

ADOLESCENT SEXUAL HEALTH IN A SELECTED REGION OF NAMIBIA

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STUDY LEADER:

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirely or in part been submitted at any University for a degree.

12/02/2001

SIGNATURE

DATE

SUMMARY

Informal discussions and the work experience of the researcher in the field of health care raised concerns about the problems regarding the sexual health of adolescents. This demonstrated the need for an integrated health care system to promote adolescent sexual health.

Against this background the study was undertaken to:

- Identify the attitudes of adolescents towards sexual health.
- Determine their knowledge of sexual health
- Determine what the practice of sexual health by adolescents entail.
- Provide recommendations where applicable.

Triangulation, which is a combination of qualitative and quantitative research methods, was used. The findings reflected the following:

- A positive attitude towards sexual health, but adolescents are involved in high risk sexual behaviour.
- Sub-optimal knowledge regarding sexual issues.
- A need for sexual education by parents and health workers, especially nurses.

The following recommendations, are proposed:

- Sex education should start at an age as early as possible, at home, by parents.
- Health workers should be trained to give proper information and advice to adolescents about their sexual health.
- Condoms should be freely available and accessible to all the people of Namibia.

- Adolescents should be actively involved in the promotion of their own sexual health.

Keywords: Prevention of teenage pregnancy / Sexually transmitted diseases / HIV / AIDS and Sex education.

OPSOMMING

Informele besprekings en praktiese ervaring van die navorsing in die gesondheidsorgveld het probleme rakende die seksuele gesondheid van adolessente uitgewys. Dit het gedui op die behoeftes aan 'n geïntegreerde gesondheidsorgsisteem ten einde die seksuele welsyn van adolessente te bevorder.

Teen dié agtergrond is die studie onderneem om:

- Die houding van adolessente teenoor seksuele welsyn te bepaal.
- Die kennis van adolessente omtrent seksuele welsyn te bepaal.
- Te bepaal wat die praktyk van seksuele welsyn van adolessente behels.
- Aanbevelings soos van toepassing te maak.

Die metode van triangulasie, wat 'n kombinasie van 'n kwalitatiewe en kwantitatiewe navorsingsmedotiek is, is gebruik. Die bevindings reflekteer die volgende:

- 'n Positiewe houding jeens seksuele gedrag, maar adolessente is betrokke by riskante seksuele gedrag.
- Suboptimale kennis ten opsigte van seksuele kwessies.
- 'n Behoeftes aan seksuele onderrig deur ouers en gesondheidswerkers, veral verpleegkundiges.

Die volgende aanbevelings word voorgestel:

- Onderrig ten opsigte van seksuele gedrag moet op die jongste moontlike ouderdom deur die ouers tuis gedoen word.
- Gesondheidswerkers moet opgelei word om die regte en relevante advies en inligting aan adolessente oor te dra rakende hul seksuele gesondheid.
- Kondome moet vrylik beskikbaar en bekomaar wees vir alle inwoners van Namibië.

- Adolessente moet aktief betrokke wees in die bevordering van hul eie seksuele welsyn.

Sleutelwoorde: Voorkoming van tienerwangterskappe/seksueel oordraagbare siektes / MIV / VIGS en seksuele voorligting.

DEDICATION

This thesis is dedicated to my late grandmother Kadiva kaHailya. To Martha Nuukongo Kandenge, this thesis should be a source of inspiration during the time of your adolescence. To my daughters Linda (Junior) Tangi and my son Twapewa, who will one day reach adolescence and then have to grapple with seemingly refractory and intractable problems of adolescent sexuality, let this be a source of inspiration. Written boldly in this thesis, is mummy's wish that they emerge triumphant from this battle!

ACKNOWLEDGEMENTS

Firstly, I am grateful to God the Almighty, without whose divine grace, most earthly ventures would remain invariably unachievable. Only in reverence to His Omnipotence, Omniscience and Omnipresence do we find meaning in life.

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I would also like to express my sincere thanks to:

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MARCH 2001

TABLE OF CONTENTS

	Page
CHAPTER 1	
INTRODUCTION TO THE STUDY.....	1 - 14
1.1 RATIONAL AND BACKGROUND OF THE STUDY	1
1.2 PROBLEM STATEMENT	2
1.3 RESEARCH OBJECTIVES	5
1.4 RESEARCH METHODOLOGY	6
1.4.1 Research approach.....	6
1.4.2 Research Design.....	6
1.4.3 Sampling	6
1.4.4 Data collection.....	6
1.4.5 Data analysis.....	7
1.4.6 Ethical considerations	7
1.4.7 Gender issues	7
1.5 PARADIGMATIC PERSPECTIVES	7
1.6 OPERATIONAL DEFINITIONS.....	9
1.7 LIMITATION OF THE STUDY	13
1.8 ORGANIZATION OF THE REPORT	14
1.9 CONCLUSION	14
CHAPTER 2	
LITERATURE STUDY	15 - 59
2.1 INTRODUCTION.....	15
2.2 ADOLESCENCE AS A PERIOD OF HUMAN DEVELOPMENT	15
2.2.1 General view on adolescence	16
2.2.2 Physical development of a female adolescent	18
2.2.3 Physical development of a male adolescent	19
2.2.4 Adolescence and sexual development.....	20

2.2.5	Psycho-social development of an adolescent	23
2.3	THE CONCEPTS OF SEXUAL HEALTH, KNOWLEDGE, ATTITUDES AND BEHAVIOUR.....	26
2.3.1	Sexual health	26
2.3.2	Promotion of sexual health among adolescents.....	26
2.3.3	(Sexual) knowledge.....	28
2.3.4	Sexual attitude	31
2.3.5	Sexual behaviour	36
2.3.5.1	Family environment.....	36
2.3.5.2	Economic circumstances	37
2.3.5.3	Religious factors.....	37
2.3.5.4	Alcohol and drug abuse	38
2.3.5.5	Cultural factors	38
2.4	REASONS FOR BECOMING SEXUALLY ACTIVE	39
2.5	ADOLESCENT ATTITUDES TOWARDS CONTRACEPTION AND ABORTION.....	40
2.5.1	Abortion.....	41
2.5.1.1	Physical consequences.....	42
2.5.1.2	Psychological consequences	42
2.6	ADOLESCENTS AND SEXUALLY TRANSMITTED DISEASES	43
2.7	PREVENTION OF SEXUALLY TRANSMITTED DISEASES	44
2.8	TEENAGE PREGNANCY AND ITS ADVERSE EFFECTS	45
2.8.1	Consequences for the mother	46
2.8.2	Consequences for the father	48
2.8.3	Consequences for the child.....	48
2.8.4	Consequences for the family.....	49
2.8.5	Consequences for the community	50
2.9	SEX EDUCATION AND SOURCES OF INFORMATION.....	50
2.9.1	Parents.....	53
2.9.2	Peers/friends	55
2.9.3	Mass media.....	56
2.9.4	The school.....	56

2.9.5	Health workers	58
2.10	SUMMARY.....	58

CHAPTER 3

RESEARCH METHODOLOGY.....	60 - 74	
3.1	INTRODUCTION.....	60
3.2	RESEARCH DESIGN	60
3.3	RESEARCH APPROACH	60
3.3.1	Qualitative approach	61
3.3.2	Quantitative approach	61
3.3.3	Triangulation	62
3.3.3.1	Data triangulation	63
3.3.3.2	Methodological triangulation.....	63
3.3.3.3	Theoretical triangulation	64
3.3.3.4	Investigation triangulation	64
3.3.3.5	Analysis triangulation	64
3.4	POPULATION AND SAMPLING	65
3.4.1	Population	65
3.4.2	Sampling	65
3.5	DATA COLLECTION.....	67
3.6	PERMISSION TO CONDUCT THE STUDY IN THE SCHOOLS	68
3.7	ETHICAL CONSIDERATION	69
3.8	INSTRUMENTATION.....	69
3.9	VALIDITY AND RELIABILITY	71
3.10	PILOT STUDY.....	72
3.11	DATA ANALYSIS AND INTERPRETATION	73
3.12	CONCLUSION	74

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH FINDINGS	75 - 112	
4.1	INTRODUCTION.....	75

4.2	SECTION A: PERSONAL AND SOCIO-DEMOGRAPHIC DATA	75
4.2.1	Age.....	76
4.2.2	Gender	76
4.2.3	Grade of education.....	77
4.2.4	Marital status of parents.....	78
4.2.5	Occupations of the parents	79
4.2.6	Number of people in the immediate family	80
4.3	SECTION B: SEXUAL KNOWLEDGE ON SELECTED SEXUAL ISSUES	81
4.3.1	Sexual knowledge	81
4.3.2	Previous pregnancies.....	82
4.3.3	Number of pregnancies.....	83
4.3.4	Abortions and age at abortion	84
4.3.5	Reason for having an abortion	84
4.4	SECTION C: SEXUAL BEHAVIOUR	85
4.4.1	Transmission of sexually transmitted diseases	85
4.4.2	Prevention of Human immune deficiency virus (HIV) infection.....	86
4.4.3	Sexual involvement.....	87
4.4.4	Age at which sexual intercourse was started	87
4.4.5	Number of sexual partners.....	88
4.4.6	Reasons for not using condoms.....	89
4.4.7	Reasons why teenagers have sexual intercourse	90
4.5	SECTION D: CONTRACEPTIVE USAGE.....	92
4.5.1	Contraceptive usage	92
4.5.2	Methods of contraception used	93
4.5.3	Sources of contraceptives	94
4.5.4	Accessibility to contraceptives.....	94
4.5.5	Parents awareness regarding their children's use of contraceptives	95
4.6	SECTION E: SEXUAL HEALTH INFORMATION.....	95
4.6.1	Discussion of sexual matters with parents	95

4.6.2	Reasons for the importance of discussing of sexual matters with parents	96
4.6.3	Sex education at school	98
4.6.4	The grade when first sex education was received.....	99
4.6.5	Sources of information on sexual matters	100
4.6.6	Additional information on adolescents' sexual health.....	101
4.7	FOCUS GROUP INTERVIEWS	102
4.7.1	Respondents' views on adolescents' sexual health	103
4.7.2	Respondents' views about the consequences of teenage pregnancies.....	105
4.7.3	Strategies to improve adolescent sexual health.....	107
4.7.4	Respondents' attitudes towards sexual health	111
4.8	SUMMARY	112

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS.....	113 - 116	
5.1	INTRODUCTION.....	113
5.2	CONCLUSIONS	113
5.3	RECOMMENDATIONS	115
5.4	SUMMARY	116
REFERENCES.....	117	
ANNEXURE A: LETTER OF PERMISSION.....	130	
ANNEXURE B: LETTER OF CONFIRMATION FOR CONDUCTING A RESEARCH IN A SELECTED REGION	132	
ANNEXURE C: RESEARCH QUESTIONNAIRE	134	
ANNEXURE D: FOCUS GROUP INTERVIEWS	143	
ANNEXURE E ABBREVIATIONS	145	

LIST OF TABLES

	page
Table 3.1	The design of the questionnaire.....
Table 4.1	71
Table 4.1	Grade of education
Table 4.2	78
Table 4.2	Occupations of respondents' parents.....
Table 4.3	80
Table 4.3	Number of people in the immediate family.....
Table 4.4	81
Table 4.4	Sexual knowledge.....
Table 4.5	82
Table 4.5	Number of pregnancies
Table 4.6	84
Table 4.6	Mode of spreading of sexually transmitted diseases
Table 4.7	86
Table 4.7	Sexual involvements.....
Table 4.8	87
Table 4.8	Age at which sexual intercourse started
Table 4.9	88
Table 4.9	Number of sexual partners.....
Table 4.10	89
Table 4.10	Methods of contraception.....
Table 4.11	94
Table 4.11	Parents awareness of contraceptives used by teenagers.....
Table 4.12	95
Table 4.12	Sources of information on sexual matters.....
	101

LIST OF FIGURES

	Page
Figure 1.1 Adolescent as a total person.....	8
Figure 4.1 Ages of participants	76
Figure 4.2 Gender of participants	77
Figure 4.3 Marital status of parents.....	79
Figure 4.4 Pregnancy status of respondents	83
Figure 4.5 Contraceptive usage.....	92
Figure 4.6 The necessity of discussing of sexual matters with parents.....	96
Figure 4.7 Discussion of sexual matters with parents	98
Figure 4.8 Sex education lessons	99
Figure 4.9 The Grade when first sex education was received	100

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 RATIONAL AND BACKGROUND OF THE STUDY

Adolescents, are the parents of the near future, their health will be a determinant of their families and generations to come. Moreover the behavioural patterns and attitudes which they develop during adolescence, will influence their capacity to guide their own children. However, if they have children before they are sufficiently mature, they jeopardise their own health and wellbeing as well as that of their children (Ferguson, 1987).

Adolescence, the period from age 12 to 19, is a time of rapid growth and difficult challenges which is marked by physical maturation, psycho-social demands (becoming independent from parents), devising their own set of acceptable ethical principles and acquiring a sense of social and personal responsibility (Druker, 1996).

The adolescent, according to Grinder (1973) is however, expected to learn how to participate effectively in society and to acquire the necessary competence to do so mainly through interpersonal relationships. This competence is continually being evaluated by parents, teachers and peers with whom the adolescent has substantial interaction.

Conger (1986) was of the opinion that out of all the developmental events of adolescence, the most dramatic is the increase of sexual drive and the new and often mysterious feelings and thoughts that accompany it. Adolescents become increasingly aware of the self and wish to test their conceptions of self against reality, this gradually leads towards the self-stabilization that will characterise

their adult years.

The above-mentioned statements, supported by practical experience of the researcher, indicate that it is important for health services to focus on the promotion of adolescents' sexual health because:

- Many teenagers are uninformed about sexual matters,
- Young people make up a large percentage of the population,
- Young women are more at risk of acquiring sexually transmitted diseases and HIV-infection which has become a major cause of ill health and death in our community,
- Teenage mothers are also more prone to have unsafe abortions or use other methods to dispose of their babies.

It is well documented by Harrison (1998) that adolescents lack sexual knowledge. He also confirmed that numerous teenagers remain considerably misinformed about contraceptives and the biological factors related to pregnancy.

Worldwide, there are vast numbers of unplanned and usually unwanted pregnancies. Illegal abortions are very common amongst teenagers in Africa. The number of maternal deaths from illegal abortions is estimated at 115 000 to 200 000 per annum (World Health Organization, 1995). In a study done by Masters *et al.* (1990), on teenage pregnancies among American teenagers, it was revealed that more than one million pregnancies occur each year, which is equivalent to one adolescent pregnancy every 35 seconds. Thirty thousand pregnancies occur annually among girls under 15 years of age while 400 000 teenagers have abortions each year, accounting for more than one-third of all abortions performed in that country. Six out of ten teenage girls who have a child before the age of seventeen will be pregnant again before the age of nineteen.

1.2 PROBLEM STATEMENT

According to the attendance records at the ante-natal clinic in Oshakati Hospital,

9500 pregnant women were served between June 1998 and December 1998 and 27% of them were teenagers between the ages of 14 and 19 years. According to the statistics from the Ministry of Education and Culture of Ondangwa West (1996) the birth rate among students (age 14 - 19 years) in schools was 22,5 per thousand. In 1997 the birth rate was 26 per thousand. In 1998 the birth rate was 29,5 per thousand with an increase of 8% since 1996.

Bam (1994), is of the opinion that family planning programmes are designed to empower women. Every women has a right to reproductive health for example to regulate her fertility safely and effectively, to understand and to enjoy her own sexuality, to remain free of diseases, disability or death associated with sexuality and reproduction and to bear and rear healthy children (Decay, 1997).

Bam (1994) connects women's ability to regulate their fertility with their opportunity to benefit from employment, education and ownership of property. He also connects the ability to control fertility with female health, including the psychosocial dimension. The ability to regulate and control fertility is a basic ingredient in the positive definition of health for women. A woman who is unable to regulate and control her fertility cannot be considered to be in a state of complete physical, mental and social well-being. She cannot have the mental joy of a planned pregnancy, or avoid mental distress of a pregnancy that is unwanted, plan her life, pursue her education and enjoy both productive and reproductive career (Arnstein, 1991).

The researcher notes with concern the increases in teenage pregnancies (Ministry of Education and Culture, 1996) and agrees with Berk, (1993) who states that teenage pregnancy has devastating effects on the teenagers concerned, their babies, their parents and society in general. The situation results in physical, psychological, educational and social problems. It has been proven that these babies (babies born to teenage mothers) are more likely to have low IQ scores, underachieve at school, and are frequently abused as their mothers vent their anger on them. Social problems such as the population explosion, poverty, diseases and crime are exacerbated by this phenomenon.

