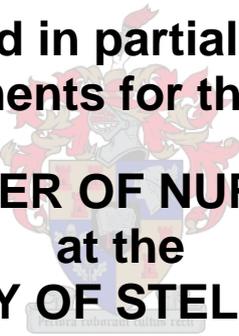


THE ADOLESCENT AND SEXUAL HEALTH

**by
IDA ASIA**

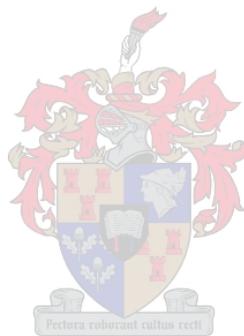
**Thesis presented in partial fulfilment of the
requirements for the degree**

**MASTER OF NURSING
at the
UNIVERSITY OF STELLENBOSCH**

The crest of the University of Stellenbosch is centered behind the text. It features a shield with a blue and white design, topped with a crown and surrounded by red and white decorative elements.

Promotor: Professor E.B.Welmann

April 2004



Dedicated to my daughter,
Xeniah Idette Asia.
May this thesis motivate you in your academic
endeavours.

SUMMARY

Title: The adolescent and sexual health.

Degree: Master of Nursing

Date: April 2004

Research and in certain instances the lack of research as well as extensive experience of the researcher in this field of study convinced the researcher that a scientific study / exploration is critical on the different aspects of adolescent sexual health. A study, based on a combination of qualitative and quantitative methods (triangulation), was conducted to identify and describe the factors playing a role in adolescents' experiencing problems in maintaining their sexual health.

Adolescents are at risk of contracting Sexually Transmitted Diseases including HIV/AIDS because of their sexual behaviour. Initiation of early sexual relations contributing to possible multiple sexual partners and failure to consistently use condoms contribute to this risk. Failure to continuously use a reliable contraceptive method also enhances the risk of unintended pregnancies and consequent exposure to the risks involved in termination of pregnancy or the psychological effects of giving the baby up for adoption, the hardship of raising the baby as a single parent or being forced to marry at a young age. Thus the physical-, emotional-, and social well being of the adolescent is at risk when they are not equipped to maintain their sexual health.

The study concludes that adolescents that are sexually active and have multiple sexual partners have a higher probability of not maintaining their sexual health.

Based on the outcome of this study the researcher feels strongly that the following needs to be addressed in order to promote the maintenance of adolescent sexual health:

- Professional nurses need to be trained and sensitized to guide and manage adolescents seeking sexual or reproductive advice;
- Sexuality programmes need to be integrated into school curricula;
- Positive use of the mass media to promote healthy lifestyles; and
- Training programmes for parents and adolescents.



OPSOMMING

Titel: Die adolessent en seksuele gesondheid.

Graad: Magister in Verpleegkunde

Datum: April 2004

Navorsing en in sekere gevalle die gebrek daaraan sowel as ekstensiewe ondervinding van die navorser in die studieveld, het die navorser oortuig dat 'n wetenskaplike studie / eksplorasië oor die verskillende aspekte van adolessente seksuele gesondheid krities was. 'n Studie, gebaseer op 'n kombinasie van kwalitatiewe en kwantitatiewe metodes (triangulasie), was uitgevoer om die faktore wat 'n rol speel in adolessente se vermoëns om hul seksuele gesondheid te handhaaf, te identifiseer en te bepaal.

Adolessente se risiko is hoog om Seksueel Oordraagbare siektes, insluitend MIV/VIGS, op te doen weens hul seksuele gedrag. Die aanvang van vroeë seksuele verhoudings dra by tot maandelike meervoudige seksmaats en die gebrek aan konsekwente gebruik van kondome verhoog die risiko. Gebrek aan die aaneenlopende gebruik van 'n betroubare kontraseptiewe metode verhoog ook die risiko van 'n ongewenste swangerskap en gevolglike blootstelling aan die risiko's verbonde aan terminasie van swangerskap of die psigologiese effekte wat gepaard gaan met aanneming, enkel ouerskap en geforseerde trou op 'n vroeë ouderdom. Derhalwe word die fisiese-, emosionele- en sosiale welsyn van die adolessent bedreig as hulle nie toegerus is om hul seksuele gesondheid te handhaaf nie.

Die gevolgtrekking van die studie is dat adolessente wat seksueel aktief is en meervoudige seksmaats het, 'n hoër waarskynlikheid het om nie hul seksuele gesondheid te handhaaf nie.

Gebaseer op die uitkoms van die studie is die navorser van mening dat die volgende aangespreek moet word ten einde die handhawing van adolessente seksuele gesondheid te bevorder:

- Geregistreerde verpleegkundiges moet opgelei en gesensitiseer word om adolessente te hanteer en van leiding te voorsien;
- Seksualiteit programme moet in die skool kurrikulum integreer word;
- Positiewe gebruik van die massa media om gesonde lewenstyle te bevorder; en
- Opleidingsprogramme vir ouers en adolessente.



ACKNOWLEDGEMENT

I would like to acknowledge and express my sincere thanks to:

- Our Heavenly Father for providing me with the wisdom and strength in completing this project.
- My promotor, Prof. E.B. Welmann for her continuous support, guidance and positive critique of the research project.
- Ms. J Barnes, Statistician and methologist at the University of Stellenbosch for her guidance with the sampling strategy of the research project.
- The Head: Department of Health, Western Cape.
- The Regional Director: Health Services, Metropole Region, Western Cape.
- Nursing staff of Werdmuller-, Bellville-, Mitchells Plain Youth Health Centres and Cape Town Station Family Planning Clinic.
- My husband, Bennett, daughter, Xeniah, parents, sisters and brothers who continuously encouraged and supported me.
- And a special thanks to the respondents who made this study possible.



Ida Asia

December 2003

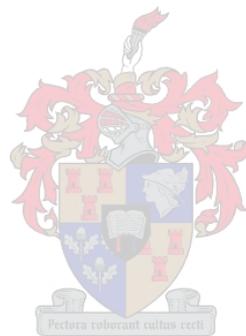


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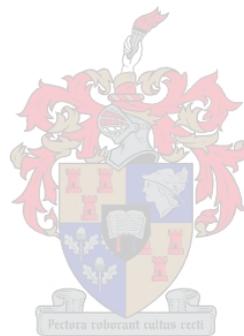
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CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

Adolescence is a period of opportunities as well as challenges. These challenges can be very traumatic and often lead to participation in high-risk sexual behavior. Much of the literature has however, suggested that the majority of adolescents do not participate in high-risk sexual behavior (Petersen, Leffert & Graham, 1995).



Over the past few years, researchers have made significant advances in knowledge of adolescent sexuality. Yet many questions remained unanswered (Hayes, 1987).

As noted in the 1995 Population Report the World Health Organization defines health as a state of physical, mental and social well-being and not just the absence of disease and pain. Sexual health refers to this state of well-being in a person's sexual health – that is:

- to feel comfortable about sex and sexuality;
- to avoid sexually transmitted diseases;
- prevention of unintended pregnancy; and

- thereby directly protecting the health of babies.

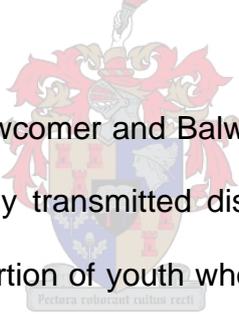
A review of the literature on sexual health indicates that adolescents face major barriers to obtaining reproductive health information and services and therefore experience severe problems in maintaining their sexual health.

Jensen, de Gaston and Weed (1994) indicated that youth feel pressure for both abstinence and having sexual intercourse, but are experiencing somewhat more pressure to be sexually active. Changes in social norms, peer pressure and the influences of the mass media all contribute to the onset of early sexual activity amongst adolescents. They are therefore more likely to be exposed to unintended pregnancy, unsafe abortions and sexually transmitted disease (Population Report, 1995). Early sexual maturity is an important mediator for the onset of problematic behaviour (Berg-Kelly & Erdes, 1997).

As noted by the 1995 Population Report the identification of risk-taking behavior and adolescents most likely to engage in such behavior is a concern of most researchers investigating the development of adolescents. Many adolescents face these health risks with limited factual information and guidance regarding sexual responsibility (Population Report, 1995).

Millions of adolescents around the world become infected with sexually transmitted diseases each year. Adolescents are particularly vulnerable to sexually transmitted diseases because of:

- limited knowledge regarding sexually transmitted diseases;
- the early onset of sexual activity often resulting in multiple sex partners;
- myths and sexual preferences;
- reluctance to seek medical treatment for STD; and
- sexual violence including rape, date rape and incest (Population Report, 1995).



The study of Newcomer and Balwin (1992) shows that temporal trends in sexually transmitted disease rates are fueled by the increasing proportion of youth who have had sex and the earlier ages they initiated sexual activity. Infection with one sexually transmitted disease puts an adolescent at risk for being infected with other sexually transmitted diseases reflecting both social and biological risk factors. Few adolescents identify themselves as having multiple sexual partners and partner switching is common (Santelli & Beilenson, 1992).

The prevalence of cervical intra-epithelial neoplasia in sexually active young females is increasing worldwide. Early onset of coitarche and multiple sexual partners are two widely accepted

behavioral risk factors for cervical abnormalities. These risk factors are particularly relevant for adolescents, as adolescence is a time when much sexual experimentation takes place (Hassen, Relakis, Matalliotakis, Koffa, Delides & Koumantakis, 1997).

Unintended teenage pregnancy and pregnancy decisions affect future education and employment prospects in addition to indicating that many adolescents who become pregnant are likely to be academically at risk. Once pregnant, the choice to terminate the pregnancy, carry to term, raise the child as a single parent or opt for adoption has important implications for the young mother and father (Resnick, 1992).

The risk of early sexual encounters and teenage pregnancy are amongst the most serious health risks that adolescents can face. These risks do not only jeopardize their physical health but also their long-term emotional, economic and social well-being (Population Report, 1995). Research on the health risks and outcome of teenage pregnancy and childbearing shows that pregnant teenagers, especially those under 15 years, have higher rates of complications, maternal morbidity and mortality and premature and low birth weight babies. Poor eating as well as poor health habits contribute to adolescent's neglecting their health during pregnancy. They fail to adjust their lifestyle to

promote a healthy pregnancy and they often do not seek early, regular prenatal care (Hayes, 1987).

Adolescents are experiencing major barriers to obtaining reproductive health information and services contributing to severe problems in maintaining their sexual health. Health related issues include sexually transmitted disease, unintended pregnancies, sexual violence, cervical cancer and complications related to pregnancy. The researcher decided that exploration for the early onset of sexual activity, sexually transmitted diseases and unintended pregnancy are the areas most needed to be explored. The early onset of sexual activity, as indicated earlier, does not only jeopardize the physical health of adolescents but also their long-term emotional, economical and social well-being. Millions of adolescents around the world become infected with sexually transmitted diseases each year. Unintended teenage pregnancies and pregnancy decisions affect future education and employment prospects.

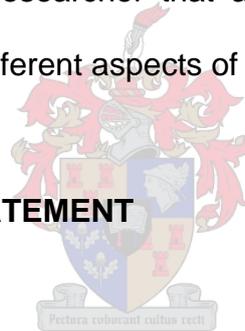
An in-depth literature study showed that adolescent sexuality has been addressed in research internationally but no comprehensive national study has ever been conducted. Thirty-seven, one percent 37,1% of the South African population is younger than 15 years. Therefore it is essential that attention be focused on the adolescent and sexual health in South Africa.

The researcher worked in the Metropole Region of the Western Cape and with five years work experience in the area of adolescent sexual and reproductive health she identified major problems dealing with adolescents in terms of maintaining their sexual health. Due to limited financial resources the researcher decided to limit the study to the Metropole Region of the Western Cape.

Research and in certain instances the lack of research as well as the experience of the researcher in this field of study convinced the researcher that a scientific study/exploration is critical on the different aspects of adolescent sexual health.

1.2

PROBLEM STATEMENT



Practice experience of the researcher, supported by literature on national and international level as well as recent research undertaken in adolescent sexuality and more specific health risks resulting from the early onset of sexual activity and teenage pregnancy, suggest a lack of factual information and guidance regarding the maintenance of adolescent sexual health.

Due to the above-mentioned the following question has originated as indicator for the research:

Which factors play a role with adolescents experiencing problems in maintaining their sexual health?

1.3 **OBJECTIVES OF THE RESEARCH**

The objectives of the research are to:

- define sexual health;
- identify and describe the factors that play a role in adolescents' experiencing problems in maintaining their sexual health; and
- propose recommendations for specific nursing actions as well as for future research investigations based on research findings.

1.4 **RESEARCH METHODOLOGY**



1.4.1 **Research approach**

An exploratory, descriptive non-experimental approach was used.

1.4.2 **Research design**

Triangulation as technique is being used where both qualitative and quantitative data is collected. Triangulation has been

selected as the most effective method because it enabled the researcher to explore variables in-depth and to examine and describe the population in detail (Burns & Grove, 1993).

1.4.3 **Sampling**

The target population is identified as all white and coloured female clients between the ages of 10 and 19 years who attend a Sexual and Reproductive Health care clinic.

The clients were selected at random when they visited the respective clinics on the day that the researcher was present at the said clinic.

The specific Sexual and Reproductive Healthcare clinics in the Metropole Region of the Western Cape that were used in the study were selected because of their available Adolescent Health care facilities. Statistics over a period of one year indicated that these were the facilities most used by adolescent clients.

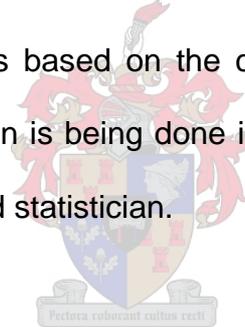
1.4.4 **Data collection**

Data was collected over a period of six (6) months. The researcher acted as primary instrument for data collection in the

study. Data has been recorded by means of tape recordings and field notes. A structured questionnaire was used as instrument during interviews.

1.4.5 **Data analysis and data presentation**

Questionnaires were analyzed by manually computerizing percentages. Compilation of data was done by means of a descriptive summary. Further findings are described using graphic presentations and tables. These presentations include a summary of the characteristics of the sample as well as frequency tables based on the categories. Data analysis and data presentation is being done in consultation with a computer programmer and statistician.



1.5 **PARADIGMATIC PERSPECTIVE**

Calista Roy's Adaptation Model serves as the conceptual framework that guides the study. In this systems model, the person is viewed as having elements linked together in such a way that force on the linkages can be increased or decreased. Increased force can for example come from the environment (Reihl-Sisca, 1989).

Roy identifies the person as an adaptive system in constant interaction with a changing environment. The environment refers to the conditions, circumstances and influences surrounding and affecting the development and behaviour of the person. The model explores the manner in which the adolescent reacts to physiological body changes and the mechanisms of perception, information processing, learning judgement and emotions. Any physiological mode, activity or action in the external environment will somehow have a positive or negative effect on the individual who will then somehow try and adapt to the circumstances.

Roy makes the following basic assumptions. Assumption one to seven were used to illustrate and confirm how one behavior or activity impact on other and how it all interlink.



1.5.1 **Assumption one: *the person is a bio-psycho-social being***

The nature of the person includes a biological component e.g. Anatomy and Physiology. Reference is made of the female anatomy and the changes taking place during adolescence leading to normal development as well as developmental and sexual problems for example the early onset of coitarche.

The person also consists of psychological and social components. Emotional and social development thus occurs. The behavior of the individual is related to the behavior of other.

Peer pressure plays a major role in adolescence. The adolescent must therefore be viewed from the biological, psychological and social perspectives.

1.5.2 **Assumption two: *the person is in constant interaction within a changing environment***

Adolescence is the transition from childhood to adulthood. The person experiences continuous changes in his/her physical (e.g. home, school), social (e.g. peer group) and psychosocial (e.g. emotional trauma, mood swings) environment and is continuously interacting with it.

1.5.3 **Assumption three: *to cope with a changing world, the person uses both innate and acquired mechanisms, which are biological, psychological, and social in origin***

Learned or acquired mechanisms are used to cope with the changing environment. For example, the adolescent will use a contraceptive method to prevent a pregnancy in case of sexual involvement with the opposite sex.

An example of an innate mechanism is to double -or group date to avoid the temptation of becoming sexually active or to masturbate as an alternative expression of sexual desire.

1.5.4 **Assumption four: *health and illness is one inevitable dimension of the person's life***

The person functions for survival, growth and reproduction. These factors can contribute to both health and illness. For example, if an adolescent practices prostitution for financial gain (survival) without practicing safer sex he/she is at risk of contracting a sexually transmitted disease and therefore does not maintain sexual health.



1.5.5 **Assumption five: *to respond positively to environmental changes, the person must adapt***

The adolescent must be able to adapt to environmental changes in order to survive. For example, moving from primary school to secondary school. A changing environment demands a positive response. Experiencing this change as an opportunity and a challenge, making new friends is adaptive. Getting into an intimate relationship with someone from the opposite sex demands a positive response in terms of saying no to high-risk

behavior. The possibility of losing a boyfriend if denied sex is adaptive.

1.5.6 ***Assumption six: adaptation is a function of the stimulus a person is exposed to and his or her adaptation level***

The person's adaptation level depends on the combined effect of three (3) stimuli:

- Stimuli immediately confronting the person. For example, factors immediately confronting the person to adapt e.g. moving to a new school.
- Environmental stimuli. For example, peer pressure to become sexually active, prostitution as means of income because of unemployment
- Nonspecific stimuli. For example, lack of parental control e.g. not setting any rules regarding dating, time to back home, sleepovers. A person's own values, societal norms, knowledge as well as the person's previous experiences will determine adaptation to change.

1.5.7 ***Assumption seven: the person's adaptation levels are such that it comprises a zone indicating the range of stimulation that will lead to a positive response***

Positive or negative response to change will depend on the person's previous experiences. For example, the ability to make responsible choices. The following questions can be asked:

Did the adolescent have the opportunity to develop this skill?

Were choices made for her by parents or other adults?

An example of a negative experience will be girls exposed to childhood sexual abuse who will respond negatively and engage in multiple sexual partners.

1.5.8 **Assumption eight: *the person is conceptualized as having four modes of adaptation: physiological needs, self-concept, role function, and interdependence relations***

The four modes include the following:

- The person adapts according biological needs e.g. to satisfy his/her sexual need by either becoming sexually involved or release sexual tension by other means such as masturbation;
- The person's self-concept is determined by interaction with others. For example, an adolescent girl, overweight with severe acne, suddenly receives overwhelming attention from the "hunk" of the school. Because of her low self-esteem due to her physical appearance she would agree to any expectations of the boy raised upon her in order to hold on to this "relationship";

- Role function within society e.g. his/her role within the peer group; and
- Relations with others. For example, when breaking up with a boy-/girlfriend will change your mode of obtaining attention and affection e.g. lack of trust in the opposite sex or having non-committed multiple sexual relationships.

1.6 OPERATIONAL DEFINITIONS

- **Adolescence** has been defined by the World Health Organization as noted in the 1995 Population Report as:
 - progression from appearance of secondary sex characteristics;
 - development of adult mental processes and adult identity; and
 - transition from total socio-economic dependence to relative independence.
- **Cephalopelvic disproportion:** The woman's pelvic opening is too small to allow the infant's head to pass through during delivery.
- **Coitarche:** The onset of the first sexual relations (Hassen, Relakis, Matalliotakis et al., 1996).

- **Committed relationship:** where adolescents are going steady or are engaged to their partners (Santelli & Beilenson, 1992).

- **Dating:** The term refers to a relationship of affection with a member of the opposite sex. During adolescence these relationships are frequently undertaken more for resolution of social than sexual goals. Dating is associated with both sexuality and independence (Cerqueira Leite, Buoncompagno, Conqueira Leite, Mergulhao & Battiston, 1995).

- **Early sex:** if reported having sexual intercourse before the age of sixteen (16) years (Fergusson, Horwood & Lynskey, 1997).

- **Health** is being defined by the World Health Organization (WHO) in the 1995 Population Report as a state of physical, mental and social well-being and not just the absence of disease or pain.

- **Heavy petting** refers to stimulation of the breasts using the mouth or the hands and touching the genitals over the clothes (Greathead, 1990).



- **Life-style** refers to the sum of behavior chosen by an individual or group (Berg-Kelly, 1995).
- **Menarche** refers to the onset of the first menstrual period.
- **Multiple sex partners** refer to reporting of more than one sex partner (Miller, Clark, Wendell, Levin, Gray-Ray, Velez & Webber, 1997).
- **Parental control** refers to supervision and control over dating hours, location and partners of choice (Santelli & Beilenson, 1992).
- **Problem behavior** refers to behavior not conducive to healthy development e.g. failure of adequate self-protection or deviant behavior (Berg-Kelly, 1995).
- **Risk taking behavior:** behaviors linked to morbidity during adolescence e.g. unsafe sex. The most frequently noted health risks related to sexual behavior are sexually transmitted disease and teenage pregnancy. Adolescents who initiate sexual activity earlier are more likely to become teen parents, to have multiple sexual partners and to engage in unsafe sexual practices (Graber & Brooks-Gunn, 1995).

- **Sexual health** refers to this state of well-being in a person's sexual health. That is:
 - 1) to feel comfortable about sex and sexuality;
 - 2) to avoid sexually transmitted disease; and
 - 3) prevention of unintended pregnancy and thereby directly protects the health of babies (Population Report, 1995).

- **Sexually active:** once adolescents report ever having had sexual intercourse, they become "sexually active" (Newcomer & Baldwin, 1992).

- **Sexuality** includes all dimensions of personality and does not only refer to a person's capacity for erotic response. It refers to all aspects of sexual being. It includes a person's biological, behavioral, clinical and cultural dimensions (Masters, Johnson & Kolodny, 1986).

- **Sexually transmitted disease (STD)** refers to infection being spread by through sexual intimacy. This includes oral, anal and vaginal intercourse (Masters et al, 1986).

- **Unintended pregnancy** is a pregnancy which is not planned and not welcome at the given time which can result in psychological discomfort, severe economic consequences and multiple health risks (Population Report, 1995).

- ***Unprotected sexual intercourse*** refers to having engaged in sexual intercourse without using a recognized form of contraception.
- ***Vaginitis*** refers to any vaginal inflammation that can be caused by infection, allergic reaction hormonal efficiency or chemical irritation (Masters et al., 1986).

1.7 STUDY LAYOUT

1.7.1 Content of the chapters

Chapter 1 describes the scientific foundation of the research project that includes the problem statement, objectives of the research, research methodology, conceptual framework, operational definitions and the study layout.

Chapter 2 describes a literature review on:

- The adolescent as a bio-psycho-social being;
- Coping with a changing world;
- High risk sexual behaviour and related conditions;
- Adaptation levels and the impact on adolescents;
- Sexuality education; and
- Self-esteem, role function, and interdependent relations.

Including the factors that play a role in adolescents experiencing problems in maintaining their sexual health.

Chapter 3 describes the research methodology of the project.

Chapter 4 describes the interpretation and the analysis of the data obtained in the research project.

Chapter 5 describes the recommendations proposed, based on the outcome of the study.

1.8

CONCLUSION

The scientific foundation of this study is presented in this chapter. The Roy Adaptation Model has been discussed because it serves as the conceptual framework guiding the study. Hereby, the forces on adolescence are illustrated.



CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

As indicated in Treece and Treece (1982) the literature forms an integral part of research in general where knowledge gained from earlier studies is being considered. The literature review is necessary to enhance the knowledge, insight and general scholarship of the researcher. The literature will be discussed under the following headings:

- The Adolescent as a bio-psycho-social being;
- Coping with a changing world;
- High risk sexual behavior and related conditions;
- Adaptation levels and the impact on adolescents;
- Sexuality education; and
- Self-esteem, role function, and interdependent relations.

Adolescence is a stressful phase of life. Young people face the impact of puberty, physical and psychosocial powers and emergence from the family home to a foreign society. (Committee on Adolescence, 1986).

Adolescence is a time during which young people continue to develop the social and intellectual skills that will prepare them

for adult roles and responsibilities (Millstein, Petersen & Nightingale, 1993). Adolescents possess the capacity to engage in adult activities because they are physically strong and sexually fertile but on the basis of their immaturity they indulge in activities that may result in disruptive consequences (Committee on Adolescence, 1986). Adolescent transitions are not experienced uniformly across individuals. The development of the individual prior to making the transition, the timing of the transition and the interaction of the adolescent within the social environment may mediate the subsequent influence of the transition (Graber & Brooks-Gunn, 1995).



During adolescence young people are experiencing critical and defining life events e.g. first marriage, first sexual intercourse and parenthood. The age at puberty is decreasing while the age of marriage is increasing. Therefore, the period between the onset of puberty and marriage has increased. First sexual experience and childbearing may take place for many in a different period and social context (Population Report, 1995).

Adolescents become sexually involved because of pressure, to belong, to feel grown up, to experience affection and closeness, to experiment and to satisfy themselves (Neinstein, 1991).

The age of physical maturity has declined over the years and the age of economic independence and marriage has increased (Neinstein, 1991).

Numerous studies have shown that more than two-thirds of adolescents cannot communicate with their parents about sexual matters. The mass media promote an unrealistic image of sexual behavior leading to confusion about sexuality. Adolescents experience increasing pressure by peers to become sexually active. They also experience a sense of immortality resulting in risk taking behavior. They do not consider the consequences of their actions and are often caught between parental-, personal- and peer-group values and confusing messages portrayed by the media. Resultant guilt experienced because of their behavior may contribute to an unhealthy attitude about sex. Sexuality education stresses reproductive function and lacks input on decision-making, relationships, coping with feelings and values-clarification (Neinstein, 1991).

Calista Roy's adaptation model will be used to view the elements linked together and how they contribute to the adolescent experiencing problems in maintaining their sexual health.

Calista Roy's Adaptation Model serves as the conceptual framework that guides the study. In this systems model, the person is viewed as having elements linked together in such a way that force on the linkages can be increased or decreased. Increased force can for example come from the environment (Reihl-Sisca, 1989).

The adolescent is identified as an adaptive system in constant interaction with a changing environment. The researcher will explain how adolescent girls act and react to their changing environment, indicating the conditions, circumstances and influences surrounding and affecting their development and behavior. In applying the model the researcher will also indicate the adolescent's response to the neural-chemical-endocrine systems of the body as well as their mechanism of perception, information processing, learning, judgement and emotions.

Basic assumptions made by Calista Roy will be discussed to show how internal and external forces are impacting on the adolescent and its effects on their sexual health.

2.2 THE ADOLESCENT AS A BIO-PSYCHO-SOCIAL BEING

As noted in the 1995 Population Report adolescence has been defined by the World Health Organization as:

- progression from appearance of secondary sex characteristics to sexual and reproductive maturity; and
- development of adult mental processes and adult identity transition from total socio-economic dependence to relative independence.

Sexuality includes all dimensions of personality and not only refers to a person's capacity for erotic response. It refers to all aspects of being sexual. Sexuality includes a person's biological, psychological, behavioral, clinical and cultural dimensions (Masters et al., 1986).

The following is a description of the stages of sexual maturity:

"Pre-adolescent' sexual development includes the following:

- A low physical and mental investment in sexuality;
- Collecting of information and myths about sexuality from friends, school and family is common; and
- Physical appearance is pre-pubertal" (Neinstein, 1991).

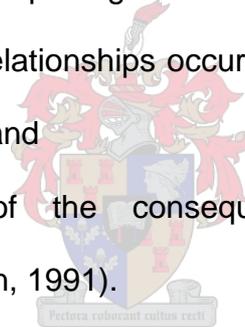
Early adolescence includes the following characteristics:

- The onset of physical maturation;
- Concerns and curiosity about their own body and that of peers;
- Sexual fantasies occur, often leading to guilt feelings;

- Self-stimulation (masturbation) also accompanied by guilt;
- Non-physical sexual activity e.g. Frequent and lengthy telephone calls to friends (Neinstein, 1991).

During middle adolescence

- Physical maturation is attained with menarche;
- Increase in sexual drive with emphasis on physical contact;
- Sexual behavior includes exploring and exploiting;
- Dating and petting become more common;
- Casual relationships occur with both coital and non-coital contact; and
- Denial of the consequences of sexual behavior (Neinstein, 1991).



During late adolescents

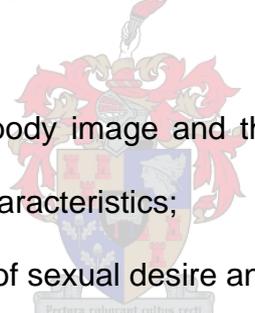
- Physical, social and legal maturation are attained;
- “sexual behavior becomes more expressive and less exploitative” (Neinstein, 1991); and
- Development of intimate relationships.

Hormonal factors play a role in the onset of sexual activity. It may directly lead to sexual arousal or indirectly by social

stimulus associated with physical changes (Millstein et al., 1993).

Girls who are early developers and who receive little or no information are more likely to have negative experiences during adolescence. They react to menarche with surprise and pride. Information regarding menarche is gained primarily from mothers or close girl friends. Girls would discuss menarche more frequent than breast development and pubic hair changes.

Sexual well-being of adolescents includes four developmental challenges:

- 
- Positive body image and the development of secondary sexual characteristics;
 - Feelings of sexual desire and arousal;
 - Involvement in sexual behaviors; and
 - Safer sex practices.

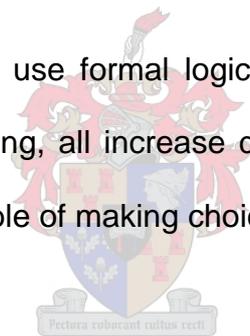
The way in which adolescents' experience these changes, as well as others' response to their physical development contribute to adolescents' feelings toward their bodies (Millstein et al., 1993).

Heath (1977 in Forster & Sprinthall, 1992) in his study has shown that cognitive development in one are does not

necessarily generalize to advanced development in other domains. This is supported by the original study by Gilligan, Kohlberg, Lerner and Belenky (1971 in Forster & Sprinthall, 1992) that indicated that adolescents demonstrated a significant decline in moral judgement when reasoning about personal sexual activity and moral or ethical dilemmas.

Adolescents develop the ability to consider alternatives. They can explore potential consequences without having to think or experience the results (The Committee on Adolescence, 1986).

The capacity to use formal logic, think hypothetically and use abstract reasoning, all increase during adolescence. They are also more capable of making choices (Petersen et al., 1995).



The vast majority of adolescents have the cognitive skills to understand the consequences of their action at levels similar to those of adults (Graber & Brookes-Gunn, 1995).

Byrnes (1988 in Green et al. 1992) suggested that cognitive development may be specific to the content domain in which individual have experience. There is a definite change in the quality and power of thought between 11 and 15 years. This phase, is also the beginning of Piaget's formal operational

period, is characterized by abstract, analytic, and recursive thinking as well as systematic hypothesizing.

Elkind (1978 in Green et al 1992) indicated that as adolescents gain experience, egocentricity decreases. Adolescents responds therefore less to situational pressure as experience produce a stable sense of self.

As stated by Peel (1997 in Green et al. 1992) the transition into mature decision-making capacity may depend on both cognitive development and cognitive egocentrism.

In most cultures worldwide children between the ages of 10-11 and older appear able to articulate a fairly accurate understanding of conception and pregnancy. Virtually all teenagers know that Aids is transmitted via sexual intercourse and intravenous drug usage (Millstein et al., 1993).

Sexual well-being means feeling comfortable with the choice to express sexuality, engage in sexual behavior voluntarily and practicing safer sex (Millstein et al., 1993).

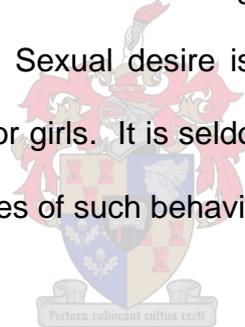
Sexual well-being also includes:

- 1) Feeling comfortable regarding pubertal changes, satisfaction with body image and acceptance of sexual desirability; and

2) Accepting sexual arousal as a response to internal hormonal changes and external responses to the physical manifestations of the internal changes and thus acceptance of these feelings.

Sexual behaviors result from arousal. This may be expressed individually or with another person. Masturbation is a form of individual response. The adolescent can choose to engage in masturbation or not to. Sexual behavior with a partner includes kissing, petting and sexual intercourse.

Double standards still exists regarding sexuality concerns for boys and girls. Sexual desire is seen as paramount for boys and is ignored for girls. It is seldom discussed in girls but rather the consequences of such behavior like teenage pregnancy.



Negative consequences of sexual behaviors are being emphasized at all times instead of looking at positive conditions that will contribute to responsible sexual behavior as well as delay in sexual initiation (Millstein et al., 1993).

The adolescents' ability to manage their sexual well-being is being influenced by a number of social cognitive processes.

Social cognitive factors may influence the adolescent's ability to manage their sexual well-being. Adolescents who are capable of applying concepts of mutuality and reciprocity to a sexual

relationship more willing discuss sexual issues with their partner (Millstein, 1993).

Furby and Beyth-Marom (1992) and Gardner (1990, in Millstein, 1993) indicate that adults and adolescents older than 15 years have similar decision-making abilities but consider the consequences of decisions regarding sexuality differently which might lead to risk-taking behavior in adolescents.

Studies have shown that with age, adolescents are increasingly able to take other's perspectives and to understand concepts of mutuality in relationships with age mates. Adolescents who apply concepts of mutuality to a relationship will be able to communicate with a partner regarding sexual activity and contraception (Millstein et al., 1993).



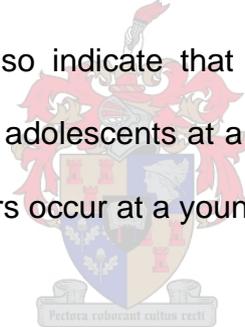
Adolescents gain much of their information regarding sexuality from peers. Misinformation is thus frequently communicated this way. Adolescents act on what they think their friends are doing as indicated by Newcomer, Gilbert and Udry (1980, in Millstein, 1993).

Jessor and Jessor (1977, in Millstein, 1993) state that, teenagers whose communication with their parents are poor, are

likely to initiate sex earlier than those who do not communicate at all.

Hofferth and Hayes (1987, in Millstein, 1993) indicate that teenagers who achieve less academically are more likely to commence sexual relationships than those who fare better at school.

Irwin and Millstein (1986) define risk-taking as those behaviors linked to morbidity during adolescents such as unsafe sex, substance abuse and behavior associated with accident and injury. They also indicate that interrelations among the said behaviors place adolescents at a very high risk of morbidity and if these behaviors occur at a young age the risk is even greater.



Foster and Sprinthall (1992) state that “Sporadic risk taking or exploratory sexual behaviour may be endemic to early adolescence, when social interaction and biological drive interact as teenagers strive for competence in unfamiliar domains”.

Adolescents tend to engage in a series of sexual behaviors with the opposite sex prior to sexual intercourse, including kissing and fondling of the breasts and genitals. Over the past twenty-

five (25) years the age of sexual initiation has decreased (Millstein et al., 1993).

Research by Berg-Kelly and Erdes (1997) indicate that early initiation of adult lifestyles related to problematic health problems.

Earlier physical maturity, social pressures and greater availability of contraceptives have all contributed to early initiation of sexual intercourse (Hudson & Ineichen, 1991).

Research findings demonstrate the effects on early maturing girls of early sexual involvement including internalizing and externalizing problems as well as lower educational and occupational attainment in adulthood (Petersen et al., 1995).



Girls who become teenage mothers may be early developers according a study by Skinner in South London. The growing efficacy, availability and acceptability of contraception are other reason for early sexual experience by teenagers (Hudson & Ineichen, 1991).

Sexual intercourse as part of a relationship will continue to occur while the teenage culture encourages adolescents to believe that everybody is “doing it”. Miller (1983) reported that the

average age for the onset of sexual activity was just over thirteen (13) (Hudson & Ineichen, 1991). A Study done by Schofield (1968) indicated that early sexual experience was not always pleasurable (Hudson & Ineichen, 1991).

If reported having sexual intercourse before the age of sixteen (16) years, it is regarded as early sexual activity (Fergusson, Horwood & Lynskey, 1997).

Early and frequent dating is linked to early sexual activity. Adolescents in committed relationships are more likely to become sexually active and are also more likely to plan first sexual intercourse (Santelli & Beilenson, 1992).

Because of a wide range of sexual, emotional, social and cognitive changes that occur in early adolescence, 11-15 years, the developmental challenges increase. Higher level of cognitive functioning would enhance higher level of decision-making. Therefore abstract reasoning is required for decision-making and problem solving (Green et al. 1992).

According to Newcomer and Baldwin (1992) age is the most important predictor of sexual initiation. Poor youth are more likely to initiate their sexual careers than better-off peers (Newcomer & Baldwin, 1992).

Black youth, lower income and those adolescents' whose parents have low levels of education are more likely to initiate sexual activity (Barton, Watkins & Jarjoura, 1997).

This is supported by a study by Pittman, Wilson, Adams-Taylor and Randolph (1992) indicating that there definitely is a relationship between socio-economic status and ethnicity. Their study further confirms that early sexual encounters, early parenthood and Sexually Transmitted Diseases are more common amongst low-income adolescents than their more affluent peer.



The Group for the advancement of psychiatry (1986) agrees that the socio-economic milieu strongly influences psychological development and emotional attitudes. Therefore, patterns of adolescent sexual behaviour are influenced by socio-economic environment.

Because of strong cultural sanctions against pre-marital sex and early marriage, sexual activity amongst teens is lower in most Asian countries such as China and Japan. African countries appear to have high rates of teenage sexual activity with early marriages (Newcomer & Baldwin, 1992).

A study by Chilman (1978 in Group for the advancement of Psychiatry, 1986) indicates that one-quarter of white males and females had experienced sexual intercourse by the age of 16 years, while by the same age about fifty percent of black females were sexually active.

