the 2009 HIV prevalence in the population aged 15 to 49 was estimated to be 17.8 percent. An estimated 5.63 million adults and children were living with HIV in 2009. Of these 5.3 million were adults aged 15 years and older, 3.3 million were females, and 334,000 were children (SANAC, 2011:22).

HIV has now reached virtually all demographic groups globally, irrespective of age, race, and income level (Stanberry & Rosenthal, 2013:6). None of the case-control studies of HIV and cancer conducted in Africa have shown an excess risk of invasive cervical cancer and HIV. There is, however, evidence that the risk of pre-invasive disease is increased in the presence of HIV infection, and that this is confined to women who are infected with HPV (Parkin et al., 2003:274).

Infection with HIV type one and development of the AIDS was one of the major epidemics of the latter part of the 20<sup>th</sup> century (Stanberry & Rosenthal, 2013:5). In many parts of the world, HIV/AIDS is still viewed solely as a terminal illness, a disease from which there is no recovery. However, with the ever improving availability of antiretroviral therapy, HIV is increasingly recognised as a chronic rather than terminal illness. This transition requires care and psychological adjustment in children and young adults.

HIV is transmitted in three major ways: through sexual contact, through blood, and from mother to child. The majority of HIV-1 infections are acquired through heterosexual contact, which accounts for approximately 85 percent of all infections

globally. However, increasing numbers of infections are being reported in other “at risk” groups, such as men having sex with men and sex workers. Heterosexual spread in the general population is the main mode of transmission in sub-Saharan Africa, which remains the most heavily affected region, with 68 percent of the global burden. Currently HIV affects both men and women worldwide in approximately equal numbers, although more women than men are living with HIV-1 in sub-Saharan Africa. The presence of other diseases, in particular STIs such as genital herpes, chancroid (ulcerative diseases), gonorrhoea, and Chlamydia (non-ulcerative), enhances the risk of sexual transmission of HIV (Stanberry & Rosenthal, 2013:7). There is a relationship between HPV and HIV in how they are transmitted and their potential to kill if left untreated. It is important for society to create awareness and adopt healthy lifestyles that will prevent new infections and assist those that are already infected.

The National Strategic Plan on HIV, STIs and TB 2012-2016 (SANAC, 2011) marks a milestone in the nation’s response to the dual epidemics of HIV and TB. This five-year plan reflects the progress the Government has made in achieving a clearer understanding of the challenges posed by these epidemics and the increasing unity of purpose among all the stakeholders who are driven by a shared vision to attain the highest impact of the country’s policies towards the long-term vision of zero new HIV and TB infections (SANAC, 2011:8).

Over the past few years the stakeholders, such as the Department of Health, the South African Government and non-governmental organisations (NGOs), have found some marked progress in a number of critical areas in their response, such as a significant reduction in a vertical transmission of HIV, as well as expanding access to a comprehensive package HIV, STI and TB services. The antiretroviral treatment (ART) expansion programme has resulted in an increase in ART facilities countrywide to about 2,553 currently, and more people accessing treatment. The stakeholders, including the South African Government, are making continuous efforts to strengthen the prevention strategies and the programme of Medical Male Circumcision is increasingly bearing fruit in terms of uptake of the programme. To date, more than 250 000 men have undergone medical male circumcision nationally and more men are encouraged to use this service as part of a comprehensive

package of prevention. It is also good to note that there is an increase in the number of both male and female condoms being distributed nationally (SANAC, 2011:8).

The response of South Africans to the call to action through the country's theme "I am responsible. We are responsible, South Africa is taking responsibility" has been successful, reaffirming the fact that all are indeed united in the Government's efforts to reduce new infections and to create an environment that is enabling for all (SANAC, 2011:8).

It is important to list the SANAC (2011) key strategic objectives in order to reaffirm the above statements and report on the progress made by South Africa in terms of combating the spread of epidemics:

- Addressing the structural barriers that increase vulnerability to HIV, STI and TB infection.
- Preventing new HIV, STI and TB infections.
- Sustaining health and wellness.
- Increasing protection of human rights and improving access to justice.

The Minister of Health, Dr Aaron Motswaledi, continues to strive to seek and implement innovative ways to implement and sustain the interventions over the short-, medium- and long-term (SANAC, 2011:9). If people living in South Africa would be committed to working with the Department of Health or follow the department's recommendations in order to work on the South African National Strategic Plan, the above listed key strategic objectives would be attained over time. HIV infection is a global problem and South Africa can learn from countries that have already implemented successful programmes that combat the spread of HIV/AIDS.

#### **2.3.5.1 HIV prevalence, surveyed and self-reported, among young people in South Africa**

The uptake and acceptance of HIV Counselling and Testing (HCT) is essential for HIV prevention efforts. Just over half of the 18-24 year old men and women in the quantitative sample (52.2 percent) have had an HIV test in their lifetime. Of these, 5.2 percent reported testing positive, 64.9 percent tested negative, and 7.3 percent

did not want to indicate their status. While it is likely that the actual prevalence among those surveyed is higher because figures are based on self-reported data, it should be noted that figures show a much lower prevalence in women than in men (Swartz et al., 2011:7).

At 52.2 percent the percentage of young people who had tested for HIV has increased dramatically since loveLife 2003 (loveLife, 2012), when only one in five young people said they had tested. Of the 2066 young people in loveLife 2011 who had tested for HIV, 73.8 percent had done so in the past year. However, women (69 percent) were still more likely to have tested for HIV than men (38 percent). Of those who did not know their status, 52.1 percent of young people reported that they wanted to know, 27.6 percent did not want to know, and 20.4 percent were not sure. More women (62.2 percent) than men (47.9 percent) wanted to know their status. loveLife exposure increased young people's desire to test for HIV, and they were more likely to test for HIV more than once. Participation in loveLife increased young people's desire to know their HIV status from 52.8 percent to 60 percent (Swartz et al., 2011:7).

### **2.3.6 Carcinoma of the cervix**

According to Parkin et al. (2003:268), cancer of the cervix and uterus is the second most common cancer among women worldwide, with an estimated 468 000 new cases and 233 000 deaths in the year 2000. Almost 80 percent of the cases occurred in developing countries where, in many regions, this is the most common cancer amongst women.

Carcinoma of the cervix may be considered a STD, as there exists a well-documented association between specific sexual practices of patients (and their male partners) and risk of the disease. Consistent with an infectious aetiology, women with multiple sexual partners and women who begin sexual relations at an early age are at increased risk of developing cervical cancer (Spitz & Newell, 1992:38).

The National Guidelines for Cervical Cancer Screening Programme was introduced by the National Department of Health (NDoH) in 2000. The aim was to reduce the incidence and mortality of cervical cancer in South Africa by screening at least 70

percent of women aged 30 years to 59 years within 10 years of initiating the programme. The reason for selecting the minimum age of 30 years is to increase the efficiency of cervical cancer testing, as the risk of the disease increases with age and the resources are limited. According to the national policy, every woman who uses public health facilities is entitled to 3 free pap smears in her lifetime, starting from the age of 30 years, with an interval of 10 years between the tests. The project for implementation was steered by the NDoH, the Women's Health Research Unit (WHRU) of the University of Cape Town, the Women's Health Project of the University of the Witwatersrand, and Engender Health, USA. Implementation of the programme was supposed to be integrated into the District Health System.

There are five components towards rendering a successful programme:

- strengthening the health system by improving resources;
- re-training of service providers at the primary care level;
- quality improvement in cytology laboratories;
- health education for service users, both within the facilities and in the community;
- and
- active recruitment of target population by healthcare providers.

The global extent of cervical cancer remains a significant cause of mortality among women, even though it is the cancer with the greatest demonstrated potential for secondary prevention. It is one of the most preventable and treatable cancers, since it takes many years to develop from the precursor lesion and remains for the most part localised. The slow progression of a pre-cancerous lesion to cervical cancer provides a window of 10 years or more to detect and treat. It is one of the leading causes of mortality and morbidity in developing countries, and the second most common cancer among women worldwide (second to breast cancer). It comprises approximately 12 percent of all cancers in women. More than 493 000 new cases were diagnosed, with more than 273 000 deaths in 2000. About 85 percent of these deaths occur in developing countries. In Africa, an estimated 36 900 new cases are diagnosed each year. In Uganda, it is the most common malignancy in women, with over 80 percent of diagnosed patients in Mulango hospital presenting with advanced stages of the disease. The age-standardised incidence rates for cervical cancer in

Southern Africa per 100 000 females of all ages are as follows: Lesotho, 61.6; Swaziland, 58.9; South Africa, 37.5; Botswana, 30.4; and Namibia, 22.25 (Kawonga, Moodley, Bradley & Hoffman, 2004:37).

Locally, the reported prevalence of cervical cancer for black women in South Africa is 40 per 100 000. At least 1 in 23 black women will develop cervical cancer in her lifetime. A total of 6 061 new cases of cervical cancer were reported in the South African cancer registry in 1998, representing 20 percent of all cancers related to women for that year. In 1999, 5 203 new cases were reported, representing 17 percent of all cancers amongst females only for that year. About 84 percent of all women presenting with cervical cancer in 1998-1999 were African women. Statistical notes from the Department of Health, however, indicated an average of 3 387 new cases reported between 1993 and 1995, with 1 497 deaths in 1994. They also reported a lifetime risk of 1 in 34 for black females and 1 in 93 for white females. Incidence rates for cervical cancer in black South Africans are reported to be similar to those found in the rest of Africa. Current estimates are that annually 6 742 women are diagnosed with cervical cancer, and 3 681 die from it. It is the first most common cancer among women aged between 15 and 44 years. The risk of developing cancer of the cervix increases with age, peaking at 136.4 per 100 000 in women between the ages of 64 and 69 in 1999. Previously, pap smears were done on an ad hoc basis, offered on request by women in their reproductive stage who came for Family Planning. Women who had access to private health care had pap smears on demand, whereas women using the public health sector were not informed of the availability of the service (Kawonga et al., 2004:38).

Health clinics' records were reviewed at the facility to determine the percent of women aged 30 to 39 years who used the facility and had pap smears over the period August 2003 to July 2007. Facility managers at the Holani Clinic and Stanza Bopape Community Centre were interviewed. A review of records at Holani Clinic indicated that the percent of women aged 30 to 59 years who had undergone pap smears while attending the clinic from January 2004 to July 2007 was 8 percent. The Stanza Bopape Community Centre had incomplete records. Only about 50 percent of the women interviewed had undergone a pap smear. Socio-demographic factors like age, education, and employment did not have a significant effect on the

knowledge, attitude and practice of cervical cancer screening by the targeted service users. Women of lower parity had undergone more pap smears than those of higher parity. Women of lower parity had more knowledge about pap smears. The knowledge and practice of pap smear among women aged 30 to 59 who attended the clinics were significantly associated with getting information from the nurse. Knowledge of the National Cervical Cancer Screening Policy by the service providers was limited. Both facilities had adequate resources for performing the procedure. The number of trained staff per facility was adequate for the performance of the procedure. There was enough privacy to do the procedure. Specimen transportation was adequate, and turnaround time was acceptable.

Thus the extent of pap smear investigation at the facilities are inadequate. The service providers need to calculate the minimum number of pap smears needed per day to reach the required targets. Nurses at the primary healthcare setting play a major role in improving the uptake of cervical cancer screening. There is a need to actively recruit women to come for a pap smear, while at the same time strengthening health education (Letebele-Hartell, 2009:92). The researcher understands that the most important tool in dealing with cervical cancer is through pap smear screening. The South African Government has done well by introducing the HPV inoculation programme at schools for female youth between 9 and 12 years old, as youth will grow up knowing and understanding the importance of prevention of cervical cancer. This also deals with the questionable issue of user-friendly services provided in health care centres.

#### **2.3.6.1 Human papilloma virus (HPV) inoculation**

There is an accumulating body of evidence implicating HPV in the cause of cervical neoplasia. The supporting evidence includes the oncogenicity of animal papilloma viruses, the association of HPV infection of the cervix with condylomata and koilocytotic atypia, which resembles mild to moderate dysplasia, and the detection of HPV antigens and DNA in cervical lesions. HPV types 6 and 11 are closely related to mild dysplasia, which are less likely to regress and more likely to progress to carcinoma in situ (Spitz & Newell, 1992:39).

Parkin et al. (2003:274) state that the evidence for the causative role of certain types of HPV, especially HPV 16 and HPV 18, in cervical cancer aetiology is now accepted. Several studies in Africa have examined the association between HPV infection and precursor lesions (CIN and squamous intra-epithelial lesions), the latter usually diagnosed on the basis of cytology. Stanberry and Rosenthal (2013:25) confirmed the statement of Parkin et al. (2003:274), by stating that HPV infection is now accepted as the major cause of cervical cancer and there is a growing body of evidence supporting the role of HPV infection in penile, vulval, vaginal, and anal cancers.

Genital HPV infections are transmitted by sexual activity and are more common in men and women with multiple sexual partners and those who start sexual activity at a younger age. HPVs are divided into high risk, based on their observed association with genital tract tumours, and low risk, based on their association with benign genital conditions, in particular condylomata acuminata (genital warts) (World Health Organization, 2007:12).

#### **2.3.6.2 Smoking**

There is now extensive data supporting a causal and independent relationship of smoking with squamous cell carcinoma of the cervix (but not adenosquamous or adenocarcinoma). The proposed mechanism of action could be direct (mutagenic activity or cervical mucus has been demonstrated in smokers) or through the immune suppressive effects of smoking (Spitz & Newell, 1992:40).

Based on a study conducted in Zimbabwe, the prevalence of smoking in women in Bulawayo was very low, and there was no apparent excess risk for cervix cancer in smokers (Parkin et al., 2003:271).

## **2.4 CAUSES OF RISKY SEXUAL BEHAVIOUR**

A cluster of individual, social and structural factors predicts risky behaviour. LoveLife's theoretical approach focuses on addressing the individual, social, and structural drivers of risk tolerance. The quantitative study found evidence for a theoretical approach, clearly pointing to individual, social and structural factors that predicted behaviours associated HIV infection. Univariate and multivariate analysis were used to gain deeper insights into these relationships. These factors represent

loveLife's main focus points in its programmatic work, while others are generic biomedical indicators. While there are many different individual factors impacting on predictors for HIV infection, it is interesting to see that low perception of HIV risk is the most prominent theme, followed by a deficient sense of future and the circumcision status of men. Network resources and communication are important social factors. Structurally, education and employment status were the most frequent predictors for HIV infection. The qualitative interviews also emphasised the impact of structural factors on young people's lives and revealed the complex interplay between these and individual factors. The study identified low self-esteem, lack of personal agency, limited resources, and uncertainty around future opportunity, as well as the high rate of unemployment as reasons for risky behaviour. Young people were able to point to structural challenges in their environment, but were aware of how these affected them. Subsequently they internalised their challenges as a result of individual action or failure (Swartz et al., 2011:17).

#### **2.4.1 Peer pressure**

According to Le Roux and Smit (2002:91), the decline of intimate family relationships spells isolation and estrangement for the teenager, which results in feelings of loneliness. The teenager may deal with these feelings of loneliness or protest by conforming to the peer group, which may have a negative influence on the child. The child that is searching for intimate relationships may be sexually exploited, commit to drug or alcohol abuse, or other harmful practices such as sexual risk behaviour.

The biopsychosocial approach takes into account social factors that influence people's behaviour. Peer pressure is also temporally ordered by major sources of influence developmentally as the child matures. Family factors are primary and earliest in their sustained impact on the infant and youth. As the child matures and goes to school, school and community environmental factors have more impact. Eventually peer influences predominate, becoming the final common pathway to sexual behaviour in youth. This reinforces the importance of social workers working in health care to understand the social background of clients, as well as the emotional state of the client in order to appropriately address their needs. Peer

pressure contributes to sexual risk behaviour, which has a psychological impact that affects the level of social functioning or acceptance of the participants.

This approach was appropriate for this study, as sexuality addresses the biological, socio-cultural, psychological, and spiritual dimensions from a cognitive domain (information), affective domain (feelings, values and attitudes), and the behavioural domain (communication and decision-making skills). This model deals with the same components that sex education deals with (biological, psychological and social components of individuals).

#### **2.4.2 Gender Based Violence (GBV)**

According to Muller, Holley, Minnie and Muller (2009:46), the most prevalent and problematic types of GBV include: sexual violence (including rape and sexual assault), domestic and intimate partner violence, human trafficking, female genital mutilation, and conflict induced GBV (including rape as a weapon of war).

**Sexual violence** is the use of physical violence or psychological pressure to compel a person to participate in a sexual act against their will, whether or not the sexual act is consummated. It has a profound impact on physical and mental health (Muller et al., 2009:47).

**Domestic and intimate partner violence:** the movement towards the exposure of private violence (for instance, domestic and intimate partner violence) has helped to alleviate the vulnerability of women and children to a large extent by bringing these issues into the public domain. The fact is that women and children are often in the greatest danger in the place where they should be safest: the home. Intimate partner violence includes violence perpetrated in informal and domestic partnerships. It is by far the most common form of sexual violence (Muller et al., 2009:48).

**Human Trafficking:** according to Muller et al. (2009:48), human trafficking has increased significantly following an increase in migration across the world, and the continued restrictions on movement of labour. The International Labour Office (ILO) estimates that 2.5 million women, men and children are trafficked within and across

borders at any given time and that “at very least, one third of these are trafficked for economic purposes other than sexual exploitation” (Alston, 2004:219).

**Female genital mutilation** is a harmful traditional practice that is recognised as a particularly dangerous form of GBV and comprises all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (Muller et al., 2009:55).

**Prostitution as sexual violence:** radical feminists have argued that prostitution is a practice that constitutes sexual violence and/or sexual slavery. Prostitution is an expression of male sexuality, which is a pervasion because its primary motivation is not pleasure, individual or mutual, or the enhancement of personal relationships, but control of and power over women (Jeffreys, 1985:68). In the 1990s, Barnardo’s, the Children’s Society, and radical feminists all argued that ‘child prostitution’ should be a priority for government policy. They mounted separate campaigns to redefine youth prostitution as an act of child sexual abuse perpetrated by child sex offenders and ‘abusing adults’. This was motivated by concerns that young people were being wrongly punished by criminal law, that adults engaged in procuring young people were being wrongly punished by criminal law, and that adults engaged in procuring young people or purchasing sex should be criminalised rather than those ‘being abused and exploited through prostitution’ (Stacey, 2009:91).

According to Letherby, Williams, Birch and Cain (2008:207) when a man seeks to satisfy his sexual desires on a child, he is not a curb crawler (a person who drives around areas known for street prostitution soliciting prostitutes for sexual activity); he is clearly a child sex offender. It is worth noting that Southern Adirondack Library System (SALs) frequently draws attention to the age of sexual consent and sexual immaturity. The reconfiguration of ‘young woman’ as abused child is justified on the grounds that those under the age of 16 years cannot give consent to intercourse, thus a child cannot consent to her own abuse and should not therefore be labelled as a prostitute (Swann, 1998:19). If prostitution of sexuality and the reduction of oneself to sexual object is increasingly demanded of adult women, it is an even more pressing requirement of teenagers. With the sexualisation of society, sexual debut is occurring at earlier ages, in the teenage years. Sexual norms in high school and college dating are expressed now in the language of prostitution: hooking up

identifies dating for the purpose of having sex. Sexual development of teenagers initiates female sexual subordination in the early years and cuts off female potential for development (Barry, 1995:63).

Tjaden and Thoennes (1998:28) state that sexual abuse can also take the form of rape. The legal definition of rape includes only slight penile penetration in the victim's outer vulva area. A complete erection and ejaculation are not necessary. Rape is the perpetration of an act of sexual intercourse whether:

- will is overcome by force or fear (from threats or by use of drugs);
- mental impairment renders the victim incapable of rational judgment; or
- the victim is below the legal age established for consent.

In view of the above the researcher would like to quote the following Bill of Rights (Constitutional Committee, 1991) which states the following:

- **Human Dignity** – The dignity of all persons shall be respected. No-one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.
- **Gender Rights** – Legislation shall provide remedies for oppression, abuse, harassment or discrimination based on gender or sexual orientation.
- **Equality** – No individual or group shall receive privileges or be subjected to discrimination, domination or abuse on the grounds of race, colour, language, gender, or creed, political or other opinion, birth or other status.

#### 2.4.2.1 Intimate partner violence

A study conducted in Khayelitsha in Cape Town by Jewks and Abrahams (2003) to explore the perpetration of physical or sexual violence against a man's current or ex-girlfriend was assessed using an adaptation of the World Health Organization's (WHO) violence against women instrument. More than six items on physical violence were covered: pushed, shoved, slapped, hit with fist, kicked, beaten up, strangled, burnt, hurt/threatened with a weapon, and throwing something that could hurt her. A total of four sexual violence items were asked, namely: physically forcing a girlfriend to have sex when she did not want it, frightening her into having sex, and forcing her to have oral sex and/or anal sex. All questions were asked both for the past year and the year before that, and participants were asked to indicate whether

the behaviour happened never, once, a few times, or many times. Men who only responded 'once' to all queries about frequency were classified as perpetrating violence only once, because even men who endorsed multiple items could have perpetrated only one multifaceted event (Jewks & Abrahams, 2003:125-134). The amount of violence aimed at women is staggering internationally. Following the Beijing Women's Conference in 1995, public awareness has been drawn to the horrific treatment of women by men in many parts of the world (Van Wormer & Bartollas, 2000:88).

Physical and sexual violence against women and the threat of this violence affect virtually all women everywhere. Woman-hating is at the heart of both rape and battering: rape can be construed as an assault that is sexualised and partner violence often includes sexual abuse. Both forms of victimisation, rape and battering, are about power and humiliation; they are both about male dominance and female subordination (Van Wormer & Bartollas, 2000:57).

Violence is rooted in disparities of power based on gender, race/ethnicity and class. It is rooted in these factors singly or in combination and in psychological, even biological variables as well. Whether a woman is subjected to a one-time rape by a stranger or a pattern of brutality by a family member, sexual or otherwise, the emotional scars may be with her always (Van Wormer & Bartollas, 2000:86). The researcher believes that these scars do not vanish on their own; professionals are needed to help deal with the effects of rape/sexual violence trauma that women experience in order to have better and healthy relationships with the men in their lives.

Largely as a result of the efforts of the women's movement over the past two decades, there has been a rise in consciousness of the seriousness of the crimes of rape and domestic abuse. There still exists a taboo, however, in defining these crimes in gender-specific terms (Van Wormer & Bartollas, 2000:87). Identifying the problem as men's violence against women is often viewed as an attack against men in general. For this reason, gender-neutral terms such as 'domestic' or 'family violence' are preferred by many writers today. Whichever terms are used, the reality of the nature and extent of men's violence against women, not only during the rape and pillage of war or in gang initiation rituals, but in everyday dating and family

situations as well, is a harsh reality. National government sponsored data gathering based on nationwide surveys of victims and arrest data from police departments are the most valid statistics (Van Wormer & Bartollas, 2000:87). Based on the above explanation by Van Wormer and the researcher's work experience at People Opposing Women Abuse (POWA), the researcher is of the opinion that the national campaigns raising awareness on women rape/sexual violence do not get the same support from the government and private sectors as HIV/AIDS campaigns. The support that the country gave to the HIV/AIDS pandemic is the kind of support that the issue in discussion needs.

The effect of family problems on the quality of life is sometimes obvious and sometimes not. Physical violence against a person by someone in his or her primary group produces emotional trauma, as well as physical pain. Alienation from those in one's primary group is emotionally traumatic (Lauer & Lauer, 2008:354). It is important for social workers and health professionals to be aware of the trauma that the consequences of rape or incest can further cause on the client when planning treatment intervention for them.

Various studies have been done on this topic and it is without a doubt that education of society on what abuse is, is of paramount importance. Women will not be able to report abuse/rape if they do not know that they are being abused. Based on the study conducted by Rasool, Vermaak, Pharoah, Louw and Stavrou (2002:XV), women are most likely to define abuse in terms of physical aspects, even though many had experienced other types of abuse. Eighty percent had experienced emotional abuse, 76 percent physical abuse, 63 percent sexual abuse and 62 percent economic abuse. Thirty-two percent had experienced all types of abuse. Although many women do not report abuse to the authorities, the assumption that women do not speak about abuse is false. For all types of abuse, at least half the survivors spoke about the incident immediately. Most told friends and family members.

Survivors of sexual violence were as likely to be abused by a stranger as by a partner or spouse (Rasool et al., 2002:1). Many societies implicitly or even explicitly tolerate and condone sexually violent behaviour under specific circumstances: for example, heads of households (usually males) may abuse others (wives, dependent

relatives, children and servants) more or less with impunity. According to Rasool et al. (2002:42), women in the study experienced a range of different types of sexual abuse, although most abuse involved unwanted kissing and touching, and forced sexual intercourse. Their findings indicate the importance of extending the definition of rape to include actions in which penetration does not occur, as envisioned in the new Sexual Offences Bill (Constitutional Committee, 1991).

The profession of social work has a dual focus on enhancing the social functioning of individuals and the responses of social institutions to human needs (Dhooper, 1994:14). A biopsychosocial model of health requires the perspectives of a number of professionals to most effectively deliver health services (Gehlert & Browne 2012:33). Social workers handling rape and sexual violence need other professionals like a district surgeon to assess the severity of harm/tearing/scars during these incidents, and this information is recorded in J88 forms that are used during court proceedings as evidence.