In addition to the above-mentioned problems, the researcher's work experience has drawn attention to increased occurrence of Sexual Transmitted Diseases (STD's) and Acquired Immune Deficiency Syndrome (AIDS) amongst adolescents. It is evident from research that adolescents (i.e. 12 to 19 years old) are sexually active. Studies in various parts of the world have shown that sexually active adolescents range from 14 years upward with some starting as early as twelve and thirteen years of age (Ministry of Education and Culture, 1990). This increase in adolescent sexual relationships also results in an increase in teenage sexual problems such as sexually transmitted diseases, HIV/AIDS, abortions and teenage pregnancies (Ministry of Education and Culture, 1990).

Sexually transmitted diseases particularly among young women and men, represent a major public health problem in developing countries. Brabin *et al.* (1995) found in a study done on reproductive tract infections in young girls in Nigeria, sexual maturation and sexual debut at an early age, inadequate provision of sex and health education, high risk of sexually transmitted diseases, unwanted pregnancies and an increase in HIV positive cases. These findings were evident and led him to assume that adolescent health deserves special attention.

The researcher as a community health worker has a dual roll. She is firstly responsible for certain teaching duties to student nurses and community members regarding the field of community health. Secondly, she is responsible for the practical accompaniment of students in the hospital/clinic , community and or home environment of the clients.

Whilst executing this dual roll, the researcher had numerous discussions with the young adult nurse, who had adolescent sisters, brothers and family members, as well as adult members of the community. The discussions were about health issues which included the sexual health of adolescents. The discussions confirmed the preliminary and informal findings of the researcher as indicated in paragraph 8, 11 and 12. This has strengthened the decision of the researcher

that it seemed to be necessary to do formal research on this issue.

The researcher has conveyed her concerns as mentioned above to the community. She was then requested to do research on this issue in this region to prove to them that the problems identified by the researcher, do exist in their community and region.

The researcher is thus convinced that in order to address all these problems as stated above, it became urgent to do research on the adolescents' attitude towards sexual health as well as their knowledge and practices in this regard in the Oshana region.

The above-mentioned information and the practical experience of the researcher supported by national and international literature, indicated a need to investigate the adolescents' knowledge of, attitudes to, and practice of sexual health.

This led to the following questions as an indication for the research:

- What are the attitudes of the adolescents towards sexual health?
- What is the knowledge base of adolescents with regard to sexual health?
- What does the practice of sexual health by adolescent's entail?

1.3 RESEARCH OBJECTIVES

Objectives enable the researcher to determine whether the problem has been solved. The following are the objectives set on the research questions:

- To identify the attitudes of adolescents towards sexual health.
- To determine their knowledge of sexual health.
- To determine what adolescents' practice of sexual health entails
- To make recommendations where applicable.

1.4 RESEARCH METHODOLOGY

1.4.1 Research approach

A descriptive and non-experimental approach is used to explore and investigate adolescents' sexual knowledge of, attitudes towards and practice of sexual health.

1.4.2 Research design

According to Uys and Basson (1991) a research design is a structural framework within which the study is conducted. Every project requires a research design that is carefully tailored to the exact needs of the researcher as well as to the problem being studied. For this study triangulation will be used. According to Burns and Grove (1993) triangulation is a combination of multiple methods in the study of the same phenomenon. It ensures a comprehensive approach to reach the objectives. In this research qualitative and quantitative methods will be used.

1.4.3 Sampling

A simple random sampling will be used for inclusion of adolescents between the ages of 12 and 20 years from secondary schools in the Oshana region into the research.

1.4.4 Data collection

Data collection will be done over a period of one year, by utilising a questionnaire consisting of open-ended and close-ended questions. Focus group interviews will be conducted and audiotaped. The data will be transcribed and recorded. A

pilot study will be undertaken before the actual data collection and these schools and the participants will be excluded from the final study.

1.4.5 Data analysis

Data analysis will be done with the help of computer programmes and statisticians.

1.4.6 Ethical considerations

This includes consent to be obtained from the principals of the schools to conduct the research as well as consent from all participants. Participation will be voluntary and participants will retain their right to withdraw at any time without any pressure or coercion. Participants' anonymity and confidentiality will be assured.

1.4.7 Gender issues

In this study both male and female adolescents will be participating. In the context of the study "he" will be used and it will refer to both male and female adolescents.

1.5 PARADIGMATIC PERSPECTIVES

A characteristic of human sciences research is that the research in the various disciplines are characterised by a number of paradigms or research traditions, whilst in the natural sciences it appears that a specific paradigm dominates (Mouton and Marais, 1990). The researcher believes in:

- Theory of holism
- Theory of system interaction

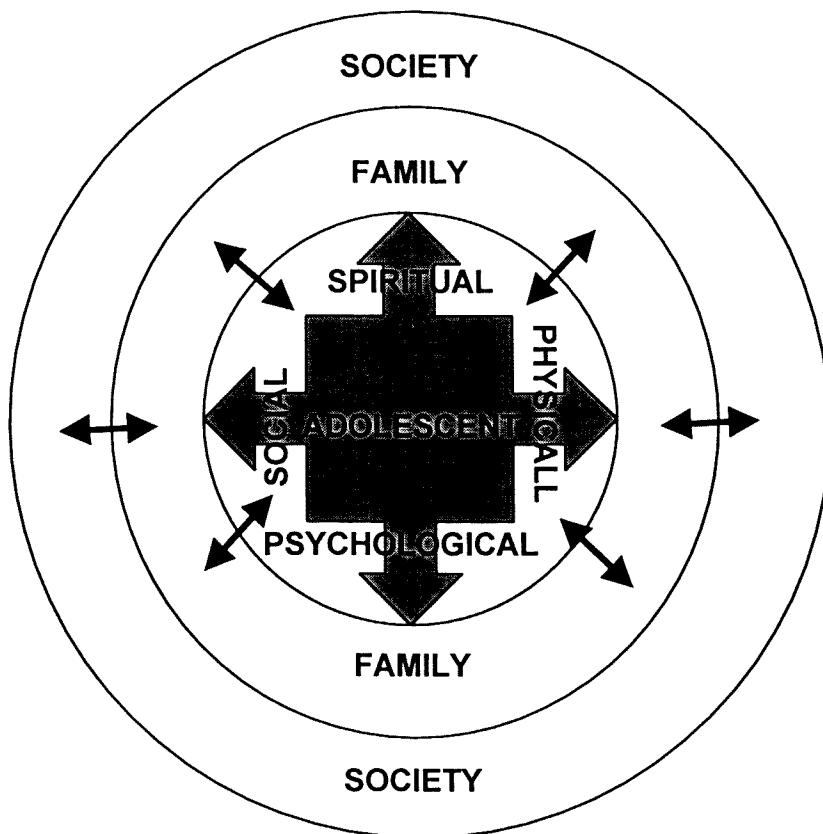
According to George (1990), holism is a theory which advocates that the universe and especially living nature are correctly seen in terms of an interacting whole and not as a mere sum of individual parts. This simply means that the human being is holistic, that the mind and the body are not separated, but function as a whole entity and that the patient responds as a total person to every nursing action or intervention.

The researcher believes that a human or individual is multi-dimensional and is composed of the following components as described by Virginia Henderson: biological (physical), psychological, social and spiritual (George, 1990). The researcher also supports the views of Neuman, which are similar to those of Henderson, who believes that each human being is a "total person" and this person is a composite of physiological, psychological, socio-cultural, developmental and spiritual variables (George, 1990).

Based on the above-mentioned beliefs, the researcher believes that adolescents in this research are to be considered as human beings, a composite of physiological, psychological, socio-cultural developmental and spiritual variables. They also have to be treated with respect and dignity. A holistic approach in this research is most important, enabling the researcher to identify and to meet the specific needs of adolescents. The researcher also agrees with King's beliefs regarding interaction of systems. King believes that human beings are open systems in constant interaction with their environment. King therefore also believes that the goal of nursing is the health of individuals and the health care of groups (George, 1990).

The researcher's philosophy, based on King's premise, holds that adolescents are human beings, they are part of a group which is the family, and they are part of society. Adolescents should not be viewed in isolation, but be seen in constant interaction with the environment.

FIGURE 1.1
ADOLESCENT AS A TOTAL PERSON



(Figure by the researcher)

Figure 1.1 illustrates how the adolescent is viewed as a total person. The adolescent is made up of biological, psychological, spiritual and social aspects and therefore needs to be approached holistically. The adolescent is also an integral part or member of the family, of society and is continuously in interaction with them.

1.6 OPERATIONAL DEFINITIONS

In a sensitive field of study such as sexuality, it is necessary that relevant concepts utilised in the study are defined or clarified to ensure consistent interpretation.

- Adolescence: It is a period of transition between childhood and adulthood (Brunner and Mazel, 1986).
- Attitudes: Are the person's beliefs about an object and his feelings towards the object (Ajzen and Fishbein, 1997).
- Confidentiality: It means that information obtained by the health care team from or about a patient is considered to be privileged, except in specified circumstances that may vary by illness and jurisdiction and may not be disclosed to a third party without the patient's consent.
- Culture: Consists of values, attitudes, habits and customs that are acquired by learning (Clark, 1994).
- Early adolescence: A stage which refers to adolescents who are between 12 to 14 years of age; a stage characterised by a desire for autonomy, pre-occupation with body image self-centeredness and concrete thinking (Stuart and Wells, 1982).
- Education: In this discussion education means assisting the child to become mature by being moulded to display the image of adulthood, a sense of responsibility, awareness of the requirements of propriety, a conscience so that he will develop socially acceptable attitudes with regard to sexual matters.
- Holism: A theory that the universe and especially living nature are correctly seen in terms of an interacting whole that is more than a mere sum of individual parts (George, 1990).

- Late adolescence: A stage which refers to adolescents who are between 18 - 20 years of age, a stage where most adolescents become abstract in their thinking (Jacobson, 1991).
- Masturbation: Masturbation refers to self-sexual stimulation.
- Middle adolescence: A stage which refers to adolescents who are between 15 - 17 years of age; a stage characterised by a desire for autonomy and risk-taking (Stuart and Wells, 1982).
- Peers: A peer is someone who is of the same age and has similar interests or behavioural patterns.
- Professional: A person with tertiary education at a university/college/technikon, but not technical college.
- Reproductive health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes.
- Sex “being male or female”: In colloquial language the word sex has assumed the function of a verb and it is therefore erroneously referred to as the sex act, while in actual fact it is a noun referring to gender.
- Sexuality: It refers to all those aspects of a human being that relate to being a boy or a girl, woman or a man and is an entity subject to dynamic life changes. It reflects our human characteristics not solely our genital nature (Holly, 1989).

Sexually active person: Anyone who has had heterosexual activity which could lead to pregnancy.

Sexual behaviour: It consist of actions that are empirically observable, for example what people do sexually with others or with themselves, how they present themselves sexually and how they talk and act (Jacobson, 1991).

Sexual matters: Means all matters typically belonging to a certain sex, amongst others:

- the anatomical, physiological and functional aspects of the male and female body.
- the psychic (cognitive and affective) aspects of sexuality.
- normative and behavioural codes of the community with regard to males and females.
- typical role expectation and role fulfilment peculiar to males and females
- homogeneous and heterogeneous interpersonal relationships (Van Rooyen and Louw, 1994).

Sexually Transmitted Diseases: Sexually Transmitted Diseases are diseases most frequently transmitted by sexual activity and primarily of the genital tract but the focus of infection can move to other tissues or organs depending on the nature or etiological agent and the type of physical contact (Ajzen and Fishbein, 1980).

Teenager: It is a special individual who is between the ages of 14 and 20 and busy undergoing a dramatic change from childhood to adulthood.

1.7 LIMITATION OF THE STUDY

According to Burns and Grove (1993) limitations are restrictions in the study that may decrease generalisation of findings. The fact that this study is being done on adolescents in a selected region in Namibia could be regarded as a limitation. Generalisation to adolescents in the whole of Namibia would be impossible. The study findings can only be generalised to adolescents in the selected region in which the study has been conducted because this area is regarded as a rural area. Time and financial restraints contributed to the limitations. The sample size might be a limitation, but the researcher has indicated that it is in line with recommendations by expert researchers.

The reliability of the research findings might be questioned but the researcher is of the opinion that it can be considered as reliable because:

- the instrument was newly developed by the researcher
- the concepts were derived from existing literature and
- the content validity was confirmed by expert nurses in die field.
- A pilot study was done and similar results were found throughout the research process.

Another limitation could be that the respondents did not respond honestly in the questionnaires and during focus group interviews. The researcher however is of the opinion that it was accommodated by assuring the respondents of anonymity and the fact that no information that could identify them was asked. The researcher also met with the volunteer respondents of the focus groups to build a rapport and lastly because the researcher is a well respected member of the community a trusting relationship existed.

1.8 ORGANIZATION OF THE REPORT

Chapter 1

Serves as orientation to the study. It covers the background, statement of the problem, objectives of the research, research methodology, paradigmatic perspectives, operational definitions and limitations of the study.

Chapter 2

Literature study

Chapter 3

Research Methodology

Chapter 4

Data Analysis and discussion of Research findings

Chapter 5

Conclusions and Recommendations

1.9 CONCLUSION

In this chapter the problems associated with adolescents' sexual health have been highlighted and the need for more information has been identified.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

A literature study gives an overview of previous research undertaken regarding the specific problem under investigation and places the research in a broader context.

It also relates a study to the larger, ongoing dialogue in the literature about a topic, filling in gaps and extending prior studies (Cresswell, 1994). It provides a framework for establishing the importance of the study, as well as a benchmark for comparing the results of a study with other findings.

In this research a literature study was undertaken in order to broaden knowledge on:

- Adolescence as a period of human development
- Adolescent sexual health: knowledge, attitudes and practice
- Adolescents' attitudes towards contraception and abortion
- Adolescence and sexually transmitted diseases
- Teenage pregnancies and its adverse effects
- Sources of information influencing adolescents' sexual knowledge

2.2 ADOLESCENCE AS A PERIOD OF HUMAN DEVELOPMENT

A review of the literature on adolescence compels the reader to make an important observation, namely, that adolescence does not occur in a vacuum.

Many factors shape it. In fact, were it not for historical, economic, socio-cultural, physiological and psychological influences, adolescence, as a period of human development that has kindled so much interest, would not exist. This perception of interconnectedness has lead Lerner (1992) to assert that all levels of the context, including biological, psychological and socio-cultural, change in reciprocal relation to one another.

2.2.1 General view on adolescence

Adolescence, the period from ages twelve to twenty, is a time of rapid change and difficult challenges (United Nations, 1988). Physical maturation is only one part of this process. Adolescents face a wide variety of psycho-social demands, such as becoming independent from parents and acquiring a sense of social and personal responsibility (United Nations, 1988).

Many young people going through adolescence suffer doubts and uncertainties about themselves and the world around them. Even though these anxieties are experienced by most adolescents, many feel alone with these feelings of confusion (Money, 1994). Decay (1997) described adolescence as a bridge between childhood and adulthood, a time of a rapid growth and change and a period of anxiety because of important decisions that have to be made about their career and lifestyle.

Adolescence is the time when individuals begin to assert themselves as distinct human beings (Grinder, 1973). The adolescent, according to Grinder (1973), is however expected to learn how to participate effectively in society and to acquire the necessary competence to do so mainly through interpersonal relationships. This competence is continually being evaluated by parents, teachers and peers with whom the adolescent has a substantial interaction.

Brim (as cited in Grinder, 1973) stated that it is the important person in the adolescent's life who partially directs and prescribes his behaviour. He learns to

live up to the standards of certain significant persons while he causes conflict which in turn leads to anxiety that is so commonly experienced by the adolescent.

Grinder (1973) believed that the distinctive personality of each adolescent depends upon the relative significance to his of the persons with whom he interacts, the kinds of behaviour available to his and the ways in which he assimilates new expectations and earlier experiences.