Newcomer and Baldwin (1992) state that patterns of sexual initiation and sexual intercourse reveal strong differences by ethnicity, age and race.

“Physical and sexual maturity amongst adolescents is not accompanied by an ability to handle their sexuality in a responsible manner” (Hudson & Ineichen, 1991).

Young people possess the capacity to engage in adult activities. Adolescents may indulge in activities that can result in disruptive consequences (Committee on Adolescence, 1986).

Making decisions about sexual behavior and its consequences is not easy (Hudson & Ineichen, 1991).

A study by Tubman, Windle, M and Windle, RC (1996) states that “Sexual intercourse activity, once initiated, was found to be relatively persistent, rather than sporadic, for most adolescents. “National surveys of youth in the 1970s and 1980s document continuing increases in the percentage of 15-19-year-old women

reporting premarital intercourse.” The study also indicates the decline in age for first intercourse from 19 in 1971 to approximately 16.5 in 1988.

United States (US) adolescents initiate sexual intercourse at the same age as their European and Canadian counterparts but are more likely to become pregnant, probably because effective contraceptive use is lower within the US (Santelli & Beilenson, 1992).

Studies indicate that initiation of adult lifestyle is related to problematic health behavior. Factors like ethnicity and socio-economic background contribute to the initiation of early adoption of adult lifestyle. Early sexual maturation is an important mediator for onset of this behavior because early sexual intercourse allows adolescents to socialize with people older than themselves (Berg-Kelly & Erdes, 1997).

Santelli and Beilenson (1992) also indicate that poverty and ethnicity have been traditionally risk factors for initiation of early sexual activity. They further indicate that Black teens living in poverty are more likely to initiate sexual activity. However, ethnic differences disappear when the socio-economic status improves. Santelli and Beilenson (1992) indicate that there is no

or minimal effects of family communication on early sexual initiation.

Newcomer and Udry (1984) found a direct relationship between a mother's sexual behavior as a teenager and that of her teenage daughter.

A study by Zelnik and Kantner (1979) has shown that the majority of adolescents were sexually active and will engage in sexual activity whether contraceptive methods are available or not.

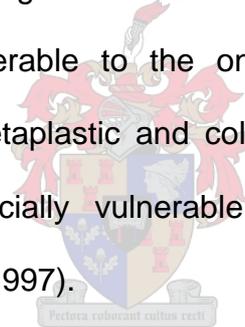
Most common reasons provided by adolescents for not using contraception when involved in a sexual relationship were not expecting to have intercourse and lack of access to contraception (Population Report, 1995).

Cobliner (1974 in Green et al., 1992) indicated that many adolescents had not yet reach the stage of operational thinking and thus, were not fully capable of considering the consequences of their actions. The one, who has reached this stage, is more likely to use contraceptives if sexually active.

The bio-psychosocial conditions influence the likelihood that an adolescent will become infected with sexually transmitted diseases and HIV (Santelli & Beilenson, 1992).

The average age for menarche has decreased resulting in early sexual initiation, increasing the number of years of possible exposure to STDs (Yarber & Parrillo, 1992).

Early age of sexual initiation is thought to be the most significant risk factor. This is related to the biological changes that occur in the cervix during adolescence. The adolescent cervix is especially vulnerable to the onset of carcinogenesis. The presence of metaplastic and columnar cells on the ectocervix makes it especially vulnerable to Human Papilloma Virus (Hassan et al., 1997).



A hostile and distant relationship between the parents of adolescents contributes to teenage pregnancies. Girls who experience better relationships with their father than their mother tend to turn to men for attention and approval.

Some girls can experience pressure from a parent and family members to become pregnant. Reasons include the mother's need to replace the lost relationship with her daughter, the loss of a sibling or pleasure in the daughter's sexuality and proof of

her femaleness (Group for the Advancement of Psychiatry, 1986).

Meyerowitz and Malev (1973 in Group for the advancement of psychiatry 1986) found that attitudes such as the belief in the external locus of control, combined with the belief in fate, hopelessness and amorality, feelings of social rejection, and acting out behaviours all contribute to unintended pregnancies. Less predictive attitudes included the desire to be independent and leave home, apathy and passive responses towards aggression such as family abuse or violence.

2.3

COPING WITHIN A CHANGING WORLD



Puberty is being characterized by an increase in sexual- feelings and –arousal. Media messages, music and fashion have the potential to stimulate sexual arousal in both boys and girls. However, girls respond less to erotic or provocative stimuli than boys do (Millstein et al., 1993).

Information about sex, gained through the mass media, is often distorted, misleading and incomplete. Casual sex is depicted as acceptable and often without risk or negative consequences such as unintended pregnancy and sexually transmitted disease. From most mass media adolescents learn behavior that puts their health at risk (Population Report, 1995).

Various degrees of family dysfunction as well as stressed family dynamics have been associated with early sexual activity amongst adolescents. Communication between parent and adolescent, marital status of parents influences adolescent sexual initiation (Swenson, 1992).

A study by Jensen, Gaston and Weed (1994) indicated that adolescents do experience pressure from society and the media to become sexually involved. It also indicates that when parents are the main source of sexuality education, their children engage in less pre-marital sexual activity. The study also shows that non-virgins cared more about their boyfriends' feelings in comparison to virgins who cared more about their parents' feelings as important factors that influence them in decision-making regarding sexuality. This supports findings of studies that early dating is predictive of adolescent sexual behavior.

Social and intellectual aspects may influence sexual behavior. However, emotional difficulties often result due to conflicts about their body image, sexuality and relations with the opposite sex (Leite et al., 1995).

Mogotsi (1997 in HST Update issue no, 27) indicate in a study done in the North West Province that schoolgirls have

“superficial “ knowledge about Aids. They gained a combination of appropriate and inappropriate information from peers. Limited sexual information was gained from parents. The study also revealed that adolescents do not perceive themselves to be at risk of contracting HIV. This made them vulnerable to infections.

Cicirelli (1980 in Rogers & Lee, 1992) indicated that mother-daughter relationship do have an influence on sexual behavior and stated that the mother is the major influence in the life of her daughter.

Goldfarb et al. (1985 in Group for the Advancement of Psychiatry, 1986) found that “girls most likely to become pregnant were from large families, received their sex education late and from other adolescents, and although of normal intelligence performed poorly academically or disrupted their education”.

Stierlin (1974, Group for the advancement of Psychiatry 1986) indicated that rejecting and neglectful parents often contribute to children running away from home, contributing to an acute crisis turning into one of chronic duration.

There is a definite correlation between teenage unemployment and early parenthood (Hudson & Ineichen, 1991).

The cost of teenage pregnancy and motherhood is not counted in terms of money spent on services but also looking at emotional cost involved. The impact of a teenage pregnancy and its effects are felt within the immediate family but also across generation. Many studies have indicated that patterns of early sexual activity and parenthood repeat through generations. The loss or lack of self-sufficiency due to an unintended pregnancy helps to create a low morale and emotional vulnerability, losses that are costly to the human psyche (Hudson & Ineichen, 1991).

Families resulting from adolescent childbearing start out with grave disadvantages that reduce their life choices and those of their children (Hudson & Ineichen, 1991).

Morrison, Brown and Myers (1992) indicated that teenage child bearers have lower career aspirations, lower income, lower occupational prestige, less job satisfaction and career progress and less time spend on the job than their peers without children.

McCarthy and Menkin (1979) stated that married teenage parents are more likely to separate or divorce than more matured couples. This trend was more profound among Whites than among Blacks.

Barton, Watkins and Jarjoura (1997) stated that although teenage pregnancy prevention programs have little effect on the sexual behavior of young people, it did however, result in an increase in contraceptive usage to reduce the rate of pregnancy.

Adolescence is characterized by a series of developmental tasks which include learning to manage feelings of sexual arousal, developing forms of intimacy and autonomy, experiencing heterosexual relationships and developing skills to control the consequences of sexual behavior (Millstein et al., 1993).

Adolescence provokes exploration, experimentation, peer affiliation and adaptation. Rapid changes in the social structure over years e.g. the increased sexual activity, increased media stimulation, changes in the family structure and decrease role in the job market have intensified the pressure on adolescents to cope within society. Attempts by adolescents to cope with these pressures often result in risk-taking behavior with negative consequences on their well-being.

Safer sex refers to practices to avoid unintended pregnancies as well as sexually transmitted diseases. Pregnancies can be prevented, by using contraceptive methods and engaging in sexual practices other than vaginal intercourse. The only

contraceptive method known to be effective in preventing sexually transmitted disease is the condom (Millstein et al., 1993).

Safer sex is dependent on the use of contraception or sexual practices that do not expose adolescents to sexually transmitted disease or pregnancy. Adolescents have the highest rate of sexually transmitted disease excluding HIV and Aids (US Congress, 1991).

Adolescence provokes exploration, experimentation, peer affiliation and adaptation. Multiple changes in the social structure over the years e.g. the increased sexual activity, increased media stimulation, changes in the family structure and decrease role in the job market have intensified the pressure on adolescents to cope within society. Attempts by adolescents to cope with these pressures often result in risk-taking behavior with negative consequences on their well-being.

Over one million American teenagers become pregnant each year. Fifty one percent (51%) use no contraception during first intercourse and twenty percent (20%) of teenage pregnancies occur within one month of sexual initiation (Neinstein, 1991).

Despite improved contraception usage over the past 20 (twenty) years, many teenagers still do not use contraception or use it inconsistently when involved in sexual relationships. When involved in a committed relationship, adolescents shift from using condoms and withdrawal to more reliable methods such as the contraceptive pill. The number of adolescents not using any form of protection declined from 9.9% to 7.6% (Santelli & Beilenson, 1992).

As noted by Holloway (1994) Sweden's rate of sexually transmitted diseases is the lowest in the world due to mandatory sex education programs in schools.

In many countries, sexuality education for adolescents is non-existent while the age of sexual initiation is falling. Sexual initiation of a female adolescent is often with an adult male and that of the adolescent male with a prostitute making their first opportunity for effective education the ante-natal or Sexually Transmitted Disease clinic (Rowe, 1994).

Health providers and teachers should inform adolescents about the most common STDs, such as Gonorrhoea, Chlamydia, Herpes, Human Papilloma Virus (HPV) as well as less common diseases such as Syphilis, Trichomonas, crabs and HIV (Middleman & Evans, 1995).

Swedish society has a tolerant attitude towards adolescent sexuality, promoting open discussion on the topic resulting in low adolescent pregnancy rate. The state religion is Lutheran (Berg-Kelly, 1995).

Ribar (1991 in Population Report, 1995) indicated that family structure, ethnicity, parents, socio-economic status and religion were important determinants of unintended teenage pregnancies.

Psychological and socioeconomic influences are conducive to teenage pregnancy. However, the socioeconomic environment influences the psychological development and emotional attitude of adolescents. In the same manner the socioeconomic environment can influence adolescent sexual behavior (Group for Advancement of Psychiatry, 1986).

Ribar (1991 in Population Report, 1995) stated that family structure, ethnicity, parents, socioeconomic status and religion were important determinants of teenage childbearing.

2.4 HIGH RISK BEHAVIOUR AND RELATED CONDITIONS

Some adolescents may have high rates of risk behaviors but also have high rates of protective factors. Emerging sexuality

and related behaviors are not inherently risk behavior leading to morbidity and mortality for all teenagers (Graber & Brookes-Gunn, 1995). Irwin and Millstein (1986) defined risk-taking behavior as behaviors linked to morbidity during adolescence including unsafe sexual activity.

Certain behaviors including sexual activity, substance abuse and disengagement from school seem to group together to define adolescents who indulge in high-risk lifestyles. These adolescents whose lifestyles incorporate all these behaviors are likely to be at risk for mortality and morbidity (Graber & Brookes-Gunn, 1995).



Health behavior is not altered unless the consequences are perceived as serious. Adolescents would therefore only alter their sexual behavior if they came to realize that the behavior could cause serious negative consequences. Ambivalence, secretiveness and negativity characterize adolescents' sexual identity. Adolescents would often admit having had sexual intercourse without planning it or without thinking of the possibility of a pregnancy. They tend to underestimate their risk and also believe that they are at less risk than peers Turner, Miller, and Moses (1989) and Weinstein (1982, in Millstein et al., 1993)

A study by Potthoff, Bearinger, Shay, Casonto, Blum and Resnick (1998) indicates that..."many health compromising behaviours of adolescents are strongly related to one another...". They found that the usage of tobacco, alcohol and other drugs are strongly related to sexual intercourse.

Neinstein et al. (1991) indicated that the manners in which the developmental challenges of adolescents are expressed depend on personality traits and other characteristics established in childhood. They identified the following general characteristics regarding risk-taking behavior in adolescence:

- Many behaviors affecting health either positively or negatively are only being tested during the teenage years e.g. sexual activity
- The consequences of risk behavior may be:
 - immediate e.g. drinking and driving;
 - delayed e.g. sexual activity and pregnancy; or
 - remote e.g. early sexual activity, multiple sexual partners and cervical cancer. Teenagers tend to change behavior sooner in case of immediate consequences.
- Consequences of risk behavior may be universal, related to factors like environment, situation or gender and related to the intensity of their involvement.
- Factors that influence health-related behaviors e.g. their values, attitude, attitude, self-concept etc. are usually acquired during adolescence.

- Risk-behavior tends to occur in clusters e.g. smoking, drinking, early sexual activity etc.
- High-risk adolescents have multiple handicaps e.g. the effect of drug abuse (Neinstein, 1991)

Hahn (1995, in Smith, 1997) indicated that ...”sexual activity is “migrating down” to very young adolescents”. This places them at risk of contracting sexually transmitted diseases and unwanted pregnancy according to Irwin and Shafer (1992, in Smith, 1997).

Although the possible consequences of teenage pregnancy and childbirth are not desired, many adolescents are sexually involved without taking any precautions. For many teenagers under sixteen (16) years, sexual activity has no bearing on the future because consideration of the future does not impinge on their daily lives (Hudson & Ineichen, 1991).

Young adolescents are more likely to engage in sporadic and unplanned sexual activity, are less likely to use contraception and are more likely to risk pregnancy and sexually transmitted diseases while older adolescents tend to be more sexually active (Smith, 1997).

Sexual behavior is often linked with other aspects of adolescent problems e.g. substance abuse. Unprotected sexual behavior contributes to health risks such as sexually transmitted diseases (Petersen et al., 1995).

(Mott and Hauren, 1988; Hogan, Astone and Kitagawa, 1985 in Swenson, 1992) indicate that drug and alcohol use are often associated with early sexual activity.

The initiation of sexual behavior is an important factor in the link between sexual initiation and risk behaviors. Adolescents who initiate sexual behavior earlier are more likely to become teenage parents, to have more sexual partners and to engage in unsafe sexual practices. Age of initiation has been linked to poorer adjustment or health outcome. Jessor (1992 in Graber & Brooks-Gunn, 1995).

Confusion, ignorance and embarrassment about sexual matters condemn most sexually active teenagers to the possible consequences that could change their lives (Hudson & Ineichen, 1991).

Pollack (1992) indicated that 20% of sexually active teens fall pregnant within six months of commencing sexual activity. Data from the 1982 National Survey of Family Growth stated that 73%

of teenagers wait an average of 23 months after their first sexual intercourse to seek contraceptive advice.

As indicated in the 1995 Population Report, the most common reason provided by young women for not using contraception was that they did not plan to have sex, with the second most common reason being not knowing about contraception. Adolescents know little or have incorrect information about contraception. Even if they know about it, it is not always used to access it. Where access is possible, they often have to deal with insensitive and judgmental staff.

(Moore, Adler & Kegeles, 1996) found the following five factors that influence teenage current contraceptive use initial compliance with a method

- 
- not receiving contraception at first family planning clinic visit
 - number of family planning visits
 - coital frequency and
 - delay in accessing reproductive health care.

Various studies as shown in Green et al. (1992) examining reasons for nonuse of contraceptive methods when sexually involved included the following:

- fear of becoming infertile
- being too young to become pregnant

- having to have intercourse frequently to become pregnant
- knowing where they should be in their menstrual cycle in order to become pregnant
- feeling about obtaining contraceptive methods
- not planning to engage in sexual intercourse before hand
- desire to become pregnant
- lack of caring about falling pregnant
- a negative attitude towards contraception (Green, Johnson & Kaplan, 1992).

Green et al. (1992) indicate the following in relation to partner influence upon contraceptive usage:

- the length of the relationship
- any plans of getting married in the near future
- the intensity of the relationship and the influence of parents including the following:
 - attitude towards premarital sex
 - discussion of sex or contraception with children

There usually exists a long delay between sexual initiation and the first attempt to visit a Sexual and Reproductive Health Care facility. The delay is between nine and twelve months. There are various reasons for teenagers visiting family planning clinics for the first time such as suspected pregnancy. Adolescents indicate a variety of reasons for not seeking contraceptive

assistance like fear of their families finding out about their sexual status, fear of being examined, fear that contraception could be harmful (Santelli & Beilenson, 1992).

For girls under the age of 17 years, parents and friends are the main sources of referral to a family planning clinic (Santelli & Beilenson, 1992).

A study by Swenson (1992) indicated that although knowledge about and use of contraception have increased in the last decade, 40% of teens still do not use contraception.

Adolescents' reasons for not using contraception included concern about side effects, running out of pills, the spontaneous nature of intercourse and wanting to fall pregnant as well as the fear of being examined at the clinic and denial of the risk of pregnancy. Failure to use contraception consistently after first intercourse is one of the major reasons for unintended pregnancies (Swenson, 1992).

Neinstein, Mackenzie and Yates (1991) indicate that 51% of adolescents in the United States use no contraception during first intercourse and 20% of teenage pregnancies occur within one month of first intercourse.

The ideal method of contraception for adolescents would be 100% effective with no associated health risks or side effects, be accessible, inexpensive and easy to use. However no contraceptive method can fulfill these requirements (Pollack, 1992).

It is critical to stress to teenagers that regardless of their preferred method of contraception, only abstinence and the use of condoms have been proven effective against the transmission of sexually transmitted diseases including HIV (Middleman & Emans, 1995).

A study by Moore et al. (1996) indicated adolescents' belief about the effectiveness of condoms for the prevention of pregnancy and sexually transmitted diseases were not associated with their intentions to use it consistently. Adolescents who believed that condoms were either uncomfortable or inconvenient were less intent to use it in future.

Latex condoms used at every sexual act are the best method for teenagers because it protects against sexually transmitted diseases, and pregnancy. It is more readily available than any other method (Population Report, 1995).

The pill is the most commonly used contraceptive method amongst teenagers. Using the pill does not require male cooperation and is not related to coital episode, both being advantages. For teenagers, oral contraceptives together with condoms provide the best possible combination of protection and prevention against sexually transmitted disease (Pollack, 1990).

Pollack (1990) describes the pill as the safest contraceptive methods for adolescents and has many non-contraceptive health benefits.

Moore et al. (1991) indicated that less than 10% of adolescents use the pill at the time of their first sexual intercourse.

Several regimes of combined oral contraception can be used soon after unprotected sexual intercourse to prevent a pregnancy. Post coital contraception is not a substitute for other family planning methods but can be crucial to prevent an unintended pregnancy.

The Progestin-only injectable is very effective and does not require the need to remember to take a pill every day. It is required only every three months for Depo-Provera and every two months for Nur-Isterate (Population Report, 1995).

Sexually Transmitted Diseases (STDs) refers to diseases that are contracted through sexual intimacy including oral, anal and vaginal intercourse (Greathead, 1988).

Sexually transmitted disease has a major demographic, economic, social and political impact in Sub-Saharan Africa. Adler (1997 in Joint Congress of the Infectious Diseases & Sexually Transmitted Diseases Societies of Southern Africa) stated that according the World Bank in 1993, for women aged 15-44 years, sexually transmitted disease were the second commonest cause of health life lost after maternal morbidity and mortality. In Sub-Saharan Africa 50% of cases of infertility were due to gonorrhoea or chlamydia. Infertility is a personal and social tragedy.



Sexually Transmitted Disease is the product of certain sexual behaviors including age at first intercourse, partner switching and frequency of intercourse, usage of condoms and the likelihood of encountering the particular organism during sexual activity. Infection with one sexually transmitted disease puts an adolescent at risk for being infected with other sexually transmitted diseases. Few adolescents identify themselves as having multiple sexual partners and partner switching is common (Santelli & Beilenson, 1992).

Yarber and Parrillo (1992) found that sexually transmitted diseases are a serious health problem for adolescents resulting from specific risk taking behavior.

Cates and Raul (1985 in Yarber & Parrillo, 1992) indicate that the incidence of sexually transmitted disease amongst adolescents grew to epidemic levels in the 1960s and 1970s.

Rowe (1994) indicates in the WHO Biennial Report 1992-1993 that "Sexually transmitted diseases (STDs) are a major public health problem in all countries, but are especially so in developing countries, where access to adequate diagnostic and treatment facilities is very limited or non-existent".

Sexually transmitted disease prevalence estimated to be 25% among sexually active adolescents. All sexually active adolescents are at risk for contracting sexually transmitted disease and Human Immunodeficiency Virus (HIV). Urban, low-income teenagers are at higher risk for health consequences due to cohort trends in sexual behavior (Tubman, Windle, M. & Windle, R. C., 1996).

The World Bank has estimated that sexually transmitted disease in developing countries is twice as high in females as in males aged 15-44 years. Women are more susceptible to infection

and experience symptoms, complications and secondary ascending infections more frequent than men.

The World Health Organization Biennial Report (1992-1993) noted that “Sexually active adolescents are at greatest risk of acquiring Sexually Transmitted Disease (STDs), because of both their behavioral and anatomical characteristics, and bacterial and viral STDs can seriously compromise their future reproductive health and fertility”.

The immature immune system of adolescents has had less prior exposure to sexually transmitted disease and is therefore less protected against infections (Lawrence & Neinstein, 1991).

Sexually transmitted disease among adolescents indicates age-specific rates higher than any other age. Trends in sexually transmitted disease rates are enhanced by early initiation of sexual activity. Initiation of sexual intercourse at a young age, tend to lead to the accumulation of multiple sexual partners resulting in exposure to sexually transmitted diseases (Newcomer & Baldwin, 1992).

A survey done in Hlabisa District, South Africa indicated that women aged 15-49 (N = 55,974) an estimate of 13,943 (25%) was infected with trichomonas, gonorrhoea, chlamydia or syphilis

(Wilkinson, Karim, Harrison, Lurie, Colvin, Connolly & Sturn, 1997).

Sexually active adolescents have the highest rates of sexually transmitted diseases of any age group. Gonorrhoea, the most commonly reported sexually transmitted disease (STD), has increased dramatically among all age groups between 1960 and 1970. STDs have severe consequences for adolescents. It is also very costly considering the cost of short-term treatment and long-term outcome such as sterility, cervical cancer and death due to sexually transmitted disease complications (Santelli & Beilenson, 1992).



Between 1981 and 1988 Gonorrhoea rates for White adolescents in the United States declined slightly while rates for Black adolescents actually increased. Chlamydia may be responsible for an increase in lower genital tract infection among adolescents than gonorrhoea. Yarber and Parrillo, (1992) found that ethnic differences in Gonorrhoea trends occurred among teenagers. White teenagers had a slower decline than their older counterparts while Black teenagers showed an increase in Gonorrhoea cases between the period 1981-1989.

Lawrence and Neinstein (1991) indicate that the rates of Gonorrhoea, has decreased over the years while the rates of Syphilis had increased dramatically amongst Americans.

Between 1984 and 1987 the increase for Syphilis cases in 15-19 year old males was 11% and 28% for females.

In England and Wales the highest incidence of Gonorrhoea in women is in the age group 16-19 years and in men in the age group 20-24 (Rowe, 1994).

In the United States of America (USA), up to 25% of new cases of Gonorrhoea reported to the Centers for Diseases control are in the age group 15-19 years, while in the United Kingdom, one third of all female cases and one eighth of male cases occur in this age group (Rowe, 1994).

Adolescents account for 25% of the reported 700 000 Gonorrhoea cases per annum in the United States, 35% being females between 15-19 years (Lawrence & Neinstein, 1991).

An estimate of one million new cases of Gonorrhoea occur in USA each year with a large proportion of these cases occurring in the younger patients due to their high risk taking behavior (Middleman & Evans, 1995).

Yarber and Parrillo (1992) indicate that Chlamydia infections are responsible for a higher incidence of lower genital tract infection among adolescents than Gonorrhoea. Studies further indicate

that Chlamydia among adolescents is two times more common than Gonorrhoea.

Between 10-25% of sexually active females have Chlamydia Trachomatis cervicitis, while 5-10% of sexually active male college students in the USA suffering from asymptomatic chlamydial urethritis forming a reservoir for re-infecting their female partners (Rowe, 1994).

Co-infection with Chlamydia often occurs in USA each year. Various studies between 1981 and 1989 indicate that the prevalence of Chlamydia among adolescent females was between 10-37% (Middleman & Evans, 1995).

The number of females between the ages 15-19 years seeking medical treatment for Viral STDs increased for both genital herpes and genital warts during the past two decades (Yarber & Parrillo, 1992).

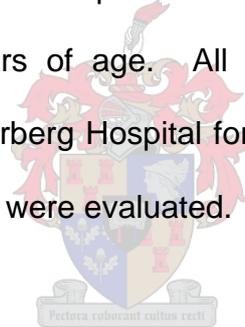
It is estimated that by the end of their teenage years 4% of Whites and 17% of black teenagers will have been infected with the Herpes Simplex Virus (Newcomer & Baldwin, 1992).

The 1995 Population Reports indicate that, up to six (6) million of the people infected with Human Immunodeficiency Virus (HIV) are younger than twenty-three (23) years of age. The

reports also indicate that young women are facing the highest risk for HIV infection through heterosexual contact.

A study conducted in Zimbabwe indicates that 30% (size of sample not indicated) of pregnant girls between 15 –19 years were HIV positive (Population Reports, 1995).

A survey by Zeier, Cilliers, Cotton and Beale (1997) (N=1,590) indicated that prior to 1990 the age group with the highest incidence of HIV infection was 25-34 years. From 1995 there was an increase in the age groups 15-19 and 20-24 years. The group with the most rapid increase was Black females between 15 and 24 years of age. All newly diagnosed HIV-positive patients in Tygerberg Hospital for the period December 1984 to December 1996 were evaluated.



The Department of Health estimated that there were 1,8 million HIV infected people in South Africa. The SA Blood Transfusion Service has also reported infected cases in 15-19 year old males and in a girl as young as 12 years. Of these many are the victims of rape (Wood in AIDS Bulletin, April/May 1996 Vol. 5 No 1).

Lower genital tract infection among adolescents, have its greatest impact in later life. Untreated STDs can lead to pelvic inflammatory disease (PID). PID is highest for adolescent

females (Yarber & Parrillo,1992). Westrom, (1980 in Yarber & Parrillo, 1992) indicates that the risk for PID in sexually active 15-year-old females was estimated to be 1:8 with the highest rate of hospitalization for PID.

Gonorrhea and Chlamydia infections can cause PID leading to damage to the uterine tubes and thus infertility. “ Infertility is particularly tragic for young women in cultures where children are women’s primary means to social status” (Population Reports, 1995).

Determinants of sexually transmitted diseases risk in Adolescence included risk factors such as sexual activity, substance abuse and health care behaviors. Sexual activity is considered the most crucial risk factor for acquisition of STDs. Risk behaviors include age of sexual initiation, number of sexual partners and casual sex (Yarber & Parrillo, 1992).

Santelli and Beilenson (1992) indicated that the probability of someone acquiring a STD is resulting from sexual behaviors including age at first sexual intercourse, partner switching, frequency of sexual activity and non-usage of condoms.

Most young people know very little about STDs and even if they know they still use condoms inconsistently. Young people may

be forced into a sexual relationship or have little power to negotiate the use of condoms especially when they are involved with an older partner (Population Reports, 1995).

Reported use of condoms by sexually active adolescents ranges from 38-66%. Surveys indicate that less than half of teenagers use condoms all the time when having sex. It was found that adolescents with multiple sexual partners are the ones less likely to use condoms (Yarber & Parrillo, 1992).

Newcomer and Baldwin (1992) indicate that condoms are not used at every sexual episode or with every partner.

Moore et al. (1996) state that adolescents' beliefs about effectiveness of condoms for preventing sexually transmitted disease or pregnancy were not associated with their intentions to use it. However, intentions to use condoms were related to beliefs about physical and interpersonal consequences e.g. discomfort or inconvenience.

Age of sexual initiation has been associated with the number of sexual partners and cervical cancer. The earlier the sexual debut, the more sexual partners, people tend to have. The interval of exposure to different partners is therefore longer. Adolescents who initiated coitus before the age of 18 years,

75% reported having two (2) or more partners while 45% reported having four (4) or more partners (Yarber & Parrillo, 1992).

Newcomer and Baldwin (1992) indicate that if adolescents initiate sexual intercourse at younger ages, they will accumulate more sexual partners and thus be more exposed to STDs.

Santelli and Beilenson (1992) indicated that adolescents seldom identify themselves as having multiple sexual partners therefore, partner switching is common. They stated that 34% of women between 18-19 years indicated that they had two or more partners in the past twelve months prior to the study. The finding is based on the researchers understanding of findings of previous research on adolescent fertility. Therefore, the sample size is not noted.

Aral and Holmes (1990 in Yarber & Parrillo, 1992) have shown that persons, who had multiple sexual partners over a short period of time, are at increased risk for Gonorrhea, Syphilis, Chlamydia and Chancroid. They also indicated that these people are at greater risk for acquiring viral infections. The 15-19 year old age group appeared to be group with the highest risk for exposure to multiple partners.

Drug and substance abuse also contribute to an increase in STDs. Substance abuse is associated with high-risk sexual behavior by temporarily increasing the sex drive and is also associated with the exchange of sex for money. This behavior exposes the adolescent to multiple sexual partners (Yarber & Parrillo, 1992).

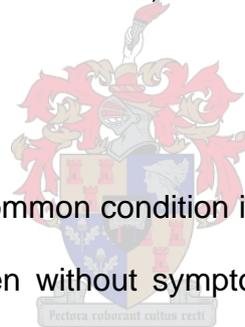
Periodic abstinence is common amongst teenagers. Santelli and Beilenson (1992) indicated that 44.9% White females between 15-19 years were sexually experienced and only 28% had sexual intercourse during the month of the study while only 14.9% were consistently active during the past twelve months prior to the study.

Adolescents may be more reluctant to seek treatment for STDs due to embarrassment, ignorance, no access to clinics and inability to afford services. They tend to consult traditional healers or obtain medication from pharmacists or drug hawkers without proper diagnosis resulting in STD symptoms being masked without the disease being cured. STDs are hereby transmitted to sexual partners and contribute to complications such as infertility (Population Reports, 1995).

A survey undertaken in primary care facilities in Hlabisa District, Kwazulu-Natal during the period February 1996 and January

1997 indicated that 26% (N=6,584) of sexually transmitted disease cases amongst females were in the group 16-18 years compared to only 18% of males. This suggested earlier sexual activity and more alarmingly with older men, who are most likely, to be infected with sexually transmitted diseases (Harrison et al. 1997).

Population Reports (1995) indicate that STD pathogens can penetrate the cervical mucus of adolescents more easily than that of older women. The cervixes of younger women are more susceptible to Gonorrhoea, Chlamydia and HPV that causes cervical cancer.



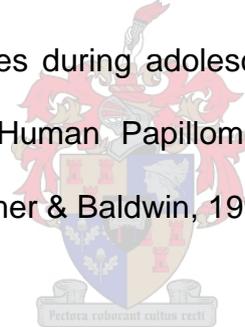
Cervicitis is a common condition in sexually active females. The condition is often without symptoms and is usually caused by Sexually Transmitted Disease. During adolescence the junction of columnar and squamous epithelium is on the ecto-cervix (Lawrence & Neinstein, 1991).

A study by Blum (1997) indicated that cervical cancer was on the increase in adolescent girls. This risk is being increased by early initiation of sexual intercourse and having multi sexual partners.

Approximately one-third of females will suffer from vaginitis during their lifetime, with the majority of first episodes occurring during adolescence (Lawrence & Neinstein, 1991).

Rowe (1994 in the WHO Biennial Report 1992-1993) indicates that “Carcinoma of the cervix is the most common malignancy in women in developing countries, ...”

The Human Papilloma Virus (HPV) causes cervical cancer. The age of sexual initiation and the number of sexual partners are contributory factors to cervical cancer. The cervix goes through maturation stages during adolescence making teenagers more susceptible to Human Papilloma Virus and thus to cervical cancer (Newcomer & Baldwin, 1992).



Rowe indicates in the WHO Biennial Report 1992-1993 that “More than 700 000 women die annually from breast, cervical, ovarian or uterine malignant disease.” Rowe further indicates that of the mentioned cancers, cervical cancer is strongly linked to the HPV virus.

Hassan et al. (1997) noted that the prevalence of cervical cancer in young women was increasing worldwide. The prevalence of cervical pre-cancerous lesions has increased by more than 60% in the past 15 years. Young women in their

teens and young twenties are frequently seen with pre-invasive cervical cancer (Hassan et al., 1997).

Early age of sexual initiation is thought to be the most significant risk factor. This is related to the biological changes that occur in the cervix during adolescence. The adolescent cervix is especially vulnerable to the onset of carcinogenesis. The presence of metaplastic and columnar cells on the ectocervix makes it especially vulnerable to Human Papilloma Virus (Hassan et al., 1997).

Multiple sexual partners are risk factors relevant to adolescence because adolescence is a time of sexual experimentation. Hassan et al. (1997) found that women with seven or more partners had a six-fold increased risk of developing cervical cancer compared to those having one or no partner. The increase in sexual activity and frequency of STDs among adolescents has been considered as predisposing factors to cervical cancer (Hassan et al., 1997).

Teenage births account for 33% of all births in South Africa. Teenage pregnancies have enormous short- and long-term effects on society as a whole. Teenagers discover the consequences of unwanted pregnancy often too late (Roux, 1996).

50% of teenage pregnancies occurred within six months of sexual initiation while one fifth of pregnancies occurred within the first month (Santelli & Beilenson, 1992).

Many pregnant adolescents must cope with, not only the unwanted pregnancy, but also poverty, social isolation and insufficient social support while simultaneously negotiating the developmental tasks of adolescents (Wiemann, Berenson, Wagner & Landwehr, 1996).

A teenage pregnancy is a problem that not only affects the teenage girl but the father, family, the health care system as well as society as a whole. Adolescents' decision to initiate sexual activity contributes to the enormous problem of babies being born to teenage mothers. Pregnancy poses a problem to these young girls due to the fact that they lack emotional and physical capacity to handle the responsibility (Rogers & Lee, 1992).

Dryfoos (1990 in Barton, Watkins & Jarjoura, 1997) stated that adolescents are always at risk of pregnancy if sexually active and not using contraception.

A study by Rogers and Lee (1992) acknowledged teenage pregnancy as a problem affecting not just the teenage girl but also their families with impact on the health care system and society as a whole.

One in every ten teenagers over the age of fifteen years becomes pregnant each year in the United States. Approximately fifty (50) % of these girls give birth while forty (40) % end with termination of pregnancy (Kenney, Reinholtz & Angelini, 1997).

Kenney et al. (1997) stated that “ According to the Alan Guttmacher Institute (1985), 25% of all American women have been pregnant before they are 18 years old”. Research by the Institute also indicated that teenage pregnancy, abortion and birth rates in the United States was 96 per 1000 for girls 15-19 years old compared with 14 in the Netherlands, 35 in Sweden, 43 in France, 44 in Canada and 45 in England and Wales (Group for the Advancement for Psychiatry, 1986). The majority of teens do not want to become pregnant. 85% of teenage pregnancies are unintended (Kenney et al., 1997).

Stier (1993 in De Ville, 1997) indicated that in 1988 approximately 13% of all births in the United States were to women younger than twenty years. The majority of adolescent parents were between 15-19 years.

A study by the Centers for Disease Control (1990 in De Ville 1997) indicated that there were 37.5 births per 1000 women

between the ages of 15-17 years and 1.4 births per 1000 girls aged 10-14 (De Ville, 1997).

Kenney et al. (1997) noted that several studies have suggested that childhood and adolescent sexual abuse experiences might be related to teenage pregnancies. "One study reported that over 60% of 445 teenage mothers had coercive sexual experience and 33% had nonconsensual sex prior to their pregnancy". The sexually abused women with teenage pregnancies were more likely than those not abused, to display problem behavior such as early sexual encounters and engage in more promiscuous relations.

Hall in (Rogers & Lee, 1992) noted the lack of emotional bonding in the family as a contributory factor to teenage pregnancy. Some adolescents therefore, risk pregnancy as a means of gaining love.

As noted in the 1997 Reproductive Rights Alliance Barometer the incidence of abortions in the Netherlands is the lowest in the world. Only 5:1000 pregnancies are terminated.

As noted by the US, Centers for Disease Control (1987) abortion is the leading method of birth control in developing countries and the second leading method of birth control worldwide. More than 60% of women having abortions are younger than 25

years, the highest rates occurring in the age group 18-19 years as indicated by Foster and Sprinthall (1992).

Moore et al. (1991) found that abortion was used as a backup and not a substitute for contraceptive use. They therefore, suggested that clinics and health care providers do not need to be concerned that the availability of abortion will discourage effective contraceptive use.

Pregnancy, wanted or unintended, can be dangerous for both mother and baby due to complications of childbirth and unsafe abortion. Complications of pregnancy or unsafe abortion are amongst the main causes of death for women under the age of 20 years. Young mothers, especially those under the age of 17 years, are more likely than older women to suffer pregnancy-related complications or die during child- birth (Population Report, 1995).

Untreated pregnancy-induced hypertension can cause cardiac failure and result in the death of both mother and baby. Hypertension accounts for a large proportion of maternal deaths in women under the age of 20 years (Population Report, 1995).