The researcher strongly agrees with the Gehlert and Browne's (2012:20) statement that "health social workers operate in a variety of environments and assume numerous roles in the design, delivery, and evaluation of care. Social workers facilitate linkages across organizational systems and professions to improve health care for both individuals and populations."

#### 2.4.2.2 Types of Rape

There are different forms of rape namely: date rape, stranger rape, incest, and rape in war.

Below is an example of **date rape** as shared by an English woman interviewed by Liz Kelly (1988):

I didn't dare say no, I didn't dare to ... you know you don't want to, but you are still doing it. That's why in my eyes now its rape with consent. Its rape because it's pressurized, but you don't do it because you don't feel you can say no.

**Stranger rape:** this excerpt is from a Pulitzer Prize-winning newspaper series on rape victim Nancy Ziegermeyer who agreed to 'go public' (Van Wormer, 2001:110):

He talked about how his sister had been raped by a White man. He talked about slavery and the things that White people did to Black slaves. After a while, the man rolled her over so that her abdomen was on the console between the two

front seats (of the car) and attempted anal intercourse. Then he rolled her over to her back, forced himself into her.

**Incest:** from Dorothy Allison's (1993:9-18) non-fiction novel, *Bastard Out of Carolina*, comes the following gripping account:

He fumbled with his fingers between my legs, opened me, and then reared back slightly, looking down into my face with his burning eyes .... Now he said ... You'll never mouth off to me again" ... he reared up supporting his weight on my shoulder while his sex into me like a sword.

**Rape in War:** Psychotherapists working in Paris with refugees who have been tortured describe the "suffering that never goes away." According to Van Wormer (2001:110), it manifests itself as a:

... deep breakdown of the individual and feelings of shame and humiliation that are especially strong since the crime was committed in front of witnesses, the family, the village. Young women who were virgins at the same time of the rape say no one will ever want them. It is possible for them to imagine having a normal relationship with a man. Horror gives way to the absurd. These women feel guilty rather than victimized. They cannot accept that their torturers were the inhuman ones.

### **2.4.3 Alcohol and Substance use**

Alcohol consumption and its abuse have been globally associated with risky sexual behaviours like unprotected sexual intercourse (Cooper, 2002:101-117). A more recent study by Irwin, Morgenstern, Parsons, Wainberg and Labouvie (2006:299-307) confirms this assertion. Its outcome reiterates that unprotected sex was more common during episodes of alcohol consumption compared to when alcohol was not consumed. It is apparent that alcohol and substance use are implicated in youths' sexual decision-making. Gebregiorgis (2000:43) supports this view by adding that the odds of unprotected sex are generally slightly higher among male youths compared to their female counterparts (Damtie, 2013:5).

#### **2.4.3.1 Relationships between alcohol use and sexual risk behaviour**

The study conducted in South Africa revealed that male and female 'drinkers' and their sexual partners were generally of the view that alcohol consumption and sexual risk behaviour are strongly related. Such a view was expressed by one male participant who described the link as: "a match made in heaven! You cannot separate the two!" (Younger male risky drinker; focus group; city site). Different views were held about alcohol's effects on sexual behaviour during the period

before, during, and after an episode of sexual intercourse, although these are not always clearly distinguishable into distinct periods (Morojele, Kachieng'ab, Mokoko, Nkoko, Parry, Nkowane, Moshia & Saxena, 2006:217–227).

According to a study conducted by loveLife in 2011 (loveLife, 2012) in South Africa, alcohol consumption was cited by young people and their communities as an issue of concern, and its link to risky sexual behaviour was also discussed in qualitative interviews. The majority of youth (78 percent of females and 59 percent of males) had not drunk any alcohol in the past year, but those who had did so excessively (classified as 5 or more drinks on one occasion). This is much lower than the 49.6 percent of learners of Grade 8-11 that reported drinking in the 2008 Youth Risk Survey. In this 2011 survey, however, 54 percent of young people (59 percent of males and 49 percent of females) reported drinking heavily (5 or more drinks) while in the Youth Risk Survey only 28.5 percent reported drinking heavily (34 percent of males and 24 percent of females). In addition, 18.6 percent of males and 6.9 percent of females reported drinking before sex, and one tenth of the qualitative sample discussed taking sexual risks because they were too drunk to think straight or did not have condoms with them. In the qualitative interviews alcohol consumption was discussed as a means of asserting and regaining a sense of power and control. Interviewees also observed that young women in their communities were drinking alcohol more than they used to, when previously only men's drinking was a concern (Swartz et al., 2011:15).

Statistical analysis of 2011 loveLife study (loveLife, 2012) also suggested that alcohol and drug use are linked to low self-esteem. In a multivariate prediction model, low levels of self-esteem were associated with ever having used drugs, drinking alcohol before sex in the past 3 months, using cannabis before sex in the past 3 months, and using drugs before sex in the past 3 months (Swartz et al., 2011:15).

The consequences of drug and alcohol addiction do not only affect the individual user, but also their families, communities, and the entire society and economy. Alcohol and drug misuse thrive in areas of social exclusion and disadvantaged areas with high unemployment, low quality housing, and a lack of social and community services (Rassool, 2011:13, 34).

Sexual risk behaviour, such as unprotected sex and early sexual initiation, exposes youth to the risk of contracting HIV or STIs and/or HPV that causes cervical cancer (biological effect). These behaviours have serious effects on youth as more often than not they result in teenage pregnancies (social) which then affect their concentration at schools (psychological) and result in school drop-out. This links up with the biopsychosocial approach which looks at an individual's biological, psychological, and social elements when assisting patients in the health field.

## 2.5 INTERVENTION STRATEGIES

The intervention strategies for early screening and prevention will be discussed below.

### 2.5.1 Cervical cancer screening

A cervical cancer prevention and control programme consists of three service delivery components that must be linked together: community information, education screening services, and diagnostic or treating services (planning and managing programmes). Management of cervical cancer is by the following means:

- **Primary Prevention:** Health promotion. MesSages to promote abstinence, mutual monogamy, and the use of condoms should be improved. Women should be advised against smoking. Effective health education mesSages are necessary to increase the uptake of cervical cancer screening among women. Mass media has been used in different settings, and proved that the promotion of cervical cancer screening through the media increases uptake, even though it is on a short-term basis. Different types of media have been used, like radio, TV, and print media (Letebele-Hartell, 2009:92).
- **Secondary Prevention:** Screening. Cervical cancer screening and treatment is justified, based on the general principles of public health screening, namely:
  - It is an important health problem since it has a high morbidity and mortality.
  - It has a detectable pre-clinical phase.
  - The natural history is known.
  - There is a recognised treatment for lesions identified following screening.
  - The screening test used is acceptable and safe.

There must be a defined target population, means to identify, invite, screen, and follow up with women in that population. In implementing the programme for cervical cancer screening, certain infrastructure requirements need to be met:

- The facility should have a private examination area and an examination bed should be available.
- There should be trained health professionals.
- Sterile vaginal speculums should be available.
- Supplies and equipment for preparing and interpreting pap smears should be available, like slides, light, fixing spray, wooden spatula or brush, and Cytology requisition forms.

The National Department of Health and The Department of Education have collaborated to introduce the Grade 5 Inoculation Programme that was rolled out from 2014. This allows education about Cervical Cancer from a very young age in order for girls to make informed choices later in their lives. The researcher believes that this is the best strategy and the departments are working towards closing the gap between awareness and female sexual behaviour in the country (Letebele-Hartell, 2009:92).

- **Tertiary Prevention:** Surgical Intervention – Palliative care: healthcare personnel should be adequately trained to be able to interpret results and know what steps to follow. Referral systems should be in place for abnormal smears. CIN I or low-grade squamous intra-epithelial lesions (SIL) and CIN II and ASCUS should have smears repeated after 12 months. If the diagnosis remains the same or worsens, they should be referred for a colposcopy. If negative on the second smear, it should again be repeated after 12 months. CIN III or AGUS should be referred immediately for colposcopy. If positive, it may be treated with cryotherapy or the LLETZ (large loop excision of the transformation zone) method. The pap smear has a sensitivity of 51 percent (average), which is the ability of a test to detect all those with the disease in the screened population. It has a specificity of 98 percent (average), which is the ability of a test to identify correctly those free of disease. The relatively low sensitivity implies that some clients may have lesions, but be missed by the test; thus the reason for repeated smears. Developed countries can afford to have more frequent smears and may thus pick up all those positive smears that may have been missed on previous

occasions. The sensitivity of the pap smear test differs in developing and developed countries, being much lower for the low resourced countries: as low as 29.5 percent for India, and as high as 70 percent in developed countries (Letebele-Hartell, 2009:92).

The policy on cervical cancer screening in South Africa is implemented by the National Department of Health, for implementation by the provinces. All primary healthcare facilities in South Africa should be able to do cervical cancer screening by meeting all the infrastructure requirements. According to Letebele-Hartell (2009:92), there are at least 35 cytological laboratories, private and public sector, and adequate treatment centres for referral in the Free State, South Africa.

### **2.5.2 School-based health programmes**

For the purpose of this study, the researcher is going to explain the role of school in the lives of female youth in preventing STIs. The role of school is to educate and empower female youth with rich/sound sexual health knowledge in order to help them to make informed choices. It is also to help them develop resilience so that they would make the right decisions when they face the pressures and challenges that life may bring their way. School-based health programmes are implemented in the schools to identify and treat health problems of the youth at an early stage, to address health, economic, political, and educational issues that have an impact in the life orientation of youths. Sawyer, Afifi, Bearinger, Blakemore, Dik, CEzeh & Patton, 2012:1630) support this statement and add that investment in the youths' education will empower them from primary level in the subject Life Orientation (LO) to enhance their knowledge about the reproductive system (Sawyer et al., 2012:1630).

Globally it is reported that 500 000 of youths are infected with STIs, including HIV and AIDS, each day. However, they are vulnerable to STIs because of their social, political, cultural, biological, and economic experiences that impact on their well-being or upbringing (WHO, 2009:2). Youths need to be informed about reproductive health and be provided with supportive environments at schools and in the community which need to be user-friendly to prevent onset of STIs, HIV and AIDS (WHO, 2009:3). The Government of South Africa suggests that it is important to

have youth specific intervention programmes, such as school-based sexual health programmes, which will empower youths and enable them to acquire skills to protect themselves from STIs, including HIV and AIDS (SANAC, 2011:7).

To prevent new infections of STIs, HIV and AIDS among the teenagers who are the youths of the future, the Department of Basic Education (DBE) in South Africa provides reproductive health promotion information to learners from primary school phase. The introduction of LO as a subject was one of the interventions approved by the DBE (2008:1) to provide learners with knowledge about sexuality issues, including HIV. The introduction of the LO subject is acknowledged by Mulaudzi (2007:34) and Lebesse, Davhana-Maselesele and Obi (2010:34). The authors agree that abstinence must be included and promoted, while a safe environment has to be created to talk about sexual health with children and youths. Harrison, O'Sullivan, Hoffman, Dolezal and Morrell (2006:2) point out that the need for school-based sexual and reproductive health promotion is mostly in developing countries to prevent the youth from becoming involved in sexual risk activities that lead to reproductive and sexual health problems.

### **2.5.3 Family involvement and support**

Family plays a major role in shaping youth from childhood with regards to the way they socialise in life, in the environment, and how to relate with others in the society. Woods (2009:199) states in the youths' development stages, informal education is managed in the safety of their homes and is family-based on their culture. The impact of family and community rituals play a major role in shaping youths' sexual risk behaviours.

Communication is therefore the key factor among families, peers, and the community in empowering youths to make informed decisions about sexual behaviour (Upreti, Regmi, Pant & Simkhada, 2009:386), because they are exposed to so many diverse negative influences from outside the family circle. For example, peer pressure to engage in early sexual debut, pressure to use alcohol or drugs to "fit in," and pressure to have unsafe sex with multiple partners for money (DiClemente, Salazar & Crosby, 2007:889). These authors further state that one of the multiple intervention approaches is the mesosystem approach. The family is an

important part of this system and DiClemente et al. (2007:892) advise that the family should make a point of knowing the whereabouts of their children and who they associate with in an attempt to protect and reduce their risk behaviours.

Regarding the study, they conducted in Nepal, Upreti et al. (2009:386), explain that the main reason for knowledge differences about safe sexual activities and reproductive health matters, as well as the quality of health among youth can be ascribed to poor informal education and fewer discussions about sexual matters among family members and adult friends of the youth in the community. Adult friends may include an older sibling, an uncle or aunt, or even a close family friend. It was suggested by the findings that rural youths have high practices of premarital sexual relations without having knowledge of the use of protective measures against STIs, including HIV and AIDS, which put them at risk of contracting these diseases (Upreti et al., 2009:386).

The modern family finds itself in a society characterised by rapid technological, industrial, economic, and social changes (Hartell, 2000:38). These changes, which often have a negative influence on the family, can disturb the educational climate in many families. Pretorius (2008:63) states that there are numerous factors, such as poverty, community unrest and unemployment, hampering modern family life. The modern family is subjected to changes that impede and complicate the role and responsibilities of parents in such a way that the parents neglect their educational responsibility or transfer it to others.

The consequence of complex and dynamic changes in society is that it becomes more difficult to adequately educate children. The child experiences childhood in a changing world as traumatic, since the world and society tend to be hostile toward children and this hostility may threaten the child's development towards adulthood (Hartell, 2000:38).

Pretorius (2008:184) states that absence of guidance towards purposeful leisure time spending may lead to the youth declining into idleness, boredom, and loneliness. Some youths may participate in undesirable activities, such as drug abuse and sexual experimentation, under the strong influence of peer pressure. The young girl with inadequate guidance regarding how she spends her leisure time may

then be tempted to spend her leisure time under the influence of negative societal factors that may place her in situations such as sexual experimentation, in which she becomes more vulnerable to STIs, including HIV/AIDS.

The low level of income (salaries) of especially black parents (Hartell, 2000:45), unemployment, long illness, death, and the fact that financial support is not easily obtained makes the nuclear family even more vulnerable with regard to economical sustainability.

Social workers in the health field need to use the biopsychosocial approach when handling the patients who are dealing with the consequences of sexual risk behaviour, such as HIV (biological) infection, as they deal with stigma (psychological) attached to the infection and the overall acceptance within the communities (social). The researcher believes that a solution to the risky sexual behaviour of female youth would be reached if all avenues that attribute to this behaviour are explored thoroughly and a biopsychosocial approach is implemented to address it.

## **2.6 SUMMARY**

This chapter discussed a literature review regarding young adult life stage, focussing on the following elements: risky sexual behaviour of female youth, sexuality and sex education, STIs, HIV, cervical cancer and HPV. Organisations involved in sex education and their area of focus were discussed in order to understand their impact and influence on the risky sexual behaviour of female youth.

There are two important elements that were explored, namely the consequences of risky sexual behaviours amongst female youth and the examples of risky sexual behaviours, such as unprotected sex, multiple sexual partners, and early sexual initiation. The consequences of risky sexual behaviours include: STDs/STIs, teenage pregnancies, HIV infections, cervical cancer on the long-term, and suicide.

The section provided an overview of the available literature on factors relating to risky sexual behaviours. The chapter also focussed on the three types of sexual risk behaviour that have received the most research attention in South Africa: being sexually active (as opposed to abstaining from or postponing sexual activity); having

many partners (either serially or concurrently); and practicing unprotected sex (which includes the irregular or incorrect use of condoms).

Chapter 3 will present the research methodology and research findings.

### **3. CHAPTER 3: RESEARCH METHODOLOGY AND FINDINGS**

#### **3.1 INTRODUCTION**

In this chapter, the researcher will focus on the research methodology, including the research approach, type of research, research design, and the research methods, including the research population, the sampling method, methods of data collection and analysis, trustworthiness, the pilot study, and ethical considerations.

The researcher will also discuss the findings in detail which will include a thematic analysis of the themes and sub-themes as they emerged while collecting and analysing data.

#### **3.2 RESEARCH APPROACH**

The researcher selected the qualitative approach because the study seeks to understand the phenomenon of risky sexual behaviour female youth. The purpose of this approach is to construct detailed descriptions of (social reality) the sexual behaviour of female youth in rural and urban areas. It seeks to understand personal behaviour experiences.

The approach was applicable due to the fact that the researcher wanted to use interviews to get an in-depth understanding and knowledge of participants' reproductive health and the impact of their sexual behaviour, which is a sensitive topic. The researcher sought to utilise inductive logic in utilising in-depth interviews to investigate the specific (risky sexual behaviour of female youth in urban and rural areas) phenomenon and then make recommendations or generalisations about the phenomenon. Qualitative approach concepts are in the form of themes and the researcher categorised themes together that state participants' views (Creswell, 2009:65). The data from the interviews appear in the form of words, reported in participants' own words (verbatim) in the report. The researcher interviewed participants until saturation point was reached. The participants have detailed knowledge and understanding of what they experience and the consequences of their behaviour, making the information rich in nature (De Vos et al., 2011:66).

Researchers using qualitative techniques examine how people learn about and make sense of themselves and others (Berg, 2007:9). It was the researcher's

intention to explore and seek answers to the risky sexual behaviour of female youth and share the results through recommendations in report form.

### **3.3 TYPE OF RESEARCH**

Researcher used the applied research method, as the researcher's primary motivation is to assist in solving a particular problem facing the South African community, namely the risky sexual behaviour of female youth that results in STIs like HIV and HPV that may lead to cervical cancer and many other social problems. In this case, the risky sexual behaviour of female youth is self-destructive and most often results in females dropping out of school due to pregnancy. In this way applied research may assist the community to overcome the problem or design interventions which will help solve it (Bless, Higson-Smith & Kagee, 2006:45).

The researcher's primary motivation was to assist in addressing the persisting challenge that female South African youth are faced with. As mentioned earlier, there are interventions that are in place at schools (such as the LO and Sexuality Education subjects in the Department of Education school curriculum) to address high pregnancy rates amongst female youth. The teenage pregnancy rates are relatively high in South Africa, as mentioned earlier by Matlane (2013), and existing interventions have to be enhanced in order to solve the sexual challenges of the community's female youth. The researcher therefore aimed to collect new knowledge regarding risky sexual behaviour practices that can be used within the social work profession to design or improve existing interventions.

### **3.4 RESEARCH DESIGN**

The case study research design was used by the researcher, as she wanted to compare cases in urban and rural areas. In contrast to other methodological frameworks, the case study design is more of a choice of what to study than a methodological one. However, "whether a researcher considers case study as a way of conceptualizing human behaviour or merely as a way of encapsulating it, its strategic value lies in its ability to draw attention to what can be learned from a single case" (Schram, 2006:107). The researcher sought to explore the risky sexual behaviour of female youth and its consequences.

Since qualitative researchers are primarily interested in the meaning subjects give to their life experiences, they have to use some form of case study to immerse themselves in the activities of a single person or a small number of people in order to obtain an intimate familiarity with their social worlds and to look for patterns in the research participants' lives, words, and actions in the context of the case as a whole (Fouché & Schurink, in De Vos et al., 2011:320). Creswell and Plano Clark (2007:73) explains that a case study involves an exploration of a "bound system" (bounded by time, context and/or place), or a single or multiple case, over a period of time through detailed, in-depth data collection involving multiple sources of information. As pointed out by Babbie (2001:285), there is a little consensus on what constitutes a case or a "bounded system" in Creswell's term. The case being studied may refer to a process, activity, event, programme or individual, or multiple individuals. The exploration and description of the case takes place through detailed, in-depth data collection methods, involving multiple sources of information that are rich in context. As such, the researcher needed access to, and the confidence of participants. The researcher conducted a study on a small number of participants, thus a collective case study, which was female youth between the ages 18 and 20 years in an urban area (Tembisa, Gauteng) and in a rural area (Kameeldrift Village in Hammanskraal, Gauteng). The collective case study is an instrumental case study extended to a number of cases. Cases are chosen so that comparisons can be made between cases and concepts and in this way theories can also be extended and validated (Mark, 1996:12).

The researcher's experience in the social work field was an advantage to explore and describe the social phenomenon in a language understood by participants and ensured confidentiality, as the participants were unknown to the researcher. The researcher wanted to get very personal information about the risky sexual behaviour of female youth. The product of this research is an in-depth description of cases, and case-based themes. The researcher situates this system or case within its larger context, but the focus remains on either the case or an issue that is illustrated by the case (Creswell, 1998:61). Babbie (2001:8) points out that case study researchers, in contrast to grounded theorists, seek to enter the field with knowledge of the relevant literature before conducting the field research.

### **3.5 RESEARCH METHODS**

The research methodology is organised under the following headings: the study population, the sampling method, methods of data collection and analysis, and trustworthiness.

#### **3.5.1 Study population and sampling**

McBurney (2001:248) refers to the population as the sampling frame. Strydom (2011:223) describes a population as the totality of persons, events, organisational units, case records, or other sampling units with which the research problem is concerned.

The population was school-going females aged between 18-20 years in the Gauteng province. There were two targeted groups of population. The first one was in Kameeldrift Village, Hammanskraal in the Tshwane Municipality, Gauteng province. This is a rural area with limited resources. The second population was in Tembisa, Ekurhuleni Municipality, Gauteng province. These were township girls between the ages of 18-20 years. The researcher is familiar with both areas and they are characterised by high teenage pregnancy rates and reported cases of learners caught having sex on the school premises. The community leaders of identified areas were contacted and informed of the study. The researcher seeks to understand the risky sexual behaviour of female youth in rural and urban areas.

It is important for the researcher to mention that there are female youth that are using contraceptives for medical reasons, for an example when they have acne problems or to control heavy menstrual flow. A study conducted by Jewks and Wood in 2006 aimed to gather information that could be used to improve access to and overall quality of contraceptive services for adolescent women in the Limpopo province. The study reported that 5 percent of the population reported using contraceptives for medical reasons (Jewks & Wood, 2006:109).

#### **3.5.2 Sample and sampling method**

According to Patton (2002:244) there are no rules for sample size in qualitative inquiry. Sample size depends on what the researcher wants to know, the purpose of the enquiry, what is at stake, what will be useful, what will have credibility, and

what can be done with the available time and resources. According to Strydom and Delport (2011:391) it can be confirmed that in qualitative investigations non-probability sampling is used almost without exception. A sample of 12 participants was selected; six from a rural and six from an urban clinic.

Strydom and Delport (2011:391) stated that probability and non-probability sampling techniques can both be used in qualitative studies, but the researcher sees non-probability sampling as the most appropriate for this study. The researcher therefore used purposive sampling to select 12 participants, namely six female youth from a rural area and six from an urban area. Purposive sampling is based entirely on the judgment of the researcher, in that a sample is composed of elements that contain the most characteristic, representative, or typical attributes of the population that serve the purpose of the study best (Grinnell & Unrau, 2008:153; Monette, Sullivan & De Jong, 2005:148). The sampling criteria were as follows:

- Female youth between the ages of 18 and 20.
- Female youth who are sexually active, as they request contraceptives at the clinic.
- Female youth who are from Ivory Park in Tembisa and Kameeldrift Village in Hammanskraal, both in Gauteng.

The researcher obtained permission from the clinic's leadership. The nurse informed the female youth who met the criteria and were accessing contraceptives at the clinic of the study, by using a letter of introduction to tell the potential participants about the study. Those interested were asked to leave their contact details for researcher to contact them, which she did.

### **3.5.3 Data collection methods**

The data collection technique that was used was the semi-structured, one-to-one interview. According to Strydom in De Vos et al. (2011:352), researchers use semi-structured interviews in order to gain a detailed picture of participants' beliefs about, or perceptions or accounts of a particular topic. The method gives the researcher and participant much more flexibility. The researcher is able to follow up particular interesting avenues that emerge in the interview and the participant is able to give a fuller picture. Semi-structured interviews are especially suitable when one is

particularly interested in complexity or process, or when an issue is controversial or personal. For the purpose of this study the researcher was interested in participants' personal information pertaining to risky sexual behaviour. The researcher had a set of predetermined questions on an interview schedule, but the interview was guided rather than dictated by the schedule. Participants shared more closely in the direction the interview took and they were perceived as the experts on the subject and were therefore allowed maximum opportunity to tell their story (Strydom, 2011:352). According to Creswell and Plano Clark (2007:6), "qualitative data consists of open-ended information that the researcher gathers through interviews with participants. The general open-ended questions asked during these interviews allow the participants to supply answers in their own words." The quantity and quality of information exchanged depends on how adept and creative the interviewer is at understanding and managing the relationship (Monette et al., 2005:178). The researcher has strong interviewing skills and understanding of the specific social phenomenon, as she is an experienced and qualified social worker. The researcher also has good insight into sexuality as she worked for loveLife Trust as a professional counsellor from 2002 to 2006.

The study is not attempting to generalise that all or only female youth practise risky sexual behaviour; male youth also practise it. However, Shisana et al. (2012:53), specifically refer to female youth between the ages of 20 and 34 as the most at risk population (MARF) and the age group selected by the researcher falls under this same age group.

All interviews were voice recorded to avoid loss of information, with the permission of the participants.

### **3.5.4 Methods of data analysis**

The researcher used the data analysis steps of Creswell, as described in Schurink, Fouché and De Vos (2011:404):

The steps are as follows:

- **Planning for recording data:** The researcher used a card system and at the end of each interview she put notes and data collected in an envelope and

numbered it before doing the next interview. The researcher planned for the recording of data in a systematic manner that was appropriate to the setting, research participants, or both, that will facilitate analysis, before data collection commences (De Vos et al., 2011:404). The researcher took extra precautions and used appropriate measures. For example in rural areas, where there may be no electricity, manual record keeping was implemented and the batteries of the voice recorder and cell phone were fully charged before the interviews. Voice recording by cellular phone was another backup option.