Steinberg, Belsky and Meyer (1991) revealed five general characteristics of reference from which adolescent growth and development may be viewed:

- (i) Adolescence is a time when an individual becomes increasingly aware of the self and wishes to test his conceptions of the self against reality. This gradually leads towards self-stabilisation that will characterise his adult years.
- (ii) Adolescence is a time of seeking status as an individual. It is a period of emerging and developing vocational interests and striving towards economic independence. This usually evokes a struggle against relationships with adults to whom the adolescent is subordinate on the basis of age, experience and skill.
- (iii) Adolescence is a time when group relationships become of major importance. The adolescent desires to gain status with his peers and to conform to their actions and standards. It is also a time of emerging heterosexual interests that may bring complexity and conflict to emotions and activities.
- (iv) Adolescence is a time of intellectual expansion and development. It is a time when an individual gains experience and knowledge in many areas and interprets the environment in the light of that experience.
- (v) Adolescence is a time of development and evaluation of values. It is a time of conflict between youthful idealism and reality.

Conger (1986) was of the opinion that out of all the developmental events of adolescence, the most dramatic is the increase of sexual drive and the new and

often mysterious feelings and thoughts that accompany it.

Biologically a girl becomes an adolescent when she is able to reproduce a baby. This is known as the advent of puberty which actually begins with the action of sex hormones that result in the appearance of the secondary sex characteristics (Steinberg *et al.*, 1991). This physical development is accompanied by many changes that affect the adolescent in how she views herself (Berk, 1993). To complicate matters further, adolescence has no fixed or accepted boundaries with its beginning and end not clearly defined (Bauwer, 1990).

Thus adolescence can bring new anxieties and worries due to many important changes that occur, both physically and emotionally.

2.2.2 Physical development of a female adolescent

Holly (1989) stated that adolescence is a time of profound physical changes, which increase the adolescent's awareness of and interest in sexual behaviour. Puberty is characterised by a sudden onset of hormone flow from the hypothalamus and pituitary gland, which triggers a complex set of biological responses, manifested in extremely rapid growth and development (Holly, 1989). According to Harrison (1998) the first physical sign of sexual development in girls is the beginning of breast development. Breast growth is controlled by estrogen levels, is hereditary and varies from individual to individual.

Decay (1997) stated that the appearance of pubic hair usually starts shortly after breast growth and is therefore, the next sign indicating physical development in female adolescents. Decay (1997) further agreed that breast development and the appearance of pubic hair, which is triggered by hormonal changes, are the first signs of sexual maturity. During this period the vagina begins to lengthen and the uterus is slowly enlarging. Menarche usually occurs as breast growth nears completion and invariably comes after the peak growth spurt. The average age of menarche is 12.8 years (Darling, 1996).

According to Arnstein (1991) the onset of menarche is not an indication of reproductive maturity, as initial menstrual cycles are usually sporadic, irregular and generally occur without ovulation. It is however possible to begin ovulating with the very first menstrual cycle. Vaginal secretions also increase because of the changing hormonal status. Vaginal lubrication occurs spontaneously with sexual excitement. The sensations of vaginal wetness may be curious, pleasing, shameful or alarming to the teenager (Ajzen and Fishbein, 1980).

The Group for the Advancement of Psychiatry (1986) believe that the mid-adolescent girl is in a vulnerable position regarding her self-concept and societal roles and she often experiences difficulty coping with her rapid physical changes. Greenwood (1984) states that the adolescent needs to come to terms with these body changes and accept the new body as most girls agonise over height, weight, face, size, and shape of genitals. Pimples and dandruff often occur during this time as well. All these biological development changes affect sexual attractiveness and are therefore very important to the adolescent.

The Group for the Advancement of Psychiatry (1986) agreed that all the changes in the body, not only in sexual development and function, but also in physical size, necessitate modification of the earlier established mental images of the body. The recognition and acceptance of what one is, physically and biologically, is a prerequisite for the successful achievement of a mature personal identity.

The girl must, therefore, accept and integrate the realities of menstruation, breast development and broadening of the hips. These body changes are often the source of anxiety in an interpersonal relationship.

2.2.3 Physical development of a male adolescent

Although individual differences (which are a natural phenomenon) may occur, the changes that accompany sexual maturation will more or less occur in the following order in boys:

- The testes and scrotum increase in size. At the age of thirteen the testes are about 10% of the adult size which is reached at twenty or twenty-one years of age.
- Unpigmented pubic hair growth appears.
- Accelerated and uneven body growth commences. A temporary increase in the size of boys' breasts takes place.
- The size of the penis increases. The penis grows in length and then in its circumference.
- The voice becomes deeper as a result of the larynx (adam's apple) becoming bigger. Early on in the process of voice change, the voice may alternate between a clear soprano and a deep bass, causing the boy embarrassment.
- Secondary hair growth under the arms and above the upper lip occurs. The skin becomes coarse and thickens. Oil and sweat glands become active, often causing acne.
- Sperm production increases. Nocturnal ejaculations occur.
- Accelerated growth reaches a climax. Hair growth becomes pigmented. The prostate gland becomes bigger.
- Sperm production is enough to fertilise an egg cell.
- Physical strength reaches a climax.

A young boy, caught up in this new changing body described above, will experience his body intensely and he will observe himself critically and in detail. The competent educator should therefore always bear in mind the scope and the implication of the changes (Van Rooyen and Louw, 1998).

2.2.4 Adolescence and sexual development

Sexual development is a complex process occurring at many different levels. It includes biological and psycho-social components. These components interact

as a complex set of factors and cannot be regarded as separate or divergent areas in the overall process (Department of National Health and Population Development, 1987).

At the same time that the adolescent is being confronted with a set of complex development challenges, he has to cope with his own sexuality by learning how to deal with changing sexual feelings, deciding whether to participate in various types of sexual activity, discovering how to recognise love and learning how to prevent an unwanted pregnancy (Arnstein, 1991). It is these aspects of growing up that so often cause the adolescent to feel conflict, pain and confusion.

Sexuality grows over a period of time (Greenwood, 1984). This sexual development process usually begins with the onset of puberty which begins with the action of sex hormones and results in the appearance of secondary sex characteristics (Horrocks, 1976). Puberty is thus a gradual process, extending from the time hormonal action first begins until full sexual maturity is attained.

Greenwood (1984) defined sexual maturity as being able to acknowledge and accept, without guilt feelings or anxiety, one's own sexuality and sexual responses as a healthy and integral part of one's personality. Sexual maturity is being able to enjoy physical and emotional intimacy with another person in a relaxed, responsive and confident manner, while at the same time showing appropriate sensitivity and concern for the feelings and needs of the other person.

It is during adolescence that adult reproductive sexuality is born and matures (Group for the Advancement of Psychiatry, 1986). Thus the problems that confront adolescents as they progress through the teenage years are inextricably bound to their unfolding sexuality. Greenwood (1984) states that this sexual unfolding requires a series of complex adjustments to take place both in how the adolescent views herself and those close to her. Some of these changes happen almost unconsciously, while others intrude painfully on the adolescents' consciousness, often making them feel awkward, insecure and unpleasantly self-

aware.

Sexual development or sexuality therefore involves far more than the mere act of sexual intercourse. Bam (1994) states that sexuality is emotional, physical, cognitive, value-laden and spiritual, thus encompassing both personal and social dimensions. This is a trying time for adolescents as they are faced with a body changing both externally and internally which causes emotions and feelings that they do not always understand.

Gagnon (1977) believed that most adolescents strive towards the model of the married heterosexual couple. The concept of a pair-bonded, living husband/wife relationship, even if it did not exist in any reality known to the child, is a construct that influences the development patterns of sexuality for the entire period of puberty and the conventional moment of marriage in Western society.

Greenwood (1984) outlines a number of important characteristics of female adolescent sexual development:

- (i) *Firstly, the adolescent develops a sense of body awareness. She becomes aware of her own gender, investigates her body shape and discovers the new processes that are going on in her body.*
- (ii) *Secondly, there are subtle changes in the focus of her affection and libido (emotional drive), from being exclusively directed towards parents in childhood, to involvement and commitment to a group of close friends and perhaps later, to an individual whose importance may supersede all past bonds and ties.*
- (iii) *It is during this complex process that the adolescent is defining her sexual orientation. She decides whether she feels more comfortable in the intimacy of same-sex relationships or with the opposite sex. Thus, deciding whether she is heterosexual or homosexual.*
- (iv) *Tentative steps towards physical sexual expression may come early or late in sexual development, depending on circumstances.*
- (v) *Each person has a personal sexual value system.*

Thus, sexual development and behaviour are integral human processes, starting at birth and ending at death (Kagan, 1989). Young people, however, develop their sexuality in response to their own personalities, their own temperament, feelings, and attitudes about self and others, abilities and interests, fears and wishes, memories and goals (Chilman, 1980).

2.2.5 Psycho-social development of an adolescent

Schneider in (Kagan, 1989) stated that dealing with sexual emotions and drives in a socially acceptable and self-enhancing manner is a major developmental task of adolescence. Bam (1994) was of the opinion that individual sexual development is affected far more by social experience than by the rate of physical development.

Chilman (1980) pointed out that the individual's development is strongly affected by socio-cultural factors. These include the social status of the person, as well as the cultural patterns of the larger society and the smaller reference groups to which the person belongs. Each individual reacts to socialisation in her individual fashion. Thus society's definition and view of adolescence play a large part in the way this period is experienced by the adolescents themselves. Social attitudes during this period therefore become particularly important. Bam (1994) believed that gender and sexuality development are inextricably linked. Sexual learning is part of gender learning as one learns to be sexual as a woman or as a man.

The sudden onset of hormonal flow during puberty triggers not only a complex set of biological changes, but also intricate psychological responses (Balk, 1995).

Balk (1995) identified four life tasks that affect the psychological development of adolescents. Each of these tasks, in some way, also affects their sexuality. The four tasks are:

1. Accepting one's body: Body image is directly associated with sexual

identity. Balk (1995) stated that young women often see their bodies as instruments of attraction needing outside validation of their desirability. Body image is thus directly linked to the self-concept. Adolescents are expected to learn how to accept their bodies and body changes as they are and thus develop internal body locus of control and identity, rather than become dependent on the stern judgements of others. It is this dependency that often makes the self-concept very vulnerable.

2. Choosing sex roles: From birth people begin to develop their sense of masculinity and femininity as a result of strong environmental influences. Boys and girls are often encouraged to be different in their gender roles, family responsibilities, career choice and sexual behaviour. Females are taught to be sensitive and nurturing, while males are taught to be strong and tough.
3. Establishing peer relationships: In early adolescence social groups are almost exclusively from the same sex. Regardless of sexual orientation, a variety of relationships is possible, requiring an awareness of mature social conventions and activities. The adolescent's task is to establish appropriate social skills for effective interaction. These social situations provide an opportunity for experimentation in the development of socio-sexual skills.
4. Adolescents become more involved with their friends and become dependent on them for interests, goals, ideas and values. This influence is commonly known as peer pressure. From observing and modelling one another's behaviour, including their sexual identity, adolescents can become quite vulnerable.

Adult rules of behaviour are replaced with peer-influenced or individual motivations. Family rules and values become less important and frequently become a source of disagreement and dispute. At the same time however teenagers continue to demonstrate parental dependency for example when they have economic needs. This conflict between independence and dependence can create emotional conflict. When making decisions about their readiness for sexual activity, adolescents who come from supportive and knowledgeable

families are less likely to embrace sexual experiences because of peer pressure. Responsibility and morality are difficult concepts to communicate clearly. When a comfortable dialogue between parent and teenager is not accomplished, alienation and hostility may result. Early sexual activity by the child may become another characteristic of poor family interaction.

Madaras (1989) believes that as adolescents go through puberty they experience stronger romantic and sexual feelings than ever before. For some this means spending time imagining a passionate romance with a special person or having sexual fantasies. For others it is the urge to masturbate more often. Seydel (1992) pointed out that masturbation and erotic dreams are part of normal adolescent development. For most adolescents, however, it means becoming interested in the opposite sex, having "crushes" (having sexual or romantic feelings towards a certain, special person) or going out with boyfriends/girlfriends.

Madaras (1989) stated further that these romantic and sexual feelings could be very intense and distracting. Some girls become so preoccupied with their sexual feelings that it is frightening to them, whereas for others who are more involved in extramural activities, romance and sex are not all that important. Thus just as every girl has her own individual timetable for the body changes of puberty, so every girl has her own personal timetable when it comes to romance and sexual interests.

Greathead (1988) sums up adolescence and sexual development as follows: One of the main difficulties of being a teenager is sexuality. It can be viewed as a great discovery, a great mess, a great pleasure, a great frustration and a great muddle.

The issue of sexuality, which begins in early adolescence therefore creates new challenges to personal and gender identity formation as the person matures. Sexual maturation is a process requiring growth in the understanding of oneself as a sexual being, in the ability to handle interpersonal relationships effectively

and in the capacity to plan behaviour in view of future outcomes and present problems (Balk, 1995). A current concern however is that today's adolescents may be making important life choices such as parenthood, before they are developmentally ready for such roles (Chilman, 1980).

2.3 THE CONCEPTS OF SEXUAL HEALTH, KNOWLEDGE, ATTITUDES AND PRACTICE

2.3.1 Sexual health

Sexual health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It is a crucial part of general health during adolescence and adulthood and it also sets the reproductive years for both women and men.

As a concept, sexual health means more than the absence of disease or other health problems. Sexual and reproductive health must be understood in the context of relationships, fulfillment and risk, the opportunity to have a desired child or alternatively to avoid an unwanted or unsafe pregnancy. Sexual health contributes enormously to physical and to psychosocial comfort, closeness, and to personal and social maturation. Poor reproductive health is associated with disease, abuse, exploitation, unwanted pregnancy and death (Harrison, 1998). Based on the above-mentioned statements, the researcher aligns herself with Harrison (1998) who stated that promotion of adolescent sexual health needs more attention.

2.3.2 Promotion of sexual health among adolescents

Harrison (1998) argued that young people have a right to sexual health promotion through appropriate and accessible provision of education and

services. This includes peer education, outreach and detached work and the provision of specialist young people's health services.

Sexual health promotion can be seen as comprising of several different elements, in the same way as health promotion has been described as an all-encompassing term of a range of activities (Harris, 1991). Downies's model in (Harrison, 1998) indicates that sexual health promotion can thus be described as follows:

- health education
- health protection and
- ill health prevention

Health education refers to educative/teaching activities which generally increase knowledge and examine attitudes and development skills (Harrison, 1998).

Health protection relates to policies and legislation which protect and improve people's health at a structural rather than an individual level.

The final element according to Harrison (1998) is ill health prevention, which refers to a range of services and treatments, which provide primary, secondary or tertiary prevention of ill health. Within this framework sexual health promotion can be seen as comprising sex education, sexual health protection and sexual ill health prevention.

Bloxham (1995) described a model for sexual health promotion for young people, which contains similar elements to Downies's areas of health promotion. Her model also comprises three areas:

- education
- services
- information and support

She argues that the start of good sexual health promotion for young people is

basic personal and social education.

2.3.3 Sexual knowledge

Knowledge refers to those items of fact and procedure by which an individual learns what to do or not to do in a given situation, and why it is done or should be done to make the procedure meaningful in so far as he is able to understand it (Kilander, 1990). According to Bodibe (1994) there are two currents of epistemology, which they explain as a body of theory about the origin and nature of knowledge. These are empirical and rational. In the former the contention is that the only source of true knowledge is observation through sensory perception. The latter alludes to the fact that human reason is the only source of true knowledge. In this study knowledge will be used in both these senses in terms of what adolescents already have experienced and what they know theoretically.

Gordon in (Brown, 1981) states that one could not assume that teenagers are knowledgeable about their own sexuality. Thus the sexual information they acquire is vitally important. The available knowledge is usually clouded with myth and error because it is mostly obtained from peers (Kagan, 1989). Furthermore in sex, as in other aspects of human activity, personal experience does not reveal all there is to know (Gagnon, 1977).

As already mentioned, the physical changes of puberty allow adolescents to portray their socio-sexual characteristics. Gagnon (1977) however pointed out, that teenagers generally know little more about how to conduct themselves sexually than they did before they had breasts, pubic hair, or menses. This is due to a lack of knowledge before puberty and not being told very much during puberty.