Cephalopelvic disproportion is common in young woman whose pelvic growth is not complete. It means that the pelvic opening

is too small to allow the infant's head through during labor. The risk of fistula is increased and associated with cephalopelvic disproportion. A fistula is a tear between the vagina and urinary tract or rectum. A fistula not repaired often lead to lifelong disability (Population Report, 1995)

An anemic woman is five times more likely to die of pregnancy-related complications than a woman who is not anemic. Young pregnant women are more likely than older women to be anemic. "A US study of pregnant teenagers attending a prenatal clinic found that 70% lacked enough iron" (Population Report ,1995).

Many young women get no prenatal care at all. If they do, it is often very late (Population Report, 1995).



Pregnancy before the age of 20 also poses a risk for the young mother's infant. Young mothers under the age of 15 years have higher rates of premature labor, miscarriage, still birth and infants with low birth weight. For the infants surviving, a higher risk for early death persists throughout early childhood (Population Report, 1995).

Some studies have indicated that children of teenage parents suffer a higher incidence of cognitive and educational deficits

than children from older parents. There was also a consistent relationship between lower maternal age and intellectual achievement of these children (Group for the advancement of Psychiatry, 1986).

Many teenagers with unintended pregnancies turn to unsafe abortions. Estimated abortions amongst women under the age of 20 years in developing countries range from 1 to 4.4 million per year. Unsafe abortions result in life-long disability, infertility and even death. Unsafe abortion is the greatest health risk that a young sexually active girl can face. In Africa women under the age of 20 years account for 68% of abortion complications treated at selected hospitals. Young women also delay in seeking medical care if complications arise after an abortion due to fear, shame and inadequate funds. The health risks of unsafe abortion include infection, hemorrhage, and injuries to genital organs and toxic reaction to drugs being used to induce abortion (Population Report, 1995).

Cates (1980, in Group for the advancement of Psychiatry, 1986) indicated that pregnant teenagers delay abortions until after the applicability of the simplest procedures. The delay may be because of inner conflict or inability to make an informed choice. These difficulties contribute to post abortion emotional complications such as depression.

Teenagers who obtain abortions are less likely than older women to have them early in pregnancy when it is safer (Population Report, 1995).

Various researchers have found that women who had children as teenagers tend to have more children than women who had their first child late in life. Early teenage child bearing does not only contribute to bigger families but is also linked to lower social and economical attainment, less marital stability and high welfare dependency (Morrison, Brown & Myers, 1992).

Mott and Hauren (1988 in Swenson 1992)) indicated that Black teenage mothers are more likely to have a repeat pregnancy within 24 months after the first one. Teenagers who marry are also at risk of having a baby within 2 years of the first, while the ones who returned to school are more likely to curtail their subsequent fertility.

Healthy behavior consistent with successful pregnancy depends on the mental health status of the woman. Increased stress associated with an unintended pregnancy may place the teenager at risk for psychological dysfunction. However, a study conducted by Wiemann et al. (1996) indicated that although they observed rates of anxiety and depression amongst pregnant teenagers, it was not possible to elucidate whether pregnancy in

fact promotes, exacerbates or reduces psychological distress. They also found that adolescents who attended a teenage antenatal clinic might not perceive teenage pregnancy as stigmatizing. The supportive environment was believed to reduce stress and thus lowered the prevalence of depression and anxiety.

Adolescents who become pregnant, exhibit less delinquency than their never pregnant peers. This suggested that pregnant teenagers reduce their participation in delinquent behavior in order to protect the fetus. There is the possibility that these adolescents might resume their high-risk behavior in the post-natal period (Wiemann et al. 1996: 40).

Over one million American teenagers become pregnant each year. Fifty one percent (51%) use no contraception during first intercourse and twenty percent (20%) of teenage pregnancies occur within one month of sexual initiation (Neinstein, 1992).

Hogan, Astone and Kitigawa (1985 in Santelli & Beilenson, 1992) stated that social class, marital status and improved neighborhood all predicted contraceptive use in teenagers.

Various studies as shown in Green et al. 1992 indicated, support the above by emphasizing that race, social class, religion and

religion activity, age and geographical location are all related to contraceptive use.

2.5 ADAPTATION LEVELS AND THE IMPACT ON ADOLESCENTS

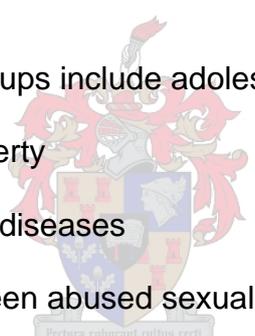
Moral standards state that pre-marital sex is bad for old and young alike. However, people are being bombarded by media messages indicating sexual involvement as the norm. Adolescents get confusing messages all the time. On the one hand they are being encouraged to abstain with no information to manage sexual feelings. They receive messages stating that pre-marital sex is unacceptable. Adolescents with a negative attitude towards sex are less likely to seek contraceptive advice. Adolescents are encouraged to act responsibly and seek contraceptive advice while effective youth services are not rendered (Millstein et al., 1993).

The bio-psychosocial factors having an impact on adolescence include the following:

- The early onset of menarche, the period between menarche and marriage extended and changed values regarding pre-marital sexual activity
- Urbanization

- Increased mobilization of families where adolescents have to form new relationships all the time, during a period where they still lack relationship skills
- Breakdown of families with single parenthood becoming more acceptable and emphasis on the nuclear family
- The increased demands of the education system becoming more technical
- Exposures of adolescents to environmental influences like drugs, violence etc.
- Pressure to adapt physically and socially (Neinstein, 1991).

Predisposed groups include adolescents:

- 
- Living in poverty
 - With chronic diseases
 - Who have been abused sexually, emotionally and physically
 - Exposed to family pathology
 - With educational handicaps
 - With homosexual orientation (Neinstein, 1992).

The strength of religious practice and frequent attendance of church have a protective effect in preventing sexual activity. These adolescents have the least permissive attitude towards sex and are less sexually active. Early sexual initiation may result in reduced religious participation (Santelli & Beilenson, 1992).

As indicated in Green et al. 1992, higher educational aspiration and better school performance is found to be related to consistent contraceptive usage.

Teenagers with low academic achievement, low academic ability and low educational goals are more likely to engage in early sexual activity (Santelli & Beilenson, 1992).

In contrast, Smith (1997) found that school achievement and aspiration are unrelated.

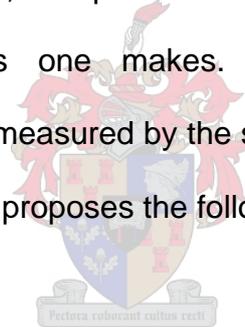
Nathanson and Becker (1986 in Santelli & Beilenson, 1992) found considerable influence and support of family and friends. Young black women were more likely to report parental involvement than their White peers. Zelnik and Shah (1983 in Santelli & Beilenson, 1992) reported that sexual initiation is strongly related to the use of contraception at first intercourse.

Positive or negative response to change will depend on the person's previous experiences. The following questions can be asked:

- 1) Did the adolescent have the opportunity to develop this skill?
- and
- 2) were choices made for her by parents or other adults?

Gender identity is established in the early years of life. However, it is in adolescence that acceptance of one's own body and sexual role must occur to ensure effective decision-making regarding a sex partner. Adolescents shift their emotional focus from parents and siblings towards other adults and peers, seeking intimacy, love relationships and sexual partners (The Committee on Adolescence, 1986).

According to Erickson (1968 in Petersen et al. 1995) the process of identity formation involves the selective narrowing of choices regarding sexual, occupational and social roles and commitment to the choices one makes. Progress towards identity achievement is measured by the status of personal commitment. Erickson further proposes the following statuses:



- **Identity achievement** where individuals have made identity commitments after actively exploring alternatives;
- **Moratorium** where individuals are currently engaging in exploration;
- **Foreclosure** where the individual makes identity commitments prematurely without exploring alternatives; and
- **Diffusion** where there exists a lack of integration in one's sense of self.

Identity development and progression towards identity achievement may be affected by experiences and opportunities (Millstein et al., 1993).

Physical change leads to changes in the sense of identity often resulting in conflict in family and social relationships. Conflict relating to dependence/independence will reflect past experiences with separation throughout childhood (Cerqueira Leite, R.M., Buoncompagno, Cerqueira Leite, A.C., Mergulhao & Battistoni, 1995).

Hogan and Kitigawa in Santelli and Beilenson (1992) indicate that parental control, control over hours, location and partners, and are strong indicators for initiation of sexual intercourse. Adolescents who viewed their parents as having few dating rules were more sexually experienced. Newcomer and Udry (1984) found that parental attitude did not have an effect on adolescent behavior.

Smith (1997) found a lack of relationship between sexual activity and supervision. She also found that single parenthood and family instability were associated with sexual initiation. Santelli and Beilenson (1992) also indicated single-parenthood as a factor.

Cates (1980, in Group for the advancement of psychiatry) indicated that the immaturity of adolescents complicates responsible decision-making. Denial is an early defense in teenage pregnant girls resulting in delayed seeking of medical advice. Their state of confusion influence rational consideration and encourage the resistance or refusal to seek termination of the pregnancy.

The choice to terminate the pregnancy, carry to term or place the baby for adopted, has important implications for the pregnant teenager (Resnick, 1992).

Resnick (1992) indicated that pregnancy decisions by young people contributed to their poor educational and economic attainment.

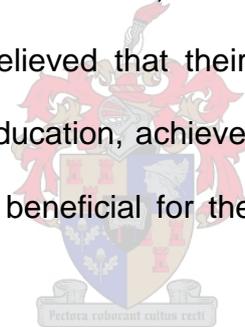


Current trends in adolescent behavior and teenage pregnancy are the result of a change in social climate, social attitude and the provision of services to teenagers (Resnick, 1992). Only 5% of teenage mothers place their babies for adoption in relation to approximately 90% of unmarried mothers who opted for adoption 40 years ago. The decline can be due to the sexual resolution in the 1960s and 1970s resulting in the diminished level of stigma associated with teenage pregnancy (Resnick, 1992).

As indicated by Greathead (1988) the following are listed as some of the reasons for choosing adoption:

- adoption against the principles of the teenager
- to keep the pregnancy a secret
- to complete schooling
- to please the family
- to provide the child with better opportunities
- to start afresh

Teenagers opting for adoption, showed higher educational aspiration and motivation, hold favorable attitudes towards adoption and believed that their decision will enable them to continue their education, achieve economic sufficiency and that the choice was beneficial for the infant's emotional and social development.

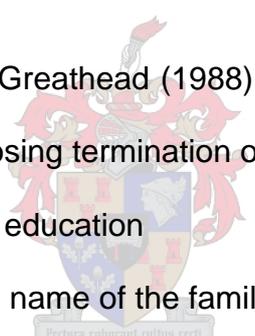


The Choice on Termination of Pregnancy Act No. 92 of 1996 was implemented in South Africa 1 February 1997. Six months post implementation, 12000 safe abortions were provided. As indicated in the Reproductive Rights Alliance Barometer (1997), the national statistics in South Africa stated that 17.4% women requesting termination of pregnancy are under the age of 18 years while 82,6% are older than 18 years. These figures excluded Northern Province.

As indicated by Resnick (1992) adolescents who terminated a pregnancy, are characterized by higher education aspirations, motivation and better school performance.

An adolescent chooses abortion after considering the long and short-term consequences, believing that it was for the greater good. The decision involved issues such as the burden of an unwanted baby, the burden of single parenting, issues involved in adoption as well as the restrictions on the further developing life of the prospective mother (Foster & Sprinthall, 1992).

As indicated by Greathead (1988) the following are some of the reasons for choosing termination of pregnancy:

- 
- A faint watermark of a university crest is visible in the background of the list. The crest features a shield with various symbols, topped by a crown and a banner with the Latin motto "Pectora roburant cultus recti".
- to finish their education
 - to protect the name of the family
 - to keep the pregnancy a secret
 - to please the boyfriend
 - as a form of contraception

Most teenage mothers, who decide to continue with the pregnancy and keep the baby, drop out of school and do not return to finish school. As a result of this abrupt withdrawal from the education system, these girls have a far less opportunity to enter the job market or gain regular employment than their peers who completed their schooling (Masters et al. 1986).

The above-mentioned finding is being supported by Gibson in Population Report, 1995 indicating that schoolgirls becoming pregnant in developing countries rarely return to school.

In Kenia up to 10,000 girls drop out of school per annum because of unintended pregnancy. The said country routinely expels pregnant teenagers with no action being taken against the father in case of a teenage boy, who may continue his schooling. Many girls risk unsafe abortion to avoid dropping out of school (Population Report, 1995).

Resnick (1992) indicated that 40 000 teenage girls drop out of school each year due to unintended pregnancy.

However, Moore and Myers (1992) indicate that the proportion of young mothers continuing schooling after childbirth has increased from 19% in 1958, to 29% in 1975, to 56% in 1986. They further indicate that despite these positive trends, early child-bearers continue to be less likely than older teens to complete high school.

Geronimus and Korenman (in Nord et al., 1992) indicated that a teenage birth significantly reduces the schooling of the parent.

Teenagers, who get married to legitimate a birth, are less likely to return to school. Thus, her low educational level places her at a disadvantage in the job market resulting in a higher risk of poverty together with the higher probability of divorce (Nord et al., 1992).

2.6 SEXUALITY EDUCATION

Sexuality education was mandated in Sweden in 1956 and became part of many school programs. Between 1975 and 1981 the abortion rate in the United States rose 43% while the rate dropped 30% in Sweden (Holloway, 1994).

Sexuality education has not been very effective in improving contraceptive use. This may be because very little concrete information on how to plan for sex or contraceptive use is being provided. Many sexually active teenagers fail to use contraceptive even if they have access to contraception (Moore, Adler & Kegeles, 1996)

Health providers can advocate and encourage teenagers to abstain including those who are already sexually active. However simply urging them to abstain would not be appropriate (Population Report, 1995).

Adolescents need accurate information regarding sexual issues in order to make informed choices and maintain their sexual health. In most cases parent and institutions are not able or unwilling to provide this information and thereby foster a negative understanding of sexuality. Inaccurate information, so often the only source of sexuality education, is provided by the media and friends (Fourth World Conference on Women for Action, 1997).

Masters et al. (1986) stated that misinformation or complete lack of information was a key factor contributing to teenage pregnancy.

Most people believe that the source of sexuality education should be the parent. In reality this does not happen. Only 10% of parents discuss sexual issues with their children (Masters et al. 1986).

As noted in Santelli and Beilenson (1992) sexuality education clearly increases the use of contraception in sexually active teenagers and thus reduces the risk of pregnancies.

2.7 SELF-ESTEEM, ROLE FUNCTION, AND INTERDEPENDENT RELATIONS

Adolescence bridges childhood dependency and adult autonomy. During this period of transition adult reproductive sexuality is born and matures. Adolescents have to learn to function as independent adults and therefore, have to loosen their parental ties (The Committee on Adolescence, 1986).

Becoming a self-governing, autonomous individual relates to developmental change in young people. There is a marked increase in self-reliance, self-control and the capacity for independent decision-making during the teenage years. Increasing conformity to peers counteracts decreasing conformity to parents (Millstein et.al. 1993).

Emotional autonomy associated with the resolution of the conflicts of adolescents is important to the coping with their sexuality as well as their social and academic development (Cerqueira Leite et al., 1995).

Self-esteem tends to be largely affected by feelings of self - confidence (Petersen et al., 1995).

Jessor (1992) in (Britto, Garrett, Dugliss, Daeschner, Johnson, Leigh, Majure, Schhultz & Konrad, 1998) defined risk behavior

as...“any behavior that can compromise the psychosocial aspects of successful adolescent development such as fulfillment of social roles, acquisition of essential skills, achievement of competence, and transition to young adulthood.”

Resnick (1992) stated that adolescent activity occurred within the context of serious, romantic relationships, with a degree of greater commitment within the relationship, resulting in greater likelihood of sexual intercourse.

A study by Lindegger (1993 in AIDS Bulletin (1996) on 120 black women and 60 black men in KwaZulu Natal indicated women in general were aware of their risk of contracting AIDS and how to protect themselves but did not perceive themselves to be at risk when in a monogamous relationship.

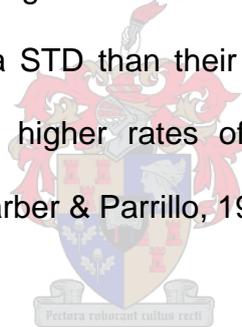
Dominant views amongst adolescents are that sex is justified as physical pleasure or as a new experience. They regard it as a sign of maturity and it reflects peer group conformity. Adolescents experience increasing pressure from their peers to become sexually active (Neinstein, 1991).

Foster and Sprinthall (1992) stated that “Sporadic risk taking or exploratory sexual behavior may be endemic to early adolescence, when social interaction and biological drive

interact as teenagers strive for competence in unfamiliar domains".

Psychological factors such as self-esteem, values, self control and motivation are associated with risk behavior leading to STD. Adolescence is often characterized by a sense of invulnerability, which encourages risk-taking behavior (Yarber & Parrillo, 1992).

The highest rates of STD occur in younger adolescent females, inner-city youth and ethnic minority teenagers. Inner-city teenagers have high rate of STD. Black teens are more likely to be infected by a STD than their White counterparts. Hispanic teenagers have higher rates of Chlamydia than their White counterparts (Yarber & Parrillo, 1992).



The World Bank in Islam (1996) indicated that Sexually Transmitted Diseases including HIV are the second leading cause of years of healthy life lost after maternal morbidity and mortality

Infection with one Sexually Transmitted Disease puts adolescents at risk of acquiring another Sexually Transmitted Disease. Gonorrhea is highly associated with Chlamydia while Syphilis is associated with HIV infection (Santelli & Beilenson, 1992).

Throughout the developing world millions of adolescents live or work on the streets making a living out of prostitution that increases their exposure to Sexually Transmitted Disease (Population Reports, 1995).

Poverty coerces many young people into early sexual activity. These young people have little bargaining power in their sexual relationships and therefore, may be unable to protect themselves from Sexually Transmitted Diseases and unintended pregnancies. In Thailand an estimated 800 000 girls under the age of twenty (20) years make a living out of prostitution. In parts of Africa young girls engage in sex with older men to pay for school fees, buy clothes and other necessities (Population Reports, 1995).

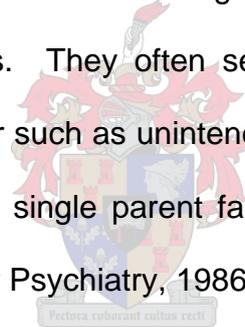


Adolescents often suffer the physical and emotional trauma of sexual assault and rape. Amongst US women 74% of 14 year olds and 60% of 15 year olds who were sexually active reported being forced to have sex (Population Reports, 1995).

Sexual abuse or coercive sex in childhood leads to the early onset of consensual sexual activity. A study undertaken in Barbados indicated that sexual abuse during childhood was the most important determinant of high-risk sexual behavior in adolescents. A US study of young women, who were pregnant by 17, indicated that 93% were sexually abused as children. It

was found that women, who experienced sexual abuse as children initiate sexual intercourse one year earlier than their non-abused peers, were more likely to abuse alcohol and drugs and were less likely to use contraception (Population Reports, 1995).

Teenage girls from disadvantaged groups often experience a sense of hopelessness about the ability to control their future and life. Therefore, they are at greater risk when behavior that conforms to conventional values such as virginity, good progress at school and setting of occupational goals fails to provide rewards. They often seek self-enhancement through deviant behavior such as unintended pregnancy. Many of these girls come from single parent families (The Committee for the Advancement of Psychiatry, 1986).

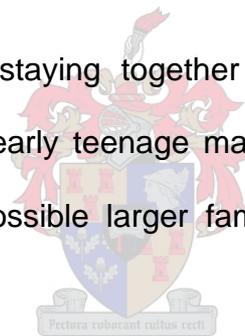


The Committee for Advancement of Psychiatry (1986) indicated that the socioeconomic environment influences certain patterns of sexual behavior and pregnancy. Teenagers in a disadvantaged community gain a sense of self-expression and status through their sexual behavior. Socioeconomic deprivation places a great burden on families as well as the adolescent, increasing their risk of becoming pregnant.

Resnick (1992) noted that single parenting have become socially more acceptable. The sexual revolution of the 1960's and 1970's resulted in a diminished level of stigma associated with single parenting in the United States.

The adolescent who decided to carry to term and raise the baby as a single parent have been characterized by lower school performance, a traditional sex role orientation, greater dependency needs, fewer economic resources, long relation with the male partner and family support (Resnick, 1992).

Promoting the staying together of expecting teenagers may result in a too early teenage marriage with potential economic difficulty and possible larger family size (Hudson & Ineichen, 1991).



Adolescents find relationships difficult to sustain therefore, marriage due to an unintended pregnancy often end in divorce (Hudson & Ineichen, 1991). McCarthy and Menkin (1979) support this and stated that married teenage parents are more likely to divorce or separate than their peers who had their children in their twenties. Factors contributing to failure of a teenage marriage include immaturity of adolescents and the stress of teenage parenting.

For teenagers the risks of childbearing do not end with the delivery. Women having their first child before the age of 20 years are more likely than older women to obtain less education, have fewer job possibilities resulting in lower income, divorce if getting married and live in poverty (Population Report, 1995).

Social consequences vary among cultures. In some cultures motherhood brings social status and respect. In some parts of Africa an unintended pregnancy can improve the woman's status by leading to marriage and ensuring economic support. In societies where teenage pregnancies are condemned, teenagers are encouraged to marry young in order to avoid the risk of a pregnancy outside wedlock (Population Report, 1995).

In societies where divorce is unacceptable, teenagers forced to marry, as a result of an unintended pregnancy may have to endure violence and abuse by the partner.

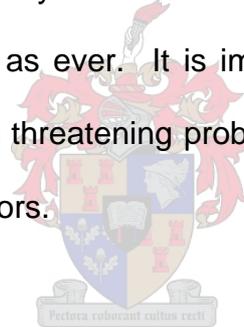
Some teenagers are sent away from home by parents to avoid embarrassment by the family or some prefer to run away from home where others even attempt suicide to avoid a scandal (Population Report, 1995).

There are numerous risks to babies born to teenage mothers

such as lower educational attainment, behavioral problems, problems with self control and the likely hood of themselves become teenage parents (Hudson & Ineichen, 1991).

2.8 CONCLUSION

Adolescence is a time of dramatic change in terms of physical development, sexual maturation, cognitive abilities, identity development, social and interpersonal change, developing relationships and dating. Problems of early sexual encounters, teenage pregnancy and sexually transmitted disease are as prevalent today as ever. It is important not to focus solely on individual health threatening problems, but to review the holistic contributory factors.



It is not easy for any teenager to seek contraceptive advice. They need to overcome many obstacles and need to be handled with sensitivity and understanding. Many teenagers have been sexually active for a while before having the courage to seek contraception. They are often not aware of the risks involved in engaging in unprotected sexual activity.

Due to factors such as youth and social pressure, young girls are more vulnerable to sexual violence such as rape, sexual abuse and sexual exploitation.

Teenage child bearers are less likely to complete high school, than their peers who did not have babies. Early childhood is also linked to lower social and economic attainment, poverty and less marital stability.

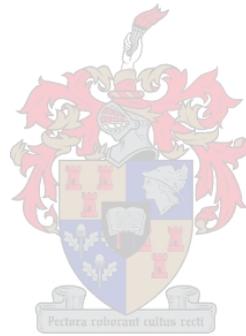
Sexually transmitted diseases are a serious health problem in adolescents occurring in 25% of sexually active teenagers. Adolescent females and low-income, urban minority groups are particularly at risk. Teenagers are particularly at risk because of their high-risk sexual behavior such as early sexual activity, multiple sexual partners and failure to use condoms consistently.



Adolescents need information and educational programs in order to protect and maintain their sexual health and exercise their rights. Sexuality education enables young people to make informed choices, including whether to become sexually active or not and thereby decreasing the rate of teenage pregnancy and sexually transmitted diseases. Studies have indicated that sexuality education delays or decreases adolescent sexual activity. Therefore, withholding information does not guarantee abstinence.

It is important that adolescents are assisted in the task of being directed to the healthiest choices appropriate for their

circumstances. There are no quick fixes to factors contributing to ill sexual health.



CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to define the research methodology that was applied to determine what factors contribute to adolescents experiencing problems in maintaining their sexual health. The following aspects are discussed in this chapter:

- Research approach
- Research design
- Population and sampling
- Instrumentation
 - Validity
 - Reliability
- Pilot study
 - Data analysis
 - Ethical.



3.2 RESEARCH APPROACH

An exploratory, non-experimental approach is being used.

Descriptive surveys have tended to be the most frequent type of investigation with exploratory surveys and clinical experimentation becoming popular. An exploratory survey might be undertaken to determine the needs of a section of a population. The survey approach is a non-experimental study in which the researcher investigates a group of people or a community. Asking questions, conducting interviews, observation or doing telephone interviews can do this (Treece & Treece, 1982).

Surveys do not aim to discover the cause of a phenomenon but intend to provide an accurate quantitative description. During a survey all or part of a group of people or things can be sampled. Survey data are usually obtained by means of a questionnaire or interviews (Treece & Treece, 1982).

In the case of an illiterate respondent it is common practice for the researcher to read the question and write down the response on the questionnaire (Treece & Treece, 1982).

The aim of nursing research is to find answers to queries by means of scientific methodology. Questions must be conceived that will produce answers through some form of data collection from observation or experimentation. The research question must be precise, based on prior knowledge and allow the

researcher to test conditions and influences (Treece & Treece, 1982).

Exploratory studies allow the researcher to study the variables pertinent to a specific situation and may be more focused upon specified areas (Treece & Treece, 1982).

With exploratory research you are free to discover any relationship that exists between any variables you are to explore (Mitchell & Jolley, 1992). This study explored the relationship between adolescent high-risk behavior and related conditions, sexuality education; adaptation levels and the impact on adolescents; self-esteem, role function and interdependent relations.



3.3 RESEARCH DESIGN

The research design is the overall plan the researcher selects for carrying out the study. The design most useful for the purpose of the research and best suited to the level of inquiry is selected (Mellish & Brink, 1990).

Van Lill and Grieve (1990) refer to the research design as “plan or strategy which a researcher follows in order to study human behavior in a scientific way.”

Qualitative and quantitative research as technique may be used together to address the same problem, known as triangulation. Field and Morse (1987) indicated that qualitative methods might be used to describe the affective aspects of the domain, while quantitative methods are used to measure other variables (Field & Morse, 1987).

According to Polit and Hungler (1992) quantitative research involves the systematical collection of numerical information under considerable control, analyzing that information using statistical information while qualitative research involves the systematic collection and analysis of more subjective materials where there tend to be a minimum of control.

For the purpose of this study triangulation is used because it enabled the researcher to explore and describe the population in detail (Burns & Grove, 1993).

3.4 **DURATION OF THE STUDY**

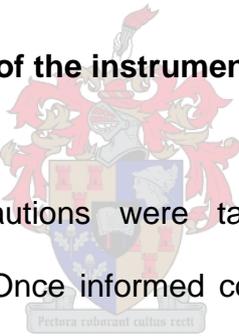
An in depth literature study has been completed prior to commencement of the data collection. The literature study was undertaken over a period of one year and data collection was completed over a period of 11 months, the total duration of the research project was therefore 23 months.

3.5 **INSTRUMENTATION**

With the use of a pre-tested questionnaire, the researcher has conducted a structured interview. The questionnaire developed, consisted of 57 items. (See Addendum 1).

The questionnaire was designed in one language (English) only and where necessary, translation was done by the researcher. The average time that was required to complete a questionnaire was 20 minutes.

3.5.1 **Administration of the instrument**



Extensive precautions were taken to protect participants' confidentiality. Once informed consent was obtained from the participants, they were interviewed privately in a consulting room in the clinic. The researcher administered a structured interview.

3.5.2 **Design and content of the questionnaire**

After an in depth literature study, the questionnaire was designed and developed for the study. The aim of the questionnaire was to determine the current sexual health status of adolescents as well as the factors that played a role in

adolescents experiencing problems in maintaining their sexual health.

The questions in the questionnaire included closed and open ended as well as multiple-choice questions.

Questions 1-5 and 9 referred to personal data.

Question 6-8 referred to religious habits.

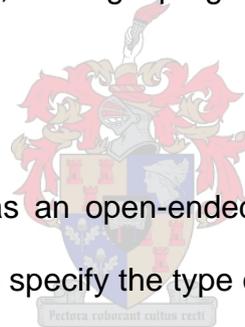
Question 10-13 referred to information gained about sexual decision-making, teenage pregnancy and sexually transmitted disease.

Question 13 was an open-ended question where respondents were required to specify the type of information gained regarding sexually transmitted disease.

Question 14-25 referred to information about sexual relations.

Questions 26-29 referred to information about dating.

Questions 30-33 were used to measure influences on adolescent sexuality.



Question 31 and 32 were open ended questions related to the encouragement adolescents receive to avoid sexual activity.

Questions 34-37, 43 and 44 referred to information about teenage pregnancy.

Questions 34, 36 and 37 were open-ended questions.

Questions 38-42 referred to information about contraception usage.

Questions 45-48 referred to information about sexually transmitted disease.

Question 45 was an open-ended question referred to sexually transmitted disease.

Questions 56 and 57 were open-ended questions and referred to respondents' attitude towards pre-marital sex.

3.6 **VALIDITY AND RELIABILITY**

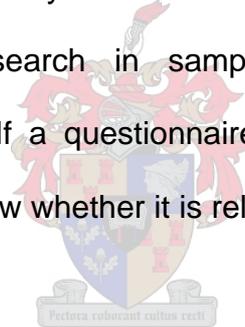
These two concepts are cardinal in any instrument of measure.

Their presence increases the value of the research.

Field and Morse (1987) refer to validity as “.....how good an answer a study yield”. The answer should be sound and represent reality.

According to Treece and Treece (1982) validity refers to an instrument’s ability to actually test what it is supposed to test, while reliability is the ability of the instrument to obtain consistent results.

Field and Morse (1987) refer to reliability as “.....a consistent element of validity.” Reliability is a central concept in quantitative research in sample selection and instrument development. If a questionnaire is used to collect data it is important to know whether it is reliable.



Content validity is being done to determine how well the instrument represents all the different components of the variables to be measured. Content validity is usually being used in questionnaires and interviews. The instrument is being constructed based on the literature review that reveals the essential aspects of the variables to be included in the content (Brink, 1996). Experienced Adolescent Sexuality trainers and experts in nursing science and research have evaluated the questionnaire. To increase response validity:

- the questionnaires were administered by the researcher herself
- the questionnaires were completed anonymously
- the researcher collected the data herself.

For all interviews to contribute to reliability, the researcher conducted a structured interview with the use of a questionnaire.

Reliability is also increased when the researcher has personal knowledge or experience regarding the subject of research, and is familiar with the research environment. The researcher met both of the above-mentioned criteria.

To identify ambiguity or errors the researcher conducted a pilot study. The pilot study was conducted under similar conditions as the actual study. The aim of the pilot study was to ascertain reliability. The promoter evaluated the instrument used as well as the content.

The researcher found that the subjects trusted her and they shared sensitive information enhanced by the non-threatening atmosphere in which the interviews were conducted.

THE PILOT STUDY

Treece and Treece (1982) refer to the pilot study as “.....the preliminary small-scale trial run of the research study”.

Pre-testing the research instrument and conducting the pilot study are important to ensure the success of the investigation. Pre-testing refers to the process of measuring the effectiveness of the instrument (Treece & Treece, 1982).

During pre-testing the reliability and validity of the instrument developed for the study, are checked (Treece & Treece, 1982).

The purpose of the pre-test is to reveal any problems related to answering, completing and returning the instrument as well as tabulating the data (Treece & Treece, 1982).

The researcher did the pilot study to make improvements to the instrument and to detect problem areas in order to solve it before commencement of the major study.

At least 5% (15) adolescent female subjects, who attended the selected Sexual and Reproductive health Care clinics, received the prescribed questionnaire to complete. No major problems were revealed during the pilot study and all ambiguity excluded from the questionnaire. All information gained during the pilot

study was kept confidential. These respondents were not included in the sample.

3.8 **POPULATION AND SAMPLING**

3.8.1 **Population**

The population implies all elements that meet the criteria (Burns & Grove, 1993).

The population consisted of four (4) clinics in the Metropole Region and estimated of 3030 female adolescents attending the clinics over a period of six (6) months.

These adolescents included Coloured and White female adolescents between the ages of 10 and 19 years. Female adolescents who registered for their clinic appointment or those who accompanied a friend, while the researcher was present and those who met the inclusion criteria for the study were invited to participate. The researcher would visit the four clinics alternatively and select all clients who meet the set criteria for the specific day at the specific point.

The researcher worked in the Metropole Region of the Western Cape and with five years work experience in the area of

adolescent sexual and reproductive health she identified major problems dealing with adolescents in terms of maintaining their sexual health. Due to limited financial resources the researcher decided to limit the study to the Metropole Region of the Western Cape.

3.8.2 **Sampling**

Burns and Grove (1993) define sampling as the process for selecting a group of people, events, behaviours or other elements with which to conduct a study.

There are mainly two types of sampling methods available, namely non-probability and probability sampling. A variety of probability sampling and non-probability sampling methods are used in nursing science. In probability sampling every member has a chance higher than zero of being selected. With non-probability sampling, not every member of the population has an opportunity for selection (Burn & Grove, 1993).

Random sampling is a method of probability sampling. Each individual has thus an equal opportunity to be selected for the sample, thus reducing sampling error (Polit & Hungler, 1992). Random sampling increases the extent to which the sample is representative of the target population. It also must take place

in an accessible population that is representative of the target population. Random sampling thus increases the validity of the study.

The Metropole Region of the Western Cape with its four Youth Health Centres (clinics) were identified for this study for the sake of convenience. The researcher could not include any other region or clinics because of time and financial constraints.

The researcher identified the following criteria for inclusion of respondents:

- Girls between the ages of 10 and 19 years attending the four Youth Health Centres
- Coloured and white adolescent girls



These criteria were determined after in depth discussion with nursing experts, the supervisor and statistician.

Random sampling was used. This method ensured that everyone in the population had an equal chance of being included in the study. This sample is considered to be representative and the findings unbiased and generalisable. The sampling strategy was suggested by an expert statistician. All four (4) Youth Health Centres, referred to as clinics 1-4, in the Metropole Region, Western Cape have been selected. The

estimated total of adolescents attending the clinic over a period of 6 months has been determined. A proportion (% of total) was calculated. The size of the sample was 302 (10%).

Table 3.1 **Proportional sampling**
N=3030

Range	Estimated total over 6 months	Proportion (%of total)	Size of sample (10% sample of total drawn)
Clinic 1 96-152 (Coloured)	744	25%	75 Persons
Clinic 11 65-129 (Coloured)	582	20%	60 Persons
100-180 (White)	840	27%	82 Persons
Clinic 111 59-76 (Coloured)	405	13%	40 Persons

Range	Estimated total over 6 months	Proportion (%of total)	Size of sample (10% sample of total drawn)
18-27 (White)	135	4%	12 Persons
Clinic 1V 13-34 (Coloured)	141	5%	15 Persons
17-44 (White)	183	6%	18 Persons
Total	3030	100%	302 Persons (10%)

The researcher wanted to determine how many girls under the age of 14 years and older than 14 years visited these facilities and divided them into two groups (group one and two). This would provide an indication of how many young adolescents (group one) attended a Sexual and Reproductive Health Clinic. Group one consisted of 13 adolescent females between the ages of 10 and 14, while group two consisted of 289 adolescent females between the ages of 15 and 19 years. Within group one no participant was younger than 14 years.

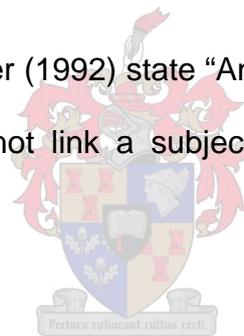
3.9 ETHICAL ASPECTS

Consent to conduct this research project was obtained from the Ethics Committee of Community Health Services Organization: Provincial Administration of the Western Cape.

3.9.1 Anonymity

Brink (1996) refers to anonymity as an act of keeping individuals nameless in relation to their participation in the research.

Polit and Hungler (1992) state “Anonymity occurs when even the researcher cannot link a subject with the information for that subject”.



For the purpose of this study anonymity was ensured, by providing each participant with a number. Information related to the subjects was available to the researcher only. Due to the number allocated to the subjects, it was not possible for the researcher to link subjects with the data for that subject. Herewith the subjects right to privacy were protected.

3.9.2 **Confidentiality**

According to Brink (1996) confidentiality refers to the researcher's responsibility to protect all data gathered within the scope of the project from being made available to any other person.

Confidentiality was ensured by the researcher in not linking any data to a specific respondent or making specific data available which could identify a respondent.

3.9.3 **Consent for the study**

Informed consent means that the subjects have adequate information about the study, understands the information enabling them to voluntarily consent to participate or decline participation (Polit & Hungler, 1992).

Brink (1996) highlight the three major elements of informed consent as the following:

- the type of information needed by subjects
- the degree of comprehension required to give consent
- the subject's free choice to give consent.

Field and Morse (1987) state that informed consent consists of the following components:

- explaining the purpose of the research
- the risks and benefits involved for the subjects
- the opportunity for subjects to ask questions
- the subject's choice to withdraw at any time or refusal to answer questions without being penalized.

For the purpose of this study verbal consent was obtained from the adolescent female clients who voluntarily participated in the research project.

The purpose and aim of the study was conveyed to all concerned in the process of acquiring permission to conduct the research project.



Structured interviews were conducted in privacy by the researcher. Total anonymity and confidentiality were assured.

Two open-ended questions were tape-recorded with the knowledge and consent of the subjects.