- **Data collection and preliminary analyses:** Schurink in De Vos et al. (2011:404) state that data analysis necessitates a two-fold approach. The first involves data analysis in the field following a period of data collection. The researcher analysed the data while in the field after every interview and categorised data. The second part is known as the office approach, which was conducted between and prior to visits in the field, as well as after completion of data collection. Generally, the office approach focused more on the “sorting, retrieving, indexing and handling of qualitative data” (Gibbs, 2007:1-2). The researcher made sure that she wrote detailed and comprehensive field notes to avoid loss of data.
- **Managing the data:** This was the first step in data analysis, also called the intensive data analysis phase. It helped to properly begin the process. The researcher organised her data into file folders and computer files. It was important for the researcher to have a backup system for keeping data. A backup of the data was therefore kept on a memory stick, in case a file was destroyed. She converted the files into appropriate text units, for example she transcribed each interview verbatim and saved it as a separate file on the computer. The researcher has stored all the information regarding each interview separately and in categories (Schurink et al., 2011:408).
- **Reading and writing memos:** The researcher read through transcripts a few times so that she could internalise information and come up with holistic information. This assisted the researcher to get a sense of the interview as a whole before breaking it into parts (Schurink et al., 2011:409). She took notes as she reviewed the material and her main objective at this stage was to try and save the data on her computer and back it up on a removable memory stick.

The researcher had to think about it whenever she had spare time (Esterberg, 2002:157). Writing of memos in the margins of field notes or transcripts helped in the initial phase of exploring a database. These memos were short phrases, ideas, or key concepts that the researcher wrote to herself about the coding process, called “analytic memos” (Krueger & Neuman, 2006:440). The basis for analysis is transcripts, tapes/voice recordings, notes and memory. In qualitative research we strive to be open to the reality of others. We seek to tell someone else’s story, but must listen before we can understand. The critical ingredients of qualitative analysis are that it must be systematic, sequential, verifiable and continuous; requires time; is jeopardised by delay; seeks to enlighten; should entertain alternative explanations; is improved by feedback; and is a process of comparison (Morgan & Krueger, 1998:3-17; Krueger & Casey, 2000:128-130).

- **Generating categories and coding the data:** The researcher identified themes from the interviews or as emphasised by the majority of participants (this is category formation). This step in the analytic process demanded a heightened awareness of the data, a focused attention to it, and openness to the subtle, tacit undercurrents of social life. The researcher identified salient themes, recurring ideas or language, and patterns of belief that linked people and settings together and recognised it as it is the most intellectually challenging phase of data analysis and one that can integrate the entire endeavour (De Vos et al., 2011:410). The process of category generation involved noting similar themes or categories between the participants. As categories of meaning emerge, one searches for those that have internal convergence and external divergence, that is the categories should be internally consistent but distinct from one another (De Vos et al., 2011:411). It was up to the researcher to choose codes that suited her, for example she had to choose between abbreviations of key words, coloured dots, or numbers. Coding could be applied in various degrees of detail, including line by line, sentence by sentence, or paragraph by paragraph, or could even be linked to the whole text (Flick, 2006:300; Charmaz, 2006:75). Lastly, the researcher used the selective coding process in selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that needed further refinement and development (De Vos et al., 2011:413).

- **Testing emergent understanding and searching for alternative explanations:** As categories and themes are developed and coding is well underway, Kreuger and Neuman (2006:452) suggest beginning the process of evaluating how things that are not in the data can be important for analysis. This entailed a search through the data during which one challenges one's understanding, and searches for negative instances of the patterns and incorporates these into larger constructs as necessary. Part of this phase was evaluating the data for their usefulness and centrality, and presenting the data/writing the report (De Vos et al., 2011:415).
- **Presenting the data:** In this final stage the researcher presents the data, a packaging of what was found in text, tabular, or figure form. Babbie (2007:389) refers to this process as "concept mapping." For example, creating a visual image of the information, a researcher presented a comparison table that compares girls from rural and urban areas in terms of one of the themes or categories in the study. Writing about qualitative data cannot be separated from the analytical process. The report was written in words or language known to participants and the researcher engaged an interpretive act when shaping the raw data (De Vos et al., 2011:418). The report is in the form of a mini-dissertation.

### 3.5.5 Trustworthiness

Qualitative researchers generally regard the following constructs as inappropriate in establishing the truth value of a qualitative research project. The constructs are internal validity, external validity, reliability, and objectivity. Two prominent qualitative researchers, Lincoln and Guba (1999:76), propose the following four alternative constructs they believe reflect the assumptions of the qualitative paradigm more accurately. The first of these criteria, namely credibility, is considered to be the most important one (Strydom and Delpont, 2011:419).

**Credibility/authenticity** is an alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject has been accurately identified and described. The researcher asked if there was a match between research participants' views and researcher's reconstruction and representation of them. The strength of the qualitative study that aims to explore a problem or describe a setting, a process, a social group, or a pattern of interaction will be its validity. An in-depth description showing the complexities of variables and interactions will be so embedded with data derived from the setting that it cannot help but be valid (Strydom & Delpont, 2011:419).

The researcher did **member checking** which allowed participants to review findings from the data analysis in order to confirm or challenge the accuracy of the work. The researcher went back to the participants after the data was interpreted, to verify whether this reflects what the participants were conveying in the interviews. The researcher listened to the tape together with each participant to verify the information received. The participants were able to identify areas that may have been missed or misinterpreted (Lietz, Langer & Furman, 2006:454). **The researcher used rich, thick descriptions to convey findings**, and because this provided many perspectives about a theme the results became more realistic and richer in detail. The researcher ensured that the findings are described properly and the participants' opinions and responses are represented accurately and verbatim.

**Researcher bias** – self-reflection was used by the researcher before she commenced with the interviews to try to neutralise her feelings, so as not to influence their story in any way. The researcher used a non-judgmental attitude to ensure that researcher bias was avoided.

**Transferability:** Here the researcher asks whether the findings of the research can be transferred from a specific situation or case to another. Lincoln and Guba, in Strydom and Delpont (2011:420), propose this as the alternative to external validity or generalisability, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer, than with the original investigator. A qualitative study's transferability or generalisability to other settings may be problematic. To counter challenges, the researcher can refer back to the original theoretical framework to show how data

collection and analysis will be guided by concepts and models. By doing so, the researcher states the theoretical parameters of the research. One additional strategic choice can enhance a study's generalisability: triangulating multiple sources of data. Data from different sources can be used to corroborate, elaborate or illuminate the research in question (Strydom & Delpont, 2011:420). The researcher's analysis of the data was guided by the biopsychosocial approach which emphasises the role of people's behaviour, what work they do, how they lead their lives, where they live, and their access to health care services in determining their health status. For an example, life expectancy and the chances of contracting a disease such as cancer, tuberculosis, or HIV/AIDS are strongly influenced by socio-environmental factors (Ross & Deverell, 2004:12). It was appropriate for the researcher to use the biopsychosocial approach, which was a holistic approach, to explore or gather information about the personal experiences of female youth regarding their risky sexual behaviour.

**Dependability:** Here the researcher asks whether the research process was logical, well documented and audited. This is the alternative to reliability, in which the researcher attempts to account for everything done during the research process by keeping records of everything saved on the computer and in hard copy, such as recordings, transcripts, letters of informed consent, and field notes, so that an audit trail is kept for another researcher to follow later. Positivist notions of reliability assume an unchanging universe where inquiry could, quite logically, be replicated. This assumption of an unchanging social world is in direct contrast to the qualitative /interpretive assumption that the social world is always being constructed, and the concept of replication is itself problematic (Strydom & Delpont, 2011:420).

**Conformability:** The final construct, conformability, captures the traditional concept of objectivity. Lincoln and Guba (1999:82) stress the need to ask whether the findings of the study can be confirmed by another. By doing so, they remove evaluation from some inherent characteristic of the researcher (objectivity) and place it squarely on the data. The question is whether the researcher provides evidence that corroborates the findings and interpretations by means of auditing (Strydom & Delpont, 2011:421). Researcher substantiated her findings with direct quotes from the interview and literature.

**Peer debriefing** determined whether the researcher understood what the participants were conveying and enhanced the accuracy of the accounts during the interviews. A colleague was used to read the transcribed interviews and relay to the researcher how she interpreted the story, in order that that the account of the interview would resonate with someone other than the researcher. The researcher used **reflexive journaling** to keep a record of her experiences, feelings, and thoughts before and after the interviews, which was also discussed with her peer, so as to not influence or bias the study (Creswell, 2009:191).

### 3.5.6 Pilot study

Strydom and Delpont (2011:394) state that the pilot study in qualitative research is usually informal, and a few respondents possessing the same characteristics as those of the main investigation can be involved in the study, merely to ascertain certain trends. The purpose is to determine whether the relevant data can be obtained from the respondents (Royse, 2004:172). Denzin and Lincoln (2000:213) state that the pilot study in qualitative research allows the researcher to focus on specific areas that may have been unclear previously to test certain questions. A pilot study also contributes to the establishment of relationships with the respondents or with the community, and to obtain permission for the project (Monette et al., 2005:93). Effective communication patterns can also be established in this manner. The pilot study assists, moreover, in estimating the time and costs that may be involved, as well as in pre-empting the problems that may arise during the actual qualitative interviews (Denzin & Lincoln, 2000:213).

The pilot study helped the researcher with project planning to identify each of the assumptions underlying the project plan/research plan (Bless, 2006:55), in this case whether the research question could be answered. The researcher selected two female youth who met the same sampling criteria as for the main study and conducted interviews with one in a same urban area, namely Hikentsile Clinic in Ivory Park, Tembisa, but in a different section/extension from where the main study was conducted, and one from a rural area in Limpopo, Mokopane in Moshate, which is similar to the rural area where the main study was conducted. The interview schedule and the recording device were tested. The researcher used different communities for the pilot test, because of the fact that she might not have been able

to get enough participants because of the sensitivity of the topic. These two females did not form part of the main study. This allowed the researcher to correct any mistakes.

Strydom (2011:240) states that since qualitative research is usually conducted in a smaller area with fewer respondents, but in greater depth and over a longer period of time than in quantitative research, it is of prime importance to undertake as comprehensive and as accurate an assessment as possible of the real situation to be investigated. During this phase of the pilot test the researcher already formed an opinion on the feasibility of the study, such as the openness of the community or group of respondents, their willingness to cooperate, the duration of the interview, and the number of respondents who were likely to be involved until data saturation.

### **3.6 ETHICAL CONSIDERATIONS**

The relevant ethical considerations are discussed below.

#### **3.6.1 Non-maleficence / avoidance of harm**

Bless (2006:141) states that the research should never injure or harm participants. Avoidance of harm is described by Strydom (2011:115) as avoiding the kind of harm to respondents in the social science that is mainly of an emotional nature, although physical harm cannot be ruled out completely. It is unethical not to deal with emotions that arise as a result of the research question, so the researcher referred the participants to Mrs Lesego Mabote, a social worker in the Department of Social Development and Family and Marriage Association of South Africa (FAMSA) in Hammanskraal, Gauteng, if they were distressed during the interview. The researcher got permission from the Department of Social Development, Hammanskraal, to refer them to Mrs Lesego Mabote and a FAMSA social worker at Hammanskraal in Tshwane, Gauteng, and in Tembisa, Gauteng, before the interview or research process commenced and informed them about participants that were to be referred during data collection should it be necessary. None of the participants needed to be referred to the social worker, but were informed about the social worker for future reference.

### **3.6.2 Informed consent**

The researcher took some time to explain the contents of the letter of informed consent to participants, such as what the study entailed and what was required of them in terms of participation. Each participant was asked to sign an informed consent letter, which was an indication that they indeed understood what had been explained to them. Each participant received a copy of the consent form for their own records and the informed consent letter contained the following details:

- The goal of the study, which was to understand the sexual behaviour practices of female youth in rural and urban areas in an attempt to enhance the existing programmes that are in place to deal with this community problem, was clearly defined.
- The possible risks and benefits of the study were clearly explained.
- It was explained that the researcher would use a voice recorder during the interview with the permission of the participants.
- It was stated that the data will be stored in a safe place at the University of Pretoria (UP) for 15 years as required.
- Participants had a right to withdraw without any consequences if the research became too much for them, and the data would be destroyed if participants decided to withdraw.
- The participants were assured of confidentiality, as it is unethical to release any information that can be linked to the identity of the participants, and that they will be assigned a number or letter to protect their identity.

Informed consent was in a written format and they got a copy for their records. Each participant was required to sign the letter before the interview took place. The researcher got the informed consent from the participants, as they ranged in age from 18-20 years. Permission was also obtained from the Clinic management in both provinces, for the research to be conducted at the clinics.

### **3.6.3 Autonomy/voluntary participation**

The principle of autonomy incorporates the freedom of individuals' actions and choice to decide whether or not to participate in research. No person should be forced, either overtly or covertly, to participate in research (Bless et al., 2006:142;

Rubin & Babbie, 2005:71). The researcher used purposive sampling where participants were informed of the study by the nurse with a letter of introduction, if they met the sampling criteria. They left their contact details with the nurse if they were interested in participating out of their own free will. The researcher then contacted them for an appointment when it was convenient for them and the interview only commenced once they had signed the consent form to participate voluntarily. Permission was obtained from the Department of Health and the head of the clinics to conduct the study there.

#### **3.6.4 Violation of privacy, anonymity and confidentiality**

Based on the fact that the researcher conducted face-to-face interviews as a method of data collection, the researcher was unable to ensure participants of anonymity, but ensured that their identity would be protected by assigning a number to each participant instead of using their names. It is imperative that researchers be reminded of the importance of safeguarding the privacy and identity of respondents, and to act with the necessary sensitivity where the privacy of subjects is relevant (Yegidis & Weinbach, 1996:34). Information provided by participants was kept confidential, particularly sensitive and personal information, and was protected and not made available to anyone other than the researchers. Data collected from participants was at all times kept under secure conditions (Bless et al., 2006:143).

#### **3.6.5 Fidelity/deception of subjects**

The principle of fidelity implies faithfulness and keeping promises or agreements, specifically between the researcher and the participant (Bless et al., 2006:142). The researcher ensured that participants were not misled by stating all the necessary details on the consent forms and on permission letters received. Signed consent forms ensure that participants are not misled based on the definition of Struwig and Stead (2001:69) of deception, which refers to misleading participants, deliberately misrepresenting facts, or withholding information from participants. They were also informed that the data will be stored at UP in a safe for 15 years for archival or research purposes.

### **3.6.6 Debriefing of participants**

According to McBurney (2001:60) debriefing sessions are sessions during which subjects get the opportunity, after the study, to work through their experience and its aftermath, and where they can have their questions answered and misconceptions removed. Based on this definition, the researcher debriefed the participants by having a discussion with them at the end of the interview and this helped to avoid misinterpretation of data. The researcher used the reflection technique to verify the information the participants had given. This also gave participants an opportunity to inform the researcher if there was an indication of any personal harm, in which case the researcher then referred them.

## **3.7 RESEARCH FINDINGS**

From the process of data analysis, the researcher identified themes, sub-themes, and categories. Subsequently, the research findings will be discussed, commencing with the profile of the participants and followed by the thematic analysis.

### **3.7.1 Profile of the participants**

The researcher used purposive sampling to select 12 participants, namely six female youth from a rural area and six from an urban area. Purposive sampling is based entirely on the judgement of the researcher, in that the sample is composed of elements that contain the most characteristic, representative, or typical attributes of the population that serve the purpose of the study best (Grinnell & Unrau, 2008:153; Monette et al., 2005:148).

The following sampling criteria were used:

- Female youth between the ages of 18 and 20.
- Female youth who are sexually active, as they request contraceptives at the clinic.
- Female youth who are from Ivory Park in Tembisa and Kameeldrift Village in Hammanskraal, both in Gauteng.

The researcher conducted 12 interviews with female youth who met the above mentioned selection criteria.

**Table 3.1: Profile of the participants**

| Participant | Age | Gender | Language | Area                | Grade                   | Race  |
|-------------|-----|--------|----------|---------------------|-------------------------|-------|
| 1           | 20  | Female | Sepedi   | Kameeldrift Village | Dropped out in grade 11 | Black |
| 2           | 18  | Female | Shona    | Kameeldrift Village | In grade 8              | Black |
| 3           | 20  | Female | Setswana | Kameeldrift Village | Dropped out in grade 10 | Black |
| 4           | 20  | Female | Sepedi   | Kameeldrift Village | Dropped out in grade 11 | Black |
| 5           | 18  | Female | Sepedi   | Kameeldrift Village | In grade 11             | Black |
| 6           | 20  | Female | Sepedi   | Kameeldrift Village | Dropped out in grade 11 | Black |
| 7           | 20  | Female | Zulu     | Ivory Park          | Dropped out in grade 11 | Black |
| 8           | 19  | Female | Sepedi   | Ivory Park          | Year 1 in College       | Black |
| 9           | 19  | Female | Sepedi   | Ivory Park          | Not in school, Gap year | Black |
| 10          | 18  | Female | Sepedi   | Ivory Park          | Year 1 AWC campus       | Black |
| 11          | 20  | Female | Xitsonga | Ivory Park          | Dropped out in grade 11 | Black |
| 12          | 18  | Female | Xhosa    | Ivory Park          | Grade 11                | Black |

It is important to outline the profile of participants, as they come from different backgrounds and the objective of the study is to investigate whether their backgrounds have an impact on their sexual risk behaviour. All participants were black females and the majority of them are Sepedi speaking. Other participants speak one of the following languages: Zulu, Xitsonga, Setswana, Shona or Xhosa. The majority of participants that dropped out of school were from a rural area, while only two participants from an urban area had dropped out of school. All participants from rural and urban areas were between the ages of 18 and 20.

The data gathered from these participants were analysed and themes were generated from the data. A detailed thematic analysis is presented in the next section.

### 3.7.2 Thematic analysis

This section will discuss the themes, sub-themes, and categories as they emerged from the analysis of data collected (De Vos et al., 2011:410). The findings were subdivided into five themes.

1. Knowledge of female youth regarding reproductive health.
2. Knowledge of preventative measures.
3. Sexual risk behaviour.
4. Consequences of risky sexual behaviour.
5. Attitudes experienced as a result of consequences of risky sexual behaviour.

**Table 3.2: Thematic Analysis**

| Themes  | Sub-themes  | Categories                                    |
|---|---|---|
| <b>Theme 1</b><br>Knowledge of female youth regarding reproductive health | Opinion on right age for first sexual encounter versus actual age at first sexual encounter | Raising awareness on STIs, including HIV/AIDS |
|   | Understanding the effects of early sexual debut   |   |
|   | Understanding causes of cervical cancer   |   |
|   | Understanding of STI prevention and treatment   |   |
|   | Access to a Health Care Centre  |   |
|   | Family involvement in sex education   |   |
| <b>Theme 2</b>  | Purpose of using contraceptives   | Awareness of pregnancy prevention measures    |

| Themes   | Sub-themes  | Categories  |
|--|---|---|
| Knowledge of preventative measures and prevention of pregnancy                               | Understanding the importance of using condoms   |   |
| <b>Theme 3</b><br>Sexual risk behaviour  | Multiple sexual partners, transactional and intergenerational sex   | Initiating poverty alleviating programmes or youth development programmes |
|  | Unprotected sex: nature of sexual behaviours, e.g. casual sex or substance use                                |   |
| <b>Theme 4</b><br>Consequences of risky sexual behaviour                                     | Understanding of the consequences of risky sexual behaviour, unplanned pregnancies, and HIV infection         | Raising awareness of HIV and cervical cancer                              |
|  | School drop-out as a result of challenges experienced in participant's role as a learner, mother, and partner |   |
|  | Lessons learnt while dealing with effects of risky sexual behaviour   |   |
| <b>Theme 5</b><br>Attitude experienced as a result of consequences of risky sexual behaviour | Changes in the attitudes of community / family  | Community education   |
|  | Changes experienced in the attitudes of peers/school and friends/family                                       |   |

The researcher will discuss the themes and sub-themes that emerged from the data, reflect participants' quotations from the interviews to support the themes, and substantiate with relevant literature.

### 3.7.2.1 Theme 1: Knowledge of female youth regarding reproductive health

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. It is broadly defined as the social construction of a biological drive (WHO, 2002:23), which often deals with issues such as whom one has sex with, in what ways, why, and under what circumstances, and with what outcomes a person engages in sex (Maticka-Tyndale et al., 2007:67).

The following sub-themes were generated for Theme 1:

- Opinion on right age for first sexual encounter versus actual age at first sexual encounter
- Understanding the effects of early sexual debut
- Understanding causes of cervical cancer
- Understanding of STI prevention and treatment
- Access to a Health Care Centre
- Family involvement in sex education

#### **Sub-theme 1.1: Opinion on right age for first sexual encounter versus actual age at first sexual encounter**

The participants were asked to share their opinion on the right age for first sexual encounter for girls or young women. Participants' views and actual experience regarding the above were as follows:

**Participant 1 – Ivory:** “I think right age for first sexual encounter is at age 18 because they won’t develop properly if they start early. My first sexual encounter was this year at age 20.”

**Participant 2 – Ivory:** “Right age is at age 21 because at young age you can get destructed. My first sexual encounter was at age 16.”

**Participant 3 – Ivory:** “Right age is at age 21 and I was 18 years old when I started having sex.”

**Participant 4 – Ivory:** “Right age to start engaging is at the age of 18 years old. My first sexual encounter was when I was 17 years old.”

**Participant 5 – Ivory:** “I think correct age to start sex is at age 21 and my first sexual encounter was at age 15 years.”

**Participant 6 – Ivory:** “Correct age to start is at the age of 18 and my first sexual encounter was when I was 17 years old.”

**Participant 1 – Kameeldrift:** “I think correct age to start sex is at age 21 and I started when I was 16 years old.”

**Participant 2 – Kameeldrift:** “Correct age to start is at 18 years and my first sexual encounter was at age 17.”

**Participant 3 – Kameeldrift:** “Correct age to start is at 18 years and my first sexual encounter was at age 13.”

**Participant 4 – Kameeldrift:** “I think correct age to start sex is at the age of 21 and my first sexual encounter was when I was 19 years old.”

**Participant 5 – Kameeldrift:** “Correct age to start is at 18 years and my first sexual encounter was when I was 17 years old.”

**Participant 6 – Kameeldrift:** “Correct age to start is at 18 years and my first sexual encounter was when I was 18 and half years old.”

It is clear that participants perceive the correct age to start engaging in sexual debut is 18 years or older. Although the majority of participants viewed this age as the correct age, a significant amount of participants viewed age 21 as the correct age for a woman to start engaging in sex. The participants’ actual experience is different from their thoughts and views. Only one participant started engaging in sex at the same age that she thinks is the right age for a girl’s first sexual encounter. This was noted during the data analysis process.

The above responses are supported by previous studies conducted in the same field. The Shisana et al. (2012), study indicates that one tenth (10.7 percent) of respondents aged 15–24 years reported having had sex for the first time before the age of 15 years. Significant differences were found by sex and race, with higher percentages of males (16.7 percent) and black Africans (11.1 percent) reporting that they had done so in comparison to their counterparts. However, no significant differences were found by locality type and province. Overall, the rates of sexual debut before the age of 15 years were stable from 2002 until 2008 at about 10 percent, and then increased slightly in 2012 to about 11 percent. More importantly, there were sex differences found, with males also consistently reporting significantly higher rates of sexual debut before 15 years of age compared to females in the 2002 to 2012 period (Shisana et al., 2012:20).

### **Sub-theme 1.2: Understanding the effects of early sexual debut**

The following quotations from participants reflect their understanding of the effects of early sexual debut.

**Participant 1-Ivory:** “Body won’t develop properly if they start sex early, breast sag, can contract HIV and can get pregnant.”

**Participant 5-Ivory:** “A girl can get pregnant and can get infected with HIV.”

**Participant 6-Ivory:** “Pregnancy at young age, and getting sick like HIV or STI, etc. This is caused by having sex while she is under age.”

**Participant 1-Kameeldrift:** “It would result in teenage pregnancy.”

**Participant 4-Kameeldrift:** “It would result in pregnancy and therefore no progress in life.”

**Participant 5-Kameeldrift:** “Can get pregnant, can get infected with HIV and STI at an early age.”

**Participant 6-Kameeldrift:** *“Can get infected with HIV and STI, can get unplanned pregnancy, and can drop out of school because of peer pressure.”*

Most of the participants in rural and urban areas highlighted that early sexual debut would result in an unplanned pregnancy or teenage pregnancy and contraction of HIV. Participants understand that sexual risk behaviour would put them at risk of getting infected with HIV/AIDS. So this supports the appropriateness of the biopsychosocial approach, because it looks at people’s behaviour, what work they do, how they lead their lives, where they live, and their access to health care services in determining their health status. The effects of early sexual debut directly affect participants’ bio, psycho and social spheres, which support the use of the biopsychosocial approach. They need support to cope with consequences of early sexual debut, such as an unplanned pregnancy and or contraction of HIV.

It is critical to mention that pregnancy among youths could be a function of sexual risk behaviours, such as unprotected sex and early sexual initiation (Damtie, 2013:5). The researcher’s focus was to establish whether there is a difference in behaviour amongst rural and urban girls, what would be the factors influencing that difference, and their understanding of the impact of risky sexual behaviour in future.