Harris (1991) believed that sexual activity begins earlier among those teenagers who have the least resources of knowledge and who are thus the most

vulnerable. Adolescents are curious and want to acquire knowledge about their sexuality and their sexual development. Gordon in (Brown, 1981) revealed the following questions as those most frequently asked by teenagers:

- 1) How can you tell if you are really in love?
- 2) Is it all right for people of our age (12 - 19) to have sex?
- 3) Is masturbation normal?
- 4) Why is it easier for males to have sex without emotional involvement than for females?
- 5) How can a girl tell if she has an orgasm?
- 6) Is the pill harmful?
- 7) How can you tell if you have a sexually transmitted disease?
- 8) What is a good contraceptive to use if you are not having sex often?
- 9) Is it normal if you do not feel ready for sex?
- 10) Why don't most parents tell their children about sex?
- 11) Can a girl become pregnant the first time she has intercourse?
- 12) Am I abnormal if I have thought about sex with people I know?
- 13) Can I get birth control without my parents knowing about it?
- 14) How can one avoid pregnancy?

Gagnon (1977) felt that appropriate and correct knowledge about the processes and sources of sexual activity and how they relate to personal conduct is often unavailable to adolescents.

Oliver (1989) did a survey on the sexual knowledge of South African women by publishing a questionnaire in a popular magazine and asking respondents to return the completed questionnaire to her. She asked the respondents at what age they had first find out about sex. The survey showed that among respondents who were under the age of seventeen, most had found out about sex at a very early age, very often before they were sixteen. She deduced that these results indicated that knowledge of sexual matters is improving, but she added that it was still hopelessly inadequate. She also states that although younger girls may know about sexual intercourse, their knowledge of human sexuality may still be very limited.

In his survey Harrison (1998) revealed that many teenagers are confused or uncertain about the "safe time" of the month and which time of the menstrual cycle poses the greatest risk of conception. Only 40% of the teenagers interviewed said that it is usually true that a girl is most likely to become pregnant about two weeks after her menstrual period begins. 59% gave the incorrect answer or were not sure. Only 22% of the subjects said that it is usually true that a girl cannot become pregnant if she has intercourse during her menstrual period, 76% gave the wrong answer or were not sure.

Seydel (1992) asked 76 schoolgirls between the age of 14 and 18 years of age, what age they thought was the right age to start having sexual intercourse. The survey showed that the majority of the participants gave the answer as the age of sixteen. A minority of 6% selected the "*only after marriage*" option.

The subjects indicated that most teenagers do not wait for the right age to start having sexual intercourse but that most start earlier. When the subjects were asked why teenagers do not wait until they are older before engaging in sexual intercourse, the most common answer given was peer pressure, followed by pressure from the partner and curiosity (Seydel, 1992).

When it comes to the effectiveness of various birth control methods in preventing pregnancy, the teenagers in Harris' (1991) survey rated birth control pills and condoms to be the most effective whilst rating withdrawal and the rhythm method as the least effective. However, Harris (1991) felt that some answers revealed ignorance or uncertainty about the effectiveness of some of the methods. For instance, 29% thought that the pill is ineffective at preventing pregnancy. Regarding the methods that were ranked the lowest in effectiveness by the subjects as a whole; there were still 17% who thought that the withdrawal method works well and 15% who thought that the rhythm method works well.

He also found that his subjects rated intra-uterine devices and birth control pills as the most likely to have harmful side effects, but when asked to describe the kind of harmful side effects, their answers revealed some confusion and

misinformation.

Harris (1991) found that teenagers who have greater knowledge about sexuality, gained from whatever source, are more likely to use contraceptives all the time if they are sexually active. He, however, found that many teenagers are confused or uncertain regarding their knowledge of basic facts about sexuality. Furthermore, he found that the teenager most at risk of pregnancy turns out to have the least knowledge.

As far as knowledge of sexually transmitted diseases and HIV/AIDS is concerned, Cresswell (1994) conducted a survey assessing the knowledge of 207 sexually active teenagers attending a family planning clinic and found that the respondents were aware of the major modes of transmission regarding sexually transmitted diseases and HIV/AIDS, but they had some misconception about the risk associated with casual contact.

Harris (1991) concluded that knowledge increases with age. It is also higher among those who have had sex education in school and among those who have talked with their parents about sex, pregnancy and birth control.

He also felt that teenage ignorance is an adult problem, both in the sense that adults need to take action to correct it and in the sense that if left uncorrected ignorant teenagers to become ignorant adults later on.

2.3.4 Sexual attitude

An attitude is defined differently by different authors. Ajzen and Fishbein (1997) view attitudes as a complex system comprising the person's beliefs about the object and his feeling towards the object. Attitudes are learned and they can be changed if deemed necessary. Attitudes are not directly observable but inferred from the person's overt behaviour. An attitude is also defined as an intensity of positive or negative affect for or against an object/subject. Attitudes of people

can differ towards this and that can be regarded as a positive or negative affect. Attitudes also vary in intensity and direction, for example, two persons may have the same attitude but may differ in how strongly they feel about the issue. Attitudes also vary in affective saliency, i.e. there are some attitudes that are accompanied by or connected with a person's emotions.

Attitudes are relatively stable in adults but that does not mean that they cannot be changed or modified. An attitude is thus a tendency, a mental set to respond in a particular way in relation to issues for example, birth control. An attitude causes a readiness or a tendency to act in a particular manner in respect of a particular object or matter in a particular situation (Jordan, 1979).

Gable (1986) also states that an attitude is composed of affective, cognitive and behavioural components that correspond respectively to one's evaluations of knowledge of and predisposition to act toward the object of the attitude. The cognitive component refers to the way in which the attitude object is perceived and conceptualized. The affective component is concerned with the emotional underpinning of the beliefs and represents the amount of positive or negative feeling that one has towards the attitude object. Lastly, the behavioural component is conceived as a consequence as well as a corollary of the other two components referring to the person's intention to behave in particular ways or his actual behaviour regarding the attitude object.

Referring to adolescents and sexual attitudes, Harrison (1998) states that once the adolescent experiences puberty and becomes sexually mature, sexuality assumes far greater importance in his or her life. At this point, adolescents must incorporate concepts of themselves as sexual beings into their male or female gender identities. In addition, they also have to discover how to express their sexuality within the context of interpersonal relationships. At best these tasks are never easy, but they can be made even more difficult by the prevailing cultural norms and morality relating to sexual behaviour (Robertson, 1987).

It is apparent that adolescents have become comparatively liberal in their views

about sex in present day society. This is manifested by greater tolerance of deviation from what their parents would regard as the norms.

In a review of the literature on teenage sexuality, Darling (1996) identifies three major changes in teenagers' sexual attitudes, which reflected their views on sexuality at that time.

The main points are summarised below:

- Premarital sex is acceptable if the people concerned are in a loving relationship but casual or exploitative sex is wrong.
- The double standards that allowed men to have premarital and extramarital sex without censure, while women who behaved in a similar fashion were vilified, have become less prevalent. Respondents advocate equality for both sexes.
- Although adolescents ostensibly have more freedom to decide on their own sexual norms, they are confused by mixed messages from parents, schools and religious groups. This creates a gulf between the adult and adolescent worlds, which prevents development and integration of experiences into sexual identities in a supportive, empowering and liberating environment. This schism has been commercially exploited and has created a lucrative market for business. Unfortunately this threatens the delicate balance in the development of the adolescent's cultural norms, values and freedoms which can be cynically manipulated commercially with the possibility of increasing polarisation away from parents.
- Adolescents are in a potentially fragile psychological and emotional state as they move from total dependence on their parents to a state of relative independence in society with its accompanying responsibilities.

It is desirable that young people should have the input of mentors and role models to assist them in their quest for self-determination. It is suggested that the use of mentors and role models could help to dispel myths and

misconceptions about sex and sexuality (Harrison, 1998). Sexuality is seen by some writers as a dimension of an individual personality (Cox and Lester, 1988). As the adolescent searches for identity and self-esteem, it may be that their sex role also becomes more clear and refined, enabling them to express themselves sexually in the long term.

Greenwood (1984) said that youngsters usually begin their interest in the opposite sex within the safety of a gang. Boys leer at girls and girls giggle at boys, then send ambassadors on their behalf to sound out feelings, before overtly declaring an interest. If their attraction is reciprocated, they may risk being acknowledged as a pair within the gang, then later as a couple. The girls may be more emotionally involved but not always. Both need to prove their attractiveness by having a special relationship, and perhaps need a secret personal life not governed by parental influence. They need someone to love and someone who cares for them. They enjoy the social status of their relationship and the perks that accrue. It serves as a testing ground to satisfy their sexual curiosity, which may be more important to the body. They may well become infatuated with each other as these processes coalesce (Greenwood, 1984).

Most girls, according to Greenwood (1984), portray certain fears when initially becoming sexually active. They wonder whether their breasts and genitals will be acceptable to a partner when being touched. They question what behaviour will risk pregnancy. They are concerned that what they have been doing will show on their faces, breasts or genitals. They fear venereal disease and cancer of the cervix. Emotionally they wonder whether having sex with a partner will make him like her more or less. They question when they should start taking the pill.

Lewis and Lewis (1980) believed that for most non-virgin teenagers, sexual intercourse is an irregular activity. The majority of non-virgin adolescents are therefore not promiscuous. According to them, the following are indicators of an adolescent involved in a sexual relationship to the extent of intercourse:

- i) No tertiary education aspirations
- ii) A serious relationship
- iii) Single-parent households
- iv) Alienation from parents
- v) Weak religious beliefs

Greathead (1988) claimed that one of the main problems in teenage relationships is that they generally do not communicate their feelings about sex to each other. The result is that many engage in a sexual relationship for which they are not ready. Girls often find it difficult to reflect a boyfriend's request for intercourse in fear of losing him (Lewis and Lewis, 1980). Girls, therefore, find it difficult to communicate to the boyfriend that they are not ready for sex. Sexual intercourse results from heavy petting and the inability to stop once a certain point is reached during sexual activity.

In late adolescence the task shifts from seeking and finding one's sexual identity to re-exploring it in all its implications. Falling in love for the first time involves feeling a truly intense concern for one other special person (Group for the Advancement of Psychiatry, 1986). In contrast to the self-centered sexual preoccupations and activities of early adolescence, the adolescent now moves toward a shared sexual experience. It is important to realise that all adolescent sexual behaviour does not develop at the same rate (Group for the Advancement of Psychiatry, 1986).

Lastly it needs to be stated that attitudes are difficult to measure because it is difficult to devise clear reliable rules. Knowledge gained about attitudes is neither fixed, complete nor universally valid. It only provides added information regarding a particular phenomenon. It thus serves as a starting point for more research and elaboration and never as a complete answer.

The researcher will attempt to measure personal qualities like attitude without claiming universality or a corpus of knowledge. The findings are therefore interpreted qualitatively.

2.3.5 Sexual behaviour

Sexual behaviour is a great variety of distinct behavioural variables, including covert behaviour such as sexual dreams and fantasies, self-stimulation and genital masturbation, dating, kissing or sexual intercourse (Money, 1994).

According to Druker (1996) all sexual behaviour is learned behaviour therefore the interplay between sexual behaviour and sexual knowledge and sexual attitudes should assume a special significance. Chilman (1980) also endorses this view by pointing out that learning plays a vital and critical role in determining the sexual patterns that are adopted to satisfy sexual drives. Druker (1996) also mentions various factors that have an influence on adolescent sexual behaviour namely:

- 2.3.5.1 Family Environment
- 2.3.5.2 Economic circumstances
- 2.3.5.3 Religious factors
- 2.3.5.4 Drugs and alcohol
- 2.3.5.5 Cultural factors

2.3.5.1 Family environment

Many studies have found that the family environment influences adolescent sexual activity (Disler, 1985; Decay, 1997). In their review of the literature, Ford, Kanter and Zelnic (1987) concluded that youths from stable family environments are less likely to engage in premarital sexual relations. Researchers studying race and premarital sex have found that by itself, race or ethnic affiliation is not related to premarital sex (Decay, 1997). Teenagers from poor families are most likely to experience first coitus at an early age (Forte and Heaton, 1988).

2.3.5.2 *Economic circumstances*

Du Toit (as cited in Preston-Whyte (1991) highlighted that poverty provides the background for early sexual involvement and teenage pregnancy. It was revealed that teenagers without economic support often survive with the help of men with whom they form permanent or semi-permanent non-marital sexual relationships (Darling, 1996). This was confirmed with findings from a study done by Craig and Richter-Strydom (1983), which revealed that some girls "sell" their bodies by means of sex to older men in order to get money. Disler (1985) revealed that the socio-economic background of adolescents has an effect on their sexual health. This was reflected in high rates of pregnancy among female adolescents and most of these girls were pregnated by businessmen and had to leave school in the end.

2.3.5.3 *Religious factors*

The influence of religion on sexual behaviour has also been demonstrated in a study done by Brock (1994) where it was revealed that children who attend church regularly and have peers attending the same church are less likely to be sexually active. The study done by Bodile (1994) revealed that more religious adolescents would demonstrate a more moderate sexual behaviour than non-religious ones.

Gorgen, Maier and Dusfeld (1993) pointed out that religion has great salience in the lives of those adolescents who are committed to its teachings. Fisher (1990) also endorses the view that church attendees are more conservative in their sexual knowledge than those who do not attend church.

2.3.5.4 Alcohol and drug abuse

The use or abuse of drugs and alcohol seems to be higher among teenagers indulging in sexual intercourse than among their virgin counterparts (Ahmed and Kajee, 1994). Adolescents may indulge in sexual activity whilst under the influence of drugs or alcohol and can thus contract sexual transmitted disease. This confirms that alcohol and drug abuse remain a health hazard.

2.3.5.5 Cultural factors

Andrews and Boyle (1995) defined culture as a complex whole which includes knowledge, beliefs, arts, morals, laws, customs and any other capabilities and habits acquired by man as a member of society. Culture represents a way of perceiving, behaving, and evaluating one's world. All people have culture expressed in their particular group and all culture is learned not only through formal study but also through a process of cultural osmosis in which the values, attitudes, roles and behaviour acceptable to and expected by a cultural group are absorbed (Clark, 1994).

The child absorbs attitudes about his immediate environment and as his horizon broadens he becomes aware of the large world outside his home and begins to recognise differences in attitudes and beliefs held by others in his neighbourhood and starts to integrate them with those learned at home.

Culture has a tremendous influence on sexual behaviour. This is supported by many authors likely Bam (1994) who stated that contraceptive use among adolescents is influenced by norms surrounding sex, contraception and fertility. The above-mentioned authors are supported by Preston-Whyte and Zondi (1991) who highlighted that societal and cultural pressure mediate access to and the use of birth control.

2.4 REASONS FOR BECOMING SEXUALLY ACTIVE

Common questions asked by researchers about the sexual attitude of adolescents are:

- Why do adolescents become sexually active?
- How do they interpret sexuality?
- What are their perceptions and views on sex?

The literature reveals many reasons for adolescents to become sexually active.

Seydel (1992) mentions a few:

- To promote self-esteem,
- To have someone to care about them and to care about someone else,
- To accommodate peer pressure,
- To feel grown up and
- To feel good (Seydel, 1992).

Adolescents regard sex as a form of recreation rather than as a form of reproduction. Harris (1991) says the colloquial term used for sex by the adolescents is to "*jol*". "*Jolling*" is associated with recreational activities such as drinking, dancing, and going out. Adolescents also view sex as a physical and biological drive. They believe that as one becomes sexually mature, the blood becomes strong. Evidence of this is menstruation in females and wet dreams in males (Harris, 1991).

They believe that it is important to release "blood" semen or vaginal fluids by having sexual intercourse because "blood" is exchanged between a man and a woman. Sex favours from older men may also encourage adolescent women to start becoming sexually active.

According to Greathead in (Harris, 1991), many researchers agree that parental attitudes sometimes play an important role in their adolescent daughter becoming sexually active. The Group for the Advancement of Psychiatry (1986)

expressed the view that loving families and parents that offer a secure sexual identity and sense of personal worth in their children produce adolescents who might be able and willing to defer active intercourse and would be less likely to engage in sexual activity carelessly.

Religion also plays an important role in the decision to become sexually active. There is however no religion that advocates early or premarital sexual relationships (Harris, 1991). Thus adolescents with strong religious beliefs generally choose not to indulge in early sexual activity. Those who do however, become sexually active usually due to peer pressure or pressure from the partner and often feel extremely guilty as a result.

According to Harrison (1998) teenagers say that social pressure is the chief reason why so many of their peers do not wait to have sexual intercourse until they are older. When older friends and brothers and sisters talk about sex, it stimulates the interest of youngsters. They may want to experience the same things as their friends.