3.10 DATA COLLECTION

Data collection is a critical phase in the process of triangulation and may be done by observing, testing, measuring, questioning and recording (Burns & Grove, 1993).

Field and Morse (1985) also state “The major mode of data collection is generally interviewing...”.

A guided interview is used when information about a topic is required where answers cannot be anticipated. This technique ensures that the researcher will obtain all information required.

The guided interview is tape-recorded and the responses are transcribed and the content analyzed at the end of the interview (Field & Morse, 1985).

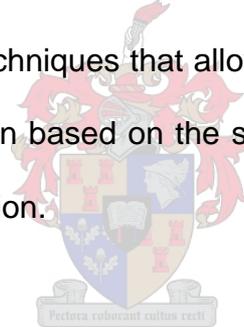
Open-ended questions would be appropriate in situations where interviews may cause embarrassment to the subjects (Field & Morse, 1985).

The data was collected by the researcher by means of a structured interview with the use of a questionnaire. Adolescent females who met the criteria were interviewed.

DATA ANALYSIS AND INTERPRETATION

Mellish and Brink (1990) identify two major steps in data analysis e.g. categorization and statistical analysis. Descriptive statistics are used to summarize findings while inferential statistics are used to infer from the sample to the population from which the sample was drawn.

Van Lill and Grieve (1990) refer to descriptive statistics as the scores that are obtained when the characteristics of people and their environment are measured. Inferential statistics refer to methods and techniques that allow inferences to be made about a total population based on the sample that is representative of the said population.



The initial analytical process of data analysis is embedded in the process of recording and analyzing the field-notes and the interview. The analytical task is making sense out of the data collected (Field & Morse, 1987).

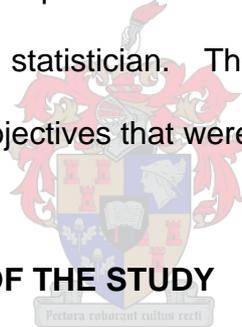
The purpose of data analysis is thus to code the data so that the categories may be recognized, analyzed and the behaviours observed noted. Thereafter a data filing system is being developed that will provide a flexible storage system to enable easy retrieval of data. (Field & Morse, 1987).

Interpretation of the findings is the step during which the researcher tries to figure out the meaning of the results. He or she must explain the findings in terms of the problem and the purpose of the study (Mellish & Brink, 1990).

In this study data has been calculated by computer. Use of frequency tables, graphs, percentage calculation and construction of tables for visual depiction of the data were obtained.

Analysis and interpretation of data was completed with the assistance of a statistician. The findings were interpreted in relation to the objectives that were set for the study.

3.12 LIMITATIONS OF THE STUDY



The following could be argued as being limitations of the research:

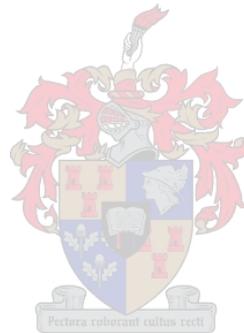
1. The results are applicable to the adolescents in the Metropole Region of the Western Cape; and
2. Very specific knowledge regarding sexual health was not tested.

The researcher believes, however that the study is credible because the principles of sampling, data collection, validity and

reliability were applied irrespective of the specific population used.

3.13 CONCLUSION

In Chapter 3 a detailed description is given regarding the methodology used in this research project. The researcher indicated how the concepts of accurate research methodology were integrated in the chapter.



CHAPTER 4

DATA ANALYSIS AND DISCUSSION

4.1 INTRODUCTION

In this chapter the data obtained is analyzed and discussed. The process of data analysis is characterized by referring, clarifying and comparing of statements, concept and theories found in the literature.

4.2 THE QUESTIONNAIRE (Addendum 1)

The questionnaire consists of 57 questions. The results are organized in descriptive tables and graphs showing the numbers and / or percentages for each item.

Question 1 relates to the age of respondents. All the clients interviewed responded, N = 302. 13 (4%), represented girls between the ages of 10 to 14 years, while 289 (96%), represented girls between the ages of 15 to 19 years.

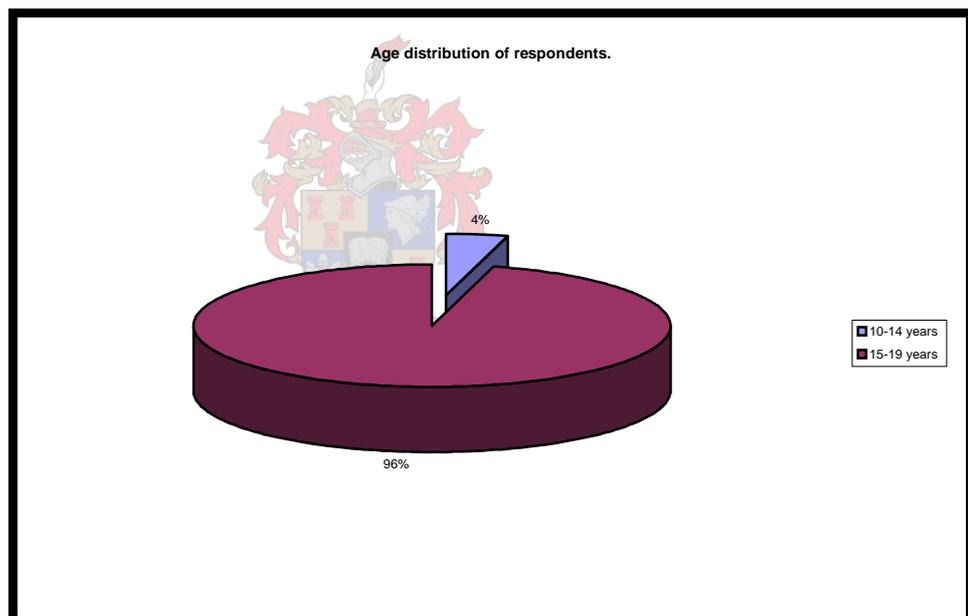
Table 4.1 Age distributions of respondents

N=302

10-14 years		15-19 Years	
N	%	N	%
13	4	289	96

Diagram 4.1 Age distributions of respondents

N=302

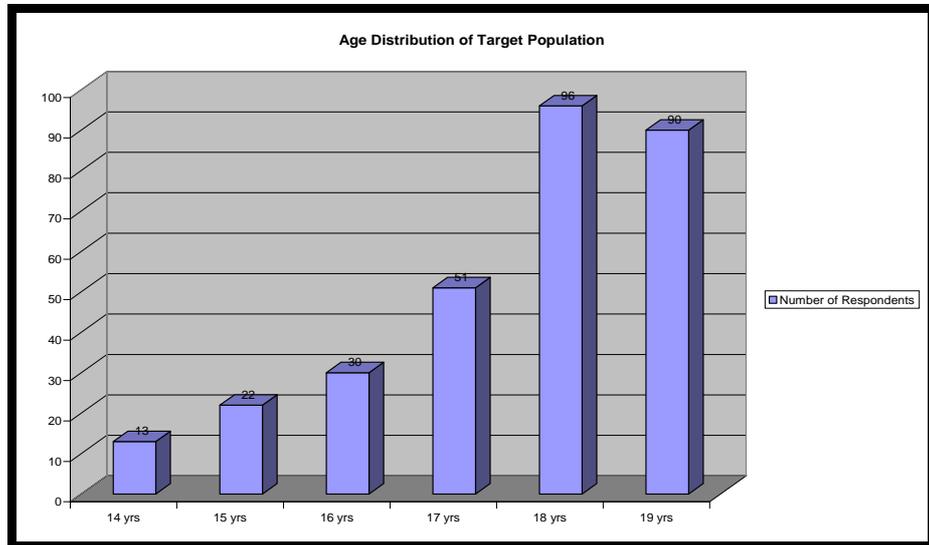


The age range of the target population interviewed varied between 10 and 19 years. The youngest participant being 14 years and the oldest being 19 years old (Table 4.1 and Diagram 4.1).

Figure 4.1

Age distributions

N=302



As seen in Table 4.1, Diagram 4.1 and Figure 4.1 none of the respondents in this sample were younger than 14 years of age. Thirteen (4%) respondents were 14 years of age and 289 (96%) respondents were between the ages of 15 to 19 years.

The majority of respondents were in the age groups 18 (32%) and 19 (30%) years. Between 4% and 17% of respondents were younger than 17 years.

This study as supported by the literature review confirms that girls under the age of 14 years do not visit Sexual and Reproductive Health facilities. However, this does not mean that these girls are not sexually active. They might not have the

courage to seek advice, contraceptive or any other advice related to their sexual health.

Question 2 refers to Ethnicity (White or Coloured) of respondents.

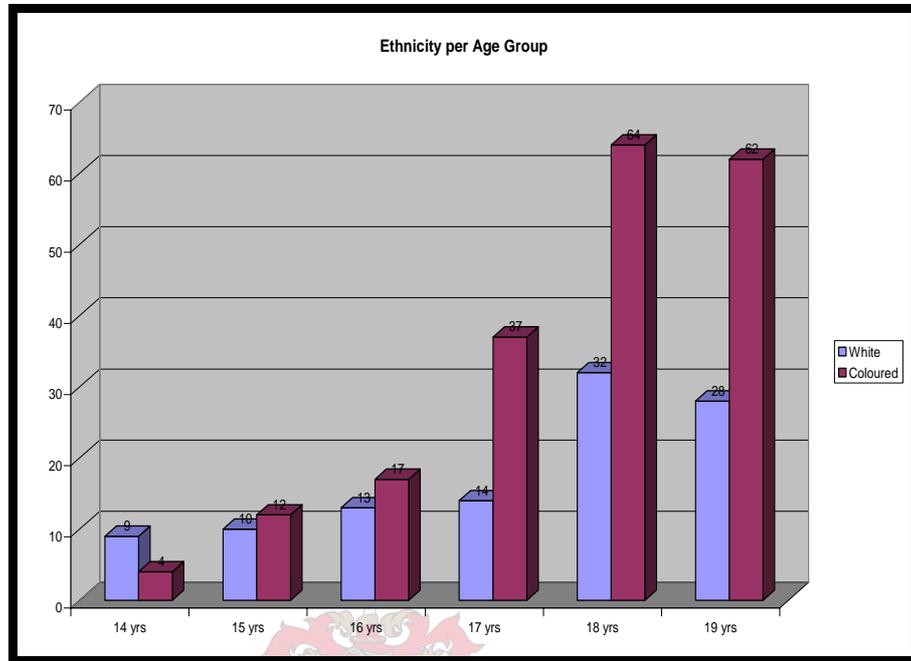
Table 4.2 Ethnicity of respondents
N=302

White		Coloured	
N	%	N	%
106	35	196	65

Whites represent (106) 35% and Coloureds represent (196) 65% of the sample. This represents the population distribution in terms of Coloured/white in the Western Cape.

Figure 4.2 Ethnicity per age group

N=302



One hundred and six (35%) of the respondents were White and 196 (65%) Coloured. However, only 1% of 14-year-old Coloured teenagers visited the health facility compare to 3% of White 14 year olds (Figure 4.2). Coloured teenagers seem to wait longer before visiting a sexual and reproductive health clinic as indicated by this study, 21% for both 18 and 19 year old groups.

According to Pittman et al. (1992) in 1988, African-American women between the ages of 15-19 had higher rates of sexual activity compared to their Hispanic and White peers. They also

reported to have had more sexual partners and were less likely to use a contraceptive method at first intercourse.

According to Pittman et al. (1992), poverty, low income, level of education and unemployment among African-American youth contribute to high risk sexual behaviour

As in other countries teenagers of colour in South Africa also has to deal with issues such as poverty, poor socio-economic circumstances and limited educational opportunities, which might contribute to the fact of prolonging their visit to a sexual and reproductive clinic. This is supported by Yarber and Parrillo (1992) who indicated that factors such as poor role models, lack of economic and educational opportunities, and inaccessibility of adequate health care might contribute to high incidence of sexually transmitted diseases in these minority groups.

As indicated in the study conducted in South Africa by Chilman (1978), 25% of White adolescents have experienced sexual intercourse by the age of 16 years while at the same age 50% of Blacks were sexually involved. However, this study showed only 13 (4%) for Whites and 17 (6%) for Coloureds. (Figure 4.2).

The following question was posed: Where did you spend the first 5 years of your life? Respondents had to choose between option a. Urban (Town or city) and b. Rural (Country).

Diagram 4.2 Urban or rural upbringing

N=302

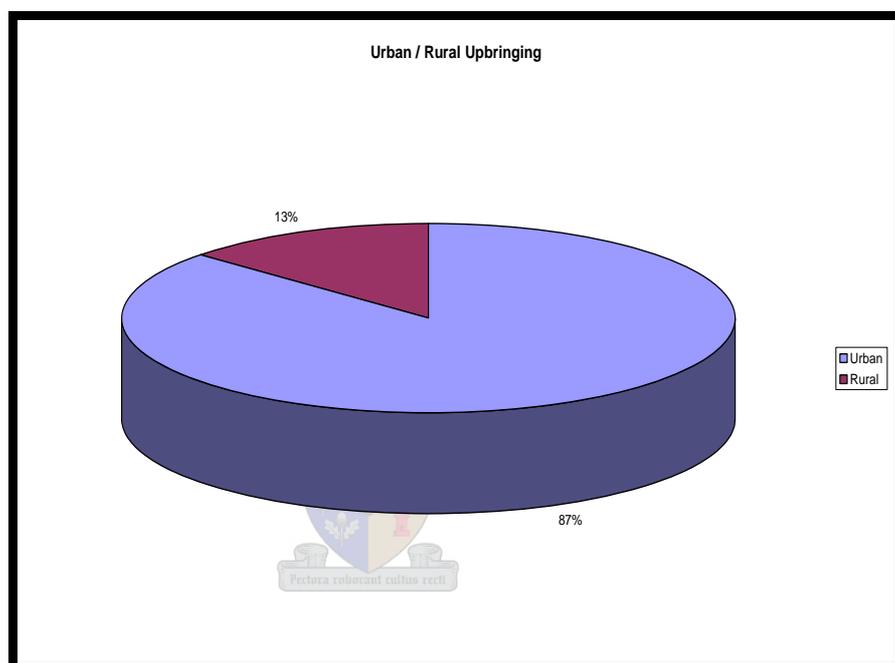


Diagram 4.2 shows that 262 (87%) of respondents spent their first five years of their lives in an urban set-up while only 40 (13%) spent theirs in a rural set-up over the same period. All 302 respondents were living in a town or city since then and during the time of the study.

This finding is supported by the literature review indicating that sexual activity is common amongst urban teenagers (Smith,

1997). Despite the fact that 40 (13%) (Diagram 4.2) of the respondents spent their first five years in a rural set-up, the impact of a rural upbringing was not remarkable. It thus appears as if they had totally conformed to the pressures associated with the urban set-up.

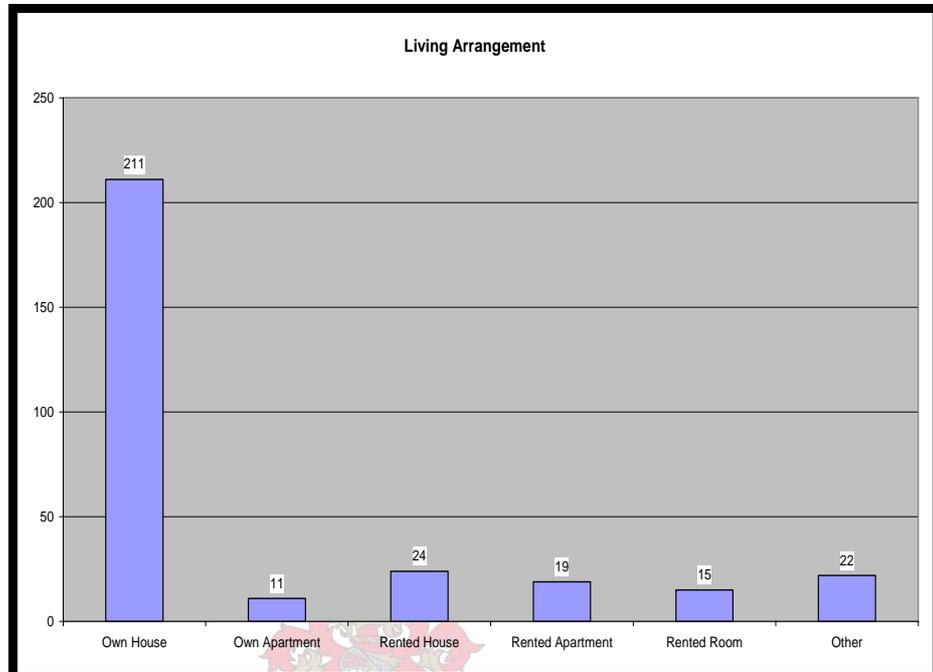
In urban areas adolescents find themselves in an environment with overwhelming peer pressure where it seems that “everybody is doing it”. However, this finding is contradictory to the response to *Question 22* where only 11 of 14 respondents indicated pressure by friends and having sex because “everybody is doing it”.

Question 5 refers to the respondents’ living arrangements.



Figure 4.3 Living arrangements

N=302



The study indicates that only a small number of respondents 11 (4%) are economically independent, and thus living on their own. 24 (8%) respondents lived with their parents in a rented house, 19 (6.3%) in rented apartments, 15 (5%) in rented rooms and the majority of 211 (67%) respondents live with their parents in their own houses. 22 (7.3%) respondents had other living arrangements like living with a granny or other family members. The living arrangements are also indicative of the socio-economic status of the parent/s for example living in their own house (Figure 4.3).

As reported by Newcomer and Baldwin (1992) significant problems exist in assessing socio-economic status of adolescents. Most adolescents are not self-supporting and the socio-economic status can thus only be measured by that of the parents. Researchers therefore rely on the measures of family structure, educational level of parents and perhaps the economic well being of the area of residence. For the purpose of this study the researcher only used the living arrangements as indicator of socio-economic measure. Thus, it seems as if the majority 67% comes from a good socio-economic environment.



The literature review suggests that socio demographic background has been associated with sexual activity in teenagers. This is supported by a study by Petersen et.al. (1995) who stated that lower socio-economic youth had the tendency for initiating early sexual activity and an increased frequency of sex. This underscores the argument that better resourced families can protect adolescents from involvement in risky behaviors such as initiation into early sexual activity.

This is supported by the findings of this study where based on living arrangement as indicative of social status of the family, the majority of respondents (68%) (Table 4.12) initiated sexual relations later (after the age of 16 years).

Question 6 refers to the religion to which the respondents were affiliated to at the time of the study. The researcher grouped the various religions and indicated worldwide-recognized religions with Christian principles. These are indicated by an asterisk in Table 4.4.

Table 4.4 **Religions of respondents**
N=302

Religion	N	%
*Baptist	11	4
*Methodist	13	4
None	18	6
*Apostolic (New/Old)	30	9
*Roman Catholic	37	12
Other	64	22
*Anglican	55	18
*Dutch Reform Church (NG)	74	25

Diagram 4.3 Religions of respondents

N=302

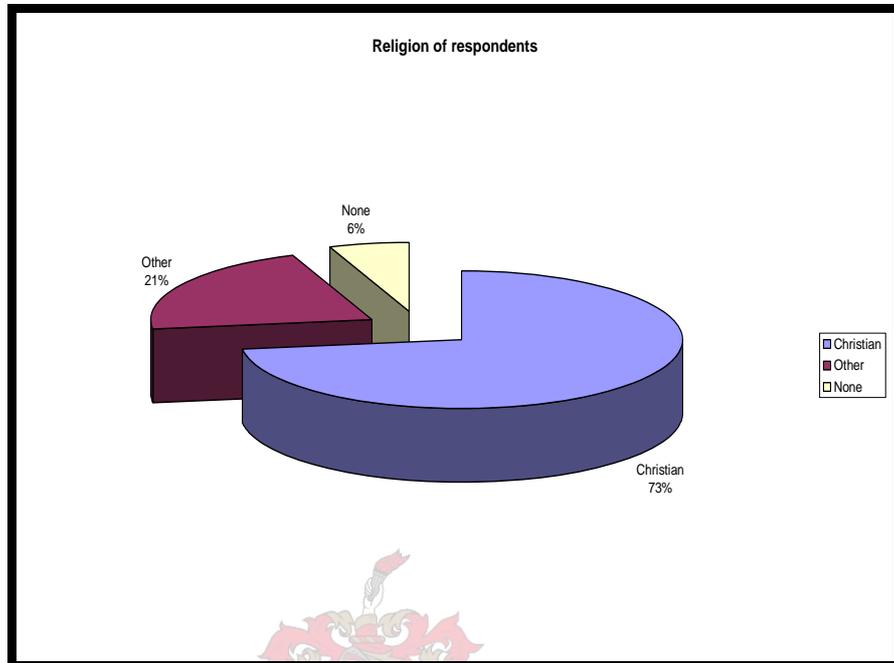


Table 4.4 and Diagram 4.3 indicate that adolescents with different religious backgrounds visited the Sexual and Reproductive Health facility and/or were sexually active. Between 4% to 9% of respondents were affiliated to the Baptist, Methodist, Moslem and Apostolic (including Old and New) faith, while between 12- 25% were affiliated to the Roman Catholic, Anglican and Dutch Reform churches. 18 (6%) were non-believers, while 155 (44%) belonged to different small religious groups e.g. Jehovah Witness, Greek Orthodox, Congregational and Church of the Nazarene.

Thus 284 (94%) respondents were affiliated to some form of religion, while only 18 (6%) did not belong to any religious group.

The majority of respondents 220 (73%) belonged to a religion (indicated with an asterisk in Table 4.4) that has been recognized worldwide as a religion with Christian principles. 64 (21%) respondents were non-Christians and 18 (6%) respondents were non-believers. This will impact on ethical and sexual decision-making as demonstrated in Table 4.30 where 51.3% stated that termination of pregnancy was unacceptable and Figure 4.15 where 62% of respondents noted sexual relations before marriage as wrong.

Questions 7 and 8 refer to the importance of religion to participants and attendance of religious gatherings.

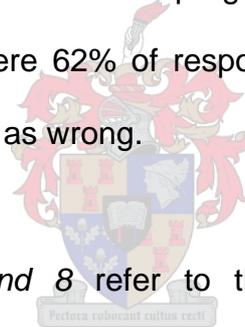


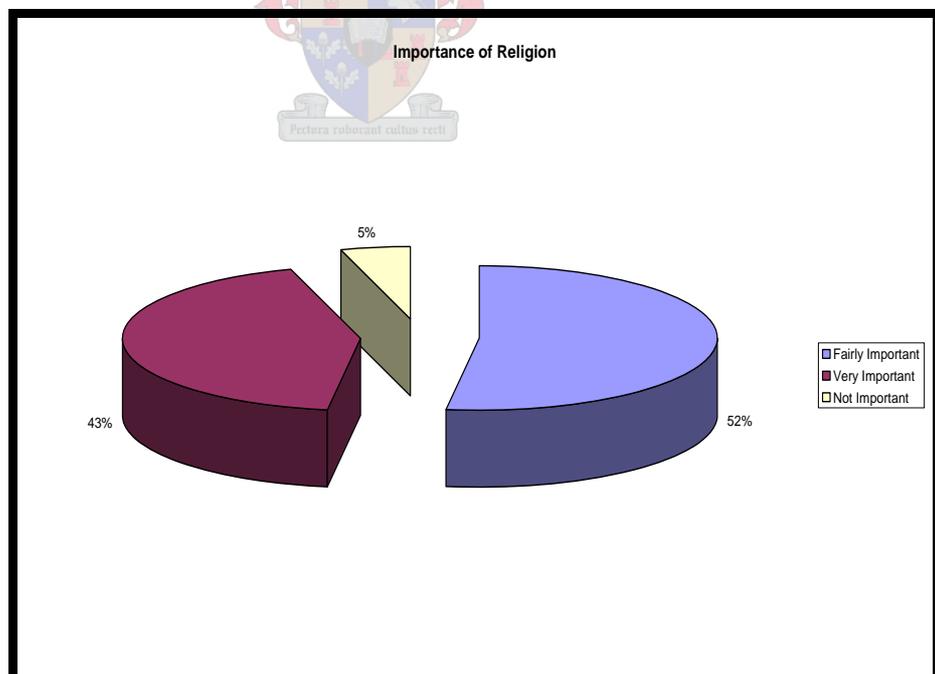
Table 4.5 Importance of religion to respondents

N=302

How important would you say Religion is to you?	N	%
a. Fairly unimportant	0	0
b. Not important at all	14	5
c. Fairly important	158	52
d. Very important	130	43

Diagram 4.4 Importance of religion to respondents

N=302



As indicated in Table 4.4 18 (6%) of respondents did not belong to a religion. Fourteen (5%) respondents indicated that religion was not important at all, however they were not non-believers.

A total of 133 (42%) respondents attended a religious gathering once or more than once per week (Table 4.6) in relation to the 43% (130) who rated religion as very important to them (Table 4.5). The literature review suggests that religious practice and belief provide a protective effect in the prevention of early sexual encounters.

However, this is contradictory to the finding of this study. The majority of respondents 73% belonged to a religion with Christian principles that did not approve of pre-marital sexual encounters while 87% (Table 4.11) were sexually active and 62% (Figure 4.15) indicating that sexual relations before marriage was wrong.

Table 4.6 Frequency of religious gathering attendance

N=302

How often have you attended a Religious gathering/service in the six months prior to the interview?	N	%
a. Once per week	109	36
b. More than once per week	24	8
Less than once per week	18	6
b. Once per month	77	25
c. Less than once per month	28	9
d. Never	46	16

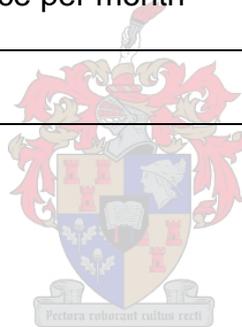


Figure 4.4 Frequency of religious gathering attendance

N=302

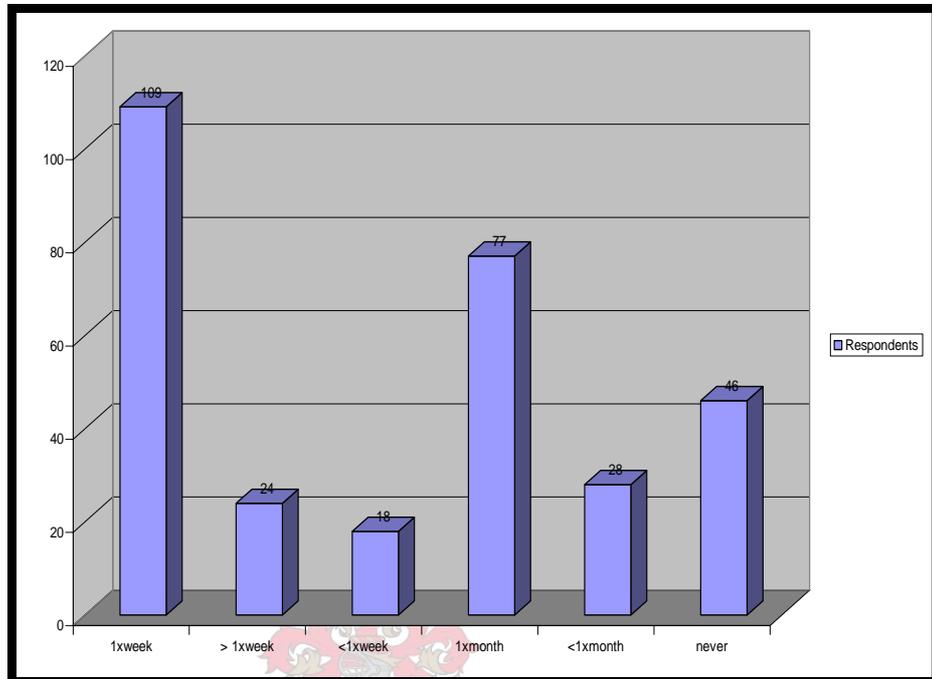


Table 4.6 and Figure 4.4 show that 109 (36%) of the respondents attended a religious gathering once per week, 77 (25%) once per month, and 28 (9%) less than once per month, 24 (8%) more than once per week and 18 (6%) less than once per week while 46 (16%) respondents never attended any form of religious gathering.

The literature review indicated that adolescents who attended church frequently and who value religion have the least permissive sexual attitude, are less sexually experienced and are less likely to use contraceptives.

With 43% (Table 4.5) of respondents indicating that religion was very important to them, only 36% attended some form of religious gathering once per week and fewer than 25% less frequent (Table 4.6). 26 (9%) respondents in both Tables 4.25 and Table 4.26 indicated religion as encouragement to avoid sexual activity. 18 (46%) (Table 4.13) non-sexually active respondents indicated that religion was their reason for not engaging in sexual activity before marriage. This supports the findings that religious practice and belief provide a protective effect in the prevention of early sexual encounters.

Question 9 refers to the respondents' educational qualifications. The researcher grouped the educational qualifications from Standard 5 to Standard 10 (Grade 7 to grade 12).

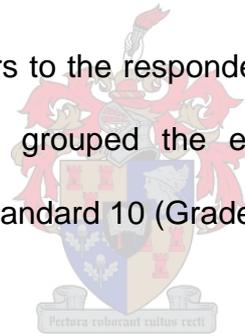


Table 4.7 Educational qualification

N=302

What is your highest completed educational qualification?	N	%
5	3	1
6	39	13
7	38	12
8	48	16
9	56	19
10	118	39

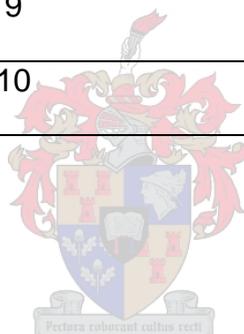
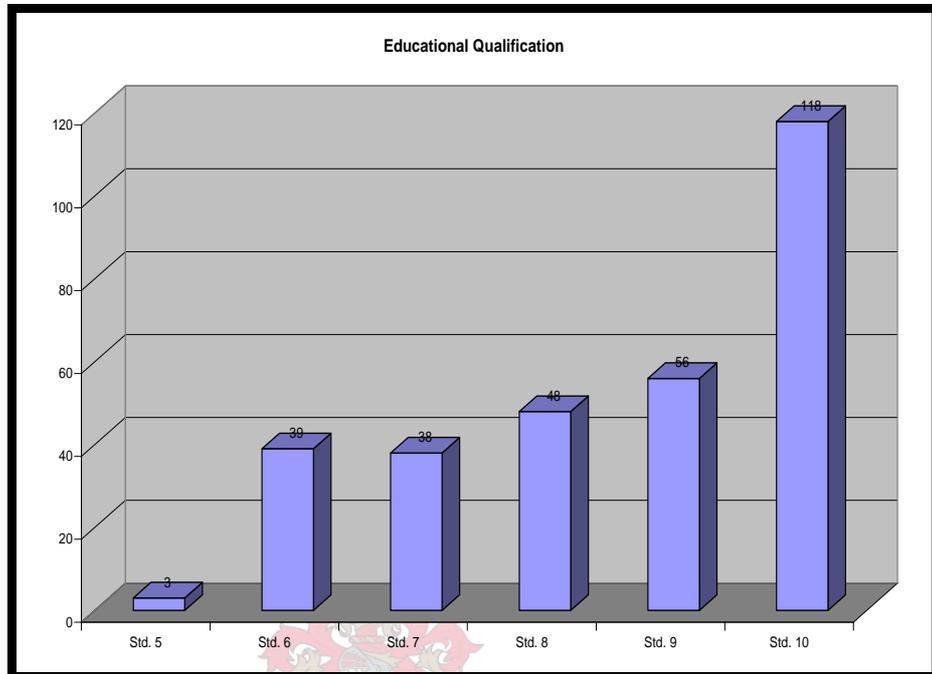


Figure 4.5 Educational qualification

N=302



Tables 4.7 and Figure 4.5 show the lowest educational qualification was Standard 5, 3 (1%) respondents and highest educational qualification was Standard 10, 118 (39%) respondents. One hundred and eighty one (60%) respondents completed between standard 6 and 9.

Hofferth and Hayes (1987, in Millstein, 1993) indicate that teenagers that achieve less academically are more likely to commence sexual relationships than those who fare better at school. As indicated by respondents during interviews all of the respondents, 118 (39%) who noted Standard 10 as their highest qualification was at the time busy with post-matric (post

standard 10) studies, either at University, Technikon or College level. Three (1%) that completed Standard 5 (Table 4.7) informed the researcher that they were no longer attending school and is thus noted as under achievers. This finding is supported by Smith (1997) who found that school achievement and aspiration were unrelated.

Question 10 refers to information gained by respondents regarding sexual decision-making (to abstain or become sexually active). The sources of information included parent/s, teacher at school, nurse at school, nurse at clinic, friends, media, not at all or other.



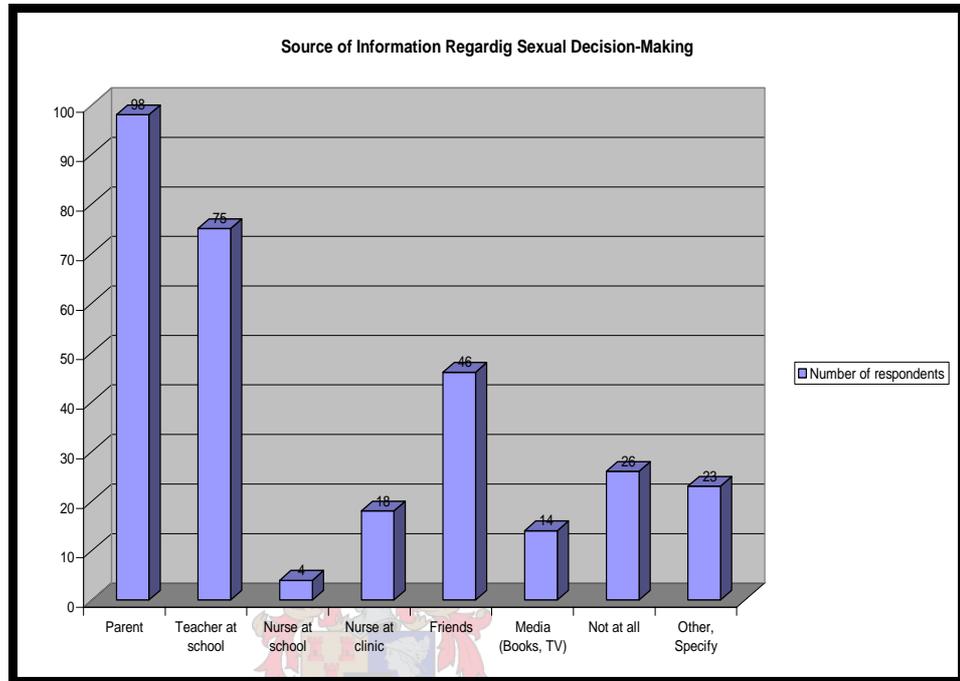
**Table 4.8 Source of information regarding sexual
decision-making**

N=302

I gained information about sexual decision-making (to abstain or become sexually involved) through	N	%
a. Parent	98	32
b. Teacher at school	75	25
c. Nurse at school	4	1
d. Nurse at clinic	18	6
e. Friends	46	15
f. Media (books, TV)	14	5
g. Not at all	26	9
h. Other, Specify	23	8

Figure 4.6 Source of information regarding sexual decision-making

N=302



The study findings (Table 4.8 and Figure 4.6) show that parents were the main source of information 98 (32%) followed by teachers 75 (25%), friends 46 (15%), nurse 22 (7%), media 14 (5%), other 23 (8%) while 26 (9%) did not receive any information at all. The “Other” referred to sister, brother, aunt, and granny.

A study by Jenson et. al. (1994) indicated that when parents are the main source of sexuality education, their children engage in less pre-marital sexual activity.

This research however indicate that despite the fact that parents were the main source of information regarding sexual decision making, followed by teachers, only 39 (13%) respondents (Table 4.11) were not sexually active. This could indicate that parents started providing information after sexual initiation by respondents or did not have adequate information to provide the necessary guidance. This could be a problem with parents with low educational qualification or discomfort discussing sexual issues.

The researcher's experience as an Educator facilitating Adolescent Sexuality Programmes in schools in the Western Cape confirmed the levels of discomfort amongst many teachers dealing with sexual issues in schools. The teachers had factual information but were not comfortable sharing this information with learners.

The literature review indicates the influence of the mass media on sexual decision-making. In this study the media was noted as a low source of information. At the time of the study the media did not play as big a role in educating teenagers regarding sexual issues.

Question 11 refers to information gained regarding teenage pregnancy. Sources of information included parent, teacher, friends, nurse, media, not at all and other.

Table 4.9 Source of information regarding teenage pregnancy
N=302

I gained information about teenage pregnancy through	N	%
a. Parent	103	34
b. Teacher at school	102	34
c. Nurse at school	2	1
d. Nurse at clinic	22	7
e. Friends	37	12
f. Media (Books, TV)	17	6
g. Not at all	13	4
h. Other, Specify	6	2

Diagram 4.5 Source of information regarding teenage pregnancy.