Violence against girls and women may result in unwanted pregnancy, either through rape or by affecting a woman’s ability to negotiate contraceptive use. Some girls and women may be afraid to raise the issue of contraceptive use with their partners, for fear of being beaten or abandoned (WHO, 1997:16).

The WHO (1997:16) further states that adolescents who are abused, or have been abused as children, are much less likely to develop a sense of self-esteem and belonging than those who have not experienced abuse. Abused and violated adolescents are more likely to neglect themselves and engage in risky behaviours such as early and unprotected sexual intercourse. A growing number of studies suggest that girls who are sexually abused during childhood are at much greater risk of unwanted pregnancy during adolescence, and consequently vulnerable with regard to HIV/AIDS infection (UNICEF, 2001:33). There is no difference stated in terms of the effect of abuse in rural versus urban areas.

### **Sub-theme 1.3: Understanding causes of cervical cancer**

The participants from rural and urban areas were asked to share their understanding of the causes of cervical cancer. They were either unclear or not aware of the causes of cervical cancer. Their responses are quoted below as follows:

*Participant 1-Ivory: "I don't know."*

*Participant 2-Ivory: "I am not sure."*

*Participant 3-Ivory: "It is caused by boys who did not circumcised."*

*Participant 6-Ivory: "No I don't know."*

*Participant 1-Kameeldrift: "No I don't know."*

*Participant 4-Kameeldrift: "it is caused by dirt that comes from a man."*

*Participant 5-Kameeldrift: "I don't know."*

*Participant 6-Kameeldrift: "I don't know, but I think it is caused by unprotected sex, rough man can hurt you inside and that can cause cervical cancer."*

The majority of participants do not know what causes cervical cancer. Only two participants from the rural area had an idea of what causes cervical cancer and the rest of the participants from the urban area did not know what causes it.

According to Parkin et al. (2003:268), cancer of the cervix and uterus is the second most common cancer among women worldwide, with an estimated 468 000 new cases and 233 000 deaths in the year 2000. Almost 80 percent of the cases occur in developing countries where, in many regions, this is the most common cancer amongst women.

Carcinoma of the cervix may be considered a STD, as there exists a well-documented association between specific sexual practices of patients (and their male partners) and risk of the disease. Consistent with an infectious aetiology, women with multiple sexual partners and women who begin sexual relations at an early age are at increased risk of developing cervical cancer (Spitz & Newell, 1992:38).

Nurses at the primary healthcare setting play a major role in improving the uptake of cervical cancer screening. There is a need to actively recruit women to come for a pap smear, while at the same time strengthening health education (Letebele-Hartell, 2009:92).

### **Sub-theme 1.4: Understanding of STI prevention and treatment**

The following quotations from participants reflect their understanding of STI treatment and prevention.

**Participant 3-Ivory:** “It’s STIs, Drop, STD which is abnormal discharge with changed colour. **Treatment-** I must go to the clinic and get treatment for seven days. I must use condom to **prevent** STIs.”

**Participant 4-Ivory:** “A girl gets STIs by using toilet paper during menstruation, I don’t know the names of STIs. You can **treat** it by going to clinic, the only thing that can help you is clinic. **Prevention-** Ensure you have one partner, because these things can be caused by multiple sexual partners. You must bath all the time and go to the clinic.”

**Participant 5-Ivory:** “Yes I do understand STIs, they are HIV or AIDS, Discharge yellowish in colour. I must use protection during sexual intercourse to prevent STI, and also go to the clinic for treatment.”

**Participant 6-Ivory:** “Yes I do understand, its STI, Cancer and HIV/AIDS. Breast cancer, Cervical Cancer the one you just told me about, Drop-Gonorrhoea, sores in your private part, yellowish discharge. **Prevention & Treatment-**Firstly when you know you are sexually active I must use protection (condom) during sexual intercourse, Secondly I must go to the clinic for contraceptives to prevent pregnancy and thirdly I must have sex with one man, I must not sleep around. This will help when something happens for me know who is responsible for it. I must go to the clinic for help.”

**Participant 1-Kameeldrift:** “I am not sure whether I can say I understand it or not because I don’t know how to explain it. I know one of the infections which is Gonorrhoea, yellow discharge, sores like cauliflower. Go to the clinic for treatment and use a condom to prevent it.”

**Participant 2-Kameeldrift:** “STI is called Jeco which is pain while having sex, I don’t know other STIs, I don’t know how they are treated or prevented.”

**Participant 6-Kameeldrift:** “You get it by having unprotected sex, one must use condom to protect yourself from STI, HIV and others, you can **treat** it by going to hospital or clinic and you can prevent it by using condom.”

All participants from the rural and urban area have common understanding that STIs are treated by going to the clinic. Participants from the rural and urban area demonstrated a lack of understanding on the types of STIs. The majority of participants reported that STIs are prevented by condom use and having one partner.

STIs represent a major public health problem, and are among the most common causes of illness, and even death, in the world and have far-reaching health, social, and economic consequences. Failure to diagnose and treat traditional infections such as gonorrhoea, chlamydia, and syphilis can have a deleterious effect on pregnancy and the new-born, for example miscarriage, prematurity, congenital and neonatal infections, and blindness. Other complications, particularly in women, such as pelvic inflammatory disease, ectopic pregnancy, infertility, and cervical cancer are large health and social problems caused by STIs (Adler, 2002:1).

Stanberry and Rosenthal (2013:4) confirm that many infections are sexually transmitted although some, including HIV and Hepatitis B and C, are also transmitted by blood or blood products. Others, like HPV and the herpes simplex

virus (HSV) can also be transmitted by close bodily contact. Stanberry and Rosenthal (2013:4) and Adler (2002:1) concur that STIs are a major cause of morbidity and mortality, with HIV causing over one million deaths per year worldwide.

### **Sub-theme 1.5: Access to a Health Care Centre**

The following quotations from the participants from the rural and urban area confirm that all participants have access to the clinic. All participants indicated that they walk to the clinic.

*Participant 1-Ivory: "Yes I have access to the clinic, I just walk to the clinic."*

*Participant 6-Kameeldrift: "Yes, it's a walking distance."*

All participants similarly agreed that they have access to health care facilities in their local area and they make use of it. The health care centres are within walking distance of both the rural and urban area. The biopsychosocial approach emphasises the role of people's behaviour and the environment, that is, access to health services in determining their health status. The biopsychosocial model focuses on the promotion and maintenance of health through socio-environmental and behaviour changes. The health care centres in both the rural and urban area provide the same services to community. There is a slight difference regarding staff compliment in these centres; there are four professional nurses, excluding the sister in charge, at Kameeldrift Clinic, whereas there are six professional nurses, excluding the Sister in charge, at Hikensile Clinic in Ivory Park. Both clinics have one doctor and social worker working at the clinic twice a week. The researcher is convinced that all participants have access to the same quality medical care.

### **Sub-theme 1.6: Family Involvement in sex education**

The *Oxford Dictionary* (2010:33) explains the concept "child rearing" as bringing children up until they are old enough to look after themselves. If you say that someone was reared in a particular way, you describe how he or she was brought up. It describes "rear" as "to care for a child or children during the early stages of life, bring up." The word "rear" is derived from Middle English "reren" which means "to lift up, raise."

Family plays a major role in shaping youth from childhood with regards to the way they socialise in life, in the environment and how to relate to others within society. Woods (2009:199) states that in the youths' development stages, informal education is managed in the safety of their homes and is family-based in their culture. The impact of family and community rituals plays a major role in shaping youths' sexual risk behaviours. The biopsychosocial approach assisted the researcher in not only exploring the biological effects of sexual risk behaviour, but also its impact on a psychological (emotional) and social (relationship) level. To be more specific, on a social level family involvement in sex education was explored, as well as attitudes experienced amongst their peers, families and the community. These ranged from support received from parents, to feelings of guilt, shame or embarrassment and hurt if they were reprimanded, punished, humiliated, isolated or labelled by family and community members when they became pregnant. The biopsychosocial approach enabled the researcher to explore the participants' experiences and their family's role in sex education. Social workers in health care fields should be aware of these experiences in order to provide potentially effective interventions using the biopsychosocial approach.

The following quotations from participants demonstrate their experience on family involvement in sex education.

**Participant 2-Ivory:** *"My mom taught me a lot about sex. I learnt from school to abstain from sex until matured enough to take care of myself."*

**Participant 4-Ivory:** *"Mom taught me about sex education from when I was doing grade 10. My maternal aunt as well and even at school they taught us. I learnt at school about the importance of protecting yourself when having sex, importance of using condom. If you can't then one must go to clinic for family planning."*

**Participant 6-Ivory:** *"My mom taught me when I was 15, when I started menstruation. She told me that I will fall pregnant if I have sex with a man and I will get infection. Yes, we benefited a lot at school, I learnt that it's not right to have boyfriend early in life and it has a lot of consequences. This affects concentration at school, can end up falling pregnant and some girls listen to friends."*

**Participant 3-Kameeldrift:** *"Yes my mom taught me about sex after I gave birth at the age of 15 years, she explained generally about life. We learnt that how one gets infected with HIV but it was a long time ago."*

**Participant 4-Kameeldrift:** *"Yes my mom taught me sex education. Yes, we learnt that one can get infected with HIV and STIs known as drop/gonorrhoea from clinic."*

**Participant 6-Kameeldrift:** *"My mom taught me about sex education from the age of 18 years. I learnt about unplanned pregnancy and STIs from school. I learnt that STI is not good for the body and you can end up with shattered dreams."*

It is clear that in both urban and rural areas parents had similar parenting styles and they view child education as their responsibility. In this study, there were more participants from rural areas who reported that they did not receive any sex education from their parents or family members.

Communication is therefore the key factor among families, peers, and the community in empowering youths to make informed decisions about sexual behaviour (Upreti et al., 2009:386), because they are exposed to so many diverse negative influences from outside the family circle. For example, peer pressure to engage in early sexual debut, pressure to use alcohol or drugs to “fit in,” pressure to have unsafe sex with multiple partners for money (DiClemente et al., 2007:889). These authors further state that one of the multiple intervention approaches is the mesosystem approach. The family is an important part of this system and DiClemente et al. (2007:892), advise that the family should make a point of knowing the whereabouts of their children and who they associate with in an attempt to protect and reduce their risk behaviours. The role of families was explored with regard to sexual risk behaviour and family involvement in sex education. The biopsychosocial approach is most suitable in assessing the role of the family and community in shaping sexual risk behaviour of youth. This approach allows parents to manage youths’ whereabouts in an attempt to shape their sexual behaviour, as this has direct impact on their biological aspect, which is pregnancy and risk of contracting HIV or cervical cancer.

Regarding the study, they conducted in Nepal, Upreti et al. (2009:386), explain that the main reason for knowledge differences about safe sexual activities and reproductive health matters among youth can be ascribed to poor informal education and fewer discussions about sexual matters among family members and adult friends of the youth in the community. Adult friends may include an older sibling, an uncle or aunt, or even a close family friend. It was suggested by the findings that rural youths have high practices of premarital sexual relations without having knowledge of the use of protective measures against STIs, including HIV and AIDS, which put them at risk of contracting these diseases (Upreti et al., 2009:386).

Pretorius (2008:33) states that the child rearing style of the parent has a significant and powerful impact on the personality development of the child. The personality of the child determines his/her behaviour and the social adaptation that the child has to utilise in different situations. Van den Berg (2004:40) stated that a girl who knows that she has parents that support her and with whom she can spontaneously communicate may be able to handle herself more assertively in unfamiliar situations and will not be predisposed to risky situations in which she is sexually exploited and more vulnerable to STIs.

Globally it is reported that 500 000 of youths are infected with STIs, including HIV and AIDS, each day. However, they are vulnerable to STIs because of their social, political, cultural, biological and economic experiences that impact on their vulnerability (WHO, 2009:2). The youth need to be informed about reproductive health and be provided with supportive environments at schools and in the community, which need to be user-friendly to prevent onset of STIs, HIV and AIDS (WHO, 2009:3). The Government of South Africa suggests that it is important to have youth specific intervention programmes, such as school-based sexual health programmes, which will empower youth and enable them to acquire skills to protect themselves from STIs, including HIV and AIDS (SANAC, 2011:7). To prevent new infections of STIs, HIV and AIDS among the teenagers who are the youths of the future, the DBE in South Africa provides reproductive health promotion information to learners from primary school phase. The introduction of LO as a subject was one of the interventions approved by the DBE (2008:1) to provide learners with knowledge about sexuality issues, including HIV. The introduction of the LO subject is acknowledged by Mulaudzi (2007:34) and Lebesse et al. (2010:34). The authors agree that abstinence must be included and promoted, while a safe environment has to be created to talk about sexual health with children and youths.

The role of school is to educate and empower female youth with rich/sound sexual health knowledge in order to help them to make informed choices. It is also to help them develop resilience so that they would make the right decisions when they face the pressures and challenges that life may bring their way. School-based health programmes are implemented in the schools to identify and treat health problems of the youth at an early stage, to address health, economic, political, and

educational issues that have impact in the life orientation of youths. Sawyer et al. (2012:1630) support this statement and add that investment in the youths' education will have benefits to youths in empowering them from primary level in the subject Life Orientation to enhance their knowledge about the reproductive system (Sawyer et al., 2012:1630). The biopsychosocial approach links here in assessing the role of the school in shaping the sexual risk behaviour of youth. The education and empowering ability of the school-based health programmes should empower female youth in order to improve their knowledge regarding the biological (pregnancy, HIV, STD's), psychological (emotional response to unplanned pregnancy or infections), and social (peer pressure, stigma) effects of youth sexual risk behaviour.

#### **3.7.1.1.1 Discussion of Theme 1**

Participants perceived the correct age to start engaging in sexual debut is 18 years or older. The participants' actual experience is different from their thoughts and views; only one participant started engaging in sex at the same age that she thinks it's the right age for a girl's first sexual encounter. Most of the participants in rural and urban areas highlighted that early sexual debut would result in unplanned pregnancy or teenage pregnancy and contraction of HIV. Participants understand that sexual risk behaviour would put them at risk of getting infected with HIV/AIDS. The majority of participants do not know what causes cervical cancer. All participants have access to a health care facility. Parents and schools assume their role to provide sex education for their children, but that does not eliminate the sexual risk behaviour that female youth engage in. There were more participants from the rural area who reported that none of their family members educated them about sex. The biopsychosocial approach is a model that seeks to address the participants holistically, in other words biological, psychological and social factors are addressed or taken into consideration when dealing with an individual or patient.

#### **3.7.2.2 Theme 2: Knowledge of preventative measures and prevention of pregnancy**

This theme focusses on participants' knowledge of pregnancy and STI prevention methods. The following sub-themes were generated:

- Purpose of using contraceptives
- Understanding the importance of using condoms

### **Sub-theme 2.1: Purpose of using contraceptives**

The participants were asked to share their reasons or purpose of using contraceptives and their views are displayed in the following quotations:

**Participant 1-Ivory:** *“To prevent pregnancy, sexually transmitted infections and HIV/AIDS infection.”*

**Participant 3-Ivory:** *“To prevent pregnancy and I double it with using condom.”*

**Participant 4-Ivory:** *“To prevent unplanned pregnancy when still studying, want to complete studies and work then I will want a child.”*

**Participant 2-Kameeldrift:** *“To prevent pregnancy.”*

**Participant 3-Kameeldrift:** *“I use it only to prevent pregnancy.”*

**Participant 4-Kameeldrift:** *“To prevent pregnancy, because I want progress in life and be successful.”*

In light of the above quotations all participants use contraceptives to prevent pregnancy. They view pregnancy as a stumbling block that would prevent them from achieving their goals. The consequences of young people’s sexual behaviour when not using contraception have become a global issue mainly because it is associated with pregnancy and STIs (Turnbull, 2010:78). The Department of Education spokesperson, Mr Charles Matlane (2013), reported that 4 800 female learners became pregnant in 2010 and 4 200 learners became pregnant in 2011 in Gauteng, South Africa. According to Bayley (2003:832), youths are twice as much likely to die from pregnancy-related health complications, such as excessive bleeding and uterine infections like myometritis. It is critical to mention that pregnancy among youths could be a function of sexual risk behaviours, such as unprotected sex and early sexual initiation (Damtie, 2013:5). In this study, protection against HIV/AIDS did not come through strongly.

### **Sub-theme 2.2: Understanding the importance of using condoms**

According to the survey conducted by loveLife in 2011, in South Africa, when youth were asked about the frequency of condom use with their main partners, casual partners and transactional partners, the results show inconsistent use between genders and between different types of partner. In the survey, of those who had had sex, 94.2 percent of young people had ever used a condom and this was slightly higher among men (96.6 percent) than women (91.8 percent). When asked about condom use with their latest regular partner, 85.3 percent of men and 80.4 percent of women used a condom during their most recent sexual encounter. Among those with non-regular or casual partners, this increased to 97.5 percent amongst men and 80.8 percent amongst women (Swartz et al., 2011:9).

Condom use with transactional partners is very low, with two thirds of young people (61 percent) reporting never using condoms when having transactional sex. More women (62 percent) than men (60 percent) report always using condoms with their transactional partners. This inconsistency is of great concern to loveLife. Programmes need to be targeted directly at young people who have transactional relationships. Further analysis needs to be done to understand what the characteristics of these relationships are and which people engage in them (Swartz et al., 2011:9).

The following quotations from the participants from the rural and urban area reflect participants' view on condom use.

**Participant 1-Ivory:** "I understand that it protects against HIV, STIs, HPV and any other sickness, it also prevents pregnancy."

**Participant 3-Ivory:** "Prevents HIV, STIs, HPV and it prevents pregnancy as well."

**Participant 4-Ivory:** "I understand because I protect myself from HIV, STIs. Protects from pregnancy. Yes, it does prevent HPV infection."

**Participant 1-Kameeldrift:** "It is important you have to use it. You have to use with the partner all the time. I use it all the time until testing for HIV and get confirmation."

**Participant 4-Kameeldrift:** "I understand because you prevent or protect yourself from different infections, I want to live a normal life so condom prevents AIDS, drop and many other infections."

**Participant 5-Kameeldrift:** "I understand because you prevent or protect yourself from different infections including HIV."

**Participant 6-Kameeldrift:** "I understand the importance because I protect myself from HIV and STIs."

It is clear that participants from both rural and urban areas understand the importance of condom use and some participants acknowledged that they use condoms. Protection against HIV came through as the main reason. Multiple sexual partnerships are high-risk sexual behaviours because of their tendency to increase the risk of HIV transmission through sexual networks (Berry & Hall, 2009:97).

#### 3.7.1.1.2 Discussion of Theme 2

It is therefore important to know the extent to which youths are engaging in multiple sexual partnerships. All participants use contraceptives to prevent pregnancy. They view pregnancy as a stumbling block that would prevent them from achieving their goals. It is clear that participants from both rural and urban areas understand the importance of condom use and some participants acknowledged that they use condoms. STDs are often associated with sexually active youths with multiple

sexual partners. In agreement, Astatke (2000:63-83) asserted that 9.2 percent of sexually active youth reported STDs and this was attributed to scholars' frequent contact with commercial sex workers and the use of multiple sex partners. This links up with the biopsychosocial approach which takes into consideration participants' or people's cultural background (social) and exposure which influence sexual risk behaviour. This approach allowed the exploration of sex education which result in female youths making informed choices (psycho), such as condom use and protection from HIV infection (bio). This approach is appropriate in assessing the sexual risk behaviour female youths in order to make recommendations for interventions that would address it.

### 3.7.2.3 Theme 3: Sexual risk behaviour

This theme focusses on the nature of the sexual risk behaviour that participants engaged in. The following sub-themes were generated for this theme:

- Multiple sexual partners, transactional and intergenerational sex
- Unprotected sex: nature of sexual behaviours, e.g. casual sex or substance use

#### **Sub-theme 3.1: Multiple sexual partners, transactional and intergenerational sex**

The participants were asked the following question: Did you ever have multiple sexual partners or concurrent sexual partners? The following quotations are participants' responses to the exploration of whether they engage in multiple sexual partners or not:

**Participant 2-Ivory:** "Yes when I started dating I had multiple sexual partners. Yes I had overlapping sexual partners but not at the same time, because I'll date a guy for a while then after two months I'll date another one."

**Participant 6-Ivory:** "Yes, last year."

**Participant 2-Kameeldrift:** "Yes I did, I had multiple sexual partners and concurrent sexual partners."

**Participant 4-Kameeldrift:** "Yes, I have multiple sexual partners but do not have concurrent or overlapping partners."

**Participant 6-Kameeldrift:** "Yes I once had them, yes I had concurrent sexual partners."

In view of the above, risky sexual behaviours are reported more by participants in rural areas than participants from urban areas. Only two participants from the urban area admitted to sexual risk behaviour, such as multiple or concurrent sexual

partners. Rising rates of premarital sexual activity, escalating numbers of unmarried women terminating unplanned pregnancies, and an increasing prevalence of HIV infection and other STIs among youths are critical as they are related to risky sexual behaviours, such as unprotected sex (Mensch et al., 1998:250). Unprotected sex is related to an increased potential of contracting STDs and unwanted pregnancies (Kost & Henshaw, 2012:2). Approximately 19 million STD cases in South Africa were diagnosed in 2012, and 13 percent of these cases were youth aged between 13 and 24 with HIV/AIDS (Kost & Henshaw, 2012:2). These infection cases were in the main attributed to unprotected sex. It is important to re-state that unprotected sex is a significant contributory factor to the rising global rate of teenage pregnancy (Damtie, 2013:14). This has huge implications relating to youths dropping out of school and thus having a lowered level of educational achievement. Unprotected sex is also closely associated with alcohol and substance use. Data obtained from a study conducted among youths in Southern Africa confirm this. The data revealed that drunkenness tends to reduce the likelihood of men using condoms with their steady partners, as well increase their potential of engaging in sexual relationships with multiple partners (Kiene & Subramanian, 2013: 583). During the data analysis process the following sub-themes were formed out of these views: poverty that leads to transactional sex and intergenerational sex, and the nature of sexual behaviours, e.g. casual sex or substance use.

In defining transactional sex, the researcher did not attempt to disentangle the complex motivations for sexual intercourse within primary partnerships, but instead focused on transactions only within relationships with roll-ons and once-off sexual partners on the presumption that such liaisons would be more likely than main partnerships to be primarily motivated by material or financial considerations. Transactional sex was thus defined as sex with a roll-on or once-off which was motivated by material gain. It was assessed by asking the following: “Have you ever become involved with a roll-on/*nyatsi/makwapheni* because he provided you with or you expected that he would provide you with” any of a list of commodities: food; cosmetics; clothes; transportation, tickets or money for transport; items for children or family, such as clothes, food or school fees; your own school or residence fees; somewhere to sleep; or cash? A similar question was asked in relation to once-offs, although the items regarding children and school fees were omitted from the list, as

these items are generally only transacted in on-going relationships. About 27.5 percent of the population admitted to having transactional sex in a study by Jewks et al. (2004:1581–1592).

The participants of this study were asked to share their views/perceptions on the reasons why they engage in risky sexual practices like transactional or intergenerational sex. They shared the following views:

**Participant 3-Ivory:** “I have transactional sexual partners but never had intergenerational sex partners.” **Reasons for engaging in risky sex practices are:** “I had that in order to get dentist treatment and for him to buy alcohol for me.”

**Participant 4-Ivory:** “I have never done those.” **Opinion on reasons for engaging in risky sex practices are:** “I think it’s peer pressure, they do not listen to parents when they talk to them, when a friend has something she doesn’t have and she needs it, when you are suffering in your home/poverty, she can decide to have sex with older people in order to get money to do hair, expensive clothes, have pocket money for school.”

**Participant 5-Ivory:** “No I never had transactional sex, but I had sex with someone who is eight years older than me.” **Opinion on reasons for engaging in risky sex practices are:** “It’s peer pressure, influence from friends, want money to buy clothes.”

**Participant 2-Kameeldrift:** “No I have no one like that, I had intergenerational sex partner.” **Reason for engaging in risky sex practices are:** “Dysfunctional families, no love at home and influence from friends.”

**Participant 4-Kameeldrift** “I had none of those.” **Reasons for engaging in risky sex practices are:** “A girl that is after money, some girls are easily influenced, dysfunctional family, because of poverty they get boyfriends to buy food.”

**Participant 6-Kameeldrift:** “Yes I had transactional sex at school, yes I had intergenerational sex partner, he did some favours, buying me clothes, giving me money and food.” **Reason for engaging in this:** “I think its peer pressure, when your friend has All Star Tekkies and you need it, when you are suffering in your home/poverty at home, when there is no money for you to go to school and when there is no one who is working/unemployment.”

In this research, young girls from both rural and urban areas reported that they have engaged in transactional sex and they view it as a means to combat poverty. The main thing that came out of this sub-theme was that peer pressure and poverty leads to young women engaging in risky sexual behaviour, namely transactional sex and intergenerational sex.

According to a report on sex workers (Kaiser Family Foundation, 2001:25), it was found that 52 percent of the clients that visit sex workers prefer girls 18 years and younger. This need arises from the myth that sexual intercourse with a virgin can cure AIDS and that young girls are perceived to be healthy and not infected with HIV/AIDS.