2.5 ADOLESCENT ATTITUDES TOWARDS CONTRACEPTION AND ABORTION

The lack of effective contraceptive use by sexually active girls is well-documented (Brown, 1981 and Gordon, 1979). The reason is attributed mostly to the lack of adequate knowledge about how to use birth control devices as well as the unavailability thereof. Much of the adolescents' knowledge about contraception is a myth and misapprehension that they have gained from peers who usually know as little as they do. Thus we have the misinformed educating the uninformed, this being a potentially dangerous situation (Gordon, 1979).

Lindsay (1983) however, claimed that many teenage girls are technically knowledgeable, but fail to use contraceptives because their attitude and not their knowledge are faulty. Fisher (as cited in Saunders, 1988) stated that many

adolescents are comfortable enough to have intercourse, especially with the aid of lust, love or alcohol, but are not comfortable enough to plan in advance. Hilton in (Eisen and Zellman, 1986) claimed that young people do not have the psychological strength to recognise the consequences of their actions.

Gordon (1979) pointed out that less than one in seven teenagers uses a reliable form of contraception the first time they have intercourse. Stark (1986) claimed that many begin to use contraception only after a pregnancy scare.

According to Harris (1991), teenagers say that "unexpected sex" with no time to prepare is the most frequent reason for not using birth control. Hilton (as cited in Stark, 1986) agreed that teenagers often act impulsively and do not always think long term when portraying certain behaviour.

Other reasons for not using contraceptives, according to Byrne (as cited in Stark, 1986) are that adolescents often deny the possibility that coitus may occur, are too embarrassed to get birth control or to discuss it with their partners and are inhibited about using birth control devices. Furthermore, feelings of guilt and anxiety are other reasons for not using birth control.

Contraceptives are most likely to be used by those teenagers who can see they have much at stake and stand to lose much by being in an unintended pregnancy (Harris, 1991). Hilton (as cited in Stark, 1986) pointed out that the older teenagers are when they initiate sexual activity, the more likely it will be for them to use contraceptives.

2.5.1 Abortion

If preventing pregnancy fails then abortion remains as a possible option available to teenagers according to Harris (as cited in Seydel, 1992). Illegal abortions are very common among teenagers in Africa. The number of maternal deaths from illegal abortions is estimated as 11 500 to 200 000 per annum. What is more

worrying are the long term consequences for those who survive illegal abortions, as the majority of these are often performed by unskilled persons. Harrison (1998) cites teenagers taking various substances, often rat poison, or putting objects into the vagina, or hitting the stomach in the hope of inducing an abortion. The major consequences of abortions are stated in the literature as follows:

2.5.1.1 Physical consequences

When the operation is legally performed by a medical doctor under clinical conditions, there are usually no detrimental physical consequences. When abortions are done in primitive circumstances by lay persons (backstreet abortions), serious complications often occur. The consequences of these sometimes result in death.

Other complications, which may result from an abortion, are:

- Perforation of the uterus wall
- Infection (septicaemia)
- Peritonitis
- Haemorrhage
- Sterility
- Death

2.5.1.2 Psychological consequences

Some research studies indicate that the woman who has had an abortion often feels relief and would have experienced no psychological trauma. Some women, however, may suffer from one or more of the following negative psychological consequences:

- Guilt feelings, especially the religious woman who believes that she is a murderer and has sinned against God

- Self-reproachment
- Sorrow
- Depression
- Anxiety
- Psychosomatic conditions
- Serious mental disturbances sometimes occur
- Suicide, in a few cases
- Emotional insensitivity and loss of self-respect, especially if she has had more than one abortion. She feels that men (her husband/boyfriend) regard her as a sex object. Conger (1986) found this especially in Rumania where some women had up to 15 abortions.

In general it seems as if the attitude of adolescents regarding all aspects of sexual health has become more liberal and that coupled with inadequate knowledge on the subject create a risky situation for the adolescent.

2.6 ADOLESCENTS AND SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases represent a major public health problem in developing countries. 70% of HIV infection in Africa is found in patients with STD (World Health Organization, 1995).

Berk (1993) as previously mentioned also found in his study on young girls in Nigeria that 40% of the girls had a reproductive tract infection. It was further found by Blecher (1992) in South Africa that a Chlamydia infection was asymptomatic in 94% of cases investigated which indicates that the real risk of sexually transmitted infections in adolescents might easily be underestimated.

Women seeking antenatal care are routinely screened for syphilis. In different

regions of Namibia 8% to 20% of pregnant women tested positive for infection with Treponema Pallidum during the period 1993 to 1996. Changing attitudes towards sex had a drastic impact on the prevalence of STD's. In fact STD's are largely a "young" peoples problem, with 86% of cases occurring in adolescents and young adults aged 15 to 29. By the age of 20, approximately one in five people has been treated for a STD in Namibia (The Namibian Demographic and Health Survey, 1994).

2.7 PREVENTION OF SEXUALLY TRANSMITTED DISEASES

The changing nature of Sexually Transmitted Diseases shifted the focus to primary prevention of these diseases, rather than concentrating on curative measures. This emphasis on primary prevention strategies has important implications for providing health care to young people. It also stresses increased attention to existing health interventions. Mechanical and chemical barriers which include condoms, diaphragms and vaginal spermicides, protect people against most sexual transmitted diseases. Any mechanical barrier that remains intact and prevent genital contact with infectious agents should reduce the risk of Sexually Transmitted Diseases (STD) and Human Immune Deficiency Virus infection that causes Acquired Immune Deficiency Syndrome (AIDS) (Stone, 1990). The co-operation programme of 1997 to 2001 between the Government of Namibia and UNICEF promotes the use of condoms for the following reasons:

1. Condoms are the only contraceptives that also prevent the spread of sexually transmitted diseases (STD) including HIV.
2. Condoms are one of the most reliable methods of birth control when used properly and consistently.
3. Condoms have none of the medical side effects of systemic birth control methods.
4. Condoms are available in various shapes, colours, flavours, textures and sizes to heighten the fun of making love.
5. Condoms can help to provide women with protection from cancer of the cervix.

6. Condoms are free in Namibia. No prescription needed.
7. Condoms make sex less messy.
8. Condoms are user-friendly.
9. Condoms are an essential necessity of modern life for many people.
10. Condoms are only needed when engaging in the sex act whilst the majority of other contraceptives need to be taken on a continuous basis.

Abstinence is the only preventative method that is 100% effective for preventing STD. The definition of the term abstinence may vary among persons using it with reference to sexual activity. Often the term is used to connote avoidance of any sexual activity rather than specific avoidance of penetrative genital contact. Although prevention of STD's by way of selection of sexual partners and restriction of sexual activities is the better attitude towards behavioural change, it has its own problems (Blecher, 1992).

Blecher (1992) explains that limiting the sexual activity to one partner will ensure freedom from STD's/AIDS transmission only if both partners are uninfected and the sexual relationship remain mutually faithful. Knowing that sexually active adolescents remains ignorant about basic human reproduction provides little comfort. Such ignorance has not led them to abstain from sexual intercourse, which in turn puts them at risk for infections and pregnancies.

2.8 TEENAGE PREGNANCY AND ITS ADVERSE EFFECTS

One of the most serious phenomena of the times in which we are living, is that more and more children have children. Teenage pregnancies have increased all over the world and in Namibia it is also a source of great concern. Such a pregnancy has a detrimental effect on the teenager, her baby, her parents, the father of the child and the community.

2.8.1 Consequences for the mother

Sapire (1996) and Nass and Fisher (1988) maintain that obstetrical risks are universally related to the age and socio-economic background of the pregnant girl and to the antenatal care she receives.

Teenage mothers tend to have more medically complicated pregnancies, including antepartum haemorrhage, anaemia, cephalo-pelvic disproportions, pregnancy induced hypertension, eclampsia and miscarriages. A higher maternal mortality rate is found than that for women in their twenties (Menkin, 1997).

Osborne (1991) however found no evidence of increased obstetrical risks in teenagers as a group, but that those who remained single showed increased rates of premature labour and peri-natal mortality as compared with married teenage girls.

Even more disturbing are the psychological and social consequences of unintended teenage pregnancies. The teenager may find herself cut off from peers by her family (Maintoxh, 1985). Conflict may arise with the grandparents over the care of the infant. There may be emotional strain between the mother and the baby's father and their respective families (Masters, 1996). The sole parenting teenager may be prone to loneliness, leading her to seek male support and thus place her at risk of further pregnancies. Depression and conflict over a pregnancy outcome with little or no support, emotionally or financially, from the baby's father is a common psychological problem (Nass and Fisher, 1988).

Unmarried teenagers who find themselves pregnant face a series of difficult choices. Some pregnant teenagers may want an abortion when they realise the physical, personal and social implications of their condition. Abortion has complications which are related to the gestational age at presentation (Rickel, 1989). Black (as cited in Sapire 1986) says that in areas where abortion is legalised, teenagers report later for termination of pregnancy, thus carrying

profound effects on the teenager's future pregnancies. In Namibia abortion is not legalised, except for therapeutic reasons, hence teenagers resort to backstreet abortionists with its devastating consequences.

If the teenager decides to have a baby, she has two options, either to keep the child or put the child up for adoption. Today's unwed youth do not choose adoption as a course of action (Masters, 1996). Sapire (1986) sounds the warning that adoption is considered a devastating experience by most adolescents and their parents.

Pregnant teenagers may face three difficult role transitions simultaneously, adolescence, parenthood and sometimes early marriage. Nass and Fisher (1988) maintain that the stress of these adjustments is often magnified by financial problems and lost educational opportunities. Most mothers who keep their babies drop out of school, hence their inability to enter the labour market or gain regular employment, and are thus over represented in poverty statistics (Masters *et al*, 1996; Sapire, 1986).

Some teenagers rush into unanticipated marriages that end up in divorce or desertion (Atwater, 1988), since teenagers are said not to be emotionally mature enough to handle a marital relationship. In contrast, Furstenberg (as cited in Atwater, 1988) found that the teenagers who made the best adjustment were those who married the father of the child, returned to school and delayed having additional children. Within five years the teenagers' lives resembled those of their counterparts who had delayed marriage and pregnancy until after their twenties.

This was supported by Rockefeller III's remark (Sapire, 1986) that the girl who has an illegitimate child at the age of sixteen, suddenly has ninety percent of her life script written for her:

"Her life's choices are few and most of them are bad ..."

2.8.2 Consequences for the father

Little is known about the effects of unintended teenage fatherhood. Masters *et al* (1996), speculated that it may be due to problems in identifying them for a study or because they are not socially or economically linked to the pregnancy in the same way as mothers. However, in a study of sixteen expectant teenage fathers found that although 62,5% of young men were judged to be coping well with the stresses of pregnancy, 25,0% were having moderate difficulty (Elster and Lamb, 1990). 12,5% were coping poorly and suffered from depression with suicidal tendencies. The implication of this study is that some teenage fathers may encounter problems resolving the stresses associated with pregnancy and parenthood.

However, male teenagers like their female counterparts, also face these role transitions for example, coping with adolescence, parenthood and sometimes early marriage simultaneously. According to Elster and Lamb (1990) the premature transition to parenthood also adversely affects educational and vocational attainments. Teenage fathers are less likely to complete their education and are subsequently over represented in unskilled and semi-skilled jobs and unemployment.

Marriages between teenagers mostly end up in divorce. In fact, as the noted sex educator Sol Gordon points out, almost 90 percent of all teenage boys who make a teenage girl pregnant, abandon her (Masters, 1990).

2.8.3 Consequences for the child

Banks and Wilson (1989) point out that, since the culture in black communities normally tend to discourage abortion and formal adoption, black teenage mothers, according to their culture, keep their babies. Attention has thus far centered on the teenage mother's hardships, but the children of teenage mothers are also at risk for a host of problems.

Several authors revealed that these children have a raised peri-natal and infant mortality rate. They do less well educationally and emotionally, have a higher frequency of congenital abnormalities and become victims of abuse or neglect in the hands of immature and irritable parents. For female children there is an increased risk of becoming teenage parents themselves (Rickel, 1989).

2.8.4 Consequences for the family

In cultures where out-of-wedlock pregnancies are regarded as a disgrace, the family will be stigmatised. To avoid the stigma, some families can arrange an unanticipated marriage between the partners, failing which some teenagers remain single, thereby contributing to the prevalence of single parent families among blacks (Ajzen and Fishben, 1997).

Family pressure may force the teenage father to avoid the parental role. His own family may worry that their son will be entrapped by his girlfriend and child (Robertson, 1987). His family might wish to avoid financial responsibility for the child. The girl's family may blame her boyfriend for the pregnancy and reject him in anger and they could also separate the teenagers in order to punish the girl. They may not wish to share control of their daughter and grandchild (Robertson, 1987).

Harris (1991) concludes that, "*when girls start having babies very young, reproduction can occur over a longer period and tends to do so with greater intensity, with shorter birth intervals, and the completed families are 30 percent larger.*" These larger families burden the entire family especially where the teenager comes from a low-income background. Even willing grandparents are unable to provide for the teenager and her children, leading to greater welfare dependency.

2.8.5 Consequences for the community

Harrison (1998) highlights that the cost of teenage pregnancies to society is higher than the cost of other pregnancies. One reason for this higher cost is that many of these girls have low birth-weight babies. These babies must often be placed in intensive care – resulting in higher medical costs. Since teenage pregnant mothers are prone to a host of physical problems for example pregnancy induced hypertension, they have to be under the continuous surveillance of the doctor and deliver in hospital, thereby further increasing medical costs. This information demonstrates the need to put emphasis on prevention of teenage pregnancies because of its adverse effects.

2.9 SEX EDUCATION AND SOURCES OF INFORMATION

Ideally sex education should start prior to the birth of a child. The parents should prepare themselves physically, emotionally, mentally and socially to become ideal role models for their children (Harris, 1991). Van Rooyen and Louw (1994) also maintains that sex education of our children needs to begin virtually from birth, since the child undergoes various phases of sexuality and has to be taught the correct behaviour in each phase. Mmolawa (1996) stated that sex education is a means of:

- Providing knowledge of the process of reproduction and the nature of sexuality and relationships.
- Encouraging the acquisition of skills and attitudes, which allow pupils to manage their relationships in a healthy and responsible way (Seydel, 1992).

Similarly, Mmolawa (1996) describes good sex education as fostering knowledge and skills. Sex education can therefore be seen as including any activity which aims to educate people about sexual health matters for example:

- To increase knowledge about the biological facts of human sexuality and

- relationships,
- To allow people to clarify their own attitudes and examine the attitudes of others towards sexuality and relationships,
 - To help people acquire the skills necessary to make sexual health decisions.

Sex education is, however, not simply about the absorption of mechanical facts, it embraces issues of ethics, morality, faith and values (Mmolawa, 1996).

According to Cox in (Seydel, 1992) one of the main tasks of the secondary school is to facilitate the development of pupils through their entire adolescent period from childhood to adulthood. Dunn, Kovas and Selwood (1988) state that sexual health is a constituent of life in schools as it is of any other part of social life. Cox in (Seydel, 1992) however states that although sexual development is an important part of adolescence, it is often seen as an integral part of schooling.

Harris (1991) was of the opinion that sexual education advertisements and information have enormous impact on teenagers' sexual behaviour. Lindsay (1983) however pointed out that due to the input of all the informal sex educators such as parents, the media and peers, there is not a question of no sexual education but there is undesirable and bad sexual education coupled with ignorance and a lack of understanding. The earlier that one begins with sex education, the better. It is a myth that a child is too young to talk about sexual matters. The researcher also suggested that by keeping children sexually ignorant they are exposed to risks and anxiety; and their sexual learning becomes more troublesome, confusing and upsetting.

Montagu (1992) claimed that the first step in combating teenage pregnancy is teaching children about sex and sexuality from an early age.

The survey conducted by Seydel (1992) also showed that sex education and sex information have an enormous, impact on teenagers' sexual behaviour. She found that teenagers who have had a comprehensive sex education course at

school are more likely to use birth control at all times if they are sexually active.

Comprehensive sex education was defined as one including at least four out of the following topics listed:

- Biological factors of reproduction
- Coping with sexual development
- Different kinds of birth control
- Where to get contraceptives
- Information about preventing sexual abuse
- Information about preventing STD's
- Facts about abortion (Harris, 1991).

Furthermore Harris (1991) found that 50% of teenagers in this study received sex education as a course on its own in only one grade at school. The other 50% received it as part of another course rather than as a separate course. Kirby in (Montagu, 1992), who did an evaluation of thirteen sex education programmes in the United States of America, stated that the most effective sex education classes do not just teach basic reproduction and contraception, they discuss dating and relationships as well as beliefs and life goals.