N=302

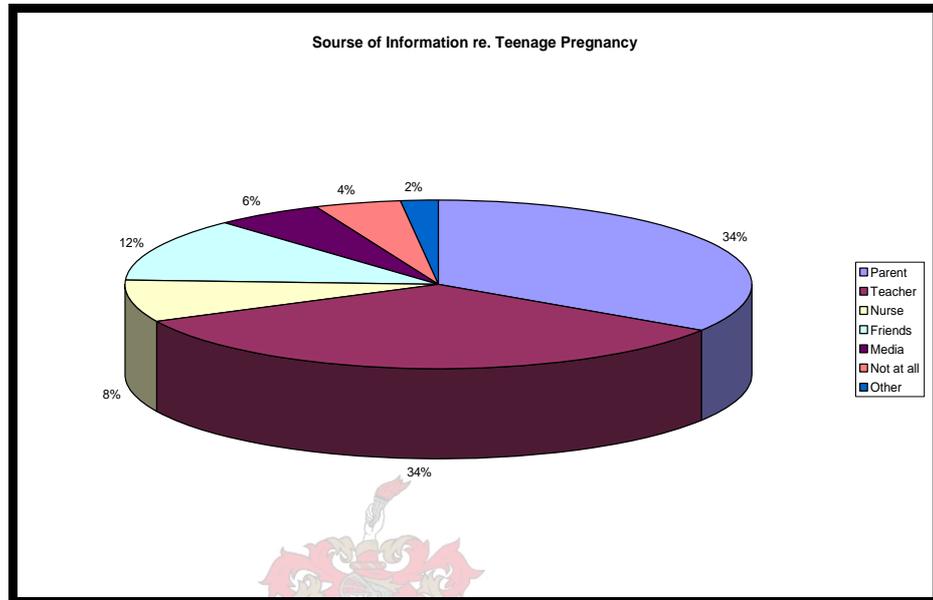


Table 4.9 and Diagram 4.5 show that the main sources of information regarding teenage pregnancy are parents and teachers at school 102/103 (both 34%) followed by friends 37 (12%), nurse (school and clinic) 24 (8%), media 17 (6%), other 6 (2%) while 13 (4%) did not receive any information regarding the topic at all. "Other" referred to sister, aunt and cousin.

Parent and teachers being the main sources of information regarding teenage pregnancy was beneficial. Diagram 4.21 indicate that only 16% of respondents had a previous teenage pregnancy, 39% completed matric (standard 10) and only 1% left school (Table 4.7) and 67% still live with parents (Table 4.4).

It is obvious that parents and teachers have a strong influence on decision-making being the two sources closest to adolescents for most of the day.

Question 12 refers to sources of information regarding sexually transmitted diseases.

Table 4.10 Sources of information regarding Sexually Transmitted Disease
N=302

I gained information about sexually transmitted disease through	N	%
a. Parent	63	23
b. Teacher at school	105	38
c. Nurse at school	12	4
d. Nurse at clinic	1	0.3
e. Friends	28	10
f. Media (books. TV)	39	14
g. Not at all	24	9
8. Other, Specify	3	1

Diagram 4.6 Sources of information regarding Sexually Transmitted Disease

N=302

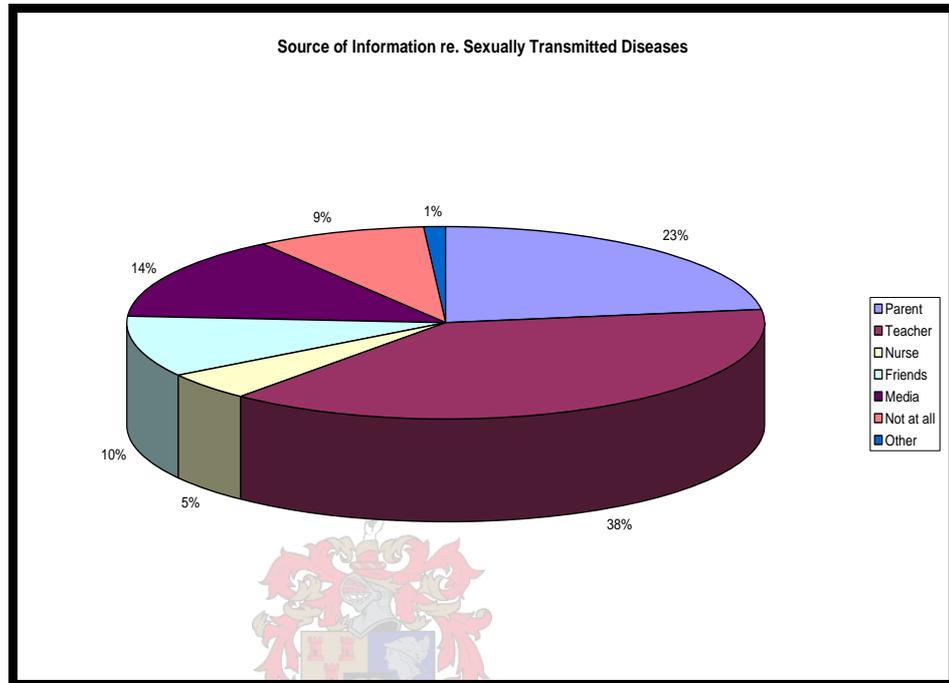
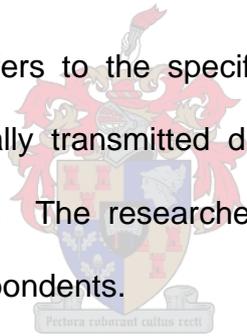


Table 4.10 and Diagram 4.6 show that 63 (23%) respondents have received information regarding sexually transmitted diseases from a parent. From the rest of the 239 respondents, 105 (38%) received information from a teacher at school and 134 (56%) from other sources such as friends 28 (10%), media 39 (14%), nurse (clinic and school) 13 (4.3%) and other (sister, granny aunt) 3 (1%). 24 (9%) of the participants reported that they did not receive any information at all.

The literature review showed that one frequently encounters inhibition and ambivalence on the part of teachers when it comes to presentation of sexuality education programmes. This is supported by the researcher's experience in facilitating Adolescent Sexuality programmes in schools.

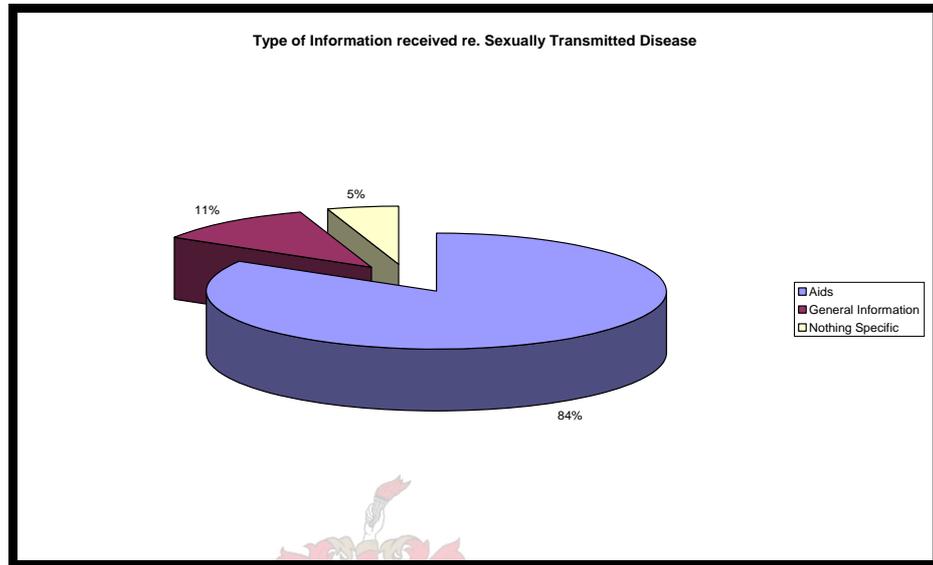
A minority of 24 (9%) respondents did not receive any information at all. This might be a small percentage but still cause for concern that these girls did not have access to any information.

Question 13 refers to the specific type of information gained regarding sexually transmitted diseases. This was an open-ended question. The researcher grouped the information as provided by respondents.



**Diagram 4.7 Type of information gained regarding
Sexually Transmitted Diseases**

N=302



The majority of respondents 170 (84%) indicated that they received information about HIV/AIDS (Diagram 4.7). The respondents indicated that a lot of emphasis was placed on HIV/AIDS. In the opinion of the respondents they received factual information on the dangers of AIDS, the transmission of HIV and how to avoid infection.

Responses included:

“I have learnt how HIV is being transmitted”

“We were taught the dangers of AIDS and how to prevent getting infected”

“I now know how to avoid getting infected”

“The importance of using condoms was stressed and how to avoid sexually transmitted disease”

“It is important not to sleep around. That is the only way to protect yourself”

“We were told that AIDS kills”

Thirty-three (16%) respondents indicated that they received general information in terms of safer sex practices, the consequences of partner switching and the usage of condoms. Responses included the following:

“To avoid sexually transmitted diseases you have to stick to one partner”

“Always practice safe sex”

“The message that I got was that I should not sleep around”

“It is important to always use condoms with an unknown partner”

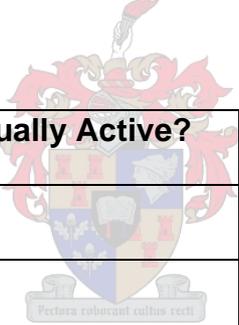
As indicated by a study by Oakley et. al. (1995) the increase in the levels of information regarding sexuality, contraception and

Sexually Transmitted Disease can enhance the sexual health of adolescents.

Question 14 refers to information about sexual activity of respondents. The respondents were asked whether they were sexually active (whether they have experienced sexual intercourse) by responding “yes” or “no”.

**Table 4.11 Information about sexual activity
of participants**

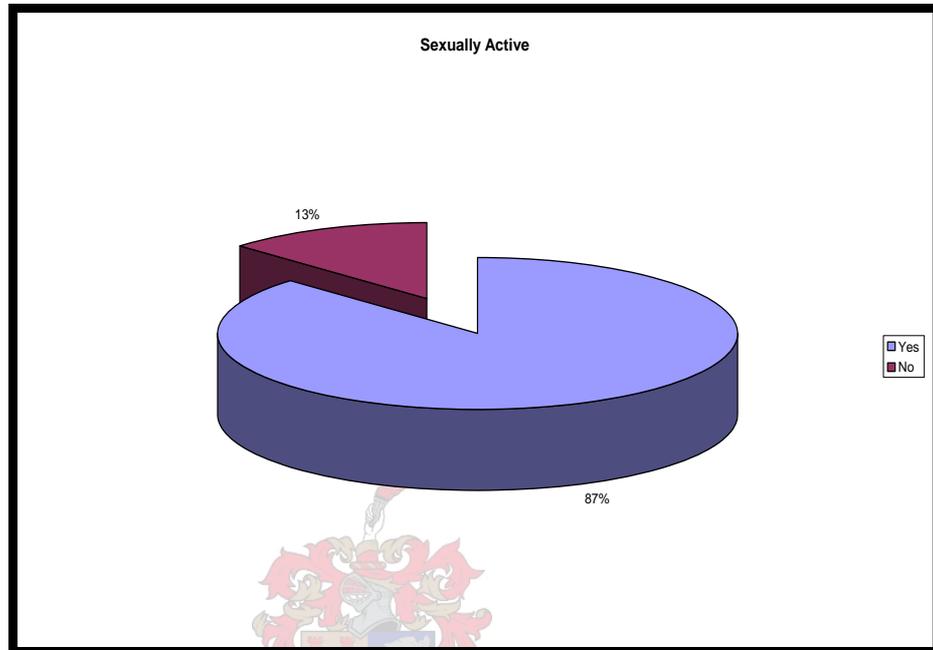
N=302



Are You Sexually Active?	N	%
Yes	263	87
No	39	13

**Diagram 4.8 Information about sexual activity
of participants**

N=302



The study showed that 263 (87%) of respondents were sexually active at the time of the study while 39 (13%) maintained their virginity (Table 4.11 and diagram 4.8). The said 13% indicated that they are considering commencing a sexual relationship.

A review of the records of 183 adolescents, 15 years and younger by Swenson (1992) in a special teen clinic, found that only 25% were not sexually active when they came to the clinic for the first time, the remainder indicating that they were sexually active. The majority of adolescents seek contraceptive advice after becoming sexually active. However, this study found that

although 88% attends the clinics to obtain contraceptive methods (Diagram 4.18) only 87% are sexually active (Table 4.11) and thus 1% is using a contraceptive method while not engaged in sexual activity. Adolescents do have the cognitive ability to consider the pros and cons of actions before actually engaging in high-risk behavior e.g. having unprotected sexual encounters and risk unintended pregnancies or sexually transmitted diseases. The one's using a contraceptive method while not engaging in sexual activity are using their cognitive ability to consider the risk before engaging in unprotected intercourse.

Question 15 refers to the age of sexual initiation if answered yes to Question 14.



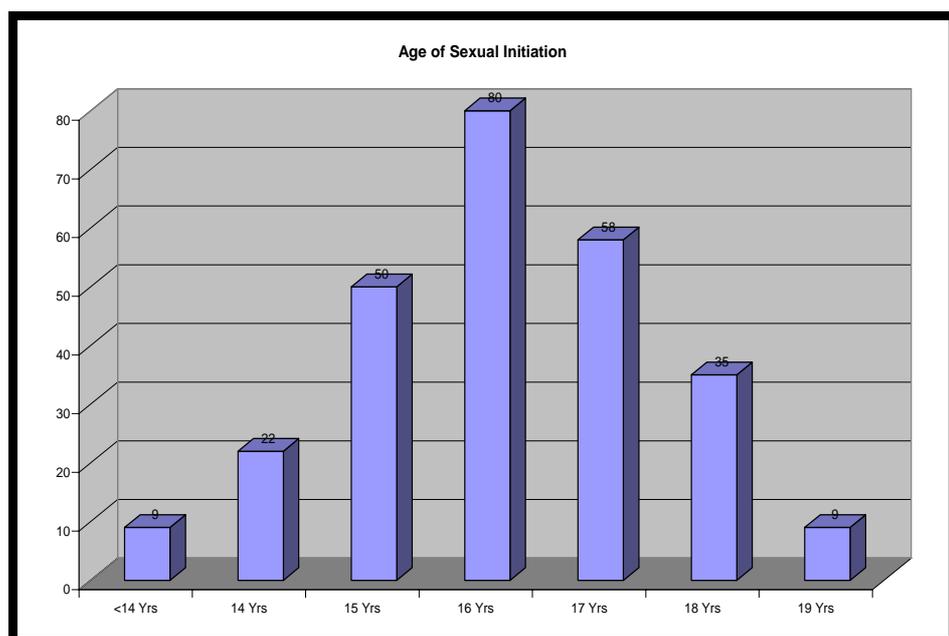
Table 4.12 **Age of sexual initiation**

N=263

How old were you with your first sexual encounter?	N	%
<14	9	3
14	22	8
15	50	19
16	80	30
17	58	22
18	35	13
19	9	3

Figure 4.7 **Age of sexual initiation**

N=263



The majority of respondents 80 (30%) (N=263) initiated sexual activity at the age of 16 years. A small number of respondents 9 (3%) initiated sexual activity at an age younger than 14 years and older than 18 years respectively (Table 4.12 and Figure 4.7).

The legal age for initiating sexual relations in South Africa is sixteen (16) years as noted by the majority of respondents (38%) (Table 4.14) in this study. An awareness of this legislation could be facilitating the initiating of sexual encounters at age 16.

Question 16 refers to the reason/s if planning to become sexually involved. This question was answered only if answered “no” to Question 14.

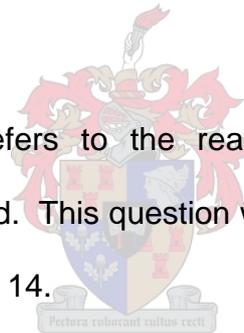


Table 4.13 **Reasons for planning to become sexually active**

N=39

Do you plan to become sexually active and why?	N	%
1. Not Ready	10	26
2. Want to Wait Till Married	8	20
3. Too Young	3	8
4. Against Principles/Religion	18	46

In Table 4.13 indicate the respondents' reasons for not being sexually active at the time of the study. The researcher grouped the responses.

Diagram 4.9 Reasons for planning to become sexually active

N=39

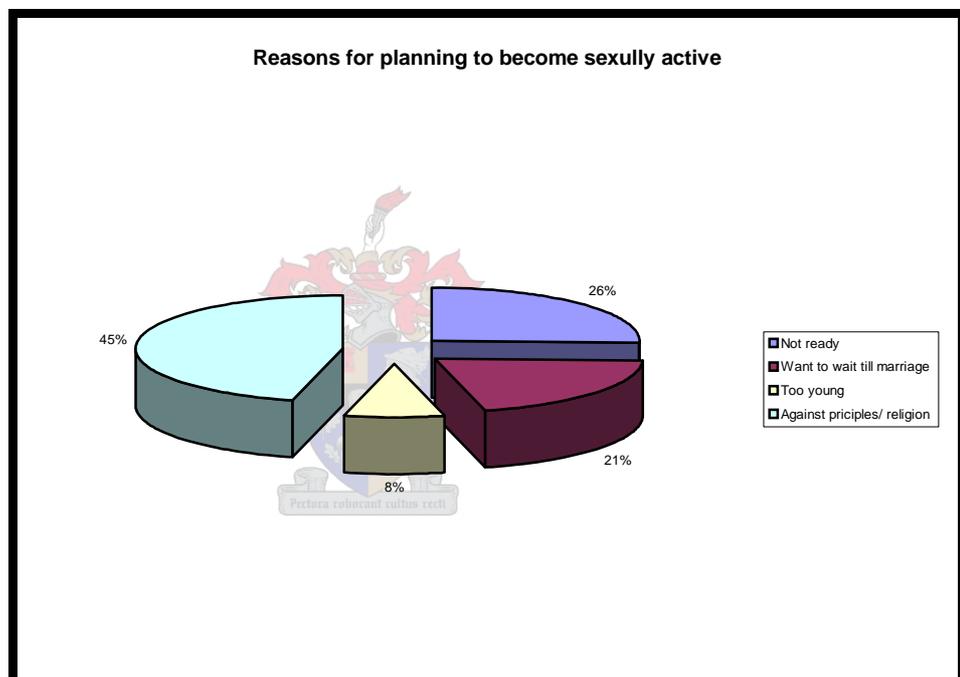


Table 4.13 and Diagram 4.9 show the non-sexually active respondents indicating that it was against their principles/religion 18 (46%), 10 (26%) indicated that they were not ready for a sexual relationship, 8 (20%) wanted to wait till married while 3 (8%) felt that they were too young for the responsibilities related to a sexual relationship.

This finding indicating religion as the reason for delaying sexual initiation correlates with 75% belonging to a religion with Christian principles. This however, is contradictory to only 9% noting religion as a factor in sexual decision-making (Table 4.27).

The literature review showed that the main reasons for adolescents delaying sexual initiation were career goals. This finding is supported by 56% (Table 4.26) of respondents indicating that a major factor influencing sexual decision-making was their future.

Question 17 refers to the legal age for initiation of sexual relations in South Africa.



**Table 4.14 Legal age for initiation of sexual relations
in South Africa**

N=302

Legal Age for Initiation of Sexual Relations in South Africa	N	%
16	115	38
17	4	2
18	85	28
19	3	1
20	2	1
21	83	27
22	5	3

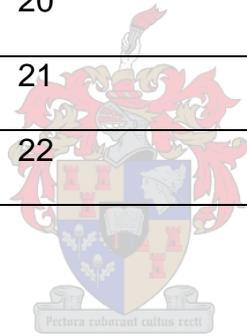


Figure 4.8 Legal age for initiation of sexual relations in South Africa

N=302

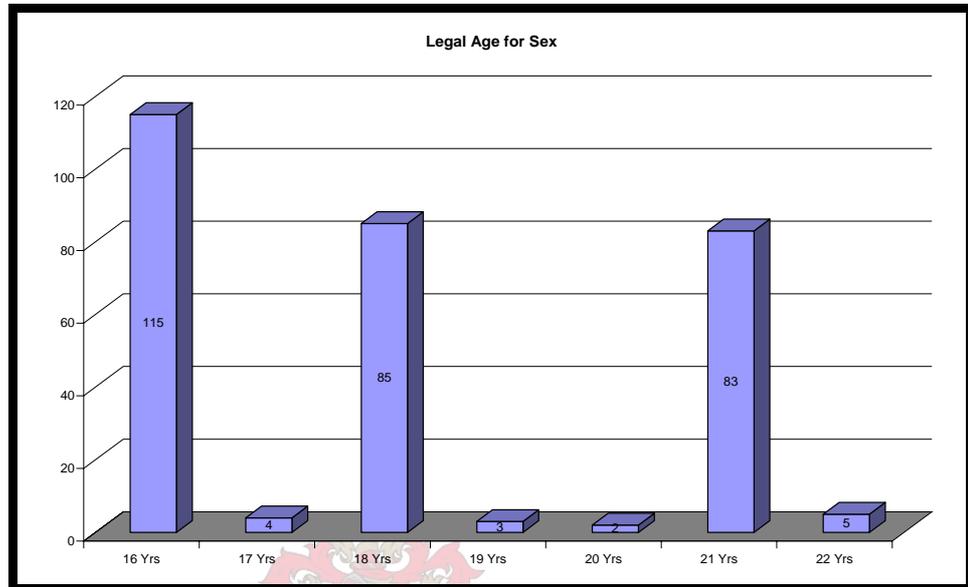


Table 4.14 and Figure 4.8 show that the majority of participants, 115 (38%) were informed about the legal age for initiation of sexual relations in South Africa. 85 (28%) indicated the legal age to be 18 years as it is for many other issues e.g. opening a bank account, voting, while 83 (27%) indicated 21 years which is “coming of age”, legal age to get married in South Africa. 4 (2%) indicated 17 years, 3 (1%) 19 and 20 years and 5 (3%) 22 years. 55% of respondents actually linked the legal age for sexual initiation to other legislation in South Africa.

Question 18 refers to the reasons for becoming sexually involved with the opposite sex.

Table 4.15 Reasons for becoming sexually involved
N=302

What are the reasons for becoming sexually involved with the opposite sex?	N	%
a. Love	207	66
b. Sexual Attraction	31	10
c. Security	16	5
d. Want to belong	12	4
e. Other	6	2
f. Not Applicable	39	13

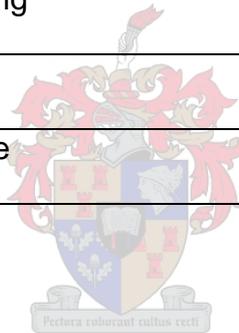
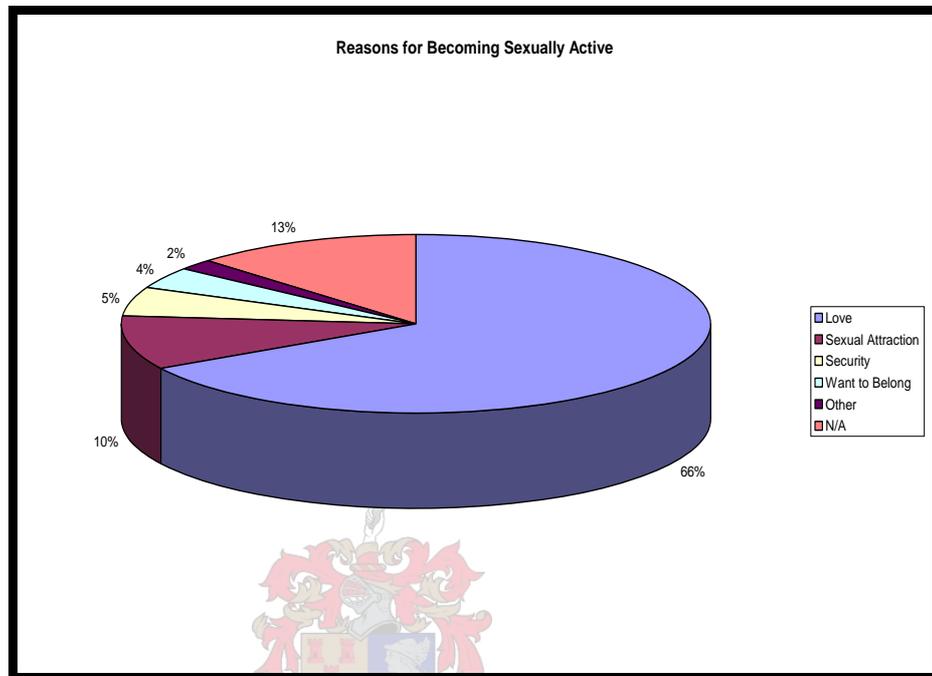


Diagram 4.10 **Reasons for becoming sexually involved**
N=302



The study shows that the majority of respondents, 207 (66%) felt that love was the primary reason for becoming sexually active. Other reasons included sexual attraction 31 (10%), security 16 (5%), wanting to belong 12 (4%) and other (one night stand, drugged, drunk, rape) 6 (2%). 39 (13%) were not sexually active. Only a small percentage (9%) (Security and want to belong) Table 4.15) indicated fear of rejection. Adolescent girls thus do engage in sexual activity as an act of affection within a meaningful relationship. Change in sex partners is therefore due to breaking up (74%) (Table 4.21). They thus engage in serial monogamous relationships without perceiving them at risk

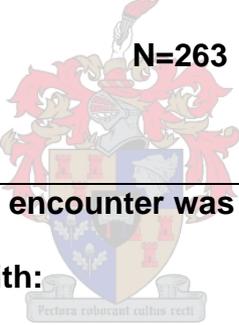
of becoming infected with a sexually transmitted disease. In Diagram 4.12 56% noted own risk as none compared to great risk (67%) (Table 4.35).

This study found that the respondents became sexually involved as an affirmation of love and commitment with 74% (Table 4.16) having the first sexual experience with her boyfriend at the time.

Question 19 refers to the respondent's first sexual partner.

Table 4.16 First sexual partner

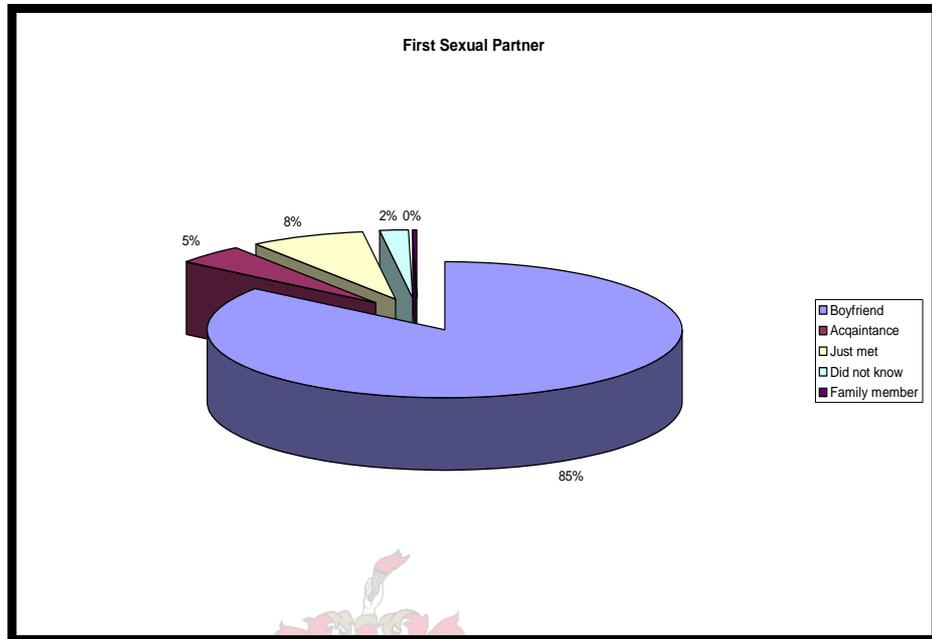
N=263



My first sexual encounter was with:	N	%
a. Boyfriend	224	85
b. Acquaintance	13	5
c. Someone I just met (e.g. a one night stand)	20	8
d. Someone I did not know	5	2
e. A family member	1	0

Diagram 4.11 First sexual partner

N=263



The study (Table 4.16 and Diagram 4.11) show that 224 (85%) of the respondents who have been sexually active had their first sexual encounter with their boyfriend at the time in contrast with the literature review that showed that adolescents in general have their first sexual encounter with someone with whom they had no emotional ties. 20 (8%) of the respondents were raped, 1(0.3%) by a family member, 5 (2%) by someone they did not know and 13 (5%) by an acquaintance.

Surveys as recorded in Population Reports (1995) confirm that young women usually report that they had their first and subsequent sexual relations with a steady boyfriend. This is

supported by a study by Resnick (1992) indicating that adolescent sexual activity occurs within the context of serious, romantic relationships.

Question 20 refers to the first sexual intercourse of respondents.

Table 4.17 First sexual intercourse of respondents

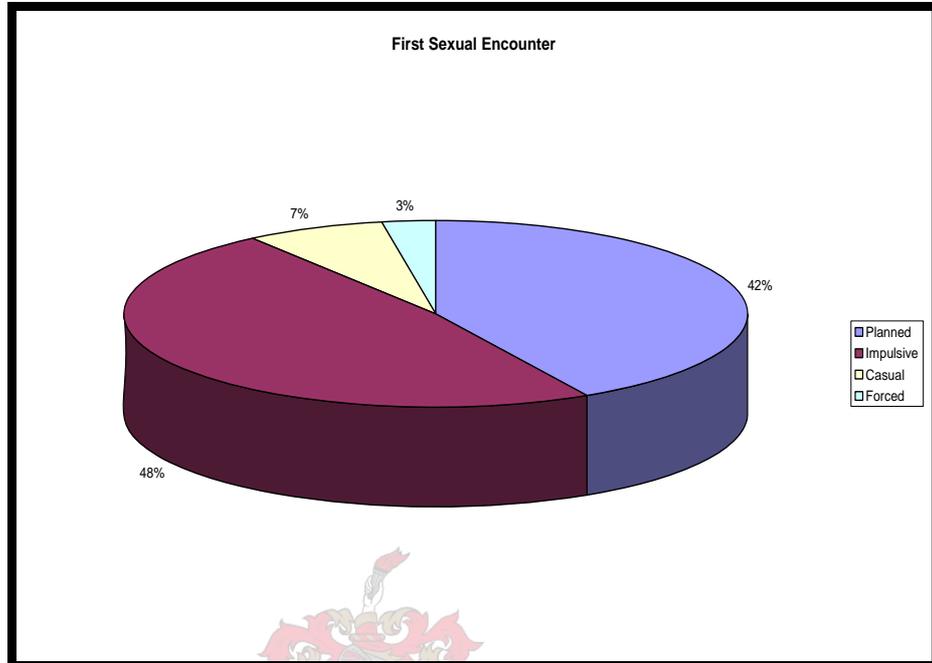
N=263

First sexual intercourse was:	N	%
a. Planned	110	42
b. Impulsive	127	48
c. Casual	19	7
d. Forced (Specify by whom)	7	3



Diagram 4.12 First sexual intercourse of respondents

N=263



The study shows that the first sexual intercourse was a planned act for only 110 (42%) of the respondents, impulsive in 127 (48%), casual in 19 (7%) and forced in 7 (3%) of cases. The forced intercourse was with a family member, someone they did not know, and acquaintances (Table 4.17 and Diagram 4.12).

This is confirmed by the literature review showing that in up to 52% of cases the first sexual encounter in general was impulsive or casual.

Brookes-Gunn and Furstenberg (1989 in Leite et al.1995) concluded in their study that the majority of adolescents do not

consciously plan their first sexual relations and that it just “happens”. The said study supports this study.

Question 21 refers to the experience of the first sexual encounter.

Table 4.18 Experience of first sexual intercourse

N=263

My first sexual intercourse was an experience that was:	N	%
a. Satisfying	105	40
b. Traumatic	47	18
c. Disappointing	110	42

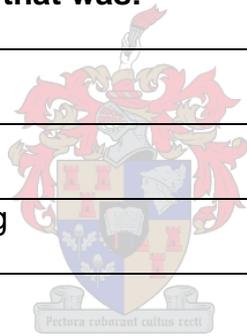
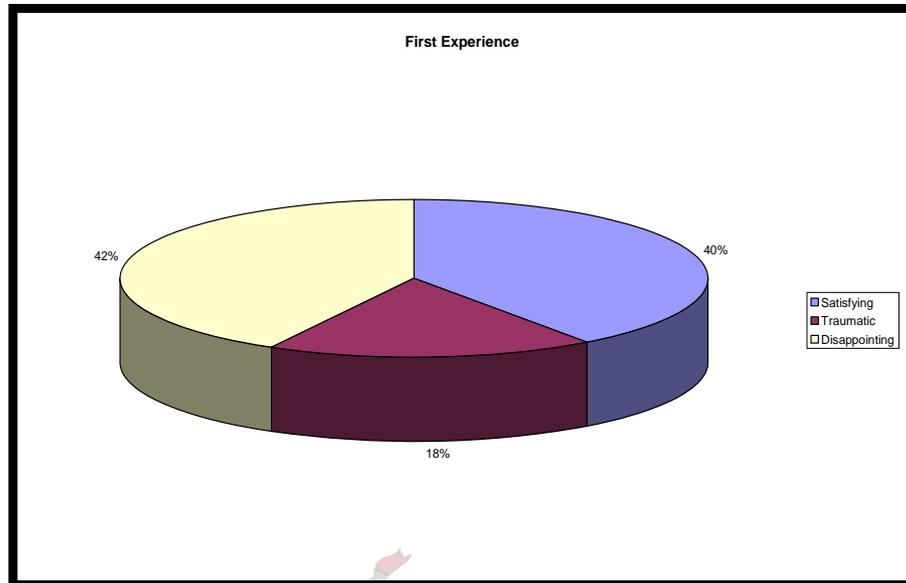


Diagram 4.13 Experience of first sexual intercourse

N=263



One-hundred-and-five (40%) of the respondents found the first sexual intercourse to be satisfying while 110 (42%) found the experience disappointing and 47 (18%) traumatic.

As indicated in Tables 4.16, 4.17 and 4.18 the majority of respondents 224 (85%) had their first sexual intercourse with a boyfriend at the time. This is contradictory to the study by R M Cerqueira Leite et.al. (1995), who found that 60% (N=268) had their first sexual intercourse with someone with whom they had no emotional ties. The majority 127 (48%) (N=263) of respondents indicated that it was an impulsive act. Perhaps for this reason, the experience has been noted as disappointing for

110 (42%) (N=263) of the respondents as shown in Table 4.17 and Diagram 4.13.

These data confirms that the majority of adolescents do not consciously plan their first sexual encounter.

Question 22 refers to respondents being pressurized by friends to become sexually involved. Respondents had to respond yes or no.

Diagram 4.14 Pressure by friends to become sexually active

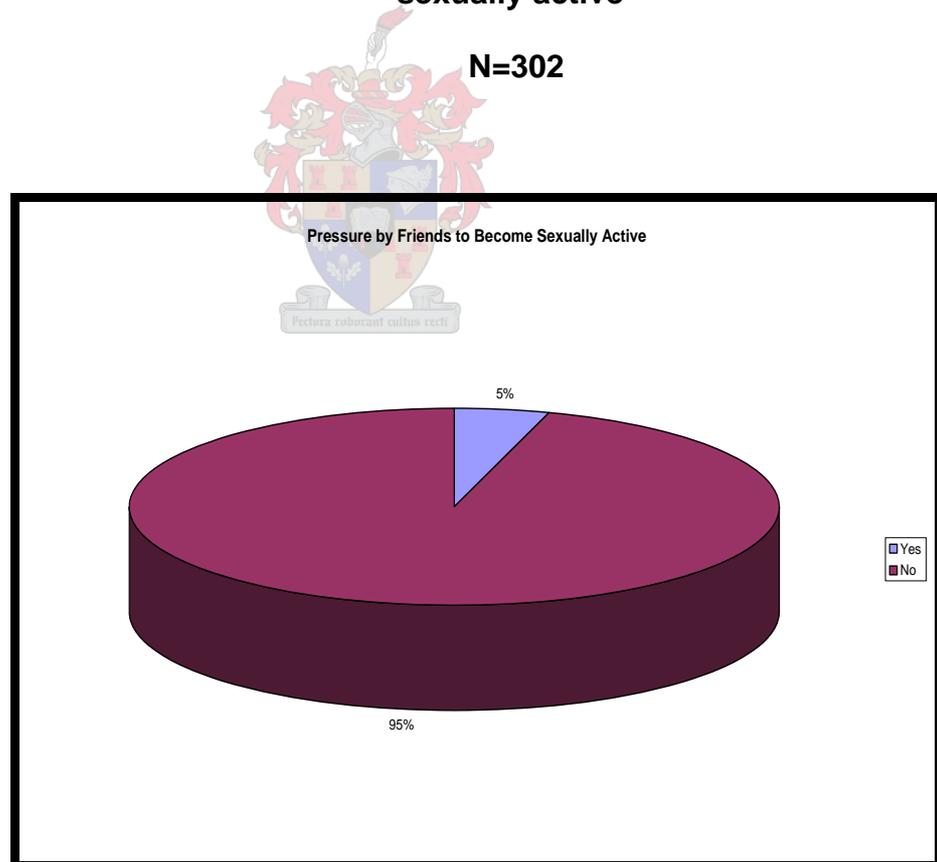


Diagram 4.14 shows that 288 (95%) of the respondents expressed that they did not experience any pressure from

friends to become sexually active while 14 (5%) admitted pressure by friends. 11 of the 14 “Yes” respondents felt pressure because all their friends “were doing it”, 2 of 14 respondents said that it made them feel part of the “in-group” while 1 of 14 respondents was pressurized by her boyfriend. This finding of the study is contradictory to the literature review showing that the sexual behavior of best -, same sex and close friends of both sexes influence the sexual behavior of adolescents.

However, research by Costanzo and Shaw, 1967 in Petersen et.al. (1995) indicated that peers hold influence in the domains of appearance and preferences associated with teen culture e.g. clothing and music. Nevertheless, a study by Lerner, Karson, Meidels and Knapp (1975 in Petersen et.al0 1995). indicated that parents have primary influence on basic values. As noted in Table 4.4 the majority of respondents 211 (67%) were living with their parents in their own house. This parental closeness and support could thus moderate negative peer influence. It can be concluded that close relationship and support by parents can be protective against negative peer influences.

Question 23 refers to the number of sex partners.