The low level of income (salaries) of especially black parents (Hartell, 2000:45), unemployment, long illness, death, and the fact that financial support is not easily obtained makes the nuclear family even more vulnerable with regard to economical sustainability. The biopsychosocial approach looks at the social element regarding the reason why participants engaged in risky sexual behaviour, such as transactional sex. Poverty is a social problem that was stated by participants as the reason they engage in it. This has serious repercussions, such as the risk of contracting HIV and HPV that causes cervical cancer (bio). This approach serves to be the most appropriate approach as it deals with the consequences of risky sexual behaviour while participants are not judged, but assessed and assisted as a whole by not only focusing on one element such as the biological or physical effect (STIs), but rather investigating the root cause, which is transactional sex caused by poverty which may have psychological effects on youth (psycho) due to the consequences of transactional sex. In this regard, a young girl may be vulnerable to HIV infection, as it may be expected that the girl within the family has to contribute to the financial welfare of the family (social). The girl may then resort to risky or harmful sexual behaviour, such as prostitution or drug dealing, in order to support her family. The girl may also be sold to older men in order for her parents and family to secure an income. According to United Nations Programme on HIV/AIDS (UNAIDS, 1999:2), the main reason for girls entering the sex industry is to satisfy their parents' urgent need for money and material goods, and the survival of the family. The researcher is of the opinion that proper poverty alleviation programmes should be in place in order to address the above-mentioned problem. Poverty seems to disempower the child caught up in its cycle and that may lead to situations such as coercive sexual practices or transactional sex. Young girls end up making it their responsibility to provide for them where their parents lack.

### **Sub-theme 3.2: Unprotected sex: Nature of sexual behaviours, e.g. casual sex or substance use**

Sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. It is often broadly defined as the social construction of a biological drive (WHO, 2002:23), which often deals with issues

such as whom one has sex with, in what ways, why, and under what circumstances, and with what outcomes a person engages in sex (Maticka-Tyndale et al., 2007:67).

It is important for the researcher to list the explored nature of sexual risk behaviours as it is one of the objectives of the study. The participants' quotations are as follows:

**Participant 1-Ivory:** "I never had that." **Nature of sexual behaviours participant has ever been involved in is:** "I had unprotected sex with one partner, but I am using condom now."

**Participant 2-Ivory:** "I never had that." **Nature of sexual behaviours participant has ever been involved in is:** "Unprotected sex with one partner."

**Participant 4-Ivory:** "I don't have casual sex partner/s." **Nature of sexual behaviour participant has ever been involved in is:** "I do not use condom every time I have sex."

**Participant 5-Ivory:** "I never had that." **Nature of sexual behaviours participant has ever been involved in is:** "I have one partner and we use condom, but not every time we have sex."

**Participant 2-Kameeldrift:** "I never had that." **Nature of sexual behaviours participant has ever been involved in is:** "Unprotected sex with one partner."

**Participant 3-Kameeldrift:** "I never had that, I am still dating my first boyfriend." **Nature of sexual behaviours participant has ever been involved in is:** "Unprotected sex with one partner."

**Participant 4-Kameeldrift:** "No, I do not have casual sex partner/s." **Nature of sexual behaviours participant has ever been involved in is:** "Unprotected sex with one partner."

All participants from rural and urban areas reported that they have engaged in unprotected sex or inconsistent condom use. Unprotected sex is related to an increased potential of contracting STDs and unwanted pregnancies (Kost & Henshaw, 2012:2). The use of condoms is often viewed as an insult and proof of distrust. It is regarded as an indication that the person using it or requesting its use probably already has a STD (Le Roux, 2002:266).

### 3.7.1.1.3 Discussion of Theme 3

Risky sexual behaviours were reported more by participants in rural areas than participants from urban areas. In this research, young girls from both rural and urban areas reported that they have engaged in transactional sex and they view it as a means to combat poverty. The main thing that came out of this sub-theme was that peer pressure and poverty leads to young women engaging in risky sexual behaviour, namely transactional sex and intergenerational sex. All participants from rural and urban areas reported that they have engaged in unprotected sex or inconsistent condom use.

When the social and cultural norms within a society sustain the man's right to determine the type and timing of sex, girls and women may be disempowered from negotiating safer sex practices such as condom use, and consequently be vulnerable with regard to HIV/AIDS infection (UNAIDS, 2001:24). This links up with the biopsychosocial approach, because it allows the exploration of sexual risk behaviour (social) and cultural norms within a society that sustains the man's rights in relation to decision making about sex (psycho), versus the inability of female youths to make informed choices such as condom use and protection from HIV infection (bio). This approach is appropriate in assessing the sexual risk behaviour of female youths in order to make recommendations for interventions that would address it. Social workers in health care should be aware of the above aspects in order to assist the clients by empowering them to negotiate safer sex practices.

#### **3.7.2.4 Theme 4: Consequences of risky sexual behaviour**

This theme focusses on the consequences of risky sexual behaviour as reported by participants. The following sub-themes were generated from this theme:

- Understanding of the consequences of risky sexual behaviour, unplanned pregnancies, and HIV infection.
- School drop-out as a result of challenges experienced in participant's role as a learner, mother, and partner.
- Lessons learnt while dealing with effects of risky sexual behaviour.

#### **Sub-theme 4.1: Understanding of the consequences of risky sexual behaviour, unplanned pregnancies, and HIV infection**

The consequences of young people's sexual behaviour when not using contraception have become a global issue mainly because it is associated with pregnancy and STIs (Turnbull, 2010:78). The researcher's focus was establishing whether there is a difference in behaviour amongst rural and urban girls, what are the factors influencing that difference, and their understanding of the impact of risky sexual behaviour in future.

Participants were asked to share their experience and perceptions on the consequences of risky sexual behaviour. Participants' perceptions and actual experience were as follows regarding the above:

**Participant 2-Ivory:** “Firstly you would get HIV and you wouldn’t know where you got it from, then you discover that you are pregnant and you wouldn’t know who the father is.”

**Participant 3-Ivory:** “Can get pregnant and not know the father of the baby and can get Sexually Transmitted Infections.”

**Participant 5-Ivory:** “They end up getting sick or something or pregnant and they don’t know where the father of the child. They might get infected with HIV and not know who infected them, Baby might get sick (infected with HIV).”

**Participant 6-Ivory:** “They end up getting sick, they get HIV infection, STI and Cervical Cancer.”

**Participant 1-Kameeldrift:** “Pregnancy without knowing the father of the baby, might contract sexually transmitted infections. Family will confront you and they will not help you with the baby.”

**Participant 2-Kameeldrift:** “I understand that I will get infected with HIV and become pregnant not knowing the father of the baby.”

**Participant 6-Kameeldrift:** “Yes I know its unplanned pregnancy and I might get Sexually Transmitted Infections.”

The above views from participants in both rural and urban areas clearly reflect that they are aware of the consequences of risky sexual behaviour. All participants are equally aware of consequences of risky sexual behaviour and mentioned unplanned pregnancy and the risk of getting STIs, including HIV.

The family is responsible for its own source of revenue; the nuclear family is dependent on one or two people for fulfilling the economic needs of the family. In times of unemployment, illness or death, there is no extended family to give support and the nuclear family might fall into economic distress. The low level of income (salaries) of especially black parents (Hartell, 2000:45), unemployment, long illness, death, and the fact that financial support is not easily obtained makes the nuclear family even more vulnerable with regard to economical sustainability. In this regard the young girl may be vulnerable to HIV infection, as it may be expected that the girl within the family has to contribute to the financial welfare of the family. The girl may then resort to risky and harmful sexual behaviour (bio), such as prostitution or drug dealing, in order to support her family (social). The girl may also be sold to older men in order for her parents and family to secure an income.

Socio-demographic characteristics, particularly gender, location, and age, are significantly correlated with sexual and preventative behaviours (Gebregiorgis, 2000:7). It is therefore important to explore these factors in research studies, as engaging in sexual risk behaviours could result in negative consequences. For example, sexual risk behaviours could lead to unwanted pregnancy, which in turn has negative implications.

The role of families was explored with regard to sexual risk behaviour and family involvement in sex education, including the family's economic needs. The biopsychosocial approach, which is a holistic approach, looks at the biopsychosocial impact of the participants' behaviour, experiences and consequences of sexual risk behaviour that in-turn affect their families, thereby determining the need for interventions. This approach serves to be the most suitable in assessing the role of the family, as well their needs which influence the sexual risk behaviour of the female youth. Social workers in the health field should provide families with the necessary resources in order to enable them to actively promote the well-being of participants under all circumstances or family adversities.

According to UNAIDS (1999:2), the main reason for girls entering the sex industry is to satisfy their parents' urgent need for money and material goods, and the survival of the family. Many parents may decide to sell their daughters and earn quick money to provide for their family's immediate needs. With weaker family ties and often less family support, girls have become common targets for recruitment into sex work, through either force or deception (UNAIDS, 1999:2).

#### **Sub-theme 4.2: School drop-out as a result of challenges experienced in participant's role as a learner, mother, and partner**

Participants were asked to share their challenges experienced in their role as a daughter, learner and partner. The quotations were as follows:

**Participant 1-Ivory:** "I left school because of my age. I am 20 years old and was still in grade 11. Boyfriend is pressurising me to have a child."

**Participant 5-Ivory:** "Yes, I couldn't concentrate in class because I was worried about child, and the father doesn't contribute at all. I had challenges of how I will be able to provide for the child. I had to drop out of school so that I can take care of her."

**Participant 6-Ivory:** "I failed in class because I couldn't concentrate. I was always worried about my baby's father. I was always thinking about the fact that I got pregnant at young age. It was difficult."

**Participant 1-Kameeldrift:** "I fell pregnant at age 15 doing grade 10. Dropped out of school, but went back after birth. I then faced problems when mother moved to Limpopo and I had no one to help with child. I had to leave school and look after my child."

**Participant 3-Kameeldrift:** "The only problem was dropping out of school, but boyfriend was very supportive, I never struggled with the child."

**Participant 4-Kameeldrift:** "The only problem was dropping out of school, my mother did not like it, she was always shouting at me."

**Participant 6-Kameeldrift:** "Treatment is no longer the same at home, my role has changed because I wanted to study further but I had to dropped out of school."

There is a significant difference in education between rural and urban female youth regarding the challenges experienced as a learner, mother and partner. Only two participants dropped out of school in the urban area, while four participants dropped out of school in the rural area.

Unwanted pregnancy has been noted in the literature to contribute to youths dropping out of school and the development of illnesses and even death associated with abortion and STDs, including HIV/AIDS (Bayley, 2003:832-843).

An analysis of Cape Area Panel Study (CAPS, 2002) data found that the prevalence of teenage childbearing in the Cape metropole was similar (22 percent) to the national average (25 percent), and lower than in the rural sample. In contrast to the rural sample, teenage mothers in the Cape metropole had different pre-birth characteristics to their peers and were likely to have had poor educational outcomes even if they had not given birth. However, teenage childbearing still had a significant impact on their performance at school. Teenage mothers in the Cape metro were one third of a grade behind their peers by age 20, 6 percent less likely to matriculate by age 20, and 16 percent more likely to drop out (SALDRU, 2008:4).

Similar to the rural study, younger teenage mothers were found to be particularly at risk of poorer educational attainment, although they were no more likely to drop out than older teen mothers. Younger teenage mothers were two grades behind, 12 percent less likely to matriculate, and 11 percent more likely to drop out (Leibbrandt et al., 2008:4).

Analysis of data from the National Income Dynamic Study in 2008 shows that teen childbearing clearly contributes to school drop-out, but that it is not the only reason girls leave school prematurely (Ranchhod et al., 2011:13).

Van Rooyen and Hartell (2001:17) state in this regard that learners are in desperate need of the guidance of trained and understanding educators with regard to sensitive issues such as sexual maturation and the coupled rise of the sex urge during puberty, sexual activity as to abstinence, safer sex, masturbation, contraception, and the role of values in responsible decision-making. A trained and motivated educator, who aims to prevent the learner from becoming infected with

HIV and minimise the vulnerability and defencelessness which may expose the teenagers to HIV infection during risky circumstances, can successfully address these issues (Van Rooyen & Hartell, 2001:17).

### **Sub-theme 4.3: Lessons learnt while dealing with effects of risky sexual behaviour**

The participants were asked to share lessons learnt while dealing with effects of risky sexual behaviour. Their responses were as follows:

**Participant 1-Ivory:** *“To avoid regrets, I learned that I must get tested before I engage in sexual intercourse and get contraceptives.”*

**Participant 4-Ivory:** *“No lessons learnt.”*

**Participant 5-Ivory:** *“I have to always use condom for protection, and also prevention (family planning) and take care of myself. It is important to abstain from sex at a young age.”*

**Participant 6-Ivory:** *“I learnt that I must study, stop dating and stop partying.”*

**Participant 1-Kameeldrift:** *“I learnt that it’s not right to have unprotected sex when young, don’t get pregnant before planning your future and that looking for a job at young age is not easy.”*

**Participant 2-Kameeldrift:** *“No lessons learnt.”*

**Participant 3-Kameeldrift:** *“Learnt that as a girl/woman it is better to have one partner, trusting each other, can go to clinic together and check your status and live right.”*

**Participant 6-Kameeldrift:** *“I learnt that as a young person focus on school and avoid boyfriends, because they will destroy your life.”*

Based on the above statements made by participants from rural and urban areas, it is noted that real life lessons have been learnt while dealing with effects of risky sexual behaviour. Participants from the rural area presented with clear lessons, while only one participant reported nothing learnt. In contrast to participants from the rural area, two participants from the urban area reported no lessons learnt while dealing with effects of risky sexual behaviour. When combining this with the level of school drop-outs, those who reported no lessons learnt are still in school while those who reported lessons learnt have either dropped out of school or are a grade or two behind their age group.

According to WHO (2002:29), behaviour cannot be changed by knowledge alone, as teenagers need the skills to put what they learn into action. Skills in negotiation, conflict resolution, critical thinking, decision-making, and communication are vital for teenagers, to enable them to relate to each other as equals, working in groups, building self-esteem, resolving disagreements peacefully and resisting both peer and adult pressure to take unnecessary risks (WHO, 2002:29).

#### **3.7.1.1.4 Discussion of Theme 4**

The key findings were as follows: all participants in both rural and urban areas are equally aware of the consequences of risky sexual behaviour and mentioned unplanned pregnancy and the risk of getting STIs, including HIV. There is a significant difference in education between rural and urban female youth regarding the challenges experienced as a learner, mother and partner. Only two participants dropped out of school in the urban area, while four participants dropped out of school in the rural area. Real life lessons have been learnt while dealing with effects of risky sexual behaviour. Participants from the rural area presented with clear lessons, while only one participant reported nothing learnt. In contrast to participants from the rural area, two participants from the urban area reported no lessons learnt while dealing with effects of risky sexual behaviour.

In using the biopsychosocial approach, sexual risk behaviour and participants' experiences and lessons learnt while dealing with the consequences of sexual risk behaviour guided an adoption of a comprehensive approach to the research. Thorough exploration and assessment of life lessons could be used to create awareness in order to combat the sexual risk behaviour amongst youth. Social workers in the health field need to recognise this aspect in order to provide appropriate support services to female youth to prevent pregnancy or to prevent school drop-outs.

#### **3.7.2.5 Theme 5: Attitude experienced as a result of consequences of risky sexual behaviour**

This theme focuses on the attitude experienced as a result of consequences of risky sexual behaviour. The following sub-themes were generated:

- Changes in the attitudes of community / family
- Changes experienced in the attitudes of peers / school and friends / family

##### **Sub-theme 5.1: Changes in the attitudes of community / family**

Participants were asked to share their experience regarding the attitude experienced from community and family members as a result of consequences of risky sexual behaviour. The participants' responses were as follows:

**Participant 1-Ivory:** “Adults were reprimanding me for having a boyfriend, they will tell me I am no longer a child now, they will pass negative comments because I dropped out of school and they will gossip about me.”

**Participant 5-Ivory:** “They did not treat me well, they complained about my pregnancy at my age and always had rude remarks.”

**Participant 6-Ivory:** “They did not treat me well, they complained about my age and the fact that I was pregnant and always had rude remarks as if I was promiscuous. They think I am going to influence their children to fall pregnant. Some of them make fun of me.”

**Participant 1-Kameeldrift:** “They talk about you are no longer a child, they talk about the fact that you dropped out of school. They look at you amazed at pregnancy, most of community members gossip, they don’t tell you in your face.”

**Participant 3-Kameeldrift:** “They were very rough at home, some community members used to shout at me especially my mother, but I decided not to walk around I was embarrassed because community gossiped about me.”

**Participant 4-Kameeldrift:** “I experienced bad treatment by community, some community members did not want me, acting bad towards me, they used to shout at me.”

The general experience of the participants was bad treatment as well as bad remarks from community and family members. This made participants’ parenting life difficult for them.

The modern family finds itself in a society characterised by rapid technological, industrial, economic, and social changes (Hartell, 2000:38). These changes, which often have a negative influence on the family, can disturb the educational climate in many families. Pretorius (2008:63) states that there are numerous factors, such as poverty, community unrest and unemployment, hampering modern family life. The modern family is subjected to changes that impede and complicate the role and responsibilities of parents in such a way that the parents neglect their educational responsibility or transfer it to others.

The view of teenage pregnancy and motherhood as something that is problematic also lies at the heart of much mainstream social policy research. These studies often rely on statistical evidence to highlight the link between teenage pregnancy and consequent poor outcomes for both mother and child. For instance, it has been found that teenage parents are more likely not to finish their education and more likely to bring up their children alone in poverty (Dennison, 2004:78; Hobcraft & Kiernan, 2001:42).

Teenage mothers and their children are also believed to be at an increased risk of poor health outcomes, including a 60 percent higher rate of infant mortality, a 25 percent increased rate of low-birth weight babies, and three times the rate of

postnatal depression (SEU, 1999:103). There is also evidence that daughters of teenage mothers have a higher chance of becoming teenage mothers themselves (Ermisch & Pevalin, 2003:29; Hobcraft & Kiernan, 2001:12), leading, it is argued, to a cycle of disadvantage where social exclusion is passed down from one generation to another. Overall this research data has been used to support the argument that teenage pregnancy not only requires policy intervention, but preventative measures to stop it occurring in the first place (SEU, 1999:63).

The consequence of complex and dynamic changes in society is that it becomes more difficult to adequately educate children. The child experiences childhood in a changing world as traumatic, since the world and society tend to be hostile toward children and this hostility may threaten the child's development towards adulthood (Hartell, 2000:38).

This links up with the biopsychosocial approach which emphasises that social factors such as poverty, community unrest, and unemployment have a direct impact on the youths' behaviour which in turn affects their biological (health or risk of infections), psychological (emotional response to treatment by community members) and social factors. Social workers in the health field should provide families with the necessary resources or empower families in order to enable them to appropriately assume their educational responsibility towards their children.

### **Sub-theme 5.2: Changes experienced in the attitudes of her peers/school and friends/family**

Le Roux and Smit (2002:91) are of the opinion that the decline of intimate family relationships spells isolation and estrangement for the teenager, which result in feelings of loneliness. The teenager may deal with these feelings of loneliness or protest by conforming to the peer group, and this may have a negative influence on the child. The child that is searching for intimate relationships and may be sexually exploited, or commit to drug or alcohol abuse or other harmful practices, such as sexual risk behaviour. For the purposes of this sub-theme, participants below shared common experience on how their peers treated them while dealing with the effects of sexual risk behaviour, such as pregnancy.

**Participant 1-Ivory:** “There were no changes with my peers. **Family** reprimands me.”

**Participant 2-Ivory:** “There were no changes when friends heard that I was dating sugar daddy, peers were encouraging me to stick with my sugar daddy and ask for expensive hairstyle and designer clothes.” **Family:** “My mother would ask me why don’t I get money from my sugar daddy, my mother was very disappointed and harsh.”

**Participant 4-Ivory:** “No changes, friends say I think I’m better because I do not have a child. Friends attitudes is bad; they want me to do same things they do. They want me to have a child like them. They will influence you to date taxi drivers. That is why I decided to have one friend and we do things together. I am avoiding bad influence as mentioned.” **Family:** “There are no changes.”

**Participant 1-Kameeldrift:** “No changes some of the friends also have kids. **Family** have comments and questions regarding why I dropped out of school, even now they still ask me why I am not at school.”

**Participant 3-Kameeldrift:** “Leaners used to laugh/tease at me and I initially went to school while I was not aware of my pregnancy and I decided to drop out of school when I found out. Friends were supportive.” **Family:** “Mother used to shout at me.”

**Participant 5-Kameeldrift:** “Classmates were okay they treated me same way. I no longer go out with friends because I have a child now, I have to take care of the baby. **Family** is supportive no changes.”

The above statements from participants clearly state that peers support each other, while some family members do not provide the necessary support.

Pretorius (2008:184) states that absence of guidance towards purposeful leisure time spending may lead to the youth declining into idleness, boredom and loneliness. Some youths may participate in undesirable activities such as drug abuse and sexual experimentation under the strong influence of peer pressure. The young girl with inadequate guidance towards positive spending of leisure time may then be tempted to spend her leisure time under the influence of negative societal factors that may place her in situations such as sexual experimentation in which she becomes more vulnerable to STIs, including HIV/AIDS. This links up with the biopsychosocial approach which takes into account people’s biological, psychological, and social factors that influence their behaviour. This reinforces the importance of social workers working in health care to understand the social background of clients as well as where the client is in order to appropriately address their needs.

#### 3.7.1.1.5 Discussion of Theme 5

The general experience of the participants was bad treatment, as well as bad remarks from community and family members. This made participants’ parenting life difficult for them. Curran et al. (2013:43), state that policy that has been

developed in response to a problem can be received as positive and even life-changing, and that society can learn from policy implementation that has successfully supported young parents. Participants from both rural and urban areas reported that peers support each other while some family members do not provide the necessary support. Family members were vocal about their feelings regarding the pregnancy and/or school drop-out. While one of the participants from the urban area reported that classmates used to tease her about her pregnancy, she further reported that her friends were supportive. This links up with the biopsychosocial approach which takes into account people's social factors that influence their behaviour. The peer pressure is also temporarily ordered by major sources of influence developmentally as the child matures. Family factors are primary and earliest in their sustained impact on the infant and youth. As the child matures and goes to school, school and community environmental factors have more impact. Eventually peer influences predominate, becoming the final common pathway to sexual behaviour in youth. This reinforces the importance of social workers working in health care to implement the biopsychosocial approach so as to understand the clients holistically, as well as where the client is in order to appropriately address their needs. Peer pressure contributes to sexual risk behaviour, which has a psychological impact that affects the level of social functioning or acceptance of the participants.

### **3.8 SUMMARY**

In this chapter attention was given to the research methodology and findings, as well as literature supporting the findings. The themes generated from this research included: knowledge of female youth regarding reproductive health, knowledge of preventative measures and prevention of pregnancy, sexual risk behaviour and exploration of multiple sexual partners or concurrent partners, consequences of risky sexual behaviour and attitudes experienced as a result of consequences of risky sexual behaviour. All themes generated were supported with quote from the interviews, substantiated with literature and where possible linked with the biopsychosocial approach underpinning this study.

In the next chapter the researcher will be discussing the conclusions and recommendations drawn from the study.

## **4. CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS**

### **4.1 INTRODUCTION**

In this chapter the focus will be on how the objectives for this study were met and the conclusions arrived at on the basis of the research findings presented in the previous chapter. The recommendations for practice and for future research will also be presented.

### **4.2 SUMMARY**

#### **4.2.1 Goal and objectives**

The goal of the research was to explore and describe the nature and consequences of risky sexual behaviour of female youth in rural and urban areas. The goal was met through achieving the following objectives as discussed below.

The objectives of the study are:

#### **To explore the knowledge of female youth regarding reproductive health in rural and urban areas**

This objective was addressed in the empirical study in Chapter 3, section 3.7.2.1. The majority of participants from both rural and urban areas displayed limited understanding or knowledge of female reproductive health. In their views, the correct age for female youth to start engaging in sex was between 2 and 5 years older than the actual age at which they themselves (participants in this study) had sex for the first time. This was addressed in Chapter 2 in the section focusing on the consequences of risky sexual behaviour, where the following sub-sections were covered: STIs; teenage and youth pregnancies; impact on mother's education; impact on children's health and education; carcinoma of the cervix; and HIV and AIDS.

#### **To explore the nature of risky sexual activities of female youth in rural and urban areas**

This objective was achieved in Chapter 2, section 2.2 and in the empirical study in Chapter 3. In the literature discussion the researcher presented various risky sexual activities, such as unprotected sex, multiple sexual partners, concurrent/overlapping

partners, early sexual initiation, inconsistent condom use, and transactional sex. In the empirical study, all participants in urban and rural areas acknowledged that they engaged in at least one or more risky sexual practices, such as unsafe sex and or inconsistent condom use.

**To contrast the nature of risky sexual behaviour of female youth in rural and urban areas**

This objective was met in the empirical study as documented in Chapter 3, in section 3.7.2.3. All participants from rural and urban areas acknowledged that they were either currently engaging in risky sexual behaviours as listed in Chapter 2, section 2.2 namely unprotected sex, multiple sexual partners, concurrent/overlapping partners, early sexual initiation, inconsistent condom use and transactional sex, or they had engaged in these risky sexual behaviours in the past. In terms of Chapter 2, the literature review, the researcher documented that there was no study that was done in the past in South Africa to compare and contrast the nature of sexual risk behaviour in both rural and urban areas. Empirical studies documented were either conducted in rural areas or urban areas. As listed in the objective above, the researcher concluded that there was no major difference in the nature of risky sexual behaviour between rural and urban female youth.