Eisen and Zellman (1986) interviewed 203 teenagers aged between 13 and 17 about their pre-intervention sexual and contraceptive knowledge, attitudes towards pregnancy and contraception, prior sex education and sexual activity experiences. They believe their findings have important implications for sex education programmes. They suggested that sexuality knowledge may be more effectively taught if motivation building and attitude changing exercises are included in sex education programmes. Many programmes take such motivation for granted, assuming that teenagers will naturally want to learn about sexuality only.

In many other countries, sex education programmes have been introduced into schools during the past 20 to 30 years, with the ages of the participants varying

from 8 to 18 years (Kagan, 1989).

Berk (1993) researched the aims and rationale of the contents of programmes and the availability of teacher training with regard to sex education in a number of countries. They found that there was no uniform system of sex education in the countries involved in their investigation. In most cases only general guidelines were provided by the education authorities and it was left to the principal and parents of the pupils of a particular school to decide whether and how sex education would be offered. In China there was the belief that children are not interested in sex and therefore sex education was only given to those people who were about to get married. Makanya (1993) did attempt to evaluate sex education in schools in South Africa, but found no adequate proof of its success or failure. Harrison (1998) pointed out that adolescents have various sources of sexual information, like parents, peers, schools, media and health workers. Each source will be discussed briefly.

2.9.1 Parents

The family is the foundation and cornerstone of society. Although vast variations in the form and functioning of the family can be found in various societies, the family is one of the most pervasive institutions of man. There is no known human society that does not have some form of family unit. For the child, the family is an entire world of people who are of extreme significance to him. It is initially the child's only world. To him it is the home from which he starts out on his lifelong journey through society. What happens to the child at this point of departure will significantly affect the later phases of the journey (Money, 1994).

Parents are responsible for the primary education of their children as well being responsible for their total education. Van Rooyen and Louw (1994) state that families are exposed and subjected to modern trends that do not simplify the task and responsibilities of the parents who remain answerable for the sexual education of their children.

Parents perceive themselves as being unable to provide adequate sex education because they feel they do not know enough about human sexuality or they do not know how to explain what they do know. It seems as if most parents feel inadequate and embarrassed about any effort to talk openly with their children about sex if it entails anything more than telling them what not to do. Thus many parents, even the best of parents, feel incompetent and inadequate. They feel ill-prepared factually or emotionally or both, to teach their children about sexual development, sex relations and reproduction with all the physical, social and ethical implications and consequences (Mtezunka, 1996).

Gagnon (1977) stated that much of the information that children get from their parents is observational and indirect because they do not get information from conversation or discussions.

Girls do tend to learn about sex from their mothers, but this information is often restricted to menstruation, pregnancy and birth (Gagnon, 1977). According to Olivier (1994) mothers do not want to admit that their daughters are growing up and feel threatened by a sexually developing teenager and thus find it difficult to discuss sex with their daughters. Olivier (1994) also stated that fathers generally do not discuss sex with their children.

Seydel (1992) felt that since parents are generally considered to bear the greatest responsibility with regard to the sex education of their children, they should be involved in the sex education given in schools.

Fisher (1986) conducted a survey on parent-child communication about sex and found that the benefits of open parent-child communication about sex may not be in the content of that communication as much as in the attitudes conveyed by the parents. Fisher (1986) felt that this finding explains why children who can talk to their parents about sex are less likely to engage in sexual activity, and are more responsible in their approach to sexuality. Their behaviour is a reflection of their parents' values.

2.9.2 Peers/friends

Adolescents rated peers as the second most important source of sexual information in the survey conducted by Harris (1991). During adolescence, close friends assume an increasingly important influence on the behaviour of the individual (Seydel, 1992). Mmolawa (1996) conducted a study on adolescent sexual behaviour and found that the sexual behaviour of young female adolescents (12 – 15 years old) was affected by a best friend's behaviour. Oliver (1989) found that most of the respondents in her survey heard about sex from their friends at school.

Various researchers have confirmed that the sexual information acquired from peers is likely to be inaccurate, and filled with misconceptions and myths (Kagan, 1989). Grinder (1973) stated that the sizeable gaps and inconsistencies in the sexual knowledge of adolescents is not surprising in view of the fact that most of the sexual knowledge comes from peers. Unfortunately peers are often a poor source of sexual information.

Gagnon (1977) states that much of the peer provided information is technically incorrect, particularly that about birth control, abortion and conception. Sexual attitudes that are supplied by the peer group are also often riddled with confusion and misconceptions.

On the other hand, teenagers feel that their friends understand them better than their families do. The closeness of these friendships enable teenagers to share strong and often confusing emotions and experiences, doubts and dreams, fears and fantasies. The sharing of these complex emotions helps young people to realise that their friends are experiencing or have experienced similar feelings and this makes life seems less threatening.

The sexuality education programmes can help teenagers by highlighting the positive aspects of peer pressure rather than by continually harping on the negative, according to International Planned Parenthood Association in (Bam,

1994).

2.9.3 Mass media

Available studies allow us to conclude that television has great potential for playing an important role in the sexual socialisation of the youth. Unfortunately, most of the sexual content still does not depict the potentially unhealthy consequences of these behaviours and does not convey the need for sexual responsibility.

Television is not the only source of sexual information available to today's adolescents, but it is an especially accessible and compelling one. It can portray human sexuality in a socially responsible manner, or it can present sexuality as a degrading and high-risk behaviour. As a source of role models, television often makes unhealthy behaviour appear to be either glamorous or at least without consequences (Brown, 1990).

It is generally agreed that children should not be exposed to programmes meant for adults only. However, the programmes scheduled before 8 o'clock at night appear to expose children to many sensitive adult issues.

From the above discussion it is clear that young people will get their information on sex, from the street corners, in the school yard, from their friends and peers and from the mass media, but it could be accepted that the bulk of it will be confusing, unreliable and frequently inaccurate. It is obvious that society cannot leave it to these sources to shape children's values about sexual health.

2.9.4 The school

The school is in a position to offer more than factual information on human sexuality. It can create an awareness of attitudes and clarification of personal

values. These factors are usually more important than knowledge in determining sexual behaviour and positive sexual adjustment or lack of it. Values governing sexual behaviour become an integral determinant of the person's response to sexual phenomena. The real value of culture, morals, religious and family beliefs cannot be ignored, since they strongly influence the development of social attitudes and values. The school is in a position to offer an environment where these aspects can be presented in an integrated and systematic manner (Makanya, 1993).

Sexuality education in the schools is one way to increase the probability that adolescents will acquire more complete and accurate information about sexuality than is occurring through other means (Seydel, 1992).

What is needed is a systematic, consistent and enlightened programme of sexuality education in order to offer young people a framework of knowledge and guidance in human sexuality from which they can develop a system of values to help them make informed decisions. The role of the school has always been to provide a curriculum which promotes the total development of the child, that is, the physical, social, intellectual and spiritual development. Sexuality education programmes therefore fall within the responsibility of the school (Seydel, 1992).

Society has given the school a clear-cut role to play as a primary and trustworthy source of truth and factual knowledge for every child. Every parent in his right mind should welcome the honest efforts of educators to present the true facts about human sexual behaviour at those moments in the child's evolution, when such facts are most necessary to him for his protection and orderly development (Blecher, 1992).

It is an unfortunate fact, however, that this education is often too limited in scope, and too biologically and physiologically oriented. It is not given optimal time and the curriculum has been planned without assessing the needs of the students beforehand.

An effective sexuality education programme needs the support of parents as well as the community. It will, however, be a while before many parents and other community leaders rid themselves of their misunderstandings and anxieties about the objectives of a sexuality education programme. The onus is therefore on the school to organise and implement parent education programmes to:

- explain the objectives of the sexuality education programme;
- alleviate parental and community concern;
- elicit support from parents and community groups even before starting the programme; and
- educate parents about human sexuality.

2.9.5 Health workers

As a result of her comprehensive training and position of trust in the community, a community health nurse has a unique opportunity to provide guidance to children, adolescents, parents, and teachers and intentionally enhance communication between the school and the community as well as between students and families (Lewis and Lewis, 1980).

Because nurses have a supportive and facilitative role, they should be used to help adolescents make informed, rational decisions about sexual issues (Lewis and Lewis, 1980) and to educate the adolescent regarding the changes created by their sexual development (Lindsay, 1990). Unfortunately the nurse's role is not acknowledged in educational settings.

2.10 SUMMARY

In this chapter the problems associated with adolescents' sexual health have been discussed. The literature has confirmed the devastating effects of teenage pregnancies and their consequences. It has also highlighted the need for more

information because adolescents are misinformed. The researcher as community health nurse had discussions with parents and other adults in the community, raising her concerns as indicated in chapter 1. The community requested her to do the research to prove to them that the problems as identified by the researcher do exist in their immediate environment. Thus it is imperative to do research on adolescents' knowledge of, attitudes and practices regarding sexual health, because the research findings will enable the nurse to improve the situation.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The aim of this chapter is to define the research methodology that has been applied to determine the sexual health of adolescents in a selected region in Namibia. In this chapter the following will be discussed:

- The approach and specific design,
- The population and sampling,
- Instrumentation,
- How data has been collected, and
- Analysis of data

3.2 RESEARCH DESIGN

A non-experimental descriptive design was used to obtain data by means of questionnaires and focus group interviews. In this research adolescent attitudes, knowledge and practices regarding sexual health is explored.

3.3 RESEARCH APPROACH

For the purpose of this research an approach of triangulation which is a combination of a quantitative and qualitative methods has been used. It is clear from recent publications that a combination of these approaches is often more applicable to research in social and health sciences. Mouton and Marais (1990)

that quantitative and qualitative methods cannot be equally weighted in a research project. The project can be driven theoretically either by qualitative components or quantitative methods and incorporates a complementary qualitative component, which is then, called triangulation. Polit and Hungler (1991) describe several differences between qualitative and quantitative approaches as follows:

3.3.1 Qualitative approach

A qualitative approach entails the following:

- It is the view of an insider and the goal is to obtain information by scrutinizing or observing the subject who has experienced the phenomenon.
- It concerns itself with the change of the dynamic nature of reality.
- It attempts to gain a complete or holistic view of what is being measured by using a wide array of data, including documents, records, photographs, observation, interviews, case studies and even quantitative data.
- Procedures used in a qualitative approach are flexible, exploratory and discovery oriented.
- Data is usually collected within the context of its occurrence.
- It also focuses on subjective data that is typically expressed or repeated through language (Treece and Treece, 1986).

3.3.2 Quantitative approach

The quantitative approach entails the following:

- It arrives at the understanding of a phenomenon from the outsider's perspective by maintaining a detached, objective view that is hypothetically unbiased.

- It focuses on the accumulation of facts and cause of behaviour, assuming that facts gathered do not change.
- The situation is structured by identifying and isolating special variables for measurement and by employing specific measurement devices to collect information of these variables.
- Is a highly structured procedure, designed to accept or reject a pre-determined hypothesis.
- It yields objective data that is typically expressed in numbers.
- There is a heavy emphasis on the reliability, that is data that is consistent, stable and replicable (Van Maaren, 1983).

3.3.3 Triangulation

According to Mitchell (1986) triangulation is the combined use of two or more methods in the study of the same phenomenon. Some researchers view triangulation as a method of linking quantitative and qualitative research. By including in the study different methods the potential for achieving greater reliability, identifying the overlapping or common variance and finding the variance unique to each type of method is increased. The integration of two or more methods can also provide an expanded understanding of the scope of the phenomenon of interest and increased confidence in the generalization of results. Combining two methods can also lead to enhancement of the validity of the study finding so (Pilot and Hungler, 1991; Sohier, 1988; Burns and Grove, 1993; Morse, 1991; Mitchell, 1986).

According to Burns and Grove (1993) there are five types of triangulation:

- Data triangulation
- Theoretical triangulation
- Investigator triangulation
- Methodological triangulation

- Analysis triangulation

3.3.3.1 Data triangulation

Data triangulation is the inclusion of multiple sources of data within the same study with each source focused upon the phenomenon of interest.

The aim of data triangulation is to obtain diverse views of the phenomenon under study for the purposes of validation. It allows one to discover which dimensions of a phenomenon are similar and dissimilar across settings which change over time and which differ by group membership (Burns and Grove, 1993; Mitchell, 1986).

3.3.3.2 Methodological triangulation

Methodological triangulation is the use of two or more methods of data collection procedures within a single study (De Vos, 1998). Methodological triangulation is the most common type of triangulation used to generate a rich and comprehensive picture of the phenomenon under study (Burns and Grove, 1993; Sohier, 1988; Mitchell, 1986).

Methodological triangulation has been further classified by Morse (1991) into:

- simultaneous triangulation and
- sequential triangulation

Simultaneous triangulation means making use of qualitative and quantitative methods at the same time. Sequential triangulation is used if the results of one method are essential for planning the next method.

3.3.3.3 Theoretical triangulation

Theoretical triangulation is the use of different frameworks or theoretical perspectives to interpret a single set of data (Burns and Grove, 1993; Sohier, 1988; Mitchell, 1986).

3.3.3.4 Investigation triangulation

It exists when multiple observers, interviews, coders, or analysts, each with prominent roles in the study, deal with the same raw data. This type of triangulation helps to reduce the potential bias possible when only a single investigator is involved. Greater reliability in data collection and analysis is possible when the data can be compared among investigators (Mitchell, 1986; Sohier, 1988; Burns and Grove, 1993).

3.3.3.5 Analysis triangulation

Analysis triangulation involves the use of two or more analysis techniques to analyze the same set of data to the purpose of validation (Burns and Grove, 1993; Sohier, 1988; Mitchell, 1986).

In this study methodological triangulation have been used. The researcher believes that the use of methodological triangulation will increase support for the validity of this study because the results should be stable. It also strengthens the result of the study and contributes to the development of theory and knowledge on how similar studies could be approached.

Coward (1990) suggest that combining quantitative and qualitative methods will increase support to validity. Construct validity is enhanced when the results are stable across multiple measures of a concept. Statistical conclusion validity is

enhanced when the results are stable across many potential threats to causal inferences. External validity is supported when results are stable across multiple settings, populations and times

3.4 POPULATION AND SAMPLING

3.4.1 Population

According to Burns and Grove (1993) population implies substances that meet the criteria of the sample for inclusion in a study. The population in this study consisted of school-going adolescents in a selected region in Namibia.

3.4.2 Sampling

The greater the probability of sample error, the larger the sample should be (Seaberg, 1988). Since a certain respondent or subject mortality occurs in any research project, it is wise to draw a larger sample than eventually is needed. Singleton (as cited in Van Maaren, 1989) mentioned the following factors which influence the size of the sample; the heterogeneity of the population, the desired degree of accuracy, the type of sample, the availability of resources and the number of variables into which the data is grouped. Seaberg (1988) and Grinnell and Williams (1990) state that in most cases a 10% sample should be sufficient for sampling errors.

Sampling involves selecting a group of people, events, behaviours or other elements with which to conduct a research (Burns and Grove, 1993). There are mainly two types of sampling methods available, namely probability and non-probability sampling.

According to Basson (1992) probability sampling is a method in which every

member has a chance higher than zero of being selected for the sample, while in the case of non-probability sampling, not every member of the population has an opportunity for selection in the sample.

Simple random sampling is the most basic of the probability sampling methods. Each individual in the population has an equal opportunity to be selected for the sample. In this study, simple random sampling has been used in order to avoid bias because each element has equal chances of being selected and included in the research. It also increases the extent to which the sampling is representative of the target population. To achieve simple random sampling, elements are selected randomly from a sampling frame. In this specific case, the Oshana region which is a rural area was chosen, because it was the closest area to the researcher. The other regions are very far, not easy accessible and because of financial and time restraints, they were not included. The chosen region was also the feeding source of the hospital where the researcher works. The names and the number of secondary schools were requested from the circuit office. This office supplied the particulars of the six schools in this region. The Oshana region is a rural area.

Simple random sampling was done. Three of the six schools (50,0%) were randomly selected for the study. Simple random sampling was done in the following way:

- the names of six secondary schools were written on pieces of paper,
- placed in the container,
- mixed well,
- drawn out one at a time until the desired sample size of three schools had been reached.

In this study the target population consisted of school-going adolescents between the ages of 12 and 19 years old. The total number of the target population was 2200 in the (3) three selected schools. Ten percent (10%) of the target population was used for the study. This resulted in a total of 220 students who

participated in the completion of the questionnaire.