Figure 4.9 **Number of sex partners**

N=263

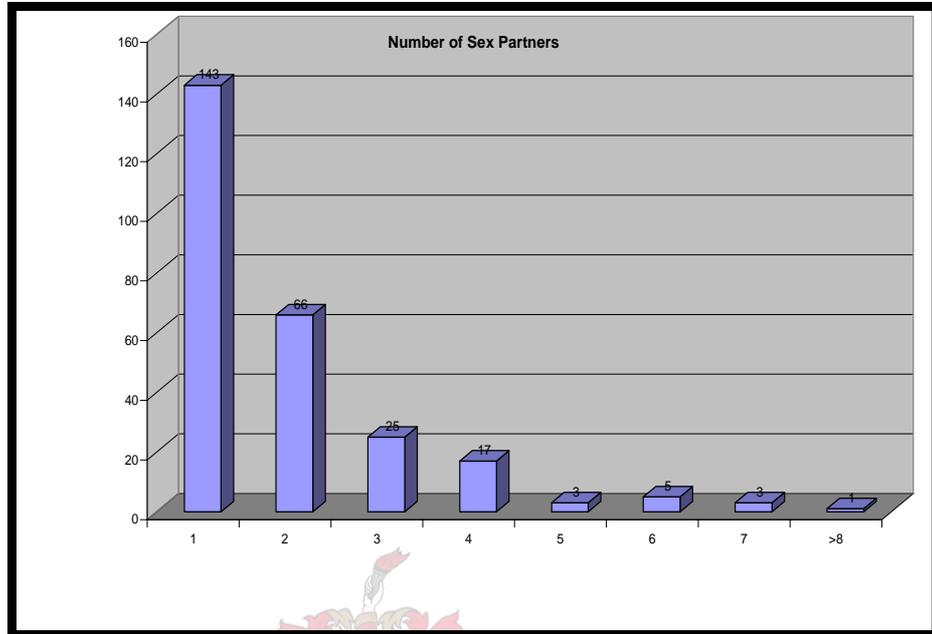


Figure 4.9 shows that 143 (54%) of the respondents had only one partner to date at the time of the study, 66 (25%) had 2 partners, 25 (10%) had 3 partners, 17 (7%) had 4 partners 3 (1%) had 5 or 6 partners, 5 (2%) had 7 partners to date. The one respondent who had more that 8 partners disclosed during the interview that she in fact had 15 sex partners to date. She was raped at a very young age and felt that she was worthless. Sex meant nothing to her.

The behavior of the respondent with more than 8 partners to date is characteristic of someone exposed to child sexual abuse. This is supported by a study by Ferguson et. al. (1997)

indicating that those reporting child sexual abuse involving sexual intercourse is at increased sexual risk during adolescence. They further indicate that these girls are characterized by higher rates of multiple sexual partners.

A study by Tubman et.al. (1996) confirmed the relationship between childhood sexual abuse and multiple sexual partners.

In a study done in the USA, 93% (N=535) of respondents whom were pregnant by age seventeen (17) two thirds reported having been sexually abused as a children. The study further found that young women who were sexually abused during childhood initiate sexual intercourse on average a year earlier than their non-abused peers (Population Reports, 1995).



Yaber and Parrillo (1992) indicated a strong association between early sexual initiation and multiple sexual partners. It is confirmed by this where the majority of respondents 80 (30%) (Table 4.12) initiated sexual intercourse at the age of 16 years and 143 (54%) (Figure 4.9) had one sexual partner to date at the time of study.

As noted in the literature review, Santelli and Baldwin (1992) indicated that because adolescents seldom identify themselves as having multiple sexual partners, partner switching is common.

Question 24 refers to the reason for changing sex partners. This was an open-ended question and the researcher grouped the responses.

Table 4.21 Reason/s for changing sex partner

N=302

What are your reason/s for changing your sex partners?	N	%
Breaking up	224	74
Not in a steady relationship	39	13
N/A	39	13

Table 4.21 shows that the majority of respondents 224 (74%) indicated that the reason for changing sex partners was primarily breaking up with the boyfriend. 39 (13%) indicated that they were not in a steady relationship while the same number 39 (13%) was not sexually active and the question was thus not applicable.

This finding is an indication that the majority of respondents were intimate only within a committed relationship. This indicates that adolescents are largely serially monogamous. This therefore, contradicts the perception that adolescents are promiscuous and sleeps around. However, although this may

be the case adolescents tend to move from one relationship to another in short periods of time. Therefore although in a monogamous relationship, it could be more than one in a short span of time and thus the risk of being exposed to more than one sex partner but at different times.

Question 25 refers to whether the respondent could discuss sexual issues with their partners.

Diagram 4.15 Discuss sexual issues with partner

N=302

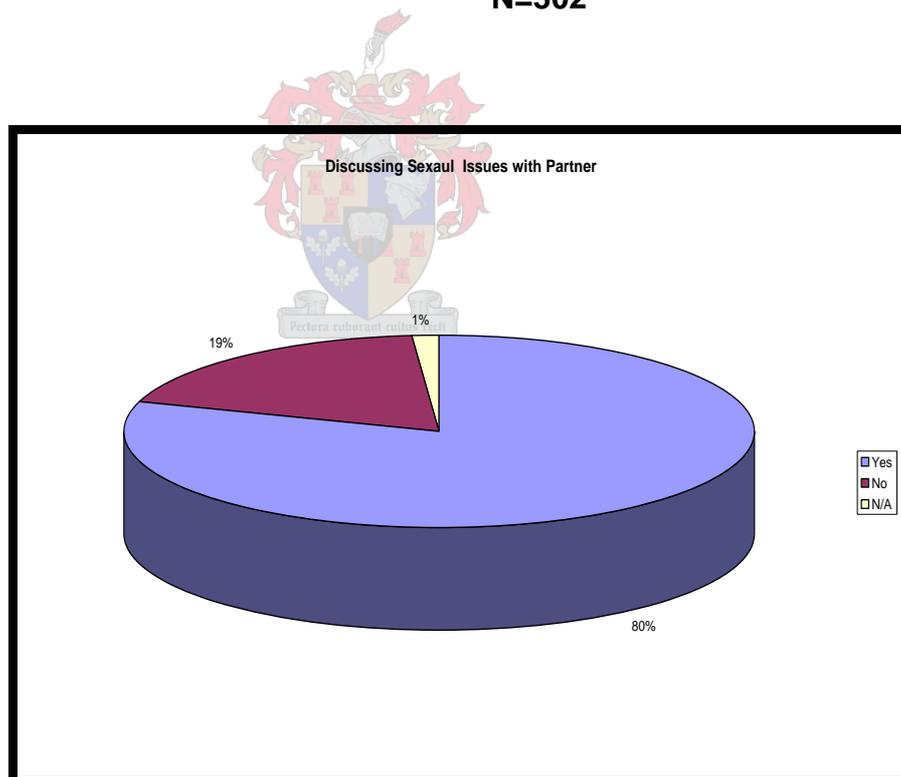


Diagram 4.15 shows that 242 (80%) of the respondents felt comfortable discussing sexual issues with their partners.

Reasons provided by the 56 (19%) of respondents who responded no, included the following:

“ I don't feel comfortable”

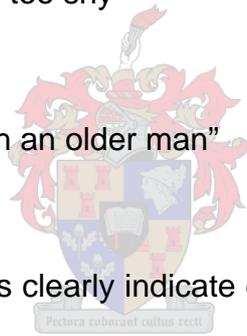
“ I'm too shy”

“I am not in a steady relationship”

“We don't talk much”

“ My boyfriend is too shy”

“I'm involved with an older man”



These responses clearly indicate discomfort with partner, lack of or poor communication in the relationship. 3 of the 4 respondents indicating N/A were married. The majority (80%) has an open relationship where intimate issues can be discussed.

A study by Millstein et.al. 1993 indicates that adolescents are able to take other's perspectives and to understand concepts of mutuality in relationships. Thus adolescents who apply the concept of mutuality to a relationship will be able to communicate with a partner regarding sexuality.

Question 26 refers to the age of first date with the opposite sex.

Figure 4.10 Age of first date with the opposite sex

N=302

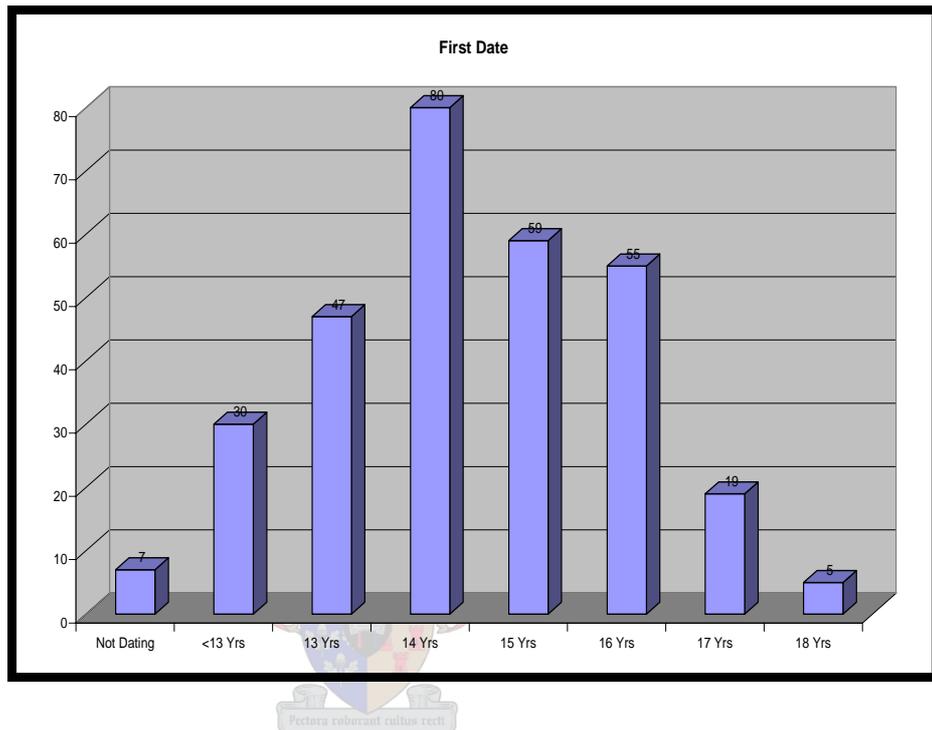


Figure 4.10 show that 7 (2%) of the respondents indicated that they did not start dating at the time of study. 30 (10%) started dating someone from the opposite sex at an age younger than 13 years. 47 (16%) had their first date at 13 years; the majority of 80 (26%) at 14 years, 59 (20%) at 15 years, 55 (18%) at 16 years, 19 (6%) at 17 years and 5 (2%) started dating at the age of 18 years. The 2% that indicated that they were not dating were between 14 and 18 years old.

Therefore, the first date for the majority of respondents occurred between 14 and 15 years of age. The term dating may be used to refer to activities ranging from “flirting” to a more serious involvement. During adolescence dating is frequently undertaken more for the resolution of social than sexual goals, especially during the early years of adolescence.

As supported by the literature review early and frequent dating are related to early sexual activity. However, the majority of respondents in this study 80% (Table 4.12) initiated sexual relations at the age of 16 years. Thus two (2) years after most of them started dating. This behavior can be attributed to the fact that 211 (67%) (Table 4.4) still lived with their parents with consequent support and influence on values. According to Cerqueira et.al. (1995) dating is associated with both sexuality and independence. The closeness in relationship means that parents can still provide guidance and support related to sexual decision-making.

It can be concluded that the age of first date and especially steady dating with the opposite sex are predictive of initiating sexual activity.

Question 27 refers to dating rules by parents/guardians.

Table 4.22 **Dating rules**

N=302

Do your parents/guardian have any dating rules regarding:	N	%
a) Hours (Time to be back home)	72	24
b) Location (Where you are going)	56	19
c) Partners	40	13
d) Not at all	126	41
e) Other, please explain.	8	3

Dating rules are experienced as confusing by adolescents. 126 (41%) of respondents have no restrictions regarding dating rules while 168 (56%) have to obey rules in terms of hours, location and partners. 8 (3%) indicated other for reasons being married or living on their own (Table 4.22).

One hundred and sixty-eight (56%) having to obey dating rules can be contributed by the fact that 67% (Table 4.4) are still living with parents in own house and thus subject to parental control.

Question 28 refers to how often the respondents were dating. The researcher grouped the responses and listed it as follows:

Table 4.23 **Frequency of dating**

N=302

How often do you date?	N	%
1. Once per week	172	57
2. Once per month	54	18
3. Twice per month	66	22
4. Not applicable	10	3

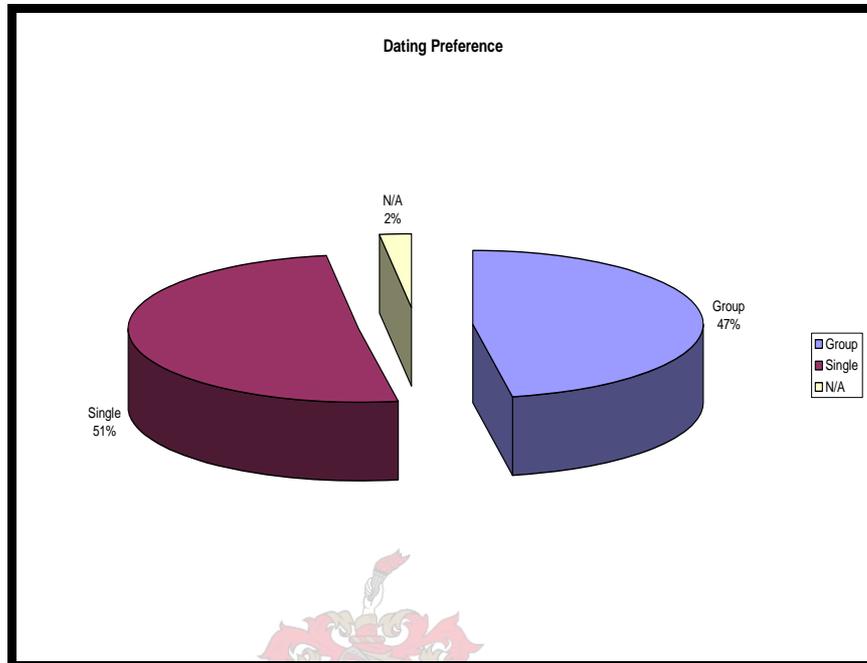
The majority of respondents, 172 (57%) dated once a week. They mentioned that they like to date every weekend and enjoyed spending as much time as they can with their boyfriends. Between 18-22% dated once to twice per month. Three percent (3%) indicated that they were not dating at all. Three of the 10 were married and this did not apply to them (Table 4.23).

Adolescents are still learning about relationships and feel that the time spent together can nurture their relationships with their boyfriend.

Question 29 refers to the subjects' preference to dating.

Figure 4.16 **Dating preference**

N=302



As seen in Diagram 4.16 152 (51%) of the respondents preferred to date single as a couple, 143 (47%) preferred to date in a group while 7 (2%) were not dating at all. Sexual activity is less likely to take place when group or double dating.

With group dating adolescents learn to socialize and learn about group interaction. Other than single dating where the opportunity is being created for being pressurized by a partner to indulge in high-risk activities. The difference between single and group dating is not significant though.

Question 30 refers to pressure experienced by adolescents to become sexually involved.

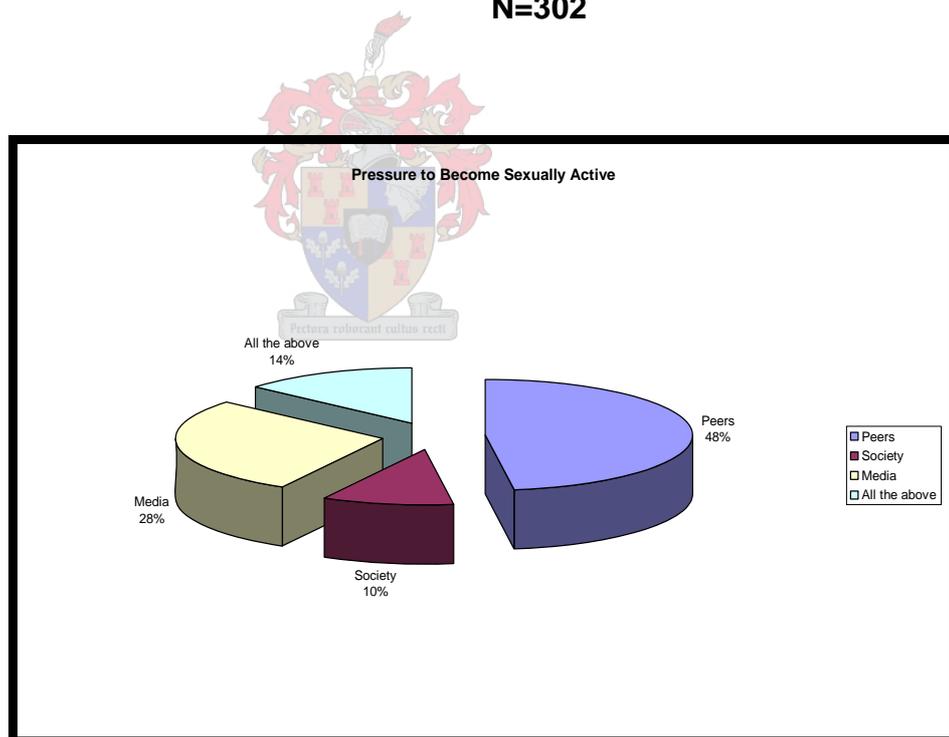
Table 4.24 Pressure to become sexually involved

N=302

Pressured by:	N	%
a) Peers	144	48
b) Society	31	10
c) Media	86	28
d) All the above	41	14

Diagram 4.17 Pressures to become sexually involved

N=302



The majority of respondents as reflected in Table 4.24 and Diagram 4.17 144 (48%) indicated that adolescents experienced pressure by peers to become sexually involved. 31 (10%) are

thought to be pressured by society, 86 (28%) by the media while 41 (14%) are thought to be experiencing pressure by all the above.

It is interesting to see that in response to *Question 22*, 288 (95%) of respondents indicated that they are not being pressurized by friends to become sexually active. It shows that they totally separate themselves from being pressured from that of other adolescents being pressured.

Question 31 refers to whom or what encourages adolescents to avoid sexual activity. The researcher grouped and listed the data as provided by the respondents as deterrents to sexual activity.



Table 4.25 Deterrents to sexual activity

N=302

Who/what encourages you to avoid sexual activity?	N	%
None	76	24
Parent	71	24
Self	55	18
Pregnancy	32	11
Religion	26	9
Disease	28	9
Other	14	5

Table 4.25 shows that 76 (24%) of respondents indicated that they received no encouragement at all to avoid sexual activity; 71 (24%) were encouraged by a parent or parents; 55 (18%) felt that they needed no encouragement from others but depended on self; 32 (11%) avoided sexual activity because of the fear of an unwanted pregnancy; for 26 (9%) religion played a role; 28 (9%) avoided sexual activity due to the fear of contracting a sexually transmitted disease including HIV/Aids while 14 (5 %) indicated other factors such as career and education.

A study by Neinstein (1991) also indicated that the mass media promotes an unrealistic image of sexual behavior leading to confusion about sexuality.

On the basis of these findings it is clear that adolescents do not receive any major encouragement to avoid sexual activity. However, the number of respondents that encouraged self and the number noted being encouraged by parents total 42%. Thus this influence can be attributed to parental support and closeness due to the fact that 211 (76%) were still living with their parents at the time of the study.

Question 32 refers to encouragement in our society to avoid sexual activity. The researcher grouped and listed the data as provided by the respondents as deterrents to sexual activity.

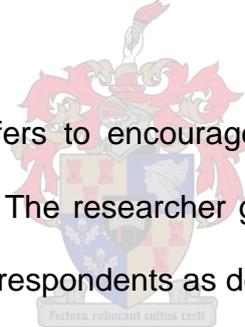


Table 4.26 Encouragement in our society to avoid sexual activity
N=302

What encouragement do you receive in our society to avoid sexual activity?	N	%
None	93	30
HIV/Aids	81	27
Teenage Pregnancy	62	21
Media Messages	33	11
Other	33	11

On the basis of these findings it is once again clear in Table 4.26 that adolescents do receive a limited amount of encouragement from society to avoid sexual activity. Thirty percent (30%) of respondents indicated that they received no encouragement from society at all; 81 (27%) indicated that media images of people infected with HIV and dying of AIDS encouraged them; 62 (21%) indicated teenage pregnancy while 33 (11%) said that media messages and other factors such as the behavior of youth, availability of contraception, future plans and the church were encouraging.

The fear of HIV /AIDS and other messages portrayed by the media equals 38%. However, what adolescents see and hear about sexuality in the media is often misleading, incomplete or distorted (Population Reports, 1995). Thus, it was difficult for adolescents to make informed choices based on media messages only.

Question 33 refers to important factors for making decisions on sexual matters.

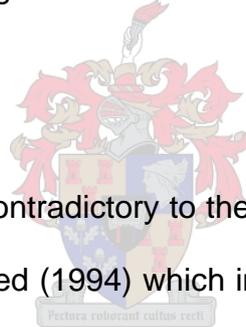
Table 4.27 Most important factors in making decisions on sexual matters

N=302



The most important factor for me in making decisions on sexual matters is:	N	%
a) My Future	172	56
b) My Health	49	16
c) My Parents Feelings	31	10
d) My Religion	26	9
e) What my partner/boyfriend thinks	26	9
f) Other, specify	0	0

Fifty six percent (56%) of respondents in Table 4.27 indicated that their future played a major role in sexual decision-making. This finding correlates well with 118 (39%) of respondents (Table 4.7) who have completed Standard 10 and are still studying towards an education; 49 (16%) indicated their health as a factor; 31 (10%) said that their decisions were based on what their parents would say; for 26 (9%) religion played a role while 26 (9%) considered their boyfriend/partner. However, Table 4.13 shows that 18 (46%) respondents indicated that their reasons for not engaging in sexual activity at the time were because of religious beliefs and is thus contradictory to this finding.



This finding is contradictory to the findings in a study by Jensen, Gaston and Weed (1994) which indicated that non-virgins cared more about their boyfriend's feelings as an important factor that influences them in decision-making regarding sexuality.

Question 34 refers to the idea of being pregnant. The researcher grouped and listed the data as provided by the respondents as their feeling about the idea of being pregnant.

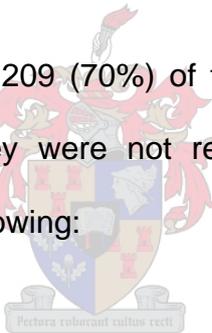
Table 4.28 Feeling about the idea of a pregnancy

N=302

How do you feel about the idea of being pregnant?	N	%
Not Ready	209	70
Unhappy	40	13
Careful/Against	27	9
Comfortable	9	3
Regret	16	5

An overwhelming 209 (70%) of the respondents in Table 4.28 indicated that they were not ready for a pregnancy. They expressed the following:

“I am too young”



“Cannot afford to have a baby”

“I will die if it happens to me”

“It will mess up my life”

“It will be one big mistake”

“I will go mad”

“I don’t even want to think about it”

Thirteen percent (13%) of respondents indicated that they would be unhappy and expressed feelings like:

“Fiasco, afraid, ashamed, scared, disappointed, devastated and uncomfortable”

Nine percent (9%) of respondents indicated that they were “careful, against teenage pregnancy, unsure, just don’t think about it”

Three percent (3%) of respondents indicated that they would be comfortable and expressed feeling like “I would like to be pregnant” and “I would accept it”

Five percent (5%) of respondents were pregnant before and indicated that they would regret another unplanned pregnancy.

1 respondent noted: “My world is falling apart.” Prior to the interview she was informed that her pregnancy test was positive.

This finding is confirmed by the literature review indicating that the majority of adolescent girls do not want to fall pregnant and that 85% of teenage pregnancies are unintended, Stier (1993).

Question 35 refers to options in case of an unplanned pregnancy.

Table 4.29 Options to teenage pregnancy

N=302

What would you opt for in case of an unplanned pregnancy?	N	%
a) Termination of Pregnancy (Abortion)	97	32
b) Adoption	32	11
c) Single Parenthood	98	32
d) Marriage	75	25

Table 4.29 shows that 97/98 (32%) of respondents indicated that they would opt for termination of pregnancy or raise the baby as a single parent; 32 (11%) of respondents would opt for adoption while 75 (25%) said that they would prefer to get married as an option.

After implementing The Choice on Termination of Pregnancy Act No. 92 of 1996, in South Africa, more teenage girls opted for legal abortion. As noted in the Reproductive Rights Alliance Barometer (1997) 17.4% of women requesting termination of pregnancy in South Africa is under the age of 18 years.

Although 97 (32%) of respondents indicated that they would opt for termination of pregnancy in the case of an unintended pregnancy, in relation to responses to *Question 37*, 155 (51.3%)

(Table 4.30) recorded termination of pregnancy as unacceptable. The respondents thus reveal ambivalence in terms of termination of pregnancy. This indicates that adolescents see termination of pregnancy as a choice for herself when needed but in general not acceptable.

The study by Resnick (1992) indicated that only 5% of teenage mothers place their babies for adoption in relation to 90%, 40 years ago. This is believed to be due to the diminished level of stigma associated with teenage pregnancy.

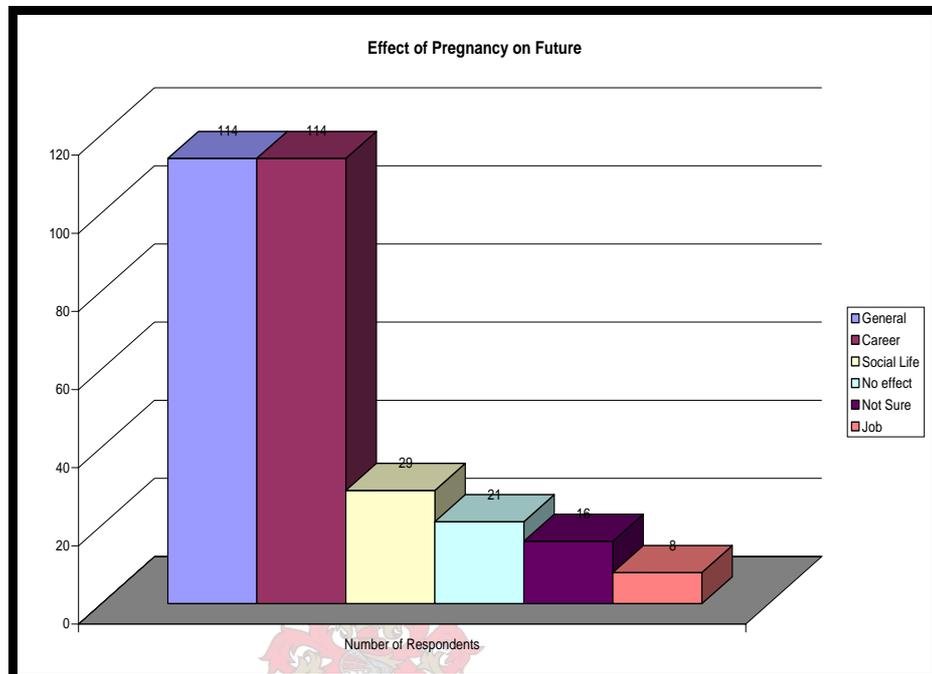
Resnick (1992) noted that single parenthood have become socially more acceptable. This supports the finding of this study. The option of single parenthood can also be associated with perceived parental support in raising the baby due to the fact that 67% of respondents (Table 4.4) were living with their parents at the time of the study.

Question 36 refers to the effect of a pregnancy on future plans. The researcher grouped and listed the data as provided by the respondents indicating the affect of pregnancy on future plans.

Figure 4.11

Affect of pregnancy on future plans

N=302



This was an open-ended question. The responses were grouped into six categories:

- Affect future in general
- Affect on career
- Affect social life
- No effect on future
- Not sure
- Affect on job

Thirty eight percent (38%) (Figure 4.11) of respondents were of the opinion that their future in general and career will be affected. Thus affect on career and future totaled 76%.

Responses such as the following were expressed:

“It will destroy my career”

“It will ruin my life”

“It will ruin my future”

“I won’t be able to continue school”

“Can’t study further”

“I will have to achieve my goals later”



“My future will be put on hold”

These responses indicate the respondents’ value of a career and future advancements. A majority of 39% respondents (Table 4.7) completed matric (Standard 10) and informed the researcher during the interviews that they were currently studying at various institutions including Universities, Technikons and Colleges in preparation of a future.

Ten percent (10%) of the respondents felt that a pregnancy will affect their social life. They responded as follows:

"I won't be able to go out with my friends any more"

"I'll have to baby sit"

"No more fun nights out "

"No partying"

"I'll be stuck with a baby"

"My time won't be my own any more"

"I'll have to think of someone else first"



Five percent (5%) were not sure of the effect while 8 (3%) were worried about losing their jobs with no income to support the baby.

Seven percent (7%) felt that it would not be a problem. 2 were married and one (1) was engaged to be married. The others indicated that they had very supportive parents who would be there for them.

This finding is supported by the literature review indicating that a pregnancy could mean the end to a school career, unlikelihood of the mother returning to school after the birth of the baby with consequence lower social and economic attainment.

Question 37 refers to the subjects' opinion regarding termination of pregnancy. The researcher grouped and listed the responses into three categories.

**Table 4.30 Opinion regarding termination of pregnancy
N=302**



What is your opinion regarding termination of pregnancy?	N	%
a) Acceptable	119	39
b) Unacceptable	155	51
c) Not sure	28	10

Table 4.30 shows that 119 (39%) of the respondents felt that termination of pregnancy was acceptable. They viewed opinions such as:

“It is OK”

“It is good that it has been legalized in this country”

“Should be allowed if raped”

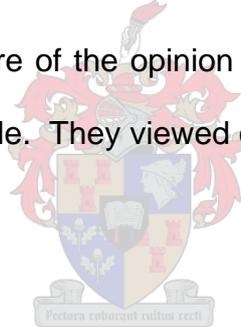
“It is your own choice”

“As long as it is safe”

“It is OK but not for me”.

This finding correlates with that found in *Question 35* (Table 4.29) where 32% of the respondents opted for termination of pregnancy in case of an unintended pregnancy. 155 (51%) of respondents were of the opinion that Termination of Pregnancy was unacceptable. They viewed opinions such as:

“It is murder”



“I am totally against it”

“I don't agree with it”

“It is sin”

“It is against my religion”

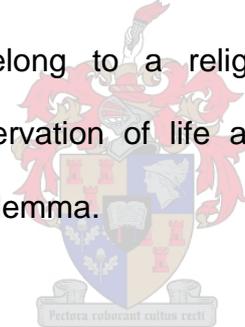
“A definite no”

“It is irresponsible”

“It is immoral”

Ten percent (10%) were not sure about their feelings. One subject indicated that she is totally against termination of pregnancy but will definite opt for it if she should have an unwanted pregnancy.

The overall feeling was that Termination of Pregnancy was wrong. This can be due to the fact that the majority of respondents belong to a religion with Christian principles preaching preservation of life at all cost and thus posing a serious moral dilemma.



It seems that adolescents do not abuse the availability of legal abortions. A study by Moore et. Al. (1996) confirmed that abortion appears to be a back-up and would not discourage contraceptive use.

Question 38 refers to the use of condoms when having sexual intercourse.

Table 4.31 The use of condoms

N=302

Do you use of condoms when having sex?	N	%
a) Always	76	27
b) Only with unknown partners	10	4
c) Intermittent use	57	20
d) Leave it up to the partner	16	5
e) No, Please explain why not	124	43

Table 4.31 shows that 76 (27%) of respondents indicated that they were always using condoms; Only 10 (4%) would use condoms with unknown partners; 57 (20%) would use condoms intermittently; while 16 (5%) left the choice to the partner. A majority of 124 (43%) indicated that they did not use condoms at all. The following reasons were provided:

“I have only one partner”

“I am not sexually active”

“It was the first time for both of us”

“I don’t sleep around”

“I had sex only once”

“I trust my boyfriend”

“I use contraceptives”

“I am in a committed relationship”

“I have only one boyfriend”

“We were both virgins”

“I don't like condoms”

“My boyfriend does not like it”



“I can't tell my boyfriend to use a condom”

“If I suggest my boyfriend use a condom he will think that I sleep around or that I do not trust him”

“I am not sexually active”

The use of condoms is often associated with occasional sexual encounters. When suggesting the use of condoms to a partner

could mean implying that the partner has been sleeping around. These responses indicated that respondents choose female methods of contraception when in committed relationships. Adolescents know the risks of contracting sexually transmitted diseases if not using condoms but may have little power in sexual relationships to suggest condom use as reflected in verbatim responses.

Question 39 refers to the use of a contraceptive method.

Diagram 4.18 **Contraceptive use**

N=302

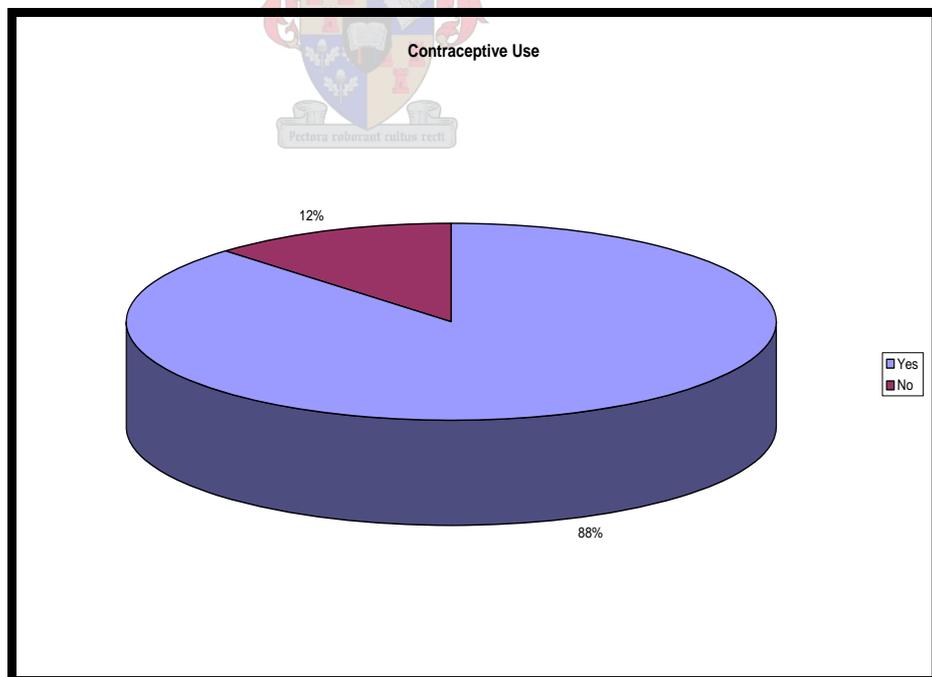


Diagram 4.18 show clearly that 265 (88%) of the respondents indicated that they were using a form of contraceptive method at

the time of the study. 37 (12%) indicated that they were not using any contraceptive method.

As indicated in Table 4.11, 263 (87%) of respondents reported to be sexually active. Therefore it seems that all sexually active respondents in this study are using a form of contraceptive method as well as 2 (1%) non-sexually active respondents.

Question 40 refers to the type of method being used.

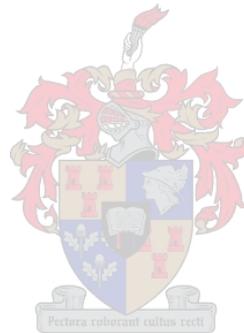
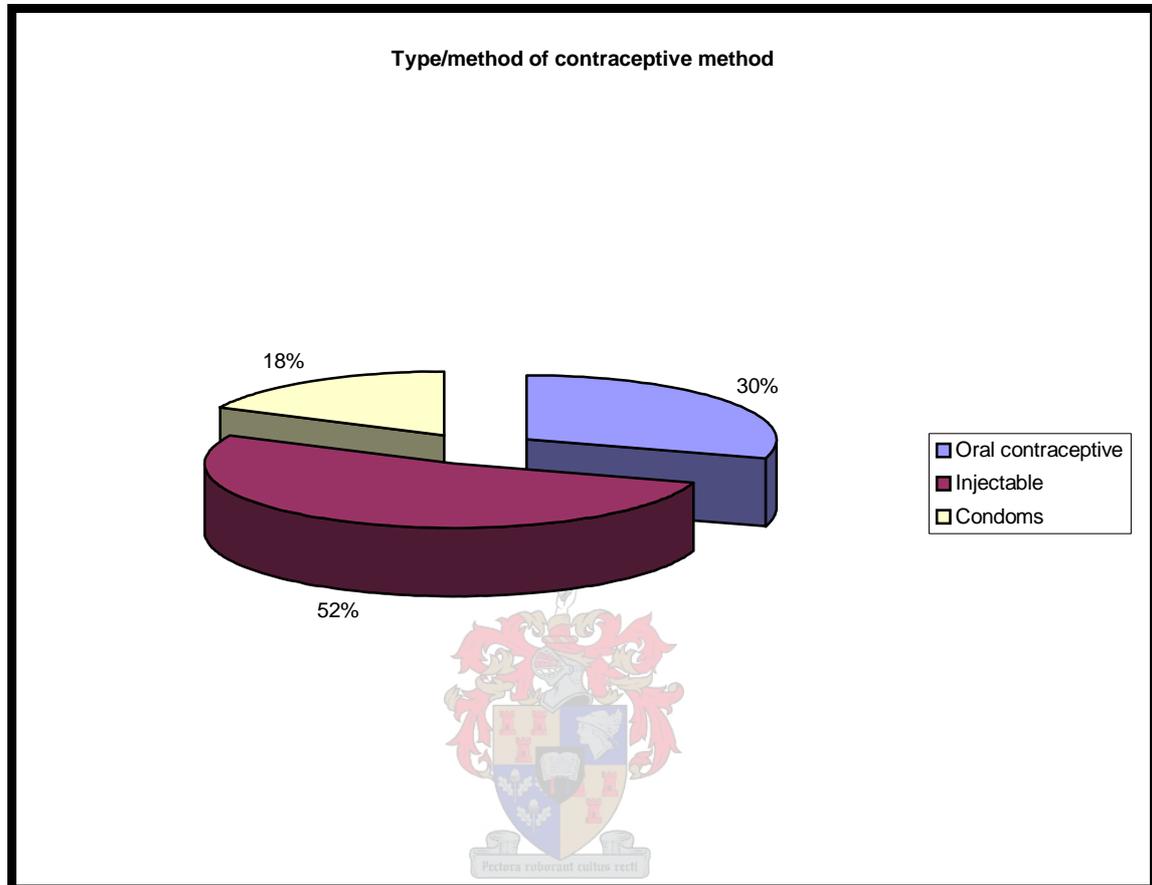


Diagram 4.19 Type/method of contraception

N=265



It is clear that in Diagram 4.19 that the majority 139 (52%) of respondents was using the injectable contraceptive, 79 (30%) used oral contraceptives with 47 (18%) of respondents using condoms as a contraceptive method. None of the subjects used spermicidal or natural methods.