**To explore the understanding of female youth regarding the nature and consequences of youth risky sexual behaviour in rural and urban areas**

This objective was addressed in Chapter 2, section 2.2 and 2.3 and in the empirical study as documented in Chapter 3, section 3.7.2.4. Although the majority of participants denied engaging in some risky sexual behaviours, they all (participants from rural and urban areas) admitted that they had engaged in one or more risky sexual behaviour, such as unprotected, intergenerational or transactional sex, as well as multiple sexual partners. Participants reported the following consequences: STIs including HIV infection, unplanned pregnancy, and dropping out of school. They reported fear of contracting the above-mentioned conditions.

**To make recommendations for improved sex education as a preventative measure for female youth against risky sexual behaviour**

This objective has been met in the empirical study in Chapter 3 and in Chapter 4. It was concluded that sex education at home by parents or guardians should be

encouraged in all family settings and parents would benefit from parenting skills in order to equip them to parent teenage children or youth. In this chapter recommendations are made for policy and for practice with regards to the review of existing policies such as the Choice on Termination of Pregnancy Act (No. 38 of 2004), as well as employment of more social workers in health care centres in order to address the challenges that youth of today face.

#### 4.2.2 Research question

The research question in the context of this study was:

**Do female youth in urban and rural areas have insight regarding the nature and consequences of their risky sexual behaviour?**

This research question has been met through the themes and sub-themes that emerged from the study answering the question.

This section will discuss the themes, sub-themes, and categories as they emerged from the analysis of data collected (De Vos et al, 2011:410). The findings were subdivided into five themes. These themes and sub-themes were discussed in Chapter 3.

**Table 4.1: Themes and sub-themes**

| Themes  | Sub-themes  | Categories                                    |
|---|---|---|
| <b>Theme 1</b><br>Knowledge of female youth regarding reproductive health | Opinion on right age for first sexual encounter versus actual age at first sexual encounter | Raising awareness on STIs, including HIV/AIDS |
|   | Understanding the effects of early sexual debut   |   |
|   | Understanding causes of cervical cancer   |   |
|   | Understanding of STI prevention and treatment   |   |
|   | Access to a Health Care Centre  |   |



| Themes   | Sub-themes  | Categories  |
|--|---|---|
|  | Family involvement in sex education   |   |
| <b>Theme 2</b><br>Knowledge of preventative measures and prevention of pregnancy             | Purpose of using contraceptives   | Awareness of pregnancy prevention measures                                |
|  | Understanding the importance of using condoms   |   |
| <b>Theme 3</b><br>Sexual risk behaviour  | Multiple sexual partners, transactional and intergenerational sex   | Initiating poverty alleviating programmes or youth development programmes |
|  | Unprotected sex: nature of sexual behaviours, e.g. casual sex or substance use                                |   |
| <b>Theme 4</b><br>Consequences of risky sexual behaviour                                     | Understanding of the consequences of risky sexual behaviour, unplanned pregnancies, and HIV infection         | Raising awareness of HIV and cervical cancer                              |
|  | School drop-out as a result of challenges experienced in participant's role as a learner, mother, and partner |   |
|  | Lessons learnt while dealing with effects of risky sexual behaviour   |   |
| <b>Theme 5</b><br>Attitude experienced as a result of consequences of risky sexual behaviour | Changes in the attitudes of community / family  | Community education   |
|  | Changes experienced in the attitudes of peers/school and friends/family                                       |   |

### **4.3 KEY FINDINGS AND CONCLUSIONS**

The following key findings are made based on the literature study and empirical findings of this study.

The researcher is of the opinion that the findings of this study cannot be generalised, but could be transferrable to similar populations. Subsequently, the conclusions regarding the themes generated from the study are discussed.

#### **4.3.1 Conclusions regarding the literature study**

The biopsychosocial model is defined as the psycho-socio-environmental model which focuses on the promotion and maintenance of health through socio-environmental and behaviour changes. The biopsychosocial approach emphasises the role of people's behaviour, what work they do, how they lead their lives (psychological), where they live (social), and their access to health care services in determining their health status (bio). For an example life expectancy, and the chances of contracting a disease such as cancer, TB or HIV/AIDS are strongly influenced by socio-environmental factors (Ross & Deverell, 2004:12). The researcher is of the view that it is important for social workers and health professionals to understand the patients or clients as a whole person when helping them in order to help address their issues that may be linked to culture or social background. It was appropriate for the researcher to use the biopsychosocial approach, which is a holistic approach, to explore or gather information about the personal experiences of female youth regarding their risky sexual behaviour. The researcher was interested in the biological (female youth), psychological, physical environment, and social attributes of risky sexual behaviour of female youth in rural and urban areas.

From the literature study in Chapter 2 it can be concluded that the key literature review did not differ much from the actual study findings. For instance, literature showed that unsafe sexual behaviour among South African youth is caused by the powerful impact of the pervasive effect of poverty and social norms that perpetuate women's subordination within sexual relationships. Personal factors and the culture or tradition interact to encourage HIV risk behaviour (Eaton et al., 2003:149-165,151). Other key literature review findings include peer pressure and STIs. STIs

represent a major public health problem, and are among the most common causes of illness, and even death, in the world and have far-reaching health, social and economic consequences. Particular approaches to building resilience through community youth development (Perkins, 2009:36) and the building of social capital (Boeck, 2009:17) demonstrate the importance of strategies which acknowledge and work with the social contexts in which young people are growing up, rather than viewing young people only as sites of individual incapacity (Curran et al., 2013:8). The researcher concludes that there are various factors, such as culture, upbringing, socialisation or social contexts, that play an important role in human behaviour and these need to be addressed in order to shape people's behaviour.

#### **4.3.2 Key Findings and conclusions from the empirical study**

Subsequently the key findings and conclusions regarding each theme in the thematic analysis will be discussed.

##### **4.3.2.1 Theme 1: Knowledge of female youth regarding reproductive health**

The research showed that participants had limited understanding of reproductive health or had fair knowledge of the subject. This includes awareness, types of STIs, risks involved when one engages in sexual risks behaviour, and treatment and prevention of STIs. Although participants had limited understanding of the subject, the majority of them expressed fear of dealing with consequences of risky sexual behaviour. The level of sexual and reproductive health knowledge of youths was generally unsatisfactory and was not at the same level with youths' sexual activity.

It can be concluded that limited understanding of reproductive health is a contributing factor to the sexual risk behaviour displayed by female youths in both rural and urban areas. It can further be concluded that fear of dealing with consequences of risky sexual behaviour does not prevent female youth from early sexual debut. This links with the biopsychosocial approach in the sense that behaviour (psycho) is viewed as an integral part of the person, their health (bio) and their environment (social). The unit of analysis is not just the person, but an integration of elements in the environment and the person, resulting in his or her behaviour. The profession of social work has a dual focus on enhancing the social functioning of individuals and the responses of social institutions to human needs.

The researcher believes that a solution to the risky sexual behaviour of female youth would be reached if all avenues that attribute to this behaviour are explored thoroughly and a holistic approach is implemented to address it.

#### **4.3.1.1.1 Sub-theme 1.1: Opinion on right age for first sexual encounter versus actual age at first sexual encounter**

It is clear that participants perceive the correct age to start engaging in sexual debut as 18 and above. Although the majority of participants viewed this age as the correct age, a significant amount of participants viewed age 21 as the correct age for a woman to start engaging in sex. The participants' actual experience is different from their thoughts and views; only one participant started engaging in sex at the same age that she thinks is the right age for a girl's first sexual encounter.

It can be concluded that early sexual debut is the biggest factor to risky sexual behaviour, as the majority of participants started engaging in sexual activities very early in life while they were not mature enough to negotiate safer sex practices. So this supports the appropriateness of the biopsychosocial approach, because it looks at people's decisions resulting in behaviour (psycho), what work they do, how they lead their lives, where they live (social), and their access to health care services in determining their health status (bio). The effects of early sexual debut directly affect participants' bio (infection with STIs or pregnancy), psycho (effect of infection or pregnancy on female youth) and social sphere (social expectation or acceptance), which support the use of the biopsychosocial approach as they may get infected with STIs.

#### **4.3.1.1.2 Sub-theme 1.2: Understanding the effects of early sexual debut**

The research showed that the majority of the participants in rural and urban areas highlighted that early sexual debut would result in unplanned pregnancy or teenage pregnancy and contraction of HIV. Participants understand that sexual risk behaviour would put them at risk of getting infected with HIV/AIDS.

It can be concluded that all participants are aware of the effects of early sexual debut and mentioned unplanned pregnancy and risk of contracting HIV as the major effects. It can also be concluded that participants' understanding of the effects of sexual debut can be an important tool used to combat the spread of HIV/AIDS by

means of peer education. This links up with the biopsychosocial approach, because it promotes a multi-disciplinary approach when treating a patient which therefore analyses the environment, culture or tradition, which informs the behaviour that has an adverse effect on the patient's biological/physical/psychological/social well-being. The effects of early sexual debut directly affect participants' bio, psycho and social sphere, which support the use of the biopsychosocial approach. The biopsychosocial approach is used to indicate health service delivery that addresses the psychological and social aspects of health and treatment that includes behavioural and environmental factors. The same approach addresses the complex issues related to environmental influences that shape the risky sexual behaviour of female youth, for an example the researcher looked at the biological (physical impact caused by the risky sexual behaviour of female youth), psychological (impact of this behaviour) and social effects (society's contribution to social life or social expectations of female youth).

#### **4.3.1.1.3 Sub-theme 1.3: Understanding causes of cervical cancer**

The majority of participants do not know what causes cervical cancer. The majority of the participants from both the rural and urban area could not even attempt to explain the causes of cervical cancer. It was as if they have never heard of the subject before. This poses high risk to participants, because they cannot protect themselves from something that they do not have knowledge of. The participants from rural and urban areas were asked to share their understanding of the causes of cervical cancer. They were either unclear or not aware of the causes of cervical cancer.

It can be concluded that lack of knowledge of cervical cancer actually prevents female youth from protecting themselves. This links up with the biopsychosocial approach which takes into considerations people's health, social and cultural backgrounds, environmental factors, as well as education or awareness about a particular subject. This model was appropriate for this study, as sexuality addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from a cognitive domain (information on cervical cancer), affective domain (feelings, values and attitudes), and the behavioural domain (communication and decision-making skills in order to prevent or protect from HPV that causes cervical cancer).

The majority of participants do not know what causes cervical cancer. This reinforces the importance of social workers, community health workers, and nurses working in the health field to educate youth on cervical cancer so that they can protect themselves from it.

#### **4.3.1.1.4 Sub-theme 1.4: Understanding of STI prevention and treatment**

All participants from the rural and urban area have a common understanding of how STIs are treated, which is by going to the clinic. Participants from rural and urban areas demonstrated a lack of understanding on the types of STIs. The majority of participants reported that STIs are prevented by condom use and having one sexual partner. It can be concluded that more education on STIs is required in both rural and urban areas in order for participants to be empowered to make informed choices. The biopsychosocial approach is appropriate because it is an approach that posits that biological, psychological (which entails thoughts, emotions, and behaviours), and social factors, all play a significant role in human functioning in the context of disease or illness (in this case STIs). It provides the basis of understanding the determinants of disease and arriving at rational treatments and patterns of health care. The biological component of the biopsychosocial model seeks to understand how the cause of the illness stems from the functioning of the individual's body. The psychological element of the biopsychosocial model looks for potential psychological causes for a health problem, such as lack of self-control, emotional turmoil, and negative thinking. The social part of the biopsychosocial approach investigates how different social factors such as socio-economic status, culture, poverty, technology, and religion can influence health. In using this approach, social workers would assist in combating STIs and empower patients to protect themselves.

#### **4.3.1.1.5 Sub-theme 1.5: Access to a Health Care Centre**

All participants agreed that they have access to health care facilities in their local area and they make use of it. Health care centres are within walking distance in both rural and urban areas. The health care centres in both rural and urban areas provide the same services to the community.

It can be concluded that the South African Government has done well in bringing services to the people, as all participants from both rural and urban areas confirmed that they had access to health care centres that was within a walking distance. Moreover, it can be concluded that both health centres provided the same service to community members, with only a difference in staff compliment, as the clinic in the rural area was serving a smaller community. This was ascertained by the underpinning of the biopsychosocial approach to health care within this study, as the participants' behaviour, experiences and awareness could be explored on a biological, psychological and social level. The biopsychosocial approach emphasises the role of people's behaviour and access to health services in determining their health status. The biopsychosocial model focuses on the promotion and maintenance of health through socio-environmental and behaviour changes.

#### **4.3.1.1.6 Sub-theme 1.6: Family Involvement in sex education**

The study revealed that the majority of the participants reported that their parents and schools assume their role to provide sex education for the children/participants. The study established that factors such as fear, lack of parental guidance, peer pressure, lack of social support, ignorance, and cultural, traditional and religious beliefs are negatively influencing participants in their important decision making. The study showed that even though there are youth care programmes, youth are still making the wrong decisions.

It can be concluded that parents and schools need to provide more education and create more awareness in order to address risky sexual behaviour. The biopsychosocial approach to this research assisted in not only in exploring the biological effects of sexual risk behaviour, but also its impact on a psychological (emotional) and social (relationship) level. To be more specific on a social level, family involvement in sex education was explored as well as attitude experienced amongst their peers, families, and the community. These ranged from support received from parents to feelings of guilt, shame or embarrassment, and hurt as they were reprimanded, punished, humiliated, isolated, and labelled by family and community members when they became pregnant. The biopsychosocial approach enabled the researcher to explore participants and families' experiences and role in

sex education. Social workers in health care fields should be aware of these experiences in order to provide potentially effective interventions using the biopsychosocial approach. The biopsychosocial model focuses on the promotion and maintenance of health through socio-environmental and behaviour changes.

#### **4.3.2.2 Theme 2: Knowledge of preventative measures and prevention of pregnancy**

The findings show that all participants use contraceptives to prevent pregnancy. They view pregnancy as a stumbling block that would prevent them from achieving their goals. The study revealed that participants are aware of preventative measures available to them at their local health care centres. It can be concluded that awareness of preventative measures and their availability in health centres allowed all participants to make means to access them to prevent pregnancy. This links with the biopsychosocial approach in the sense that the profession of social work has a dual focus on enhancing the social functioning of individuals and the responses of social institutions to human needs. The basic function of social work remains, and social workers' roles today reflect their responsibility for treating the whole person by taking a biopsychosocial approach to outreach, assessment, intervention, and care. Knowledge of preventative measures influences participants' decision making in prevention of pregnancy (behaviour), which makes them acceptable within society (social) and in turn allows them to lead healthy lifestyles (biological).

##### **4.3.1.1.7 Sub-theme 2.1: Purpose of using contraceptives**

Some participants mentioned that contraceptives help them to prevent pregnancy and STIs, including HIV and AIDS. Participants take it upon themselves to ensure that they use contraceptives in order to prevent pregnancy. They reported that their friends told them about contraceptives and they are so supportive to the extent that they accompany them to the local health centres to get contraceptives.

It can be concluded that peers have the biggest influence on each other regarding decision making and choices. Peers share information learnt and use it to educate others. Continuous education is important in order for peers to share relevant and correct information. The social workers working in the health field using the biopsychosocial approach would assist in educating youth so that they in turn share relevant and correct information amongst themselves. Social workers need a clear

understanding of peer pressure and the latest trends in order to design and implement effective educational community programmes to address social issues, such as youth pregnancy, HIV/AIDS (bio), and the psychological impact of these issues on youth. The researcher used this model in order to understand the psychosocial, environmental, and biological factors that contribute to the risky sexual behaviour of female youth in urban and rural areas.

#### **4.3.1.1.8 Sub-theme 2.2: Understanding the importance of using condoms**

All participants from rural and urban areas understand the importance of condom use and some participants acknowledged that they use it. They feel strongly that condom use helps to protect them from STIs, including HIV and AIDS. Even though they understand the importance of using condoms, only a minimum of participants admitted that they used it.

It can be concluded that participants understand the importance of condom use, but they admitted to inconsistent condom use due to the fact that the decision for condom use is not entirely upon themselves, but they have to negotiate it with their partner, which is viewed as a tedious exercise or something that is not always possible. This links up with the biopsychosocial approach which takes into consideration participants' or people's cultural background and exposure which influence sexual risk behaviour. This approach allowed the exploration of sex education which result in female youths making informed choices such as condom use and protection from HIV infection. This approach is appropriate in assessing the sexual risk behaviour of female youths in order to make recommendations for interventions that would address it. This approach was appropriate for this study, as sexuality addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from a cognitive domain (information), affective domain (feelings, values and attitudes), and the behavioural domain (communication and decision-making skills). This model deals with the same components that sex education deals with (biological, psychological, and social components of individuals).

### **4.3.2.3 Theme 3: Sexual risk behaviour**

Risky sexual behaviours are reported more by participants in rural areas than those from urban areas. This could be because of poor education and poor or absence of parental guidance. Only two participants from urban areas admitted to sexual risk behaviour, such as multiple or concurrent sexual partners. Those who admitted to multiple sexual partners reported that their peers promoted this kind of behaviour and they also did not see anything wrong with it.

It can be concluded that risky sexual behaviour in rural areas could be as a result of the absence of parental guidance, as parents leave children to seek employment or work in cities. This links up with the biopsychosocial approach, because the actual behaviour presented by participants is influenced by various factors such as: social, environmental, psychological, and biological, which do not exclude cultural belief systems. The approach takes into considerations the above elements when assisting/treating a patient. The biopsychosocial approach considers the non-medical determinants of disease in collaboration with the purely biological components. The approach addresses the complex issues related to environmental influences that shape the risky sexual behaviour of female youth, for an example the researcher looked at biological effects (physical impact caused by the risky sexual behaviour of female youth: multiple sexual partners), psychological (psychological impact of this behaviour), and social effects (society's contribution to social life or even social expectations of female youth).

#### **4.3.1.1.9 Sub-theme 3.1: Multiple sexual partners, transactional and inter-generational sex**

The study showed that peer pressure and poverty lead to young women engaging in risky sexual behaviour, namely having multiple sexual partners, engaging in transactional and intergenerational sex. Participants reported that the reason for engaging in transactional sex was a low level of income or unemployment within their families. Some participants reported dysfunctional families as the reason they get involved in transactional sex, while the minority of participants reported that they merely do not listen to their parents or elders.

It can be concluded that peer pressure and poverty leads to female youth engaging in risky sexual behaviour. It can also be concluded that dysfunctional families lead

to female youths' rebellious behaviour, who then engage in risky sexual behaviour. The biopsychosocial approach looks at the social element regarding the reason why participants engaged in risky sexual behaviour, such as transactional sex. Poverty is a social problem that was stated by participants as the reason they engage in transactional sex. This has serious repercussions, such as risk of contracting HIV and HPV that causes cervical cancer. This approach serves to be the most appropriate approach, as it deals with consequences of risky sexual behaviour while participants are not judged but assessed and assisted as a whole by not only focusing on one element, such as the biological or physical effect (STIs), but rather investigating the root cause, which is transactional sex (behaviour) caused by poverty (social problem). Therefore, the social problem (poverty) has a direct impact on behaviour and its impact on participants (psycho) which in turn affects the biological or physical domain (exposure to STIs).

#### **4.3.1.1.10 Sub-theme 3.2: Unprotected sex: nature of sexual behaviours, e.g. casual sex or substance use**

All participants from rural and urban areas reported that they have engaged in unprotected sex or inconsistent condom use. The participants' view unprotected sex with one partner as safe sex behaviour, as this was emphasised by all participants. The findings showed that the majority of participants never had casual sex, while they admitted above that they had transactional sexual partners. Casual sex was viewed by participants as misbehaviour that is unacceptable.

It can be concluded that female youth acknowledged that they had engaged in unprotected sex with one partner, but this behaviour exposes them to the risks of contracting STIs. This links up with the biopsychosocial approach, because it allows the exploration of sexual risk behaviour in relation to social and cultural norms within a society that sustains the man's rights in relation to decision making about sex versus the inability of female youths to make informed choices, such as condom use and protection from HIV infection. This approach is appropriate in assessing the sexual risk behaviour of female youths in order to make recommendations for interventions that would address it. Social workers in health care should be aware of the above aspects in order to assist the clients by empowering them to negotiate safer sex practices. The biopsychosocial approach is used to indicate an approach to health service delivery that addresses the psychological and social aspects of

health (impact of HIV infection) and treatment that includes behavioural (unprotected sex) and environmental factors (social or cultural influences).

#### **4.3.2.4 Theme 4: Consequences of risky sexual behaviour**

##### **4.3.1.1.11 Sub-theme 4.1: Understanding of the consequences of risky sexual behaviour, unplanned pregnancy, and HIV infection**

The study revealed that the all participants understand the consequences of risky sexual behaviours. Unplanned pregnancy was reported as the major consequence of risky sexual behaviour. The majority of participants reported to have fallen pregnant and having children from as early an age as 16. They reported this as a painful and unforgettable experience, while some participants referred to it as a stumbling block to their future goals.

It can be concluded that participants had painful experiences due to unplanned pregnancy. All participants are equally aware of the consequences of risky sexual behaviour and mentioned unplanned pregnancy and the risk of getting STIs, including HIV. The role of families was explored with regard to sexual risk behaviour and family involvement in sex education, including the family's economic needs. The biopsychosocial approach, which is a holistic approach look at participants' behaviour, experiences, and the consequences of sexual risk behaviour that in turn affects their families, thereby determining the need for interventions. This approach serves to be the most suitable in assessing the role of the family, as well their needs which influence the sexual risk behaviour of female youth. Social workers in the health field should provide families with the necessary resources in order to enable them to actively promote the well-being of participants under all circumstances or family adversities. The biopsychosocial approach considers the non-medical determinants of disease in collaboration with the purely biological components. For example, a biopsychosocial model of health service takes into account patients' ability to raise a child (socio-economic, as well as support structures) when creating a treatment plan for patients, rather than focusing only on laboratory results / positive pregnancy tests and physical status. The psychological impact of pregnancy or HIV infection (bio) determines the well-being (psycho) and social functioning of participants.

#### **4.3.1.1.12 Sub-theme 4.2: School drop-out as a result of challenges experienced in participant's role as a learner, mother, and partner**

There is a significant difference in education between rural and urban female youth regarding the challenges experienced as a learner, mother and partner. Only two participants dropped out of school in the urban area, while four participants dropped out of school in the rural area.

It can be concluded that the rural area environment does not allow female youth to proceed with education, while dealing with the effects of risky sexual behaviour. The biopsychosocial approach takes into consideration what biological, social and psychosocial impact a life-changing event has on the family. The financial impact on the family of a female youth who fell pregnant can be a major cause for concern and these families need to be linked with the correct resources (such as social grants) in order to maintain their financial independence and still be able to provide for their basic needs.

#### **4.3.1.1.13 Sub-theme 4.3: Lessons learnt while dealing with effects of risky sexual behaviour**

Participants reported that they learnt life lessons while dealing with the effects of risky sexual behaviour. In contrast to participants from rural areas, two participants from the urban area reported no lessons learnt while dealing with effects of risky sexual behaviour. When combining this with level of school drop-outs, those who reported no lessons learnt are still in school, while those who reported lessons learnt have either dropped out of school or are a grade or two behind their age group. There was a range of lessons that were reported to have been learnt by participants, such as: learnt to get tested before engaging with a sexual partner; learnt that it is better to stop dating and focus on their studies; learnt to use condoms to prevent pregnancy; secretly use another contraceptive to ensure that they do not have an unplanned pregnancy; and learnt that abstinence is the best prevention method.

It can be concluded that participants learnt valuable lessons while dealing with consequences of risky sexual behaviour. In using the biopsychosocial approach, sexual risk behaviour and participants' experiences and lessons learnt while dealing with the consequences of sexual risk behaviour guided an adoption of a comprehensive approach to the research. Thorough exploration and assessment of

life lessons could be used to create awareness in order to combat the sexual risk behaviour amongst youth. Social workers in the health field need to recognise this aspect in order to provide the appropriate support services to female youth to prevent pregnancy or to prevent school drop outs. The biopsychosocial approach addresses the complex issues related to environmental influences that shape the risky sexual behaviour of female youth, for an example the biological effects (physical impact caused by the risky sexual behaviour of female youth), psychological (impact of this behaviour), and social effects (society's contribution to social life or even social expectations of female youth).

#### **4.3.2.5 Theme 5: Attitude experienced as a result of consequences of risky sexual behaviour**

##### **4.3.1.1.14 Sub-theme 5.1: Changes experienced in the attitudes of her community/family**

All participants who became pregnant reported similar attitudes from community and family members. The general experience of the participants was bad treatment, as well as bad remarks from the community and family members. This made parenting life difficult for them. The majority of participants reported that community members voiced their unhappy feelings with their decision to drop out of school and labelled them because of the pregnancy. They experienced harsh comments and the reality that they are no longer perceived as children, but as mothers, leaving them feeling displaced. They neither belong to their peers nor the adult group in the community.

It can be concluded that family and community members do not promote participants' risky sexual behaviour, as they expressed unhappiness to the extent of uttering harsh words to the participants who were dealing with the effects of risky sexual behaviour. This links up with the biopsychosocial approach which emphasises that social factors such as poverty, community unrest, and unemployment have a direct impact on the youths' behaviour which in turn affects their biological (health or risk of infections), psychological (emotional response to treatment by community members), and social factors. Social workers in the health field should provide families with the necessary resources or empower them to appropriately assume their educational responsibility towards their children.