In each school selected for the research a list of registered students between the ages of 12 and 19 years was requested from the principal. From each school 10% of registered students were randomly selected to participate in the completion of the questionnaire. This is in line with Stoker (1985) in (De Vos, 1996) who suggests that of population of 10 000, 4,5% should be taken as a sample. The adolescent group between the ages of 12 and 19 was identified by the researcher as the vulnerable group. The researcher did not intend to make comparisons between age groups. A complicating factor was that in this culture the specific research is regarded as a very sensitive topic and thus the researcher was totally dependant on voluntary participation. No control was possible on the distribution of the different age groups in sample.

For the focus group interviews, 12 volunteers from each of the selected schools were asked to participate. They were not included in the 10% who completed the questionnaire. The total number of students who were involved in the completion of the questionnaires was 220 (N=220) and 36 (N=36) were involved in the focus groups interviews. This is also in line with Krueger (1994 as cited in De Vos, 1998): "Although the size of a focus group traditionally ranges from six to twelve participants, it appears that the ideal size is between six and nine participants. Groups with more than twelve members limit each participant's opportunity to share experiences."

3.5 DATA COLLECTION

The questionnaire was administered by the researcher. This was done for the following reasons:

- to avoid discussion of the questions by the students as this could affect the results
- to describe the purpose of the study and

- to clarify the questions where necessary.

The respondents were placed in one classroom. Teachers were not present during the completion of the questionnaire as their presence could affect the performance of the respondents. Those students who were going to be involved in focus group interviews were also not present during the completion of the questionnaires.

In addition to the questionnaire, focus group interviews were conducted. According to Polit and Hungler (1991) focus group interviews are interviews in which respondents assembled in a group to address questions on a given topic, usually in a structured conversation format. They also state that focus group interviews involve a group of about five to fifteen people whose opinions and experiences are solicited simultaneously.

From each selected school 12 students were voluntarily used for the focus group interviews. Before focus interviews started, the researcher introduced herself to the participants, explained the purpose of the visit and stressed the importance of active participation of all students. Students were encouraged to express themselves freely. The interviews were tape recorded and lasted about an hour. Participants gave permission for the interviews to be audiotaped. In addition to the tape recording of the interviews, notes were made by the researcher. This was done to ensure the comprehensiveness of the findings. The interviews were conducted in English and Oshiwambo in order to clarify some points. The participants were put at ease as the researcher emphasized that there were no right or wrong answers. Rigor in the process of data collection in the field is identified as the best check of validity.

3.6 PERMISSION TO CONDUCT THE STUDY IN THE SCHOOLS

In order to gain access to the information relating to the study, the director of Basic Education and Culture, Ondangwa West, was contacted. He was informed

about the study and permission to conduct the study at schools in his region was requested and granted. He was given the assurance that confidentiality would be maintained at all times. The principals of the schools in the selected region were also contacted and informed about the study and the permission to conduct the study at their school was requested and granted.

Armiger (1977) states that having human beings as research subjects can give rise to ethical sensitiveness. People prefer to be informed in advance of the kind of research that will take place and the way in which they will be involved.

3.7 ETHICAL CONSIDERATIONS

As mentioned earlier, ethical consideration is vital and verbal permission to conduct the study was obtained from the schools in which the study was to be conducted. The researcher visited the school one week prior to the distribution of the questionnaire to arrange for a convenient time and venue.

Personal consent was obtained from each student who participated voluntarily in the research. Total anonymity and confidentiality were assured.

3.8 INSTRUMENTATION

An instrument is the device or technique that a researcher uses to collect data (questionnaires, observations, interviews, scales and tests) (Polit and Hungler, 1991). The questionnaire was designed after an in-depth literature study. It was designed according to the objectives and goals of the study as stated in chapter one.

The questionnaire consisted of 43 open-ended and closed-ended questions and was divided into six sections. Section A focused on personal socio-demographic aspects, Section B focused on sexual knowledge, Section C on sexual

behaviour, Section D on contraceptive usage and Section E on sexual health information. See Table 3.1.

In conjunction with the questionnaire, focus group interviews were also conducted. An interview is an instrument used to obtain qualitative data. The focus group interviews conducted would produce qualitative data providing insight into the attitudes, behaviour and knowledge of adolescents towards sexual health. Morgan (1993) maintains that focus group interviewing has great potential for the development of a methodology for participatory action research, which will empower community members to gather information on and gain control of their own lives. This potential places focus group interviewing in a new dimension where the goal will not only be to understand people's behaviour, but to change it.

The initial questions asked in the focus group interviews were:

- What are your views about adolescent sexual health?
- What are your views about the consequences of teenage pregnancies?
- What are the strategies to be used to improve adolescents' sexual health?

During the interviews the subjects were encouraged to show continued participation by using such techniques as nodding the heads and responding to the others' ideas, by using words like "very good", "good", "maybe" etcetera. The researcher prepared certain key words beforehand so as to facilitate the discussion.

The key words were as follows:

- Prevention of pregnancy
- Prevention of sexually transmitted diseases
- Prevention of Acquired Immune Deficiency Syndrome
- Sexual intercourse
- Sex education

During the interviews the researcher avoided interrupting the participants and listened carefully. The participants raised questions during interviews but the researcher avoided answering these questions as they formed part of the discussion. These questions were however answered at the end of the interviews. Interviews were conducted until data saturation occurred which is when no new themes or essences emerge from the participants and data is only being repeated. Table 3.1 reflects the design of the questionnaire.

TABLE 3.1
THE DESIGN OF THE QUESTIONNAIRE

Section A: Personal and Socio-demographic data	Questions 1-7
Section B: Sexual knowledge	Questions 8-16
Section C: Sexual behaviour	Questions 17-24
Section D: Contraceptive usage	Questions 25-30
Section E: Sexual health information	Questions 31-37

3.9 VALIDITY AND RELIABILITY

According to Polit and Hungler (1991), Burns and Grove (1993), Uys and Basson (1991) an instrument is valid when it measures what it is supposed to measure. The content of the instrument must be closely related to that which is to be measured (Treece and Treece, 1986).

To ensure content validity, the researcher discussed the content of the questionnaire with experts in the field of management, education and community health nursing. After the discussions, some adjustments were made and some of the questions were rephrased. Coward (1990) says that combining of qualitative and quantitative methods will increase support to validity. Construct validity is enhanced when the results are stable across multiple measures of a concept. Statistical conclusion of validity is enhanced when the results are stable across many potential threats to causal inference. External validity is supported

when results are stable across multiple settings, population and ethics.

To increase response validity:

- The questionnaires were administered by the researcher herself
- The researcher was present during completion of questionnaires in order to avoid discussion and
- Anonymity and confidentiality were assured and the teachers were not present during the completion of the questionnaires.

Reliability refers to the accuracy of a measuring instrument. Reliability is the proportion of accuracy to the inaccuracy of the instrument. The concept commonly refers to the consistency of the data gathering instrument to obtain the same results from similar situations even though the subjects and environments differ (Treece and Treece, 1986).

Reliability is increased when:

- the researcher has personal knowledge or experience about the subject
- when the researcher is familiar with the research environment (Brink, 1990)

The researcher was familiar with the research environment. The fact that the researcher was not officially involved with any of the schools also increases the validity and reliability of the research. A pilot study has also been conducted and minor adjustments were made to the questionnaire afterwards.

3.10 PILOT STUDY

Treece and Treece (1986) define a pilot study as a small preliminary investigation of the same general characteristics as the major study. This means that it is developed similarly to the proposed study using similar subjects, the same setting and same data collection and analysis techniques. Burns and

Grove (1993) agree with Treece and Treece (1986) and add that it is conducted to refine methodology. A pilot study is conducted for one or more of the following reasons:

- to determine whether the proposed study is feasible,
- to identify problems with the design,
- to determine whether the sampling technique is effective,
- to examine the validity and reliability of the research instruments,
- to develop or refine data collection instruments,
- to give the researcher experience with the subjects, settings, methodology and methods of measurements,
- to try out analysis techniques.

A pilot study was done and the questionnaire was pretested using eighteen adolescents from two secondary schools in the selected region. It was done to determine possible problems or shortcomings in the methodological approach and instruments. Minor problems were found and adjustments were made in the questionnaire. Adolescents included in the pilot study were not included in the research sample.

3.11 DATA ANALYSIS AND INTERPRETATION

Data analysis is conducted to reduce, organise and give meaning to data. The analysis techniques implemented are determined primarily by the research objectives, question or hypothesis, the research design and level of measurement achieved by research (Burns and Grove, 1993).

Exploratory data analysis and confirmatory data analysis were used in the research. Exploratory data analysis is designed to detect the unexpected in the data and to avoid overlooking crucial patterns that may exist. The outcome of exploratory data analysis may be theory generation or development of hypothesis (Burns and Grove, 1993). In this study tables, graphs and

percentages have been used for exploratory data analysis. This is a way of presenting the findings of the study. It assists in identifying patterns in the data and in interpreting exploratory findings. Visualizing the data in various ways can greatly increase the insights regarding the nature of the data.

Confirmatory analysis is performed to confirm expectations regarding the data that is expressed as hypothesis, questions or objectives (Burns and Grove, 1993).

Interpretation refers to the process of making sense of the results and examining the implications of the findings within a broader context. The process of interpretation is essentially the researcher's attempt to explain the finding in the light of adequacy of the methods used in the investigation (Polit and Hungler, 1991).

Analysis and interpretation of data were completed with the assistance of a statistician and a home computer with the Excell-pakcage.

3.12 CONCLUSION

In this chapter, the research methodology was discussed in depth. It was indicated that triangulation was the most appropriate approach. After discussing the population and sampling method, the development and validation of the instruments were presented. Information was presented on the data collection and data analysis processes.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In this Chapter, information obtained from the questionnaires and focus group interviews is presented statistically, analyzed and interpreted. The process of data analysis is characterized by refining, clarifying and sharpening of statements, concepts and theories found in the literature.

The questionnaire consists of six sections. Section A: Personal and Socio-demographic data; Section B: Sexual knowledge; Section C: Sexual behaviour; Section D: Contraceptive usage; Section E: Sexual health information. The data gained from each section of the questionnaire and focus group interviews was analyzed.

220 students ($N=220$) completed the questionnaire and 36 students ($N=36$) took part in (3) three focus group interviews.

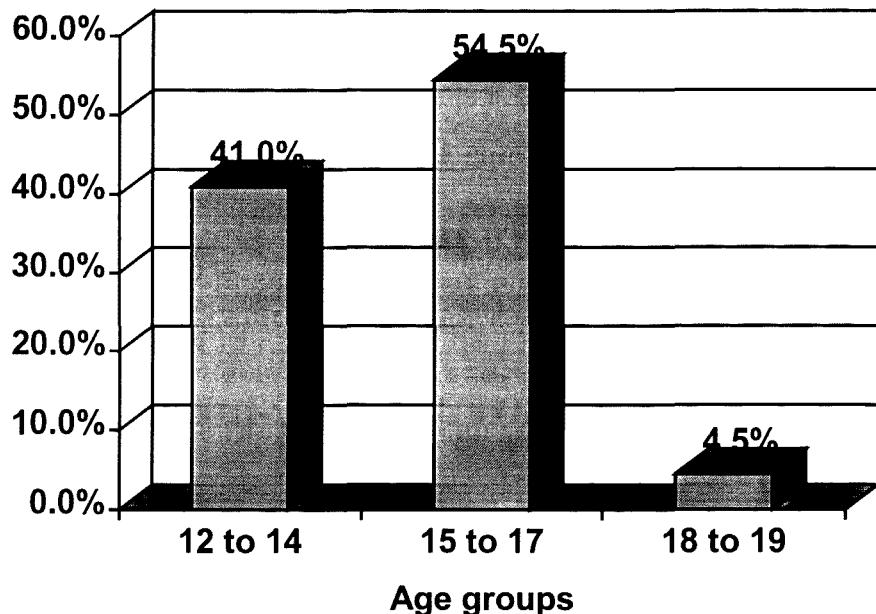
4.2 SECTION A: PERSONAL AND SOCIO-DEMOGRAPHIC DATA

Questions 1-8 relate to personal and socio-demographic data.

4.2.1 Age

The first question relates to the subjects' age. Of the sample N=220, 90 (41%) were between 12 and 14 years, 120 (54,5%) were between 15 – 17 years and 10 (4,5%) were between 18 – 19 years. Harrison (1998) in Chapter two, points out that early and middle adolescents lack information on sexuality compared to late adolescents, which confirms that these adolescents form a high risk group if not informed correctly and at the right stage. 95,5% of the respondents fell in this group. The ages of participants are reflected in figure 4.1.

FIGURE 4.1
AGES OF PARTICIPANTS

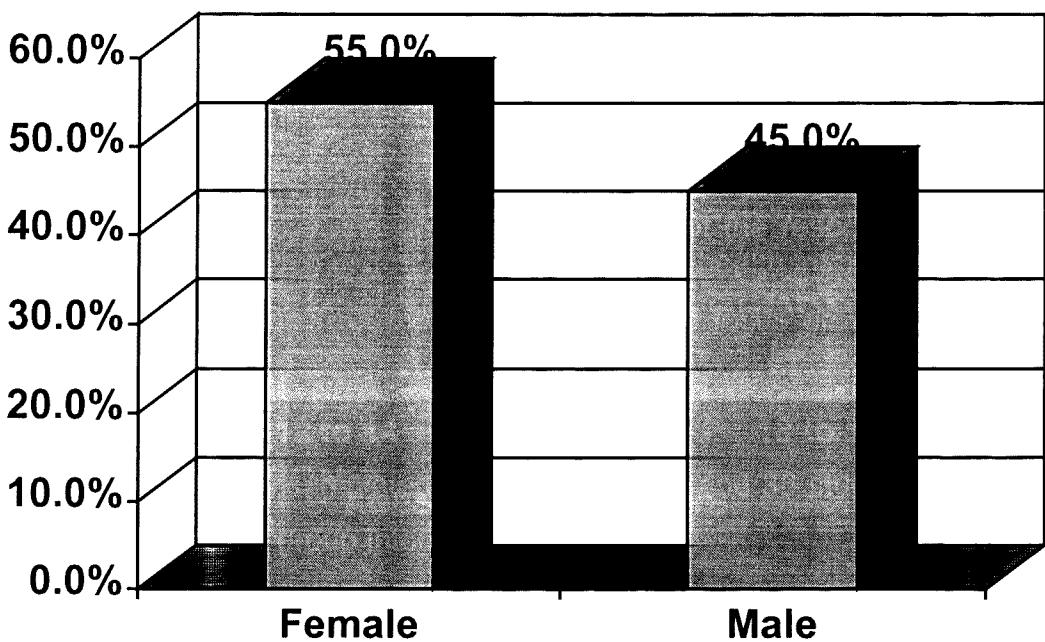


4.2.2 Gender

From figure 4.2 it would appear that both sexes were more or less evenly represented in the sample.

Both sexes have to grapple with seemingly refractory and intractable problems of adolescent sexuality, thus determining their base of sexual knowledge and sexual behaviour is of the utmost importance.

FIGURE 4.2
GENDER OF PARTICIPANTS



4.2.3 Grade of education

Of the total sample N=220, 9 (4%) respondents were in grade 8, 14 (6,4%) respondents were in grade 9, 62 (28,2%) respondents were in grade 10, 86 (39,1%) respondents were in grade 11, while 49 (22,3%) respondents were in grade 12. See table 4.1.

Findings further on, do not support this assumption. They demonstrated poor knowledge in Section B of the questionnaire.