As indicated in Diagram 4.19 47 (18%) of respondents use condoms as a contraceptive method and Table 4.31 indicates that 76 (27%) of respondents always use condoms when having

sexual intercourse. That means that 29 (10%) use condoms together with another contraceptive method.

A study by Middleman and Evans (1995) found that condoms and oral contraceptive are the most commonly used contraceptives amongst adolescents. It is clear that the respondents in this study preferred the injectable contraceptive as method of choice. It could be that the said method is preferred because it is not user dependent and they do not have to remember to take a pill every day. In cases where adolescents cannot discuss contraceptives with parents the injectable contraceptive is more convenient and private.

Question 41 refers to how the contraceptive method is being used.

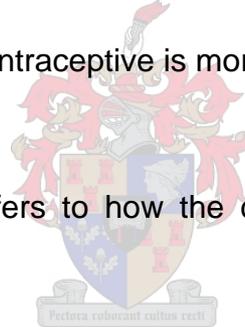


Diagram 4.20

Frequency of method usage

N=265

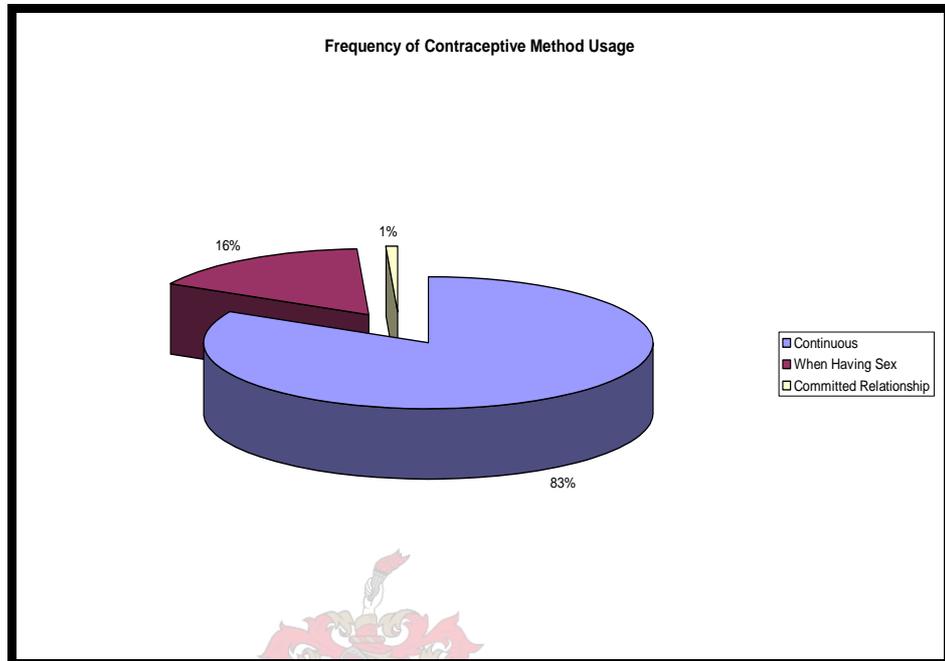


Diagram 4.20 shows that 218 (83%) of the respondents were using a contraceptive method continuously; 45 (16%) used a method only when having sex; 2 (1%) used a method only when in a committed relationship. 36 (12%) did not use contraceptive methods due to the fact that they were not sexually involved or active at the time of the study.

Contraceptive usage is not popular amongst adolescents, particularly those younger than sixteen (16) years and from economically and educationally poorer backgrounds (Hudson & Ineichen, 1991).

A study by Green, Johnson and Kaplan (1992) found that fewer than 20% (N=50) adolescents who use contraceptives do so consistently. However, this study found that all sexually active respondents were using contraceptive methods with 83% (N=218) doing so continuously.

Question 42 refers to Emergency Contraception

Table 4.32 Use of emergency contraception

N=302

Have you ever used Emergency Contraception?	N	%
a) Do not know about it	93	31
b) Never	121	40
c) Yes	88	29

Table 4.32 shows that 93 (31%) of respondents did not know about Emergency Contraception; 121 (40%) have never used it while 88 (29%) used it before. From the respondents who used Emergency Contraception before, 46 (52%) (N=88) used it once; 26 (30%) used it twice; 11 (12%) used it thrice while 5 (6%) used it four times.

If not using a reliable contraceptive method continuously the adolescents have to convert to using emergency contraceptive, often more than once.

Question 43 refers to previous pregnancies.

Diagram 4.21 **Previous pregnancies**
N=302

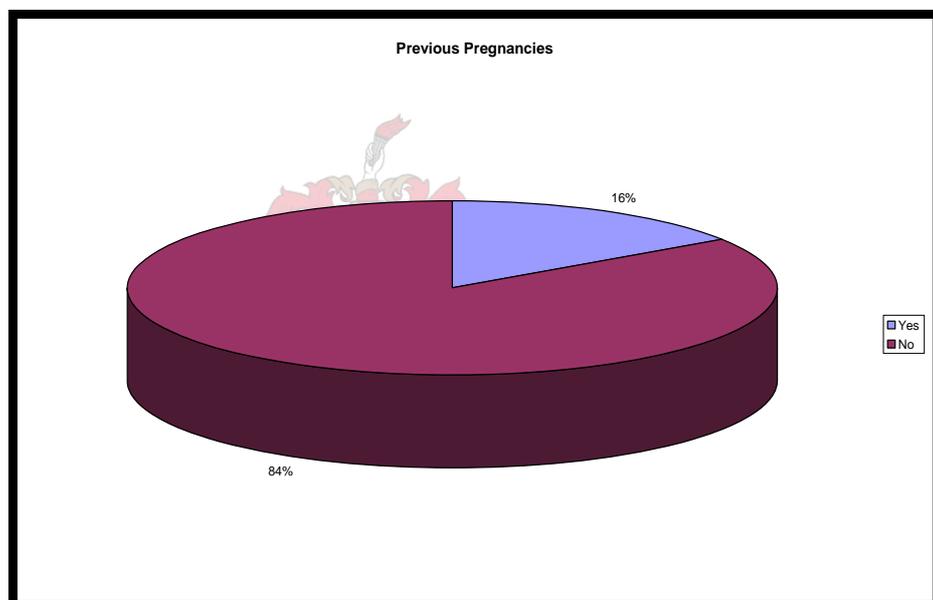


Diagram 4.21 shows that 47 (16%) of the respondents have been pregnant before while 255 (84%) have not. This finding is supported by a study done by Swenson (1992) on adolescents attending a teen family planning clinic. She found that 80% (N=183) had not been pregnant with 20% having had 1-2 children.

This study found that 3 respondents got married and raised their children. In Table 4.29 75 (25%) of respondents indicated that they would get married in case of an unintended pregnancy. 34 (72%) (N=47) of babies born to respondents prior to this study were raised by single mothers or given up for adoption while 130 (43%) of respondents indicated that they would either raise their babies as single parents or give them up for adoption

Question 44 refers to having had a previous termination of pregnancy.

Diagram 4.22 Previous termination of pregnancy

N=302

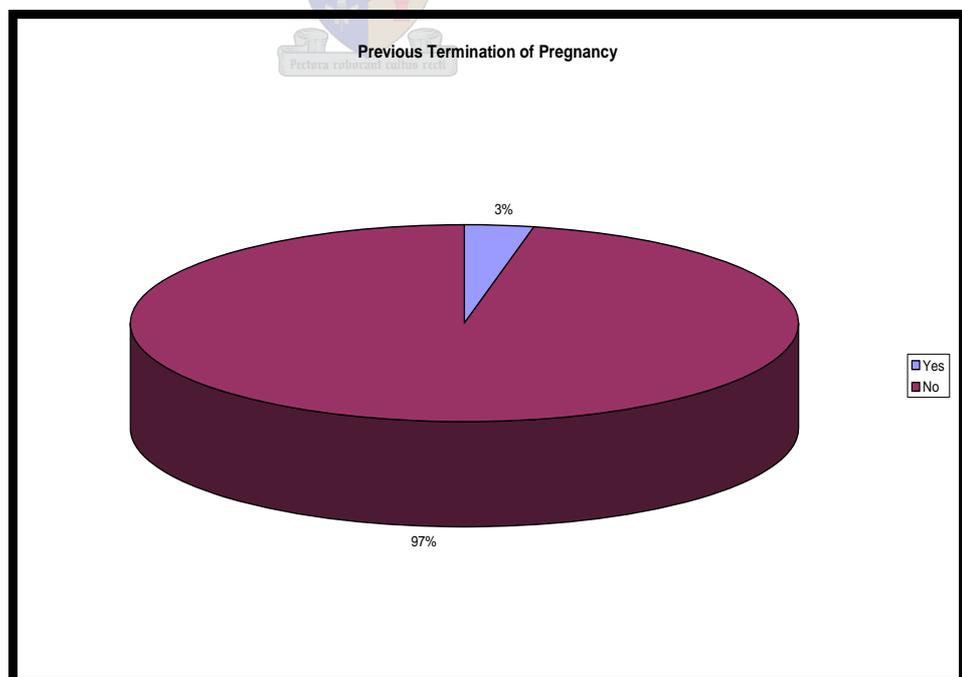


Diagram 4.22 shows that 10 (3%) of the respondents indicated that they had a previous termination of pregnancy; while 292 (97%) said no. 155 (51%) respondents indicated that they found termination of pregnancy as an option unacceptable in case of an unintended pregnancy (Table 4.30). It seems most unlikely that adolescents would choose termination of pregnancy when faced with the dilemma of an unintended pregnancy. The closeness and support of parents could also contributed to decision-making in this regard.

Question 45 refers to the nature of contracting a Sexually Transmitted Disease.

This was an open-ended question. The respondents were asked what a Sexually Transmitted Disease was. The responses have been grouped and listed as follows:

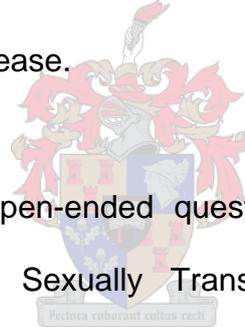


Table 4.33 The nature of contacting a Sexually Transmitted Disease
N=302

What Is a Sexually Transmitted Disease?	N	%
a) Contract when changing sex partners	176	59
b) Acquired Immune Deficiency Syndrome	52	17
c) Transmitted during sex	46	15
d) Don't know	10	3
e) Other	18	6

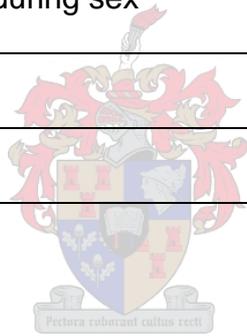
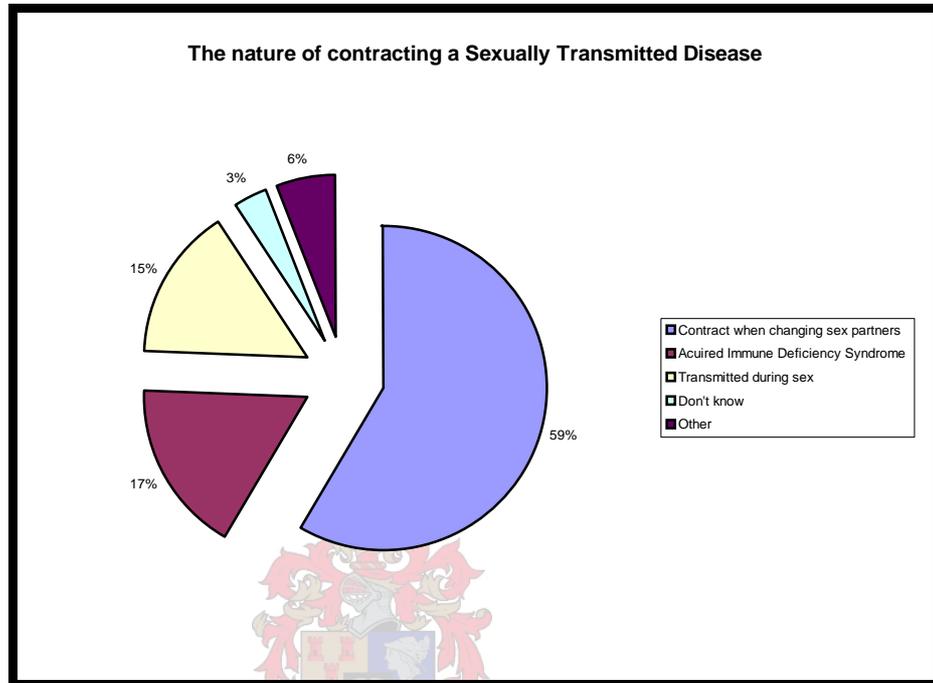


Diagram 4.23 The nature of contracting a Sexually Transmitted Disease

N=302



The respondents all agreed that Sexually Transmitted Disease was a disease. Fifty nine percent (59%) of the respondents indicated that a Sexually Transmitted Disease was a disease you contract when changing sex partners. This included: something you contract from a partner that sleeps around; having more than one sex partner; 52 (17%) referred to Sexually Transmitted Disease as Acquired Immune Deficiency Syndrome; 46 (15%) thought that you get it during sexual intercourse; while 10 (3%) indicated that they did not know what it was. 18 (6%) indicated other including: “It is a disease that affects your health”

It is a disease that you get through blood transfusions”

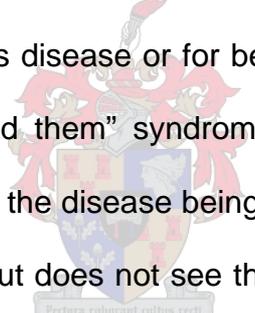
“It is a life threatening disease”

“It is a disease spread by men”

“Some form of germs”

“It is a virus infection”

It was clear that the respondents blamed their partners for being the carrier of this disease or for being responsible for spreading it. The “me and them” syndrome is identified. For example adolescents see the disease being spread by someone else that sleeps around but does not see the self as doing the same with similar behavior.

A faint watermark of a university crest is visible in the background of the text. The crest features a shield with various symbols, topped by a crown and a figure holding a staff. Below the shield is a banner with the Latin motto "Pectora roburant cultus recti".

Question 46 refers to the ways in which Sexually Transmitted Disease can be transmitted.

Table 4.34 Ways of transmitting Sexually Transmitted

Disease

N=302

In which ways can sexually transmitted disease be transmitted?	N	%
a) Blood	1	1
b) Toilet seats	0	0
c) Deep French kissing	0	0
d) Hugging/Cuddling	0	0
e) Sexual intercourse	291	96
f) Other, Please specify	10	3

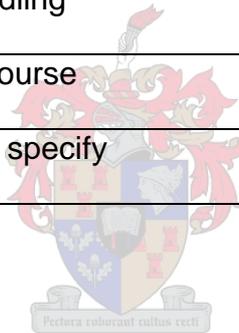


Figure 4.12 Ways of transmitting Sexually Transmitted Disease

N=302

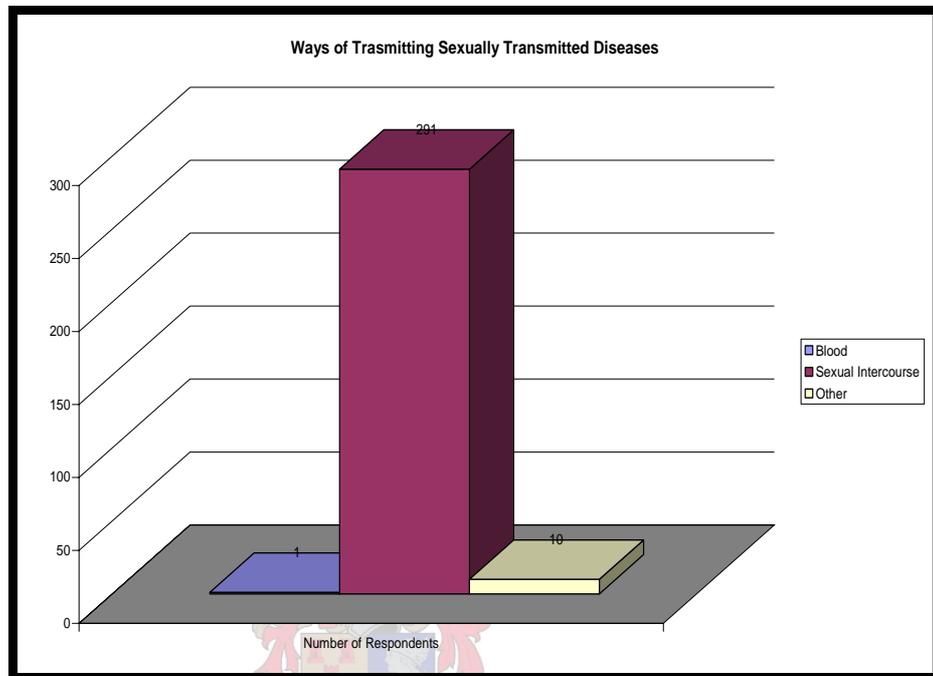


Table 4.33 and Diagram 4.24 show that a vast majority, 291 (96%) of the respondents indicated that the disease are being transmitted by sexual intercourse; 1 (1%) felt that you can get it by means of a blood transfusion and syringes; while 10 (3%) said other, where all indicated that they did not know. No one felt that it could be transmitted by means of deep French kissing, hugging/cuddling or toilet seats.

This finding is supported by 96.5% of respondents in a study conducted by Makubalo (1996) in rural Kwazulu-Natal, South Africa indicating that Acquired Immune Deficiency Syndrome (a

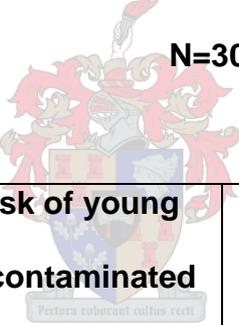
Sexually Transmitted Disease) can be transmitted by means of sexual intercourse.

Despite of this awareness only 27% (Table 4.31) of the respondents always use condoms when having sex. They thus see others at risk but not themselves.

Question 47 refers to young people's risk of becoming contaminated with a Sexually Transmitted Disease.

Table 4.35 **Young people's risk**

N=302



What is the risk of young people being contaminated with a sexually transmitted disease?	N	%
a) None	4	1
b) Slight	61	20
c) Great	202	67
d) Don't know	34	11

Figure 4.13 Young people's risk

N=302

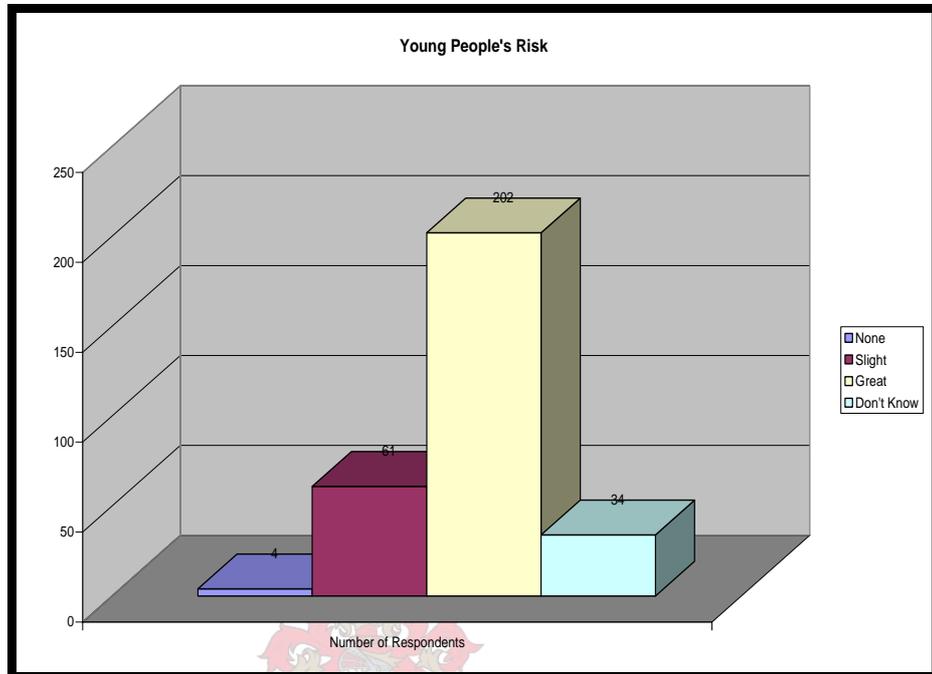


Table 4.35 and Diagram 4.25 show that 202 (67%) of the respondents felt that young people are at great risk of being contaminated with Sexually Transmitted Disease; 61 (20%) felt that the risk was slight; 4 (1%) felt that there was no risk; while 34 (11%) indicated that they did not know. Reasons provided for the responses included:

“Many are sexually active”

“Many have a lot of partners”

“Teenagers are not informed”

“Lots are sleeping around”

“Changing partners”

“Sleep with unknown partners”

“They don’t care”

“Everybody is doing it”

“Become sexually active at a young age”

“Lots have casual sex”

“Teenagers are into sex”



“Do not use condoms”

“Teenagers are into sex”

It seems despite the fact that adolescents are aware of the risk factors of contracting Sexually Transmitted Diseases, they might not realize that their peers might already be infected.

Question 48 refers to the adolescent's own risk of becoming infected with Sexually Transmitted Disease.

Figure 4.14 Adolescent's own risk

N=302

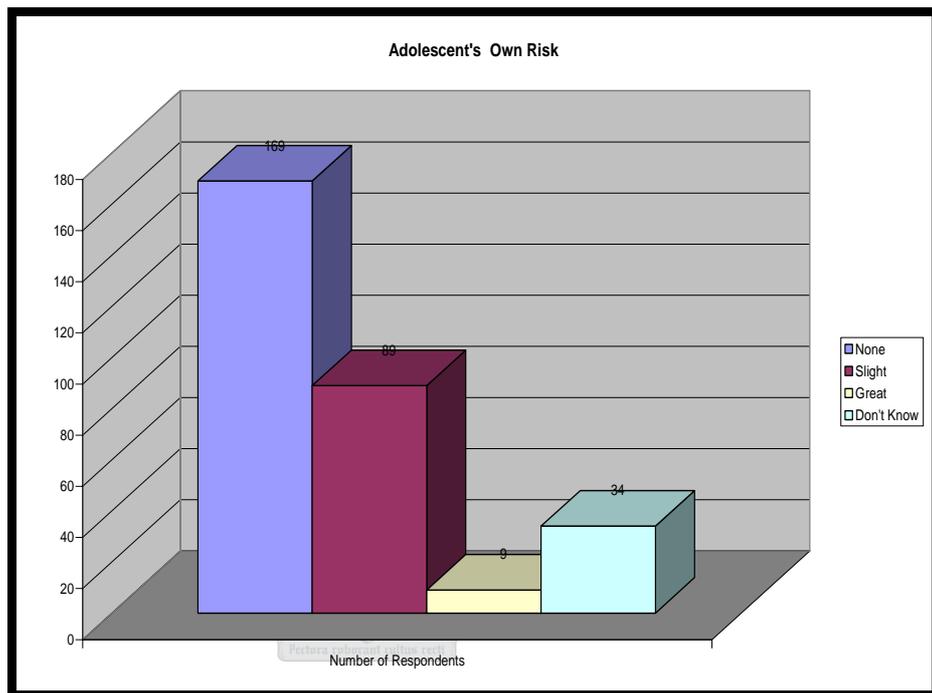


Figure 4.12 shows that 169 (56%) of the respondents indicated that they were not at risk at all; 89 (30%) indicated slight risk; only 9 (3%) indicated that they were at great risk while 34 (11%) said that they did not know.

The majority of the respondents (67%) indicated contracting a Sexually Transmitted Disease presents a great risk for young people in general (Table 4.35). However, in Diagram 4.26, 56%

considered their own risk as none with 30% indicating slight risk. This incongruence could suggest denial and projection of own fears of contracting a Sexually Transmitted Disease. This finding is supported by similar findings in a study by Cerqueira Leite et.al. (1995). The researcher also refers to this phenomenon as the “*them and us syndrome*”. This finding is quite alarming in terms of the fight against HIV/AIDS and adolescents maintaining their sexual health.

Questions 49-55 refer to myths regarding possibilities of falling pregnant.

Question 49 required the respondents to answer yes or no to the following question posed: “Can you fall pregnant without having sex?”



Table 4.37 Falling pregnant without having sex

N=302

Can you fall pregnant without having sex?	N	%
Yes	73	24
No	229	76

Only 73 (24%) of respondents indicated that it was possible for a girl to fall pregnant without having sex. The majority 229 (76%) indicated that falling pregnant without having sex was a myth. When clarified during the interview the respondents clearly referred to sex as penetration only. Heavy petting with the release of body fluids and consequent mixing of fluids due to close contact or ejaculation on pubic area did not seem to pose a problem and was not regarded as sex (Table 4.37).

Question 50 refers to the likelihood of falling pregnant if a girl did not commence menses yet.

Table 4.38 Falling pregnant before commencing menses

N=302



Can you fall pregnant if you never had your period, but are sexually active?	N	%
Yes	90	30
No	212	70

Diagram 4.26 **Falling pregnant before commencing menses**
N=302

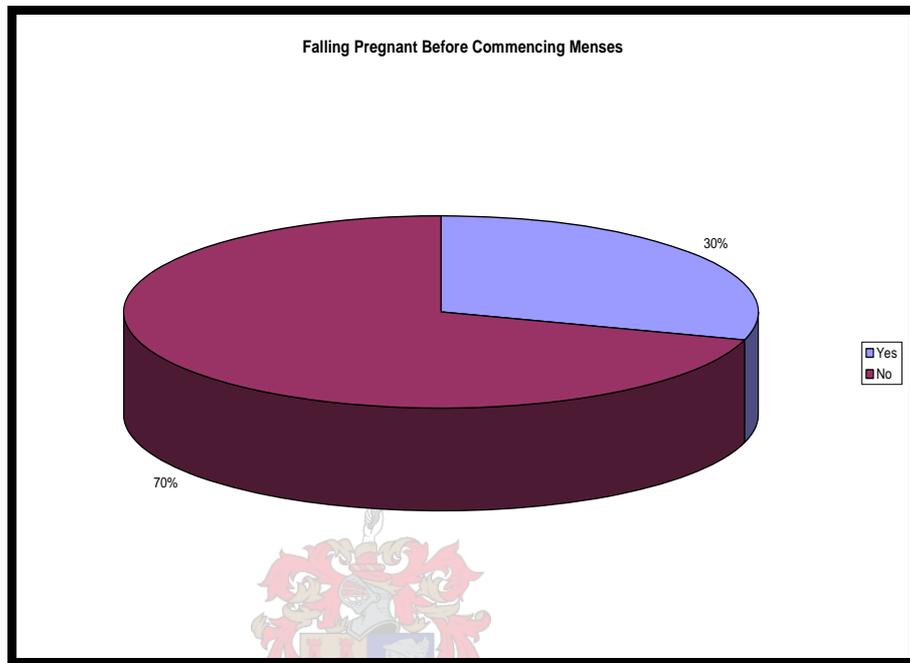


Table 4.38 and Diagram 4.26 show that 90 (30%) of the respondents felt you could fall pregnant before having a period while the vast majority of 212 (70%) answered “no”.

Question 51 refers to the possibility of falling pregnant after starting to ovulate. Respondents had to indicate whether the statement was a fact or a myth.

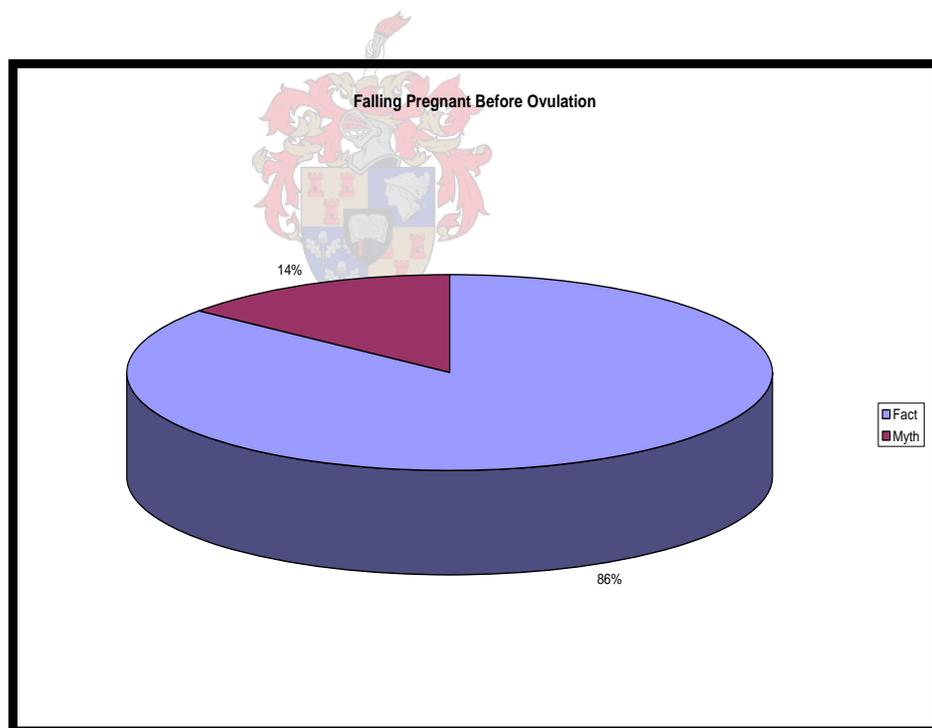
Table 4.39 Falling pregnant after ovulation

N=302

If a girl has started ovulating, she can fall pregnant	N	%
Fact	259	86
Myth	43	14

Diagram 4.27 Falling pregnant before ovulation

N=302



An overwhelming number of girls 259 (86%) were convinced that a pregnancy was possible after ovulation has commenced while 43 (14%) thought that it was a myth. In Table 4.38 and Diagram 4.26 30% indicated that you couldn't fall pregnant

without having had a period. The responses to Question 50 and 51 did not correlate. It is therefore not clear whether the respondents were knowledgeable regarding the menstrual cycle with ovulation starting before menstruation.

Question 52 refers to the possibility of a pregnancy without penetration.

Table 4.40 **Pregnancy without penetration**

N=302

If there is no penetration, there is no risk of becoming pregnant	N	%
Fact	152	50
Myth	150	50

Diagram 4.28 Pregnancy without penetration

N=302

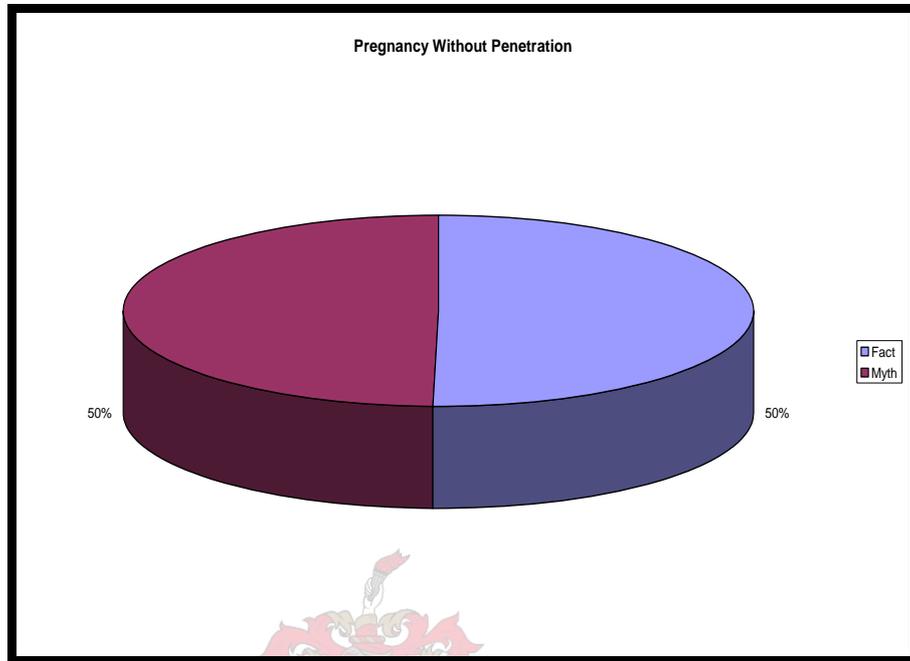


Table 4.40 and Diagram 4.29 show that the respondents were equally divided on this matter. 152 (50%) thought that it was a fact while 150 (50%) thought that it was a myth. The responses did not correlate with that of Question 49 where 76% felt that you could not fall pregnant without having sex.

Question 53 refers to an action after having sex to prevent a pregnancy.

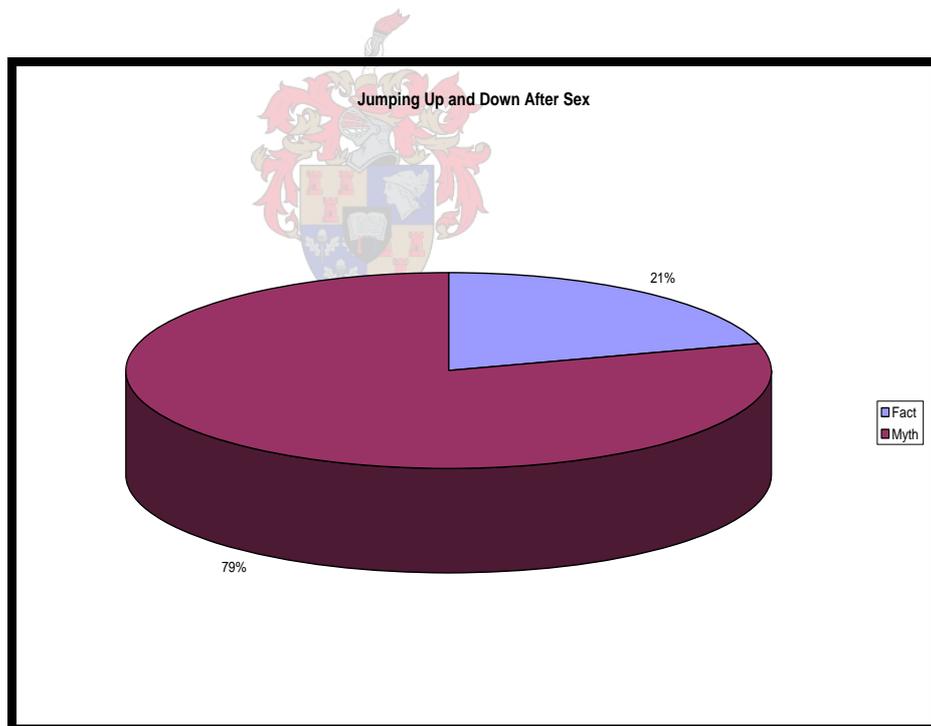
Table 4.41 Jumping up and down after sex

N=302

Jumping up and down after sex will prevent a pregnancy.	N	%
Fact	62	21
Myth	240	79

Diagram 4.29 Jumping up and down after sex

N=302



62 (21%) respondents felt that jumping up and down to prevent a pregnancy was in fact true while the majority 240 (79%) indicated that it was myth. They were clear that ejaculation

could not be reversed by jumping up and down (Table 4.41 and Diagram 4.29).

Question 54 refers to a pregnancy occurring after having sex for the first time.