#### **4.3.1.1.15 Sub-theme 5.2: Changes experienced in the attitudes of her peers/school and friends/family**

The majority of participants reported that peers support each other, while some family members do not provide the necessary support. While pregnancy is viewed as a norm amongst some peers, few participants reported that they were teased by classmates when they fell pregnant and this led to them dropping out of school. Some participants reported that their family members used to shout at them, strongly reprimand them, and question their decision to drop out of school. Some parents punished some of the participants by instructing them to drop out of school and look after their babies.

It can be concluded that risky sexual behaviour is perpetuated by the fact that participants' peers promote pregnancy by means of providing support to each other during the pregnancy. It can be further concluded that pregnancy is viewed as a norm amongst peers, which could promote this behaviour. This links up with the biopsychosocial approach which takes into account people's social factors that influence their behaviour. Peer pressure is also temporally ordered by major sources of influence developmentally as the child matures. Family factors are primary and earliest in their sustained impact on the infant and youth. As the child matures and goes to school, school and community environmental factors have more impact. Eventually peer influences predominate, becoming the final common pathway to sexual behaviour in youth. This reinforces the importance of social workers working in health care to understand the social background of clients, as well as where the client is in order to appropriately address their needs. Peer pressure contributes to sexual risk behaviour, which has a psychological impact that affects the level of social functioning or acceptance of the participants.

#### **4.4 RECOMMENDATIONS**

Based on the key findings and conclusions of the study, the recommendations from the research findings will firstly be discussed, followed by the recommendations and guidelines for practice, and lastly the recommendations for future research will be provided.

#### **4.4.1 Recommendations from the research findings**

From this research, it was evident that participants had limited understanding and awareness of the reproductive health issues while they demonstrated a clear understanding of some of the issues relating to the subject. For example, they demonstrated a clear understanding of the effects of early sexual debut.

It is therefore recommended that there should be more user-friendly programmes focusing on youth empowerment in order for them to make informed choices, because the programmes that are in place are either not reaching the target market, or have limited impact on the sexual behaviour of youth.

#### **4.4.2 Recommendations for policy**

The South African Government and private sector should look at means to address social problems such as poverty, as it became apparent that female youth engaged in intergenerational sex as well as transactional sex as a result of poverty in their families.

The South African Government should review the policies pertaining to female youth that give them too many rights at their tender ages, while they are not yet mentally developed or mature enough to deal with consequences of their decisions. Policy such as the 2007 Sexual Offences Against Children Act should increase the age to give consent for sex from 16 to 18 years, which will allow time for youth to learn and mature in order to make correct decisions. The Children's Act of 2005 (Act No. 38 of 2005) sets out principles relating to the care and protection of children, defines parental responsibilities and rights, and makes provision for matters such as children's courts, adoption, child abduction, and surrogate motherhood. The Act also clarifies the grey area that exists in relation to the age of adulthood, whereby the Age of Majority Act of 1972 stipulates the age of 21 as the age of majority, while a child was defined as someone under the age of 18. Policy on Choice on Termination of Pregnancy Act (No. 92 of 1996) should be reviewed and adjusted to only allow youth above 18 years to request an abortion and definitely not at 14 years. The Act promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs. The termination of

pregnancy may be terminated upon request of a woman during the first 12 weeks of the gestation period of her pregnancy. The termination of a pregnancy may only take place with the informed consent of the pregnant woman.

#### **4.4.3 Recommendations: guidelines for practice**

It was evident that the majority of participants were dealing with the effects of unplanned pregnancies, such as dropping out of school and harsh attitudes expressed by community members, while they found comfort and support from their peers.

- Social workers need to do more work on female empowerment strategies related to National Development Plan 2030 (SA Government, no date) to help reduce the negative impact of peer influences and build resilience skills.
- More should be done by social workers on creating awareness about factors that influence behaviour (peer pressure, culture, teenagers need to belong, ignorance, and society's expectations), for these seem to contribute negatively on the youth of today.

It is important for health care practitioners to understand the behaviour as well as cognitive development of the female youth, as the majority accessed family planning after they fell pregnant. Education of female youth should be prioritised by health care practitioners in order to close the gap between accessing family planning versus correct use of prevention methods. The majority of participants displayed a lack of knowledge of cervical cancer, therefore awareness and prevention of cervical cancer should be done by nurses and health care practitioners in order to help youth to protect themselves from it.

- Social workers should develop whole, rounded intervention programmes that will speak to parents, youth, and society in order to raise well-rounded young people.
- Parents need to be empowered and educated in parenting skills and especially sex education in order to educate their children at home.
- The government and NGOs need to develop parenting skills programmes to assist parents to cope with the demands of parenting teenagers while they manage the demands of providing for them through employment.

- It is recommended that more social workers be employed in primary health care centres in order to conduct support groups to address the issues female youths deal with on a day to day basis and empower them.
- There is a need to engage communities at all levels and to educate them about cervical cancer, HIV and other STIs, in order to clear any misconceptions or myths regarding these subjects.
- Health care professionals, such as nurses and health care workers, should receive refresher training in order to equip them to deal with challenges of today amongst female youth and their families.
- Participants expressed fear of dealing with the consequences of risky sexual behaviour, such as HIV infection. It is recommended that social workers in health care should use the biopsychosocial approach while helping female youth to address their fears, and empower them to make correct decisions.

#### **4.4.4 Recommendations for future research**

- Future research can look at the reasons why female youth engage in risky sexual behaviour on a bigger scale, including interventions that would help educators and parents/guardians to identify and manage vulnerable youths in order to positively influence their decision making.
- One of the findings of this study was that the majority of participants had to drop out of school due to unplanned pregnancies and lack of parental support. Future research could therefore focus on those girls who managed to use contraceptives correctly and prevent pregnancy until they matriculated, in order to teach others to do the same.
- Future studies should include larger populations and represent more races and provinces in South Africa.
- It would be interesting to explore the challenges female youth face while negotiating safer sex practices, such as condom use.
- Future research can explore the experiences of female youths while accessing primary health care centres for family planning.

## 5. LIST OF REFERENCES

- Adekunle, A.P. & Ladipo, O.A. 1992. *Reproductive tract infections in Nigeria: Challenges for a fragile health infrastructure*. Nigeria: University of Ibadan.
- Adler, L. 2002 *Challenge teacher development: An investigation of take-up in South Africa*. Pretoria: Van Schaik.
- Allison, D. 1993. Telling Tales, Telling Truths. In Brandt, K. *Happy Endings: Lesbian Writers Talk about Their Lives and Work*. Tallahassee, FL: Naiad Press.
- Alston, P. 2004. International Labour Office Core, Labour standards and transformation of the international labour rights regime, *European Journal of international law*, 15(3):457-521.
- Amazigo, U. Silva, N., Kaufman, J. & Obikeze, D.S. 1998. Benefits of sexuality education for young people in Nigeria. *Africa Regional Sexuality Resource Centre*, 25(2):174-178.
- Anemaw, A. 2009. Assessment of sexual risk behaviours of in-school youth: effect of living arrangement of students; West Gojam zone, Amhara regional state, Ethiopia.
- Ardington, C., Branson, N. & Leibbrandt, M. 2011. Health outcomes for children born to teen mothers in Cape Town, South Africa. *SALDRU working paper no.55*, University of Cape Town.
- Astatke, H. 2000. Use of Jessor's theoretical framework of adolescent risk behaviour in Ethiopia. *Implications for HIV/AIDS prevention in Northeast African Studies*, 7(1):63-83.
- Babbie, E. 2001. *The practice of social research*. Australia: Wadsworth Thomson Learning.
- Babbie, E.R. 2007. Social service research methodology. In Rubin, A. & Babbie, E.R. (Eds). *Essential research methods for social work*. Belmont, CA: Brooks.
- Barry, K. 1995. *The prostitution of sexuality: The global exploitation of women*. New York, NY: New York University Press.
- Bayley, O. 2003. Improvement of sexual and reproductive health requires focusing on adolescents. *Lancet*, 362(8):31-32.
- Berg, B.L. 2007. *Qualitative research methods for the social sciences*. 6<sup>th</sup> ed. United States of America: Pearson Education.

- Berry, L. & Hall, K. 2009. *HIV & AIDS and STI National Strategic Plan 2007-2011: Multiple sexual partnerships*. Cape Town: Children's Institute, University of Cape Town.
- Bless, C. 2006. Principles of ethical research. In Bless, C. (Ed.), Higson-Smith, C. & Kagee, A. *Fundamentals of Social research methods: An African perspective*. 4<sup>th</sup> ed. Cape Town: Juta.
- Bless, C., Higson-Smith, C., Kagee, A. 2006. *Fundamentals of Social research methods: An African perspective*. 4<sup>th</sup> ed. Cape Town: Juta.
- Boeck, T. 2009. Social capital and young people. In Wood, J. & Hine, J. (Eds). *Work with young people*. London: SAGE.
- Brieger, W.R., Afolabi, B.M., Oladepo, O. Delano, G. Lane, C. & Oyadrian, K.A. 2001. Sexual abstinence and use of contraceptions among young people in Nigeria. *Biology, Agriculture and Healthcare*, 4(16):111-145.
- Cameron, D. 2009. The Big Society, Hugo Young Lecture, 10 November. Available: Cape Area Panel Study. 2002. *A collaborative project of the Population Studies Center in the Institute for Social Research, University of Michigan and the Centre for Social Science Research*. Cape Town: University of Cape Town.
- Cassileth, B.R. 2003. *The cancer patient: Social and medical aspects of care*. Amsterdam: Elsevier Academic Press.
- Charmaz, K. 2006. *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE.
- Children's Act 38 of 2005 (Published in the *Government Gazette*, (28944) Pretoria: Government Printer).
- Choice on Termination of Pregnancy Act 38 of 2004 (Published in the *Government Gazette*, (27267) Pretoria: Government Printer).
- Collins Cobuild Dictionary*. 1998. London: HarperCollins.
- Congressional Research Service. 2016. Temporary Protected Status: Current Immigration Policy and Issues. Available: <https://fas.org/sqp/crs/homesecc/RS20844.pdf> (Accessed 2015/01/05).
- Constitutional Committee. 1991. African National Congress: A Bill of Rights for a Democratic South Africa: Working Draft for Consultation. *Social Justice*, 18:49-64. Available: [http://www.jstor.org/stable/29766594?seq=1#page\\_scan\\_tab\\_contents](http://www.jstor.org/stable/29766594?seq=1#page_scan_tab_contents) (Accessed 2015/09/22).

- Cooper, M.L. 2002. Alcohol use and risky sexual behavior among college students and youth: evaluating the evidence. *Journal of Studies on Alcohol*, 14(3):101–117.
- Creswell, J.W. 1998. *Qualitative inquiry and research design: Choosing among five traditions*. London: SAGE.
- Creswell, J.W. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches*. 3<sup>rd</sup> ed. Los Angeles, CA: SAGE.
- Creswell, J.W.; Ebersohn, L., Eloff, I., Ferreira, R., Ivankova, N.V., Jansen, J.D., Nieuwenhuis, J., Peiterson, J., & Plano Clark, V.L. & Van der Westhuizen. 2007. *Designing and conducting mixed methods research*. United Kingdom: SAGE.
- Curran, S., Harrison, R., & Mackinnon, D. 2013. *Working with young people*. 2<sup>nd</sup> ed. London: SAGE.
- Damtie, D.G. 2013. *Factors influencing Sexual Risk Behaviours Among Senior Secondary School Students (Youths)*. Pretoria: UNISA.
- Davidson, M. 1983. *Uncommon sense: The life and thought of Ludwig Von Bertalanffy*. Los Angeles, CA: JP Tarcher.
- De Vos, A.S., Strydom, H., Fouché, C.B. & Delpport, C.S.L. 2011. *Research at grass roots: For the social sciences and human service professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- Delpport, C.S.L., Fouché, C.B. & Schurink W. 2011. Qualitative research designs. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- Dennison, C. 2004. *Teenage pregnancy: An overview of the research evidence*. Wetherby: Health Development Agency.
- Denzin, N.K. & Lincoln, Y.S. 2000. *The handbook of qualitative research*. 2<sup>nd</sup> ed. Thousand Oaks, CA: SAGE.
- Department of Basic Education. 2008. *National Curriculum Statement Grades 10-12 (General) Subject Assessment Guidelines Life Orientation*. Pretoria: Government Printers.
- Department of Health. 2000. *HIV/AIDS & STD Strategic Plan for South Africa 2000–2005*. Pretoria: Government Printers.
- Dessalegn, N. 2006. *Gudffecha practice as child problem intervention*. Oromo City: University of Ibadan.

- DiClemente, R.J., Salazar, L.F. & Crosby, R.A. 2007. A Review of STD/HIV Preventative Interventions for Adolescents: Sustaining Effects Using an Ecological Approach. *Journal of Paediatric Psychology*, 32(8):888-906.
- Eaton, L., Flisher, A.J. & Aar, L.E. 2003. Unsafe sexual behaviour in South African youth. *Social Science & Medicine Journal*, 56(2):149–165.
- Engel, G.L. 1977. The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286):129-136.
- Ermisch, J. & Pevalin, D. 2003. Does a teen-birth have long term impacts on the mother? *Working Papers of the Institute for Social and Economic Research, paper 2003-28*. Colchester: University of Essex.
- Esternberg, K.G. 2002. *Qualitative methods in social research*. Boston, MA: McGraw-Hill.
- Fawole, I.O. 1999. A school-based education programme for secondary school students in Nigeria, a review of effectiveness. *Oxford Journals Health Education Research*, 14(5):675-683.
- Federal Ministry of Health. 2003. *National HIV/Syphilis Sentinel Survey among pregnant women attending antenatal clinics in Nigeria*. Abuja: Government Printers.
- Fishbein, M. & Ajzen, I. 2010. *Predicting & changing behavior: The reasoned action approach*. New York, NY: Psychology Press.
- Flick, U. 2009. *An introduction to qualitative research*. 4<sup>th</sup> ed. London: SAGE.
- Fouché, C.B. & Schurinck, W. 2011. Fundamental elements of research design. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- France, A. 2007. *Understanding youth in late modernity*. Basingstoke: Open University Press.
- Fugate Woods, N. 2009. A global Imperative: development, Safety, and Health from Girl Child to Woman. *Health Care for Women International*, 30(3):195-214.
- Gebregiorgis, Y. 2000. Achieving Behaviour Change: An Impact Evaluation of a Community Based Adolescent Reproductive Health Program in Ethiopia. *Society of Paediatric Psychology*, 17(5):177-186.
- Gehlert, S. & Browne, T. 2012. *Handbook of Health Social Work*. 2<sup>nd</sup> ed. New Jersey: John Wiley.

- Getnet, M., Templeton, J. & Barber, H. 2005. HIV/AIDS Behavioural Surveillance Survey (BSS) Ethiopia. *Youth Development Journal*, 33(2):60-70.
- Gibbs, G.R. 2007. *Analysing qualitative data*. Thousand Oaks, CA: SAGE.
- Govender, S. & Masango, D. S.a. Govt explains new Children's Act. Available: <http://www.southafrica.info/services/rights/childact-030707.htm#.WEhKfn0SX9B> (Accessed 2014/05/22).
- Grinnell, R.M. & Unrau, Y.A. 2008. *Social work research and evaluation: foundations of evidence-based practice*. New York, NY: Oxford University Press.
- Harrison, A., O' Sullivan, L.F., Hoffman, S., Dolezal, C. & Morrel, R. 2006. Gender role and relationship norms among young adults in South Africa: measuring the context of masculinity and HIV risk. *Journal of Urban Health*, 83(4):709-722.
- Hartell, C.G. 2000. *'n Histories opvoedkundige studie van gesinsopvoeding in skole*. Phd proefskrif. Pretoria: Universiteit of van Pretoria.
- Heron, M. 2010. Deaths: Leading causes for 2006. *National Vital Statistics Reports*, 58(14).
- Hobcraft, J. & Kiernan, K. 2001. Childhood poverty, early motherhood and adult social exclusion. *British journal of Sociology*, 52(3):495-517.
- Hoggart, L. 2007. *Young women, sexual behaviour and sexual decision making*. Bristol: Policy Press.
- Human Diseases and Conditions Forum. S.a. Available: <http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital-Infections.html> (Accessed 2016/10/12).
- International Labour Organisation (ILO) 2004
- Irwin, T.W., Morgenstern, J., Parsons, J.T., Weinberg, M. & Labouvie, E. 2006. Alcohol and sexual HIV risk behaviour among problem drinking men who have sex with men: An event level analysis of timeline follow back data. *AIDS Behaviour Journal*, 10(1):299-307.
- Iwuagwu, S.C., Ademola, J. & Ajuwon, I.O. 2000. Sexual behavior and negotiation of the male condom by female students of the University of Ibadan, Nigeria. *Nigeria School Health Journal*, 20(5):507-513.
- James, S., Reddy, S.P., Taylor, M. & Jinabhai, C.C. 2004. Young people, HIV/AIDS/STIs and sexuality in South Africa: The gap between awareness and behaviour. *Acta Paediatrica*, 93(2):264-269.

- Jeffreys, A. 1985. Hypervariable 'minisatellite' regions in human DNA. *Nature*, 314(6006):67–73.
- Jewks, R. & Abrahams, N. 2003. The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine Journal*, 56(2):149–165.
- Jewks, R. & Wood, K. 2006. Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters Journal*, 22(44):109-118.
- Jewks, R., Dunkle, K.L., Brown, H.C., Gray, G.E., Mcintryre, J.A. & Harlow, S.D. 2004. Transactional sex among women in Soweto, South Africa: prevalence, risk factors and association with HIV infection. *Social Science & Medicine Journal*, 132:1581–1592.
- Kaiser Family Foundation. 2001. Youth: Report on South African Youth. September 2001. Available: <http://kff.org/other/report/selected-findings-from-the-2001-national-survey/> (Accessed 2015/08/25).
- Kaviyva, M. 2003. The impact of biosocial characteristics on nutritional status in context to obesity of school going adolescent of Lucknow city. *International Journal of Health Sciences and Research*, 4:13-38.
- Kawonga, M., Moodley, J., Bradley, J. & Hoffman, M. 2004. Implementing Cervical Screening in South Africa. Volume I: A Guide for Programme Managers. Available: [https://www.westerncape.gov.za/text/2006/1/manual\\_vol\\_1.pdf](https://www.westerncape.gov.za/text/2006/1/manual_vol_1.pdf) (Accessed 2015/05/12).
- Kelly, L. 1988. *Surviving sexual violence*. Feminist Perspectives Series. Minneapolis: University of Minnesota Press.
- Kiene, S.M. & Subramanian, S.V. 2013. Event-level association between alcohol use and unprotected sex during last sex: evidence from population-based surveys in sub-Saharan Africa. *BMC Public Health Journal of Eating Disorders*. Available: <http://www.boimedcentral.com/1471-2458/13/583> (Accessed 2014/11/15).
- Kost, K. & Henshaw, S. 2012. *U.S. Teenage pregnancies, births and abortions, 2008: National trends by age, race and ethnicity*. New York, NY: Guttmacher Institute.
- Krueger, L.W. & Neuman, W.L. 2006. *Social work research methods: Qualitative and quantitative applications*. Boston, MA: Pearson Education.
- Krueger, R.A. & Casey, M.A. 2000. *Focus groups: A practical guide for applied research*. 3<sup>rd</sup> ed. Thousand Oaks, CA: SAGE.

- Lauer, R. & Lauer, J. 2008. *Social problems and the quality of life*. 11<sup>th</sup> ed. Boston, MA: McGraw Hill.
- Le Roux, B. & Smit, B. 2002. Estimating potential output and output gaps for the South African economy. *Working Paper 05/2002*. Stellenbosch: Stellenbosch University, Department of Economics.
- Le Roux, J. (Red.). 2002. *Temas in die sosiopedagogiek*. Pretoria: Van Schaik.
- Lebese, R.T., Davhana-Maselesele, D. & Obi. L.C. 2010. *Curationis*, 33(3):33-42.
- Leibbrandt, M., Woolard, I., & De Villiers, L. 2008. *National Income Dynamic Study*. Cape Town: University of Cape Town's School of Economics.
- Letebele-Hartell, K.E. 2009. *The extent of cervical cancer screening in Mamelodi Provincial Health Clinics*. Pretoria: University of Pretoria.
- Letherby, G., Williams, K., Birch, P. & Cain, M. 2008. *Sex as crime*. USA: Willan.
- Lietz, C.A., Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work: Implications from a study regarding spirituality: *Qualitative Social Work*, 5(4):441-458.
- Lincoln, Y. & Guba, E. 1999. Establishing trustworthiness. In Bryman, A. & Burgess, R.G. (Eds). *Qualitative research Vol III*. London: SAGE.
- loveLife. 2012. Talking Points: A survey on HIV, sexual risk behaviour, and access to opportunity among young people in South Africa. Available: <http://www.jctest.co.za/oldlovelife/corporate/files/2713/5176/9765/Talking-Points.pdf> (Accessed 2015/03/04).
- Magogodi, P. 2013. Personal interview with Mrs Precious Magogodi, National Call Centre Director, loveLife. 8 March. Germiston.
- Mark, R. 1996. *Research made simple: a handbook for social workers*. London: SAGE.
- Maticka-Tyndale, E., Tiemoko, R. & Makinwa-Adebusoye, R. 2007. *Empowering youth through sexuality education*. Nigeria: University of Ibadan.
- Matlane, C. 2013. Interview with Spokesperson, Gauteng Department of Health. 5 March. Johannesburg.
- McBurney, D. 2001. *Research methods*. 5<sup>th</sup> ed. Belmont, CA: Wadsworth Thomson Learning.
- Mensch, B. S., Bruce, J. & Greene, M. 1998. *The uncharted pasSage: Girls' adolescence in the developing world*. New York, NY: The Population Council.

- Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2005. *Applied social research: A tool for human services*. 6<sup>th</sup> ed. Australia: Thomson Brooks/Cole.
- Morgan, D.L. & Krueger, R.A. 1998. *The focus group kit, Vol.1-6*. Thousand Oaks, CA: SAGE.
- Morojele, N.K., Kachieng'ab, M.A., Mokoko, E., Nkoko, M.A., Parry, C.D.H., Nkowane, A.M., Moshia, K.M. & Saxena. S. 2006. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science & Medicine*, 62:217–227.
- Motshapi, H. 2014. Telephonic Interview with Mrs Hermina Motshapi, Matron of Gynaecology Wards of Chris Hani Baragwanath Hospital. 10 June. Johannesburg.
- Mulaudzi, F.M. 2007. Indigenous health belief, attitudes and practices among Vhavhenda: a challenge to the promotion of HIV/AIDS prevention strategies. *Curationis*, 30(3):x-y, 1-38.
- Muller, N.B., Holley, K., Minnie, D. & Muller, K. 2009. *Women and children as witnesses in cases of gender-based violence*. Port Elizabeth: Printite.
- National Department of Health. 2000. *National strategy for the implementation of the cervical cancer screening programme*. Pretoria: National Department of Health.
- National Institute of Mental Health. 2009. *Anxiety disorders*. Bethesda, MD: U.S. Department of Health and Human Services.
- New York State Department of Health. 2007. *Suicidality and violence in patients with HIV/AIDS*. New York, NY: New York State Department of Health.
- Olaseha, I. & Alao, A. 1991. Knowledge, attitude, and risk behaviours of adolescent students, towards AIDS prevention and control in Ibadan city. *Nigeria School Health Journal*, 7(2):127-133.
- Oxford Dictionary of English*. 2010. 3<sup>rd</sup> ed. New York, NY: Oxford University Press.
- Parkin, D.M., Ferlay, J., Hamdi-Cherif, M., Sitas, F., Thomas, J.O., Wabinga, H. & Whelan, S.L. 2003. *Cancer in Africa: Epidemiology and prevention*. France: IARC Press.
- Patton, M.Q. 2002. *Qualitative research and evaluation methods*. 3<sup>rd</sup> ed. Thousand Oaks, CA: SAGE.
- Payne, M. 2005. *Modern social work theory*. 3<sup>rd</sup> ed. New York, NY: Palgrave Macmillan.
- Perkins, D. 2009. Community youth development. In Wood, J. & Hine, J. (Eds). *Work with young people*. London: SAGE.

- Pettifora, A.E., Reesa, H.V, Kleinschmidtc, I., Steffensond, A.E., MacPhaila, C., Hlongwa-Madikizelaa, L., Vermaake, K. & Padian, N.S. 2005. Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. *AIDS*, 19:1525–1534.
- Phoenix, J. & Oerton, S. 2005. *Illicit and Illegal: Sex regulation and social control*. USA: Willan Publishing.
- Pretorius, J.W.M. 2008. Child rearing and personality development. In Le Roux, J. (Ed.) *Themes in Socio-pedagogies*. Pretoria: Van Schaik.
- Punch, K.F. 2005. *Introduction to social research: quantitative and qualitative approaches*. 2<sup>nd</sup> ed. London: SAGE.
- Ranchhod, V., Lam, D., Leibbrandt, M. & Marteleto, L. 2011. Estimating the effect of adolescent fertility on educational attainment in Cape Town using a propensity score weighted regression. *SALDRU, working paper no.59*. Cape Town: University of Cape Town.
- Rasool, S., Vermaak, K., Pharoah, R., Louw, A. & Stavrou, A. 2002. *Violence against women: A National Survey*. Pretoria: Institute for Security Studies.
- Rassool, G.H. 2011. *Understanding addiction behaviours: Theoretical and clinical practice in health and social science*. UK: Pulgrave Macmillan.
- Republic of South Africa. 1996. The Constitution of the Republic of South Africa, 1996 (Published in the *Government Gazette*, (17678) Cape Town: Government Printer).
- Ross, E. & Deverell, A. 2004. *Psychosocial approaches to health, illness and disability: A reader for health care professionals*. Pretoria: Van Schaik.
- Royse, D. 1994. *How Do I Know It's Abuse?* Springfield, IL: CC Thomas.
- Royse, D. 2004. *Research methods in social work*. London: Thomson Brooks/Cole.
- Rubin, A. & Babbie, E. 2005. *Essential research methods for social work*. Belmont, CA: Brooks Publishers.
- SANAC. 2011. *National strategic plan on HIV, STIs and TB 2012–2016*. Pretoria: SANAC.
- Sawyer, M., Afifi, R.A., Bearinger, L.H., Blakemore, S.J., Dirk, B., CEzeh, A. & Patton, G.C. 2012. Adolescence: A foundation for future health. *Lancet*, 379(9826):1630-1640.
- Schram, T.H. 2006. *Conceptualising and proposing qualitative research*. 2<sup>nd</sup> ed. Upper Saddle River, NJ: Pearson Education.

- Schrijvers, D., Senn, H.J., Mellsteadt, H. & Zakotnik, B. 2008. *Handbook of cancer prevention*. London: Informa Healthcare Publishers.
- Schurink, W., Fouche', C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos, A.S. (Ed.), Strydom, H., Fouche', C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human science professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- Shisana, O., Rehle, T., Simbayi L.C., Zuma, K., Jooste, S., Zungu N., Labadarios, D., & Onoya, D. 2012. *South African National HIV Prevalence, Incidence and Behaviour Survey*. Cape Town: HSRC Press.
- Shisana. O. and Simbayi. L. 2002. Nelson Mandela/HSRC Study of HIV/AIDS: *South African National HIV Prevalence. Behavioural Risks and Mass Media Household Survey 2002*. Cape Town: Human Sciences Research Council (HSRC) Press.
- SIECUS. 2003. Opponents of comprehensive sexuality education. Available: <http://www.siecus.org/pubs/fact/fact0016.html> (Accessed 05/02/2004).
- Silverman, D. 2005. *Doing qualitative research*. 2<sup>nd</sup> ed. Thousand Oaks, CA: SAGE.
- Smithbattle, L. 2003. Displacing the rule book in caring for teen mothers. *Public Health Nursing*, 20(5):369-376.
- Social Exclusion Unit. 1999. *Teenage Pregnancy*. London: The Stationary Office.
- South African Government. S.a. National Development Plan 2030. Available: <http://www.gov.za/issues/national-development-plan-2030> (Accessed 2016/09/08).
- South African Labour and Development Research Unit (SALDRU). 2008. *Revisiting the crisis of teen births: What is the impact of teen births on young mothers and their children?* University of Cape Town: Cape Town.
- Southern Africa Labour and Development Research Unit. S.a. National Income Dynamic study 2012. Available: <https://www.saldru.uct.ac.za/projects/current-projects/national-income-dynamics-study-nids> (Accessed 24/05/2015).
- Spitz, M.R. & Newell, G.R. 1992. *Recommendations for cancer prevention*. St Louis, MO: Mosby.
- Stacey, L. 2009. *Whose Child Now?* Available: [http://www.barnardos.org.uk/whose\\_child\\_now.pdf](http://www.barnardos.org.uk/whose_child_now.pdf) (Accessed 2015/05/25).
- Stanberry, L. & Rosenthal, S. 2013. *Sexually transmitted diseases: Vaccines, prevention & control*. 2<sup>nd</sup> ed. Amsterdam: Elsevier Academic Press.

- Statistics South Africa. 2010. *Millennium Development Goals country report*. Pretoria: Stats SA.
- Struwig, F.W. & Stead, G.B. 2001. *Planning designing and reporting research*. Cape Town: Pearson Education South Africa.
- Strydom, H. & Delpont, C.S.L. 2011. Sampling and pilot study in qualitative research. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for social sciences and human science professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- Strydom, H. 2011. Sampling in the quantitative paradigm. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human science professions*. 4<sup>th</sup> ed. Pretoria: Van Schaik.
- Swann, S. 1998. *A model for understanding abuse through prostitution in Barnado's: Whose Daughter Nest? Children Abused Through Prostitution*. Essex: Barnado's Children's Society.
- Swartz, S., Peltzer, K., Naidoo, P., Bray, R., Sanger, N., Garzouzie, G., Sebklew-Sehume, F., Venables, E., Koen, J., Burnett, S. & Matlhape, G. 2011. *HIV, Sexual risk behaviour and access to opportunity among young people in South Africa, Evaluating loveLife's impact on the life choices and risk tolerance of young people*. University of Cape Town: Cape Town.
- Thom, L. 1992. Factors associated with sexual risk-taking behaviours among adolescents. *Journal of Marriage and Family*, 56(3):622-632.
- Thomas, A.B. 2004. *Research skills for management studies*. London: Routledge.
- Tjaden, P, Thoennes, N. 1998. *Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*. Washington, DC: Department of Justice.
- Turnbull, SP. 2010. Adolescents' preferences regarding sex education and relationship education. *Health Education Journal* 69 (3):277-286.
- UNAIDS. 1999. *Reducing Girls' Vulnerability to HIV/AIDS: The Thai Approach*. Geneva: Switzerland.
- UNAIDS. 2001. *World AIDS Campaign: Men, culture and HIV/AIDS*. Geneva: Switzerland.
- UNICEF. 2001. *Profiting from abuse: An investigation into sexual exploitation of our children*. New York,NY: UNICEF.

- Upreti, D., Regmi, P., Pant, P. & Simkhada, P. 2009. Young people's knowledge, attitude and behaviour on STI/HIV/AIDS in the context of Nepal: A systematic review. *Kathmandu University Medical Journal*, 7(4):383-391. UK: University of Aberdeen.
- Van den Berg, D.N. 2004. *Contextual factors affecting adolescent's risk for HIV/AIDS infection: Implications for education*. Pretoria: University of Pretoria.
- Van Dyk, A. 2010. AIDS-defining opportunistic illnesses in US patients from 1994-2007. *Official Journal of the International AIDS Society*, 24(10):4-16.
- Van Rooyen, L. & Hartell, C. 2001. HIV and Education – Beyond 2000. In Calitz, L., Fugelstad, O.L. & Lillejord, S. (Eds). *Leadership in Education*. Cape Town: Heinemann.
- Van Wormer, K. & Bartollas, C. 2000. Women and the Criminal Justice System. *International Social Work*, 44:528-530.
- Van Wormer, K. 2001. *Counselling female offenders and victims: A strengths-restorative approach*. USA: Maple-Vail.
- Von Bertalanffy, L. 1968. *General systems theory: Foundations, development, applications*. New York, NY: George Braziller Publishers.
- Wenham, A. 2011. *Mothers in the making: a qualitative longitudinal study exploring the journey of becoming and being a teenage mother*. Unpublished PhD thesis. University of New York.
- WHO/UNAIDS. 2002. *Technical Update on HIV incidence assays for surveillance and monitoring purposes*. Geneva: WHO/UNAIDS.
- WHO/UNAIDS. 2007. *International Agency for Research on Cancer*. Geneva: WHO/UNAIDS.
- Woods, E.R. 2009. The association of sexual risk behaviors and problem drug behaviors in high school students. *Journal of Adolescent Health*, 20 (5) 377-383.
- World Health Organization. 1997. *Violence against women*. Geneva: WHO.
- World Health Organization. 2009. MesSage of the WHO Regional Director for Africa on Occasion of the World AIDS Day 2009. Available: <http://www.afro.who.int/en/rdo/masSages-and-press-statements/2069> (Accessed 25/08/2015).
- [www.conservatives.com/News/Speeches/2009/11/David\\_Cameron\\_The\\_Big\\_Society.aspx](http://www.conservatives.com/News/Speeches/2009/11/David_Cameron_The_Big_Society.aspx) (Accessed 25/08/2015).

Yegidis, B.L. & Weinbach, R.W. 1996. *Research methods for social workers*. 2<sup>nd</sup> ed.  
Boston: Allyn & Bacon.



6. APPENDICES

6.1 Appendix 1: Permission letter



GAUTENG PROVINCE  
REPUBLIC OF SOUTH AFRICA



**JOHANNESBURG HEALTH DISTRICT**

7 October 2015

Tobeka Xoko  
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Dear Ms. Xoko

Re: ***Insights of urban and rural female youth regarding the nature and consequences Of sexual behavior.***

Your application dated 20 August 2015 refers. The District Research Committee has reviewed your application. This letter serves as an in-principle approval to access the Districts Health facilities (mentioned below) for the above project subject to following conditions:

- The facility to be visited: Hikensile Clinic, Region A
- The research can only commence after you submit an ethics clearance certificate from a recognized institution.
- Please contact the Regional Health Deputy Director before commencing with your study.

| Region | Regional Health Manager | Contact No.  | Cell phone   |
|--------|-------------------------|--------------|--------------|
| A      | Ms Nelly Shongwe        | 011 237 8010 | 082 467 9276 |

- You will report to the Facility Manager before initiating the study.
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.
- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit a six-monthly progress report to the District Research Committee. Your supervisor and University of South Africa will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above.



Please feel free to contact us, if you have any further queries. On behalf of the District Research Committee, we would like to thank you for choosing our District to conduct such an important study.

Regards,

A handwritten signature in black ink, appearing to read 'R Bismilla', written over a horizontal line.

**Dr R Bismilla**  
**Executive Director**  
**City of Johannesburg**  
**Date:**

## 6.2 Appendix 2: Ethics approval



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Humanities  
Research Ethics Committee

18 September 2015

Dear Prof Lombard

**Project:** Insights of urban and rural female youth regarding the nature and consequences of sexual risk behaviour  
**Researcher:** T Xoko  
**Supervisor:** Dr C Carbonatto  
**Department:** Social Work and Criminology  
**Reference numbers:** 13355211 (GW20150603HS)

Thank you for your response to the Committee's correspondence of 30 June 2015.

The **Research Ethics Committee** notes that the outstanding permission from *Tshwane Research Committee (Department of Health)* was submitted as requested and has therefore given **final approval** for the above application at an *ad hoc* meeting on 18 September 2015. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

**Prof Karen Harris**  
**Acting Chair: Research Ethics Committee**  
**Faculty of Humanities**  
**UNIVERSITY OF PRETORIA**  
**e-mail:Karen.harris@up.ac.za**

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Dr L Blokland; Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris (Acting Chair); Ms H Klopper; Dr C Panebianco-Warrens; Dr Charles Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard; Dr P Wood



6.3 Appendix 3: Clearance Certificate



*Kuyasheshwal Gauteng Working Better*

**GAUTENG PROVINCE**  
HEALTH  
REPUBLIC OF SOUTH AFRICA

427 Hilda Street, 4<sup>th</sup> floor, The Fields Building, Hatfield Pretoria 0001 South Africa. Tel: +27 12 451 9124  
Enquiries: Dr. Molapane Chueu-Shabangu  
e-mail: [Molapane.Shabangu@gauteng.gov.za](mailto:Molapane.Shabangu@gauteng.gov.za)

**TSHWANE RESEARCH COMMITTEE**

**CLEARANCE CERTIFICATE**

Meeting: N/A

**PROJECT NUMBER:**

**Title:** Insights of urban and rural female youth regarding the nature and consequences of sexual risk behaviour

**Researcher:** Tobeka Xoko  
**Co-Researcher:**  
**Supervisor:** Dr. CL Carbonatto

**Department:** Social Work and Criminology

**DECISION OF THE COMMITTEE**

Approved

**NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE**

Date: 04/09/2015

.....  
**Dr. Molapane Chueu-Shabangu**  
Chairperson Tshwane Research Committee  
Tshwane Health District

.....  
**Mr. Pitsi Mofhomone**  
Chief Director: Tshwane District Health  
Tshwane District 2015-09-09

**NOTE:** Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

## 6.4 Appendix 4: Letter of Informed Consent



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Humanities

Department of Social Work & Criminology

Researcher: Tobeka Xoko

Contact Details: 083 485 7986

### LETTER OF INFORMED CONSENT

**Title of Study:** Insights of urban and rural female youth regarding the nature and consequences of sexual risk behaviour.

**Principal Investigator:** Tobeka Xoko, MSW (Health Care) student, University of Pretoria, Pretoria.

**Target group:**

- Female youth between 18-20 years of age.
- Female youth who are sexually active as they request contraceptives at the clinic.
- Female youth who are from Ivory Park in Tembisa and Kameeldrift Village in Hammanskraal, both in Gauteng.

**Purpose of the study:** To explore and describe the nature and consequences of risky sexual behaviour of female youth in rural and urban areas.

**Procedure:** You will participate in an in-depth interview with the researcher focusing on four aspects:

- Exploration of the knowledge of female youth regarding reproductive health in rural and urban areas.
- Explore the nature of risky sexual activities of female youth in rural and urban areas.
- To contrast the nature of risky sexual behaviour of female youth in rural and urban areas.

- Explore the understanding of female youth regarding the nature and consequences of youth risky sexual behaviour in rural and urban areas.

Each interview will be voice recorded for the purpose of collecting data and each interview will last approximately sixty minutes. The data will be stored for 15 years according to the prescribed standards of the University of Pretoria. The data may be used for future research.

**Risks and discomforts:** No known risks are associated with the participation in this study. Should you experience any emotional harm as a result of the interviews, debriefing after the interviews will be conducted by the researcher after completion of the interviews. If additional counselling is required, you will be referred to either Mrs. Lesego Mabote, a social worker from the Department of Social Development in Hammanskraal in Tshwane, Gauteng, a social worker at FAMSA or a social worker from Department of Health in Hikensile Clinic, Ivory Park, Tembisa, Gauteng.

**Benefits:** The study has a possibility to enhance youth sexuality education programmes. The results of this study will be used to make recommendations for improved sex education as a preventative measure for female youth against risky sexual behaviour.

**Participant's rights:** You may withdraw from participating in this study at any time and withdrawal from the study will not have any negative implications. The data would be destroyed should you withdraw.

**Confidentiality and anonymity:** The data collected during the interviews using a voice recorder and field notes will remain confidential. The data will be transcribed after the interview and your name will not be used, but rather a number or pseudonym to protect your identity and thus the data will not be linked to you in any way. The results may be published in a professional journal and will be reported in a mini-dissertation.

**Persons to contact:** If you wish to talk to anyone about the research study for any reason (for an example, because you feel you have been unfairly treated or think you have experienced emotional harm by participating in the study, or you have any

other questions about the study) you can call the researcher, Tobeka Xoko at 083 485 7986.

I..... understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and the procedures in this study. I was given an opportunity to ask questions and I will receive a signed copy of this consent form.

\_\_\_\_\_  
**Participant's signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Researcher name**

\_\_\_\_\_  
**Researcher signature**

\_\_\_\_\_  
**Date**

## 6.5 Appendix 5: Interview schedule

Research for: MSW (Health Care)  
Principle Investigator: Thobeka Xoko  
Title: Insights of urban and rural female youth regarding the nature and consequences of sexual risk behaviour

1. General
  - 1.1 Age of participant
  - 1.2 Gender of participant
  - 1.3 Education of participant (High school or tertiary level)
  - 1.4 Area where participant lives
  - 1.5 Home language of participant
  - 1.6 Type of family of a participant (Single/married/divorced parent/child headed)
  - 1.7 Composition of household
  
2. Knowledge of female youth regarding reproductive health
  - 2.1 Opinion on the right age for first sexual encounter
  - 2.2 Understanding of effects of early sexual debut
  - 2.3 Benefit/Learn from sex education offered by school/clinic
  - 2.4 Participants understanding of reproductive health
  - 2.5 Understanding causes of cervical cancer
  - 2.6 Understanding of Sexually Transmitted Infections
  - 2.7 Prevention and treatment of Sexually Transmitted Infections
  - 2.8 Have access to Health Care Centre
  - 2.9 Family involvement in sex education
  
3. Knowledge of preventative measures
  - 3.1 Purpose of using contraceptives- preventing pregnancy
  - 3.2 Age at first sexual encounter
  - 3.3 Understanding the importance of using condoms for protection against HIV, STI's, HPV
  
4. Sexual risk behaviour
  - 4.1 Multiple sexual partners

- 4.2 Concurrent and/or overlapping sexual partners
- 4.3 Transactional sex
- 4.4 Intergenerational sex
- 4.5 Casual sex
- 4.6 Nature of sexual behaviours participant has ever been involved in
- 4.7 Substance use and sex
  
- 5. Consequences of risky sexual behaviour
  - 5.1 Understanding of the consequences of risky sexual behaviour
  - 5.2 Reasons for engaging in risky sexual behaviour – peer pressure etc
  - 5.3 Changes in your life since engaging in sex
  - 5.4 Consequences of risky sex practices
  - 5.5 Challenges in your role as a learner, mother and partner
  - 5.6 Lessons learnt while dealing with effects of risky sexual behaviour
  - 5.7 Changes in role as a daughter/learner/partner
  - 5.8 Testing for HIV?
  
- 6. Attitude experienced as a result of consequences of risky sexual behaviour
  - 6.1 Changes experienced as a community member
  - 6.2 Changes experienced in her peers/school
  - 6.3 Attitudes of friends/ family
  - 6.4 Attitudes of boys/young men

## 6.6 Appendix 6: Definition of Medical Terms

- **Adenosquamous or adenocarcinoma (smoking)**

Micrograph of an adenosquamous carcinoma of the lung. Adenosquamous carcinoma is a type of cancer that contains two types of cells: squamous cells (thin, flat cells that line certain organs) and gland-like cells.

- **Carcinoma in situ**

Carcinoma in situ (CIS) is a general term for an early stage cancer. It's noninvasive, which means the cancerous cells are confined to the surface of your cervix and have not penetrated more deeply into the tissues.

- **Cervical cancer intraepithelial neoplasia**

Cervical intraepithelial neoplasia (CIN), also known as cervical dysplasia, is the potentially premalignant transformation and abnormal growth (dysplasia) of squamous cells on the surface of the cervix. Like other intraepithelial neoplasias, CIN is not cancer, and it is usually curable.

- **Chlamydia**

It is a sexually transmitted infection. The symptoms in women include: burning with urination and an abnormal vaginal discharge; abdominal or pelvic pain is sometimes present; and, blood in the urine, urinary urgency (feeling an urgent need to urinate), and increased urinary frequency can occur if the urethra is infected.

This infection is easily spread because it often causes no symptoms and may be unknowingly passed to sexual partners. In fact, about 75 percent of infections in women and 50 percent in men are without symptoms.  
<http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

- **Chancroid (ulcerative diseases) under (HIV section)**

Chancroid is a bacterial infection that causes open sores on or around the genitals of men and women. It's a type of venereal disease, which means it's transmitted through sexual contact.

- **Condylomata acuminata (genital warts)**

Genital warts are symptoms of a contagious sexually transmitted disease caused by some types of HPV. A condyloma acuminatum is a single genital wart, and condylomata acuminata are multiple genital warts.

- **Condylomata and koilocytotic atypia**

The association of HPV infection of the cervix with condylomata and koilocytotic atypia, which resembles mild to moderate dysplasia, and the detection of HPV antigens and DNA in cervical lesions. HPV has been implicated as an important etiologic factor in cervical carcinoma. The efficacy of cytology as a screening tool in the detection of cervical lesions with koilocytotic features. Cervical smears and biopsy specimens from 76 women seen between January 1983 and October 1985 were reviewed. The histologic categories consisted of koilocytotic lesions (flat condylomas) with minimal cellular atypia, CIN I, II, III, with surface koilocytes showing cellular atypia (atypical koilocytosis), CIN III with a contiguous lesion as defined in categories 1 and 2, negative biopsies.

- **Congenital and neonatal infections and blindness**

Congenital, Perinatal and Neonatal Infections are more serious in pregnancy. Blind treatment is with a penicillin plus gentamicin or cefotaxime/cefuroxime. Bacteria, parasites, or viruses can cause congenital infections, which are infections that are present at birth. These infections can be passed to the fetus or newborn in two ways. Some infections, such as rubella or cyto-megalovirus, are passed from the mother to the baby through the placenta (pluh-SEN-ta), the organ that nourishes the baby in the uterus, or womb. A baby can also become infected during the passage through the birth canal, as happens with group B streptococcus. <http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

- **Cytological Laboratories**

The Cytology department provides a wide range of cytopathology services including the routine screening of gynecologic and non-gynecologic specimens.

- **Dysplasia**

Cervical dysplasia is a precancerous condition in which abnormal cell growth occurs on the surface lining of the cervix or endocervical canal, the opening between the uterus and the vagina. It is also called cervical intraepithelial neoplasia (CIN).

- **Genital tract tumours**

Female genital tract is most common site for tumours in females. There are other less common tumours including tumours of vagina, vulva and fallopian tubes. (Blaustein's Pathology of the Female Genital Tract, 2002).

- **Gonorrhoea**

It is a sexually transmitted infection. Gonorrhoea is a bacterial infection that is transmitted during sexual activity. Women infected with gonorrhoea may not have any symptoms. STDs are infections that can be transferred from one person to another through any type of sexual contact.  
<http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

Gonorrhoea symptoms in men: Greenish yellow or whitish discharge from the penis; Burning when urinating; Burning in the throat (due to oral sex) Painful or swollen testicles and Swollen glands in the throat (due to oral sex).  
<http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

- **Hepatitis B and C**

Viral hepatitis, including hepatitis A, hepatitis B, and hepatitis C, are distinct diseases that affect the liver and have different hepatitis symptoms and treatments. Other causes of hepatitis include recreational drugs and prescription medications.  
<http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

- **Herpes simplex virus (HSV)**

Herpes simplex is a common viral infection. Infection with the herpes simplex virus, commonly known as herpes, can be due to either herpes simplex virus type 1 (HSV-1) or herpes simplex virus type 2 (HSV-2). HSV-1 is mainly transmitted by oral to oral contact to cause infection in or around the mouth (oral herpes). HSV-2 is almost exclusively sexually transmitted, causing infection in the genital or anal area (genital

herpes). However, HSV-1 can also be transmitted to the genital area through oral-genital contact to cause genital herpes. HSV can also be transmitted by close bodily contact.

- **Human papillomavirus (HPV)**

HPV is a viral infection that is passed between people through skin-to-skin contact. There are more than 100 varieties of HPV, but most emphasis is given to the 40 varieties that affect the genitals, mouth, or throat, that are passed through sexual contact.

- **Mutagenic activity**

The international pictogram for chemicals that are sensitising, mutagenic, carcinogenic or toxic to reproduction. In genetics, a mutagen is a physical or chemical agent that changes the genetic material, usually DNA, of an organism and thus increases the frequency of mutations above the natural background level. Mutagenic activity or cervical mucus has been demonstrated in smokers).

Univariate and multivariate analysis were to gain deeper insights into these relationships (under causes of risky sexual behavior).

Univariate analysis is perhaps the simplest form of statistical analysis. Like other forms of statistics, it can be inferential or descriptive. The key fact is that only one variable is involved. A multivariate statistical model is a model in which multiple response variables are modelled jointly.

- **Myometritis**

It is pregnancy-related health complications, such as excessive bleeding and uterine infection. It is a rare condition that can complicate uterine procedures. It is usually associated with endometritis and infertility will follow in most of the cases.

- **Oncogenicity of animal papilloma viruses**

Bovine papillomaviruses (BPV) belong to the Papillomaviruses (PV) family. These are small DNA viruses infecting humans as well as many domestic and wild species of animals and birds causing benign hyperproliferative lesions of both mucosal and

cutaneous epithelia. BPV cause both benign and malignant epithelial and mesenchymal tumours in cows and equids.

- **Precursor lesions (CIN and squamous intra-epithelial lesions (SIL)**

The most frequent types of cervical cancer are squamous-cell carcinoma and adenocarcinoma, which develop from the distinctive precursor lesions cervical intraepithelial neoplasia (CIN) / squamous intraepithelial lesion (SIL), and adenocarcinoma in situ (AIS), respectively. Their tumorigenesis is HPV-related.

### **Syphilis**

It is a sexually transmitted infection. Symptoms of congenital syphilis include: A highly contagious watery discharge from the nose; painful inflammation; contagious rash that frequently appears over the palms of the hands and soles of the feet; reduced red blood cells in the blood (anemia); enlarged liver and spleen and swelling of the lymph nodes. <http://www.humanillnesses.com/Infectious-Diseases-Co-Ha/Congenital->

### **Sterile vaginal speculums**

These are supplies and equipment for preparing and interpreting Pap smears. They should be available, like slides, light, fixing spray, wooden spatula or brush Cytology requisition forms.

CIN I or low-grade SIL and CIN II and ASCUS should have smear repeated after 12 months. If the diagnosis remains the same or worsens, they should be referred for colposcopy. If negative on the second smear, it should again be repeated after 12 months. CIN III or AGUS should be referred immediately for colposcopy. If positive, may be treated with cryotherapy or LLETZ (Large loop excision of the transformation zone) method.

- **Trichomonas infections**

It is a very common STD that is caused by infection with a protozoan parasite called *Trichomonas vaginalis*. Although symptoms of the disease vary, most women and men who have the parasite cannot tell they are infected.