Table 4.42 **Pregnancy after first sex**
N=302

A woman cannot fall pregnant the first time she has sex.	N	%
Fact	84	28%
Myth	218	72%

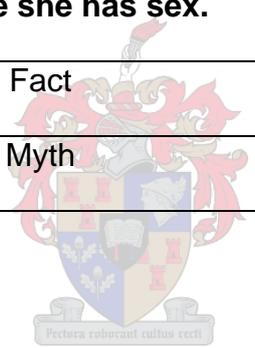


Diagram 4.30 Pregnancy after first sex

N=302

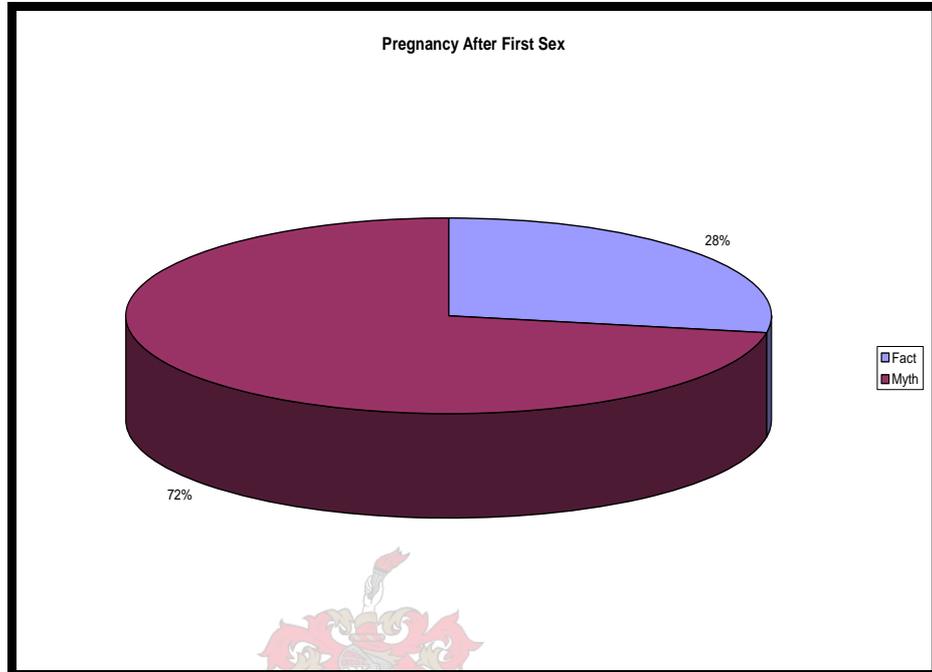


Table 4.42 and Diagram 4.30 show that the minority of 84 (28%) of respondents indicated that the said statement was a fact while 218 (72%) indicated that it was a myth and that a pregnancy could thus occur.

Question 55 refers to the risk of becoming infected with the HIV from sharing toothbrushes.

Table 4.43 HIV and sharing toothbrushes

N=302

You can become infected with HIV from sharing toothbrushes	N	%
Fact	92	30
Myth	210	70

Diagram 4.31 HIV and sharing toothbrushes

N=302

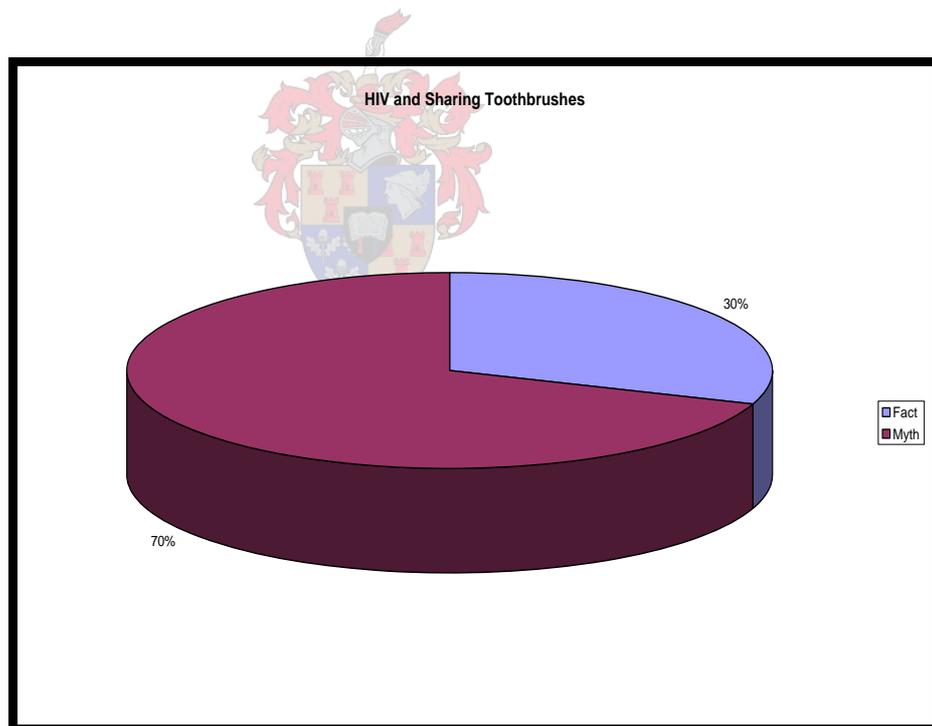


Table 4.43 and Diagram 4.31 show that 92 (30%) of the respondents felt that you can become infected with HIV from sharing toothbrushes while the majority of 210 (70%) felt that it was a myth.

Questions 56 and 57 are open-ended questions.

In Question 56 the respondents had to respond to the following cliché: “If you loved me you would have sex with me”

Table 4.44 Responses to cliché: “If you love me you will have sex with me”

N=302

“If you love me you will have sex with me”	N	%
Say No	251	83
You will wait	22	7
Other	31	10

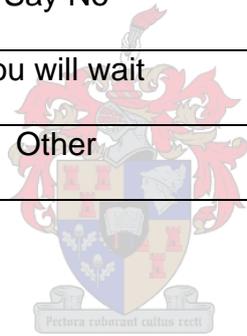


Diagram 4.32 Responses to cliché: “If you love me you will have sex with me”

N=302

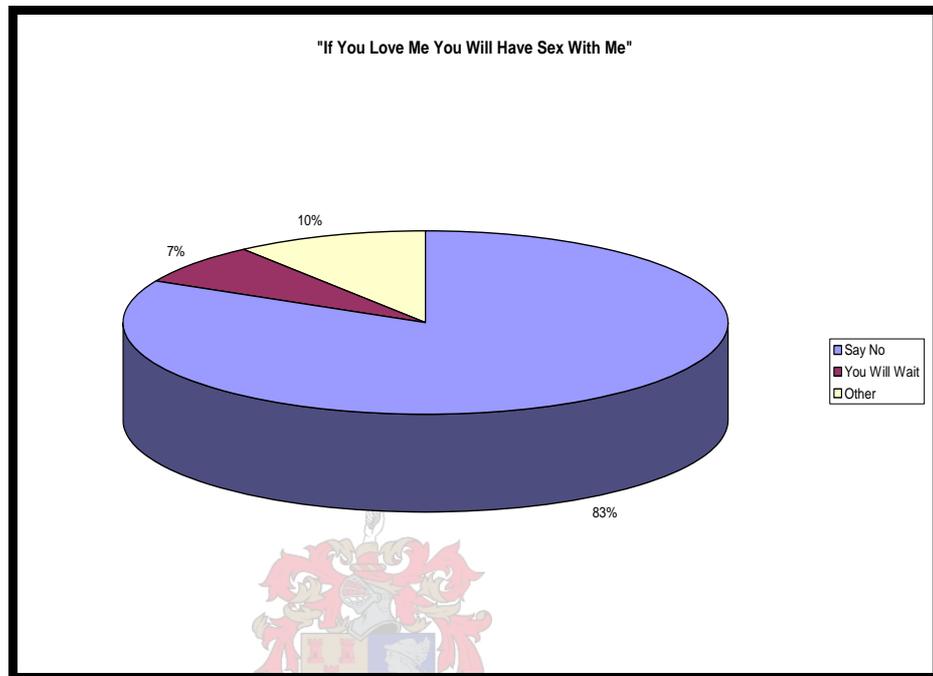


Table 4.44 and Diagram 4.32 show that the majority of respondents 251 (83%) felt that this was an old line used by guys and said no to this advance. 22 (7%) said that if the guy really loved you he would wait till she was ready. 31 (10%) was documented under other and included responses such as:

“I would like to do that”

“I will refuse”

“If I like him why not?”

“I’ll tell him to get lost”

“Try that with someone else”

“I would feel insulted”

“You obviously don’t know me”

“I don’t believe you”

“If I love him I’ll do it”

“I think that is low”

“I will end the relationship”



“He is not to be trusted”

“If you love me you would show me respect”

“Yeah right!”

“It’s a personal choice”

“Take a hike”

“I’m not stupid”

“Buzz off”

“OK”

Although 17% indicated that they felt insulted, they still were not assertive enough to say no. Reasons could be avoidance of physical abuse by the boyfriend when refusing to have sexual intercourse. Teens also regard having sex as affirmation of love and commitment and fear of rejection.

Question 57 refers to feelings about sexual relation before marriage. The responses were grouped by the researcher:

- It is wrong; OK; Sin; Wait till marriage; and No.

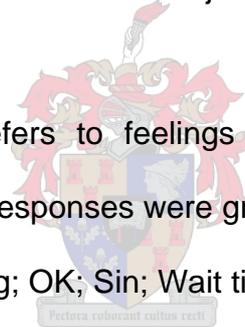
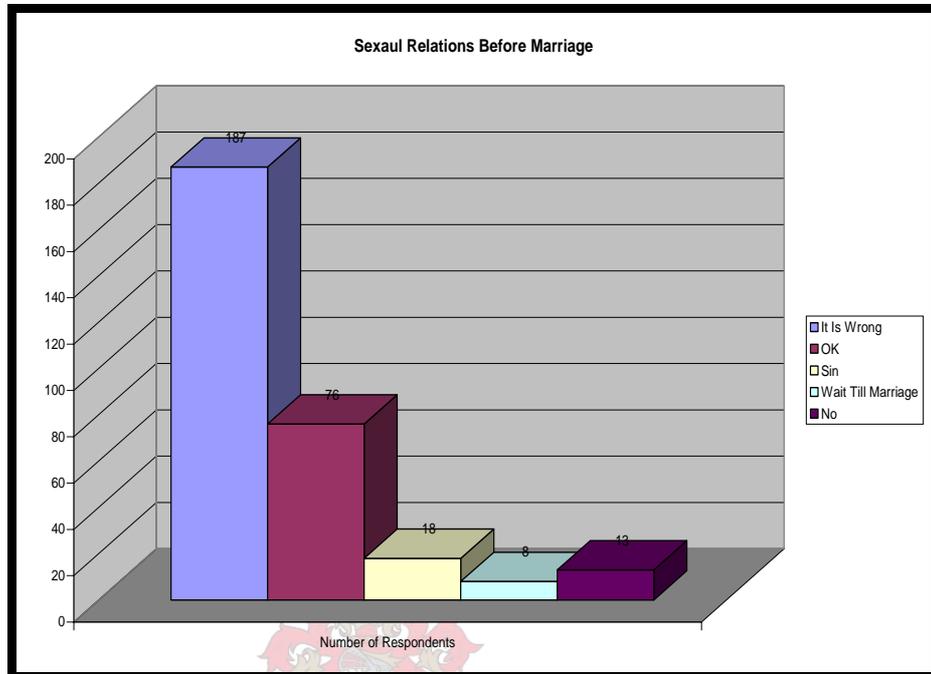


Figure 4.15 Sexual relations before marriage

N=302



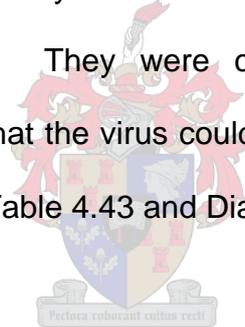
Although a majority of 263 (87%) (Table 4.11) of the respondents were sexually active at the time of the study, 187 (62%) felt that it was wrong to have sex before marriage, although they were doing it. 76 (25%) indicated that it was OK. 18 (6%) felt that it was sin according their religion. 8 (3%) felt that sex belonged within marriage. 13 (4%) said no to sex before marriage (Figure 4.15).

It seems that respondents were not knowledgeable on the menstrual cycle. In Table 4.38 70% indicated that a pregnancy was not possible before commencing menstruation and in Table 4.39 86% indicate that pregnancy was possible after ovulation.

There is thus no correlation between the two processes occurring within the same cycle.

It was encouraging to note that the majority of respondents (79%) regarded “jumping up and down after sex” as a myth. This is a practice known to be used by adolescents as experienced by the researcher during the period she worked with adolescents (Table 4.41 and Diagram 4.29).

It is alarming to note that a majority of 72% of respondents regarded “pregnancy after first sex” as a myth (Table 4.42 and Diagram 4.30). They were clear on the transmission of HIV/AIDS and that the virus could not be transmitted by sharing toothbrushes) Table 4.43 and Diagram 4.31).



The respondents seemed assertive in terms of defending themselves when a cliché like “If you loved me you will have sex with me” was being used (Table 4.44 and Diagram 4.32). Despite 87% of respondents being sexually active at the time of the study (Table 4.11) 62% felt that it was wrong (Figure 4.15).

The literature review indicating that pre-marital sex was bad according moral standards upheld by society supports this finding.

CONCLUSION

Three hundred and two respondents between the ages of 14 and 19 years were interviewed. All the girls lived in a rural area at the time of the study. A majority of 73% belonged to a religion with Christian principles.

The major sources of information regarding sexual decision-making, teenage pregnancy and Sexually Transmitted Disease were parents and teachers at school.

The majority of respondents started dating at the age of 14 with the majority initiating first sexual intercourse at the age of 16.

Despite the fact that all respondents knew that Sexually Transmitted Disease is being transmitted via sexual intercourse and that condom usage can reduce the risk of contracting Sexually Transmitted Disease, only 27% used condoms at all time when having sexual intercourse.

The respondents did not perceive themselves to be at risk of contracting a Sexually Transmitted Disease but regarded adolescents in general at great risk.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Research was done on the adolescent and sexual health. Three main objectives were set for the study namely:

- Define sexual health;
- Identify and describe the factors that play a role in adolescents' experiencing problems in maintaining their sexual health; and
- Propose recommendations for specific nursing actions as well as for future research investigations.

Triangulation as research design was used to obtain data. The data was analyzed and discussed and it was shown that the objectives were met.

This chapter includes the conclusion and describes the recommendations proposed, based on the outcome of the study.

5.2 RESULTS

302 respondents participated in the survey with almost equal numbers English and Afrikaans speaking. The difference

between English and Afrikaans speaking girls visiting the said facilities was not significant.

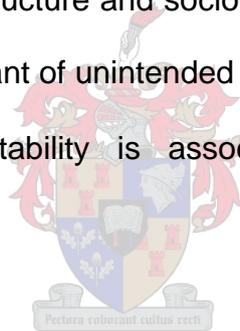
The majority of respondents were aged 18 (32%) or 19 (30%). The youngest respondent was 14 years old and the eldest being 19 years. The researcher identified that only a small percentage of girls in the age group 10 to 14 years are visiting a Sexual and Reproductive Health facility. The average age for initiating sexual activity was 16 years. The implications of early sexual encounters are clear and discussed in Chapter 2. There is a definitive relation between early initiation of sexual encounters and multiple sexual partners and the risk of contracting a Sexually Transmitted Disease (Chapter 2 number 2.2).

More Coloured (65%) than White (35%) girls visited the Sexual and Reproductive Health facilities with the majority in both groups being between 18 and 19 years old. This correlates with the literature review (Chapter 2 number 2.2).

All the respondents were living in an urban area at the time of the study. Where they stayed the first five years of their lives did not appear to have had any significant impact on sexual decision-making. It appeared as if they had instead conformed to the pressures associated with the urban set-up. The majority was still living with their parents in their own homes at the time

of the study. The support and closeness of this arrangement had an influence on sexual decision-making:

- Supportive relationships with parents are closely linked with positive self-esteem during adolescence and can make an important difference in the affective experiences with others;
- Family have primary influence on basic values;
- Parental closeness and support can moderate negative peer influence and thus protective against negative peer influences;
- Family structure and socio-economic status are important determinant of unintended teenage pregnancy; and
- Family stability is associated with delay in sexual initiation.



As found in the data analyzed, it seems that the closeness and support of the family for the majority of the respondents (67%) protected them from involvement in risky sexual behaviour such as initiating early sexual activity.

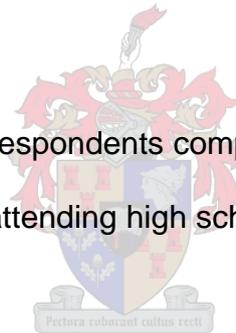
The study indicates that 94% of respondents were affiliated to some form of religion with only 6% not belonging to any specific religion. The majority of the respondents were Christian (73%) with 25% of Christians belonging to the Dutch Reform Church

having been subjected to very conservative upbringing. Religion definitely influenced how they felt about pre-marital sex:

- Religious affiliation seemed to impact on ethical and sexual decision-making where 51% of respondents indicated that found termination of pregnancy an unacceptable choice in case of unintended pregnancy; and
- 62% of respondents in this study indicated that sexual relations before marriage was wrong.

However, a small percentage noted religion as a deterrent to sexual activity.

The majority of respondents completed matric (standard 10) with only 3 not ever attending high school (standard six).



The major sources of information regarding sexual decision-making, teenage pregnancy and sexually transmitted diseases were parents followed by teachers. The quality and detail of the content of information provided was not determined.

Eighty seven percent (87%) of respondents who visited the facilities were sexually active. The remaining 13% either considered commencing a sexual relation.

The literature review showed that the main reasons for

adolescents delaying sexual initiation were career goals. This finding is supported by the 95% of respondents indicating that a major factor influencing sexual decision-making was their future.

The study showed that 3% of respondents initiated sexual activity at an age younger than 14 years; 8% at the age of 14 19% at 15 years 30% at 16 years 22% at 17 years 13% at 18 years with 1 who had an alarming number of 15 partners to date with 3% at the age of 19 years of whom only 2 had more than 1 partner. The average age for sexual initiation was 16 years. The majority of 16 year olds had multiple sexual partners. This correlates with the literature review indicating that the earlier a girl initiates sexual activity the more sexual partners she tends to have The majority of respondents were informed about the legal age for sex in the country. This knowledge could have facilitated initiating sexual intercourse at 16 years.

Sixty-nine percent (69%) of respondents indicated that their reason for becoming sexually involved with the opposite sex was love. Seventy four percent (74%) had their first sexual encounter with their boyfriend. Forty-eight percent (48%) indicated that the first encounter was an impulsive act with 42% indicating that it was planned. Forty-two percent (42%) of subjects noted the first experience as disappointing.

Only 5% indicated that they experienced pressure by friends to initiate sex. This is contradictory to 46% of respondents indicating that they experience pressure by peers to become sexually active.

The majority of respondents indicated that they felt comfortable discussing sexual issues with their partners.

Only 2% of the respondents were not dating at the time of the study. The majority of subjects started dating between the ages of 14 and 16 years. Thirty-four percent (34%) of participants indicated that they were subjected to dating rules such as what time they will be back home (hours), where they were going (location) and whom they were going out with (partner) with 42% indicating that their parents had no rules regarding dating. 46% of respondents preferred to date as a couple while 43% preferred to group date.

Dating is associated with both sexuality and independence and for this reason frequently viewed with ambivalence by parents. Parents are concerned about the choice of partners and potential unintended pregnancies that could compromise career development as well as the risk of becoming infected with HIV. Nevertheless dating represents an important step in sexual development.

Thirty-one percent (31%) of respondents indicated that they received no encouragement from society to abstain. Twenty-seven percent (27%) indicated that the fear of HIV/AIDS was a form of encouragement not to become sexually active. Fifty-six percent (56%) of subjects indicated that their future was a major factor in sexual decision-making.

Sixty-nine percent (69%) of respondents indicated that they were not ready for a pregnancy. Thirty-two percent (32%) indicated that they would opt for single parenthood. Thirty-eight percent (38%) felt that an unintended pregnancy would affect their future in general as well as career. Fifty-one point four percent (51.3%) found the idea of a termination of pregnancy unacceptable. However 32% indicated that they would opt for a termination if needed. Sixteen percent (16%) of respondents had a previous pregnancy and 3% had a pregnancy terminated. Forty-one percent (41%) of respondents did not use condoms at all with only 25% using condoms at all times during sexual intercourse. Eighty-eight percent (88%) of respondents used a contraceptive method (oral, injectable and condoms). Seventy-three percent (73%) used a contraceptive method continuously. Forty percent (40%) of respondents have never use emergency contraceptive and 31% did not know about it. Twenty-nine percent (29%) used it before. Forty-six percent (46%) used it

once, 26% used it twice, and 11% used it three times while 5% of the respondents used it four times.

The study clearly indicates that virtually all adolescents knew that sexually transmitted disease is being transmitted via sexual intercourse but this did not influence their sexual behavior at all. Only 27% (N=302) of respondents used condoms at all times when having sexual intercourse. Interventions should thus focus on changes in sexual behavior with a marked increase in condom usage additional to a reliable contraceptive method.

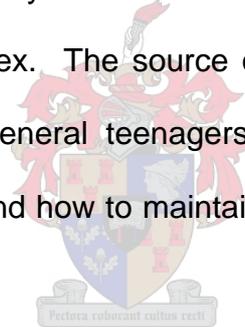
The study further revealed that, the majority of respondents did not perceive themselves to be at risk of contracting a Sexually Transmitted Disease but indicated that young people's risk of becoming infected was great. This finding suggests that adolescent girls need to be warned about their vulnerability to Sexually Transmitted Disease. This is important, as adolescents are not likely to act unless they are convinced of their own vulnerability to disease.

Questions concerning myths and factual information indicated that respondents were not well informed. This is an indication that where parents are the main source of information it is important that they become informed about sexuality to ensure correct information being distributed.

Sixty-two percent (62%) of respondents indicated that it was wrong to have sex before marriage with while 87% were in fact sexually active at the time of the survey.

The majority of the respondents 76% were living with their parents in own house. The living arrangements e.g. parents living in own house was used as an indication of the socio-economic status of the family.

Adolescents are being bombarded by media messages regarding sexuality with no clear encouragement to abstain or practice safer sex. The source of information is often not well informed. In general teenagers are not well informed about sexual issues and how to maintain their sexual health (Question 10 to 13).



Young people feel pressure for both abstinence and to engage in sexual intercourse. The respondents contradicted themselves in this study. In Question 22, 95% indicated that they experienced no pressure by friends to become sexually active and in Question 30, 48% admitted pressure by friends.

Sexual activity amongst adolescents is considered the most crucial risk factor for contracting a Sexually Transmitted Disease. Increasing this risk include a young age of first coitus,

number of sex partners and the non-use of condoms. Due to the vulnerability of the cervix of adolescents the risk of cervical cancer is increased.

With the risk of contracting HIV, a life threatening disease, the importance of sexuality education can no longer be debated and the need to promote sexual health is becoming more urgent with the emphasis on condom promotion and programmes to empowering women to negotiate safer sex practices in a relationship.

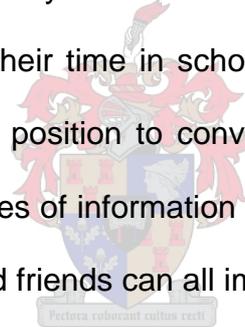
With regards to prevention of an unintended pregnancy, the respondents indicate condom use. However, it should be noted that few actually use condoms at all times when having sexual intercourse. Reason being fear of losing a partner. Thus, it is not just important to provide information on sexual decision – making, sexually transmitted disease but also to focus on the importance of self-esteem and the ability to assert oneself and negotiate safer sex.

The use of condoms together with a reliable contraceptive method may indicate underlying health related conscientiousness. However, the reluctance to use condoms additional to a reliable contraceptive use is more due to the

desire to avoid a pregnancy rather than a Sexually Transmitted Disease.

The argument that the availability of abortions might encourage ineffective contraceptive usage by adolescents was unfounded. Abortion appears to be a back up in case of unintended pregnancies and will definitely not discourage the use of contraceptive methods.

The above findings suggest that there is a great need for adolescent sexuality education in schools because adolescents spend most of their time in schools. Teachers might therefore be in the better position to convey this information. However, with other sources of information like parents, nurse at school or clinic, media and friends can all impact.



Integration of adolescent sexuality programmes in schools into the education programme can equip adolescents with the skills to prevent high risk behavior and make informed and responsible choices that will facilitate maintaining of sexual health.

Adolescent sexuality programmes need to recognize that sexual relations take place within a social context shaped by traditional

male dominance with girls having little power to assert themselves in terms of suggesting condom usage.

The actual degree of undesirable health consequences (e.g. unintended pregnancies, Sexually Transmitted Diseases) were not the foci of this study and remain unknown in this sample. Nevertheless, it is reasonable to conclude that these adolescents that are sexually active and have multiple sexual partners have a higher probability of not maintaining their sexual health. The data must be interpreted with caution due to potential bias for adolescent self-reporting.

Based on the outcome of this study the researcher feels strongly that the following needs to be addressed in order to promote the maintenance of adolescent sexual health:

- Professional nurses need to be trained and sensitized to manage adolescents seeking sexual or reproductive advice;
- Sexuality programmes need to be integrated into school curriculum;
- Positive use of the mass media to promote healthy lifestyles; and Training programmes for parents and adolescents.

5.3 RECOMMENDATIONS

The outcome of this study is to generate data that will assist health workers, school nurses and health educators to identify “at risk” adolescents and develop strategies for strengthening the sexual health promoting behaviours of adolescents.

On the basis of the conclusions, the researcher propose the following recommendations:

- 1) Professional nurses trained in adolescent sexuality should
 - Recognize the major shift needed from adolescent health problem solving to problem prevention and sexual health promotion;
 - Review and facilitate the revision of current policies and service delivery at Adolescent Sexuality Health facilities in the Western Cape;
 - Ensure access to confidential sexual and reproductive health services;
 - Continued updates of health providers to treat adolescents seeking advice, counseling or treatment with dignity and respect;
 - Offer health promotion and prevention programmes providing accurate information, education to ensure informed decision-making;

- Maintaining user friendly adolescent sexual and reproductive health facilities;
 - Service providers to maintain an degree of comfort and confidence dealing with adolescent clients;
 - Appropriate referrals; and
 - Monitor and evaluate service delivery to ensure service excellence.
- 2) Facilitate the Integration of adolescent sexuality programmes into the school curriculum;
- Provide training for teachers;
 - Assess the appropriateness of current adolescent programmes;
 - Provide input in development of curricula with factual and non-judgmental content;
 - Education should cover: values clarification; self image development; responsible decision-making; unintended pregnancy; sexually transmitted; contraceptive; communication; relationships skill;
 - The format should be participatory;
 - Monitor and evaluate these programmes to ensure quality and effectiveness.
- 3) Positive use of the mass media in terms of available services;
- 4) Training programmes for parents and adolescents including the following topics:

- Adolescent development;
- Sexual decision-making;
- Communication;
- Relationship skills;
- Teenage pregnancy and options;
- Sexually Transmitted Diseases including HIV/AIDS; and
- Contraception.

5.4 CONCLUSION

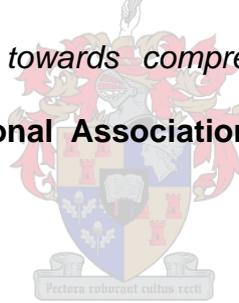
Adolescents are at risk of contracting Sexually Transmitted Diseases including HIV/AIDS because of their sexual behaviour. Initiation of early sexual relations contributing to possible multiple sexual partners and failure to consistently use condoms contributes to this risk. Failure to continuously use a reliable contraceptive method also enhances the risk of unintended pregnancies and consequent exposure to the risks involved in termination of pregnancy or the psychological effects of giving the baby up for adoption, the hardship of raising the baby as a single parent or marry at a young age. Thus the physical-, emotional-, social well being of the adolescent is at risk when they are not equipped to maintain their sexual health.

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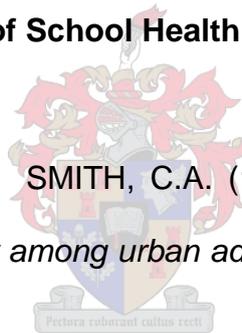
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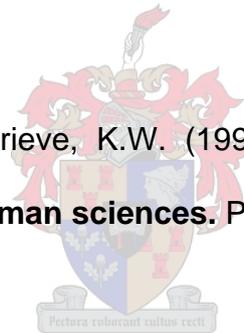
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THE ADOLESCENT AND SEXUAL HEALTH QUESTIONNAIRE

THE AIM OF THIS SURVEY IS TO DETERMINE THE CURRENT SEXUAL HEALTH STATUS OF ADOLESCENTS AS WELL AS THE FACTORS, WHICH PLAY A ROLE IN ADOLESCENTS EXPERIENCING PROBLEMS IN MAINTAINING THEIR SEXUAL HEALTH.

YOUR INPUT IS IMPORTANT TO ENABLE US TO MAKE RECOMMENDATIONS FOR THE IMPLEMENTATION OF COMPREHENSIVE HEALTH SERVICES FOR SEXUALLY ACTIVE YOUTH IN A USER FRIENDLY ATMOSPHERE.

PLEASE COMPLETE THE QUESTIONS ON THE QUESTIONNAIRE BY CIRCLING THE ANSWER OF YOUR CHOICE, EXAMPLE

1. a. b. c. OR FILL IN THE ANSWER IN THE SPACE PROVIDED.

1. Age:

2. Ethnicity: a. White b. Coloured

3. Language: a. Afrikaans

b. English

c. Other, Please state

4. Where did you spend the first 5 years of your life?

a. Urban (Town or city)

b. Rural (Country)

5. Do you live with your parent/parents in?

a. Own house

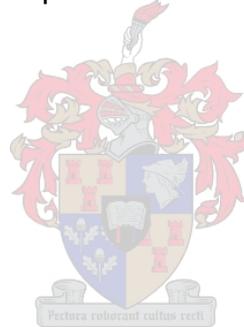
b. Rented house

c. Rented apartment

d. Rented room

e. Own apartment

f. Other, specify



6. To which Religion are you affiliated? _____

7. How important would you say Religion is to you?

- a. Fairly unimportant
- b. Not important at all
- c. Fairly important
- d. Very important

8. How often have you attended a Religious gathering/service in the six months prior to the interview?



- a. Once per week
- b. More than once per week
- c. Less than once per week
- d. Once per month
- e. Less than once per month

f. Never

9. What is your highest completed educational qualification? _____

10. I gained information about sexual decision-making (to abstain or become sexually involved) through:

a. Parent

b. Teacher at school

c. Nurse at school

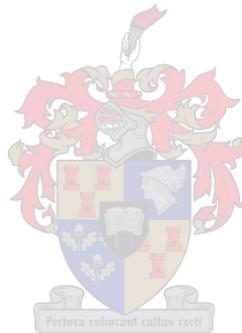
d. Nurse at clinic

e. Friends

f. Media (Books, TV)

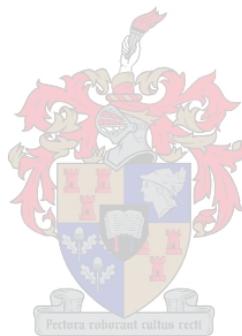
g. Not at all

h. Other, Specify



11. I gained information about teenage pregnancy through:

- a. Parent
 - b. Teacher at school
 - c. Nurse at school
 - d. Nurse at clinic
 - e. Friends
 - f. Media (Books, TV.)
 - g. Not at all
 - h. Other, Specify
-



12. I gained information about sexually transmitted disease through:

- a. Parent

b. Teacher at school

c. Nurse at school

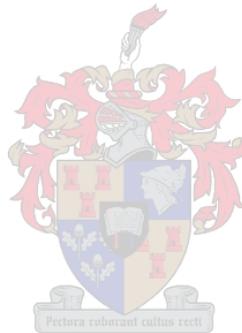
d. Nurse at clinic

e. Friends

f. Media (Books, TV.)

g. Not at all

h. Other, Specify



13. Specify the type of information gained regarding sexually transmitted disease.

14. Are you sexually active?

a. Yes

b. No

15. If answered yes to question no. 14, how old were you with your first sexual encounter?

16. If answered no to question no. 14, provide the reason/s for not being sexually active.



17. What is the legal age for initiation of sexual relations in South Africa? _____

18. What are your reasons for becoming sexually involved with the opposite sex?

a. Love

b. Sexual attraction

c. Security

d. Want to belong

e. Other, Specify

19. My first sexual encounter was with:

a. Boyfriend

b. Acquaintance

c. Someone I have just met (e.g. a one night stand)

d. Someone I did not know

e. A family member



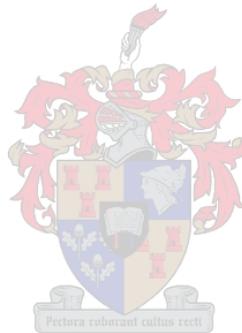
20. My first sexual intercourse was:

a. Planned

- b. Impulsive
 - c. Casual
 - d. Forced (Specify by whom)
-

21. My first sexual intercourse was an experience that was:

- a. Satisfying
- b. Traumatic
- c. Disappointing



22. Are you being pressured by friends to become sexually active?

- a. Yes
- b. No

23. How many sex partners did you have till date?

24. What are your reason/s for changing your sex partners?

25. Can you discuss sexual issues with your partner?

If no, explain why not.

26. How old were you on your first date with a person of the opposite sex?



27. Do your parents/guardian have any dating rules regarding?

- a. Hours (Time to be back home)
- b. Location (Where you are going)
- c. Partners
- d. Not at all
- e. Other, please explain.

28. How often do you date?

29. How do you prefer to date?

- a. Single (Just you and partner)
- b. Group (More than one couple going out together)

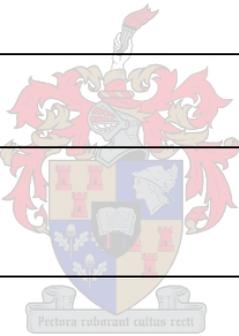


30. Do adolescents experience pressure to become sexually involved from?

- a. Peers
- b. Society
- c. Media
- d. All the above

31. Who/what encourages you to avoid sexual activity?

32. What encouragement do you receive in our society to avoid sexual activity?

The watermark is the crest of the University of Toronto, featuring a shield with various symbols, a crest on top, and a motto scroll at the bottom that reads "Pectora roburant cultus recti".

33. The most important factor for me in making decisions on sexual matters is:

- a. My future
- b. My health
- c. My parent's feelings

d. My religion

e. What my partner/boyfriend thinks

f. Other, Specify

34. How do you feel about the idea of being pregnant?



35. What would you opt for in case of an unplanned pregnancy?

a. Termination of pregnancy (Abortion)

b. Adoption

c. Single parenthood

d. Marriage

36. How would a pregnancy affect your plans for the future?

37. What is your opinion regarding termination of pregnancy?

38. Do you use condoms when you are having sex?

a. Always

b. Only with unknown partners

c. Intermittent use

d. Leave it up to the partner

e. No, Please explain why not.



39. Are you using a contraceptive method?

a. Yes

b. No

40. If answered yes to question no. 39 state the method/type

a. Oral contraceptive

b. Injectable

c. Natural method, Please specify _____

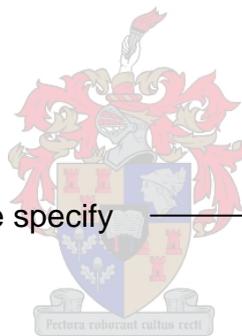
d. Condoms

e. Spermicides

41. How do you use the contraceptive method?

a. Continuously

b. Only when having sexual intercourse



c. Only when in a committed relationship

42. Have you ever used emergency contraception before?

(Emergency contraception: A method of contraception used within 72 hours of a single act of unprotected sexual intercourse in order to prevent an unintended pregnancy.)

a. Do not know about it

b. Never

c. Yes

If yes, how many times have you used this method? _____



43. Have you ever been pregnant before?

a. Yes

b. No

44. Have you ever had a termination of pregnancy?

a. Yes

b. No

45. What is a sexually transmitted disease?

46. In which ways can sexually transmitted disease be transmitted?

a. Blood (Syringes, Transfusions)

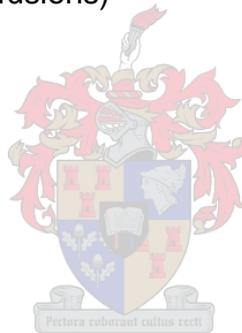
b. Toilet seats

c. Deep French kissing

d. Hugging/cuddling

e. Sexual intercourse

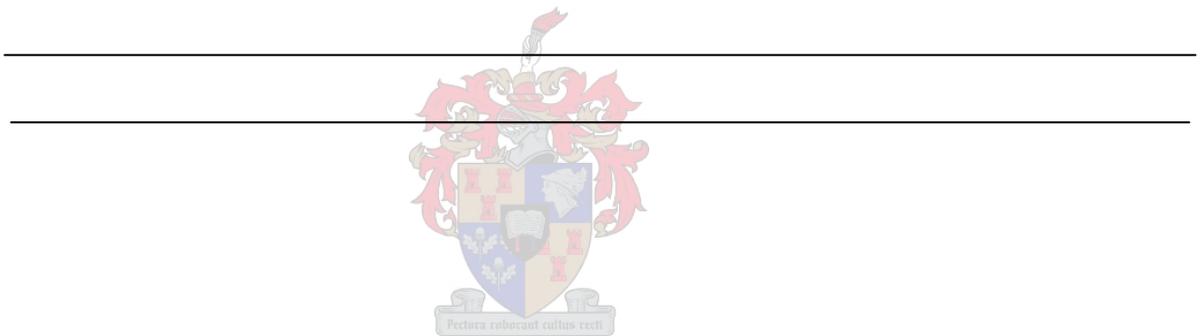
f. Other, Please specify.



47. What is the risk of young people being contaminated with a sexually transmitted disease?

- a. None
- b. Slight
- c. Great
- d. Don't know

Please explain your answer



48. What is your risk of being contaminated with a sexually transmitted disease?

- a. None
- b. Slight
- c. Great

d. Don't know

Please explain your answer

49. Can you fall pregnant without having sex?

a. Yes

b. No



50. Can you fall pregnant if you never had your period, but are sexually active?

a. Yes

b. No

51. If a girl has started ovulating, she can fall pregnant.

a. Fact

b. Myth

52. If there is no penetration, there is no risk of becoming pregnant.

a. Fact

b. Myth

53. Jumping up and down after sex will prevent a pregnancy.

a. Fact

b. Myth



54. A woman cannot fall pregnant the first time she has sex.

a. Fact

b. Myth

55. You can become infected with HIV if sharing toothbrushes.

a. Fact

b. Myth

56. How would you respond to the following cliché?

“If you loved me you would have sex with me”

57. How do you feel about sexual relations before marriage?