TABLE 4.1
GRADE OF EDUCATION

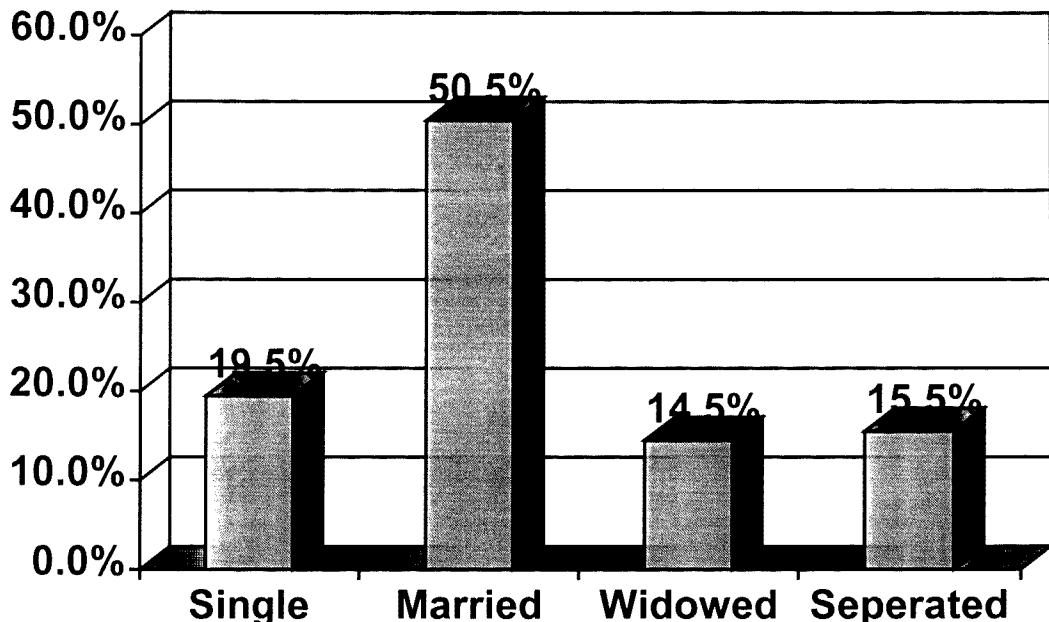
	N	%
Grade 8	9	4,0
Grade 9	14	6,4
Grade 10	62	28,2
Grade 11	86	39,1
Grade 12	49	22,3
Total	220	100

4.2.4 Marital status of parents

In response to the question which asked the respondents about the marital status of their parents, 43 (19,5%) were from single parent families, 111 (50,5%) were from married families, 32 (14,5%) were from widowed families and 34 (15,5%) were from separated families. See figure 4.3. The above data corresponds with the data of Boult and Curringham (1991) who found that a lot of adolescents lived with a melange of “parents”. However, in this data 111 respondents (50,5%) reported to be living with both parents.

This study revealed that 109 (49,5%) respondents came from single parent families. The literature study in Chapter 2 showed that those teenagers who are from single parent families are prone to sexual health problems. This is supported by this research data, which reflects that 35 (81%) out of the 43 respondents who indicated that they had been pregnant before, were from single parent families (Question 12). This study confirms the findings of Frank *et al* (1996) where it was revealed that teenagers who were from single parent families, where there is only one parent figure in the home, are more prone to pregnancy.

FIGURE 4.3
MARITAL STATUS OF PARENTS



4.2.5 Occupations of the parents

Table 4.2 reflected the occupations of the respondents' parents.

Mother's occupation

From Table 4.2 it is apparent that 127 (57,7%) respondents' mothers were employed as well as being professional people with a tertiary education background. It could be assumed that mothers with a professional background would discuss sexual health issues openly with their children.

Father's occupation

Although 101 (45,7%) of fathers were professionals, this study revealed a lack of involvement in the sex education of their children on their part. It seems as if fathers do not participate fully in the sex education of their children. This was reflected in question 30, in which 68 (52%) respondents out of the 131

respondents whose parents were aware that they were using contraceptives, 48 (70,5%) indicated that only their mothers were aware that they were using contraceptives.

TABLE 4.2
OCCUPATIONS OF RESPONDENTS' PARENTS

	Mother		Father	
	N	%	N	%
Not Working	87	39,5	71	32,3
Teacher	38	17,2	47	21,3
Doctor	11	5,0	6	2,8
Nurse	48	21,8	10	4,5
Other Profession	30	13,7	38	17,2
Mother deceased	4	1,8	6	2,8
Labourers	0	0,0	40	18,2
No Response	2	0,9	2	0,9
Total	220	100,0	220	100,0

4.2.6 Number of people in the immediate family

For this study the immediate family refers to mother, father, brothers and sisters. Out of N=220, 12 (5,4%) respondents indicated that they were two in their family, 12 (5,4%) indicated that they were three in the family, 35 (15,9%) were six in their family, 3 (1%) were seven in their family while 76 (34,5%) were more than seven in their families. This revealed that most of the participants came from larger families. In this study a large family is considered to be a family of six or more than six people in the family. See table 4.3.

The data shows that 76 (34,5%) respondents were from a large families. A large family is a family of six or more than six people, while a small family is a family of three or less than 3 people. Harrison (1998) mentions that a small family is

easier to maintain than a larger family. This is supported by Gorgen, Maier and Dusfeld (1993) who states that large families have negative influences on the sexual behaviour and knowledge of the child. These parents have to make special efforts to inform their children about sexual health.

TABLE 4.3
NUMBER OF PEOPLE IN THE IMMEDIATE FAMILY

	N	%
One	0	0
Two	12	5,5
Three	12	5,5
Four	27	12,3
Five	26	11,8
Six	35	15,9
Seven	32	14,5
More than 7	76	34,5
Total	220	100,0

4.3 SECTION B: SEXUAL KNOWLEDGE ON SELECTED SEXUAL ISSUES

4.3.1 Sexual knowledge

Four very easy questions testing their knowledge on very basic issues, which the researcher believes every adolescent should know, were asked. Harrison (1998) believes that poor knowledge about conception is a factor that leads to poor contraception and sexual behaviour. However, it should be borne in mind that age correlates with knowledge and behaviour.

A well-informed adolescent should have been able to give all the correct

answers. This did not happen and Table 4.4 revealed that 113 (51,4%) answered Question 11 incorrectly. Questions 8 to 10 were answered correctly by an average of 79,3%. This is not an acceptable situation since it is expected that adolescents should have had this basic knowledge even at an earlier stage.

TABLE 4.4
SEXUAL KNOWLEDGE

	Correct answer	True		False		Total
		N	%	N	%	%
Question 8	True	180	81,8	40	18,2	100,0
Question 9	True	164	74,5	56	25,5	100,0
Question 10	True	180	81,8	40	18,2	100,0
Question 11	True	107	48,6	113	51,4	100,0

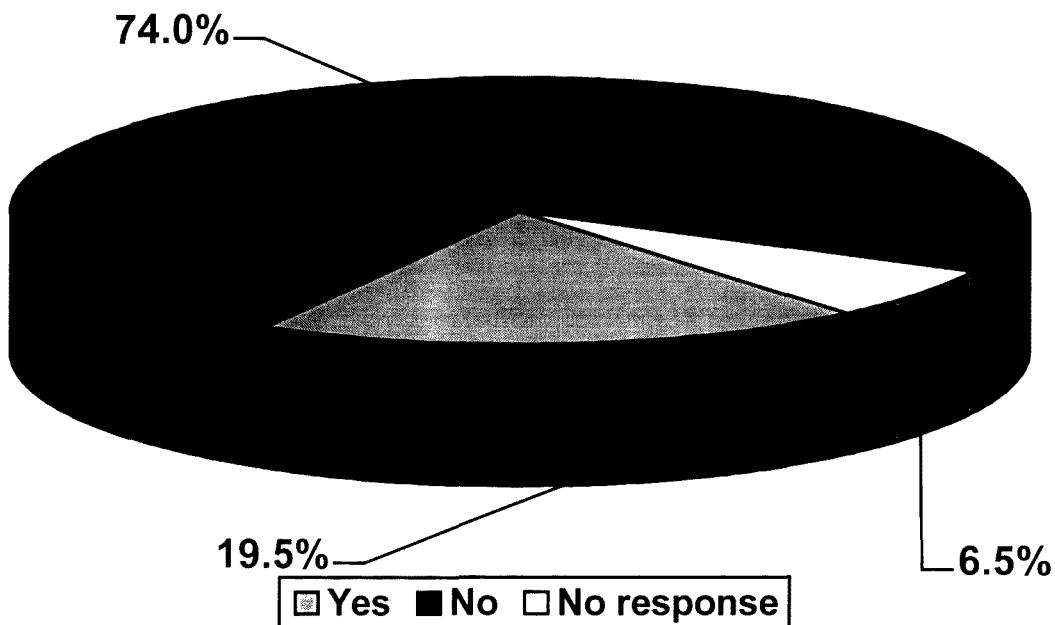
4.3.2 Previous pregnancies

In response to question 12, 163 (74%) respondents indicated that they had not been pregnant before, 43 (19,5%) indicated that they had been pregnant before and 14 (6,5%) did not respond on the specific question.

The findings further revealed that out of the 43 respondents who indicated that they had been pregnant before, 27 (62,7%) respondents gave the wrong answer, to the statement that a girl cannot become pregnant if she has intercourse during her menstrual period. The above findings demonstrate a link between lack of sexual knowledge, sexual behaviour and its consequences. 43 (19,5%) respondents having been pregnant seems a small number but it still is 43 too many which could have been prevented. Harrison (1998) believes that poor knowledge about conception is a factor that leads to poor contraception and sexual behaviour. Harrison (1998) also reveals that many teenagers are confused or uncertain about the safe time of the month and which time of the

menstrual cycle poses the greatest risk of conception.

FIGURE 4.4
PREGNANCY HISTORY OF RESPONDENTS



4.3.3 Number of pregnancies

Out of the 43 respondents who were pregnant before, 33 (76,7%) had been pregnant once, and 10 (23,3%) had been pregnant twice. See Table 4.5. The researcher's experience in this field of health showed that once an adolescent becomes pregnant once, they are more likely to become pregnant for the second time. Van Rooyen and Louw (1994) also supports the above statement by stating that teenage mothers are likely to fall pregnant again soon after the birth of the first baby.

TABLE 4.5
NUMBER OF PREGNANCIES: (N=43)

	N	%
Once	33	76,7
Twice	10	23,3
More than twice	-	-
Total	43	100,0

4.3.4 Abortions and age at abortion

Out of 220 respondents who participated in the study, 5 respondents (2,3%) had abortions, 205 respondents (93,2%) did not have abortions, and 10 (4,5%) failed to respond. From the five respondents who had had abortions, 4 of them had the abortions between the ages of 15 to 17 years. The other 1 respondent reported to have had an abortion between the ages of 18 to 19 years. Thirty five (81,3%) of the 43 respondents who had been pregnant before fell in the age group of 15 to 17 years, and those who had had an abortion also reported to be between the ages of 15 to 17 years. Harrison (1998) points out that early and middle adolescents lack information on sexuality compared to late adolescents, which confirms that these adolescents form a high risk group if not informed correctly and at the right stage.

4.3.5 Reason for having an abortion

Out of five respondents who had had an abortion, 3 respondents indicated that they were afraid of their parents and they wanted to continue with their studies. If they were pregnant, they would have to leave school. The other two indicated that their boyfriends forced them to have abortions otherwise they threatened to leave them. Hilton (as cited in Stark, 1986) claims that young people do not have the psychological strength to recognize the consequences of risky sexual behaviour and abortions. The teenager who has had an abortion suffers the

long-term consequences as the majority of these abortions are often performed by unskilled persons (Harris, 1991). These consequences have been discussed in Chapter 2.

4.4 SECTION C: SEXUAL BEHAVIOUR

4.4.1 Transmission of sexually transmitted diseases

The subjects were asked how sexually transmitted diseases are spread and they indicated the following:

- Through unprotected sexual intercourse
- Through pregnancy to the unborn baby
- Having more than one sexual partner
- Donation of infected blood
- Infected medical equipment
- Open wounds
- Kissing
- Breathing
- Food
- Clothes – see Table 4.6

The spread of sexually transmitted diseases through unprotected sexual intercourse is assumed to be general knowledge. It is a concern that a 100% response was not obtained for this statement. It is very important for adolescents to possess correct information on how sexually transmitted diseases are spread because only then can they successfully prevent them.

TABLE 4.6
MODES OF TRANSMISSION OF SEXUALLY TRANSMITTED DISEASES

	N	%
Unprotected sexual intercourse	172	78,1
Through pregnancy to the baby	25	11,3
Having more than one sexual partner	38	17,2
Infected sexual partner	34	15,4
Donation of infected blood	27	12,3
Infected medical equipment	2	0,9
Open wounds	12	5,5
Kissing	5	2,3
Breathing	6	2,7
Clothes	5	2,3

4.4.2 Prevention of Human Immune Deficiency Virus (HIV) infection

In response to question 18 on how HIV infection can be prevented, the following points were mentioned by the respondents:

- Say no to casual sex - 20 (9,0%)
- Encourage usage of condoms - 120 (54,5%)
- Have one faithful partner - 70 (31,8%)
- No sex at all before marriage - 28 (12,7%)
- No sex if infected - 10 (4,5%)

The data showed that 120 (54,5%) respondents stated that using of condoms can prevent the spreading of HIV infection, followed by having one faithful partner 70 (31,8%). 28 (12,7%) respondents indicated saying "no" to sex and 10 (4,5%) respondents mentioned no sex if a person is infected. The above findings show that the teenagers of this area are aware of the killer disease HIV infection and the data showed that they know how to prevent it. This study replicates the

findings of Hope Humana People to People (Volume 8, July 1999) which stated three ways of safe sex, as the ABC of sex:

- A - Abstain – No sex at all, its 100% safe.
- B - Be faithful to one equally faithful sexual partner.
- C - Consistent and correct condom use every time you have sex.

4.4.3 Sexual involvement

Table 4.7 reflected that the majority of respondents 131 (59,5%) have been involved in sexual intercourse, 89 (40,5%) indicated that they have not been involved in sexual intercourse. This data is supported by other studies, for example Nicholas (1993), who states that the majority of adolescents are sexually active.

These findings were also supported by the respondents involved in the focus group interviews. The research also revealed that boys are more sexually active than girls are, see data discussion under question 20.

TABLE 4.7
SEXUAL INVOLVEMENTS

	N	%
Yes	131	59,5
No	89	40,5
Total	220	100,0

4.4.4 Age at which sexual intercourse started

It is alarming that 52 (39,6%) of the 131 respondents who stated that they were sexually active, started these activities before the age of 15 years. This raises concerns as it is during this stage when adolescents are most vulnerable to

serious consequences of unsafe sexual practices because of their ignorance of sexual health issues.

TABLE 4.8
AGE AT WHICH SEXUAL INTERCOURSE STARTED

	N	%
Before 12 years	10	4,5
12 – 14	42	19,2
15 – 17	61	27,7
18 – 20	10	4,5
Not applicable	89	40,5
Not sure	8	3,6
Total	220	100,0

4.4.5 Number of sexual partners

It is alarming that 39 (17,7%) respondents indicated that they have two or more sexual partners. The study also revealed that it was only the boys who had more than one sexual partner. This puts them in the high-risk group for contracting STD's and HIV/AIDS with all its devastating complications.

This study also revealed that boys are sexually more active than girls. 105 (80%) out of the 131 respondents who indicated that they have been involved in sexual intercourse were boys and 26 (20%) were girls.

The above findings are supported by Stone (1990) who explains in Chapter 2 the positive effects of limiting sexual activity to one partner and a mutually faithful relationship. The fact that sexually active adolescents remain ignorant about sexual health issues is alarming in itself. Their ignorance has not led them to abstain from sexual intercourse, which in turn makes them vulnerable to all the serious consequences mentioned previously.

The researcher agrees with Stone (1990) who pointed out that abstinence is the only preventive method that is 100% effective in preventing STD/AIDS and an unwanted pregnancy. Stone (1990) also mentions that using condoms and sticking to one faithful sexual partner reduces the risk of STD/AIDS and pregnancies.

TABLE 4.9
NUMBER OF SEXUAL PARTNERS

	N	%
One	92	41,9
Two	22	10,0
More than two	17	7,7
None	82	37,2
No response	7	3,2
Total	220	100,0

4.4.6 Reasons for not using condoms

Table 4.7 indicates that 131 respondents are sexually active and 30 (13,6%) of the respondents indicated that they were not using condoms. Twenty (66,6%) respondents gave the following reasons for not using condoms:

- they are very young and do not have information about condoms
- wanted to enjoy sex
- they are using the injection as a method of contraception
- they were misinformed that use of a condom means that you have AIDS
- trusted my partner and
- ten (33,3%) respondents have cited the following reasons for not using condoms:
 - ▶ it was just accidental
 - ▶ I wanted to be a father

- ▶ My partner was in the safe period

Data analyses thus shows that the majority 101 (77,1%) respondents were using condoms and their reasons for using condoms were:

- Afraid of getting AIDS
- Don't want to get pregnant
- Respect for their partner
- Condoms give protection against pregnancy, AIDS and sexually transmitted diseases

Although the finding that 101 (77,1%) respondents use condoms could be interpreted as a positive step in the promotion of healthy sexual practice, it remains a source of distress that 30 adolescents still practice unsafe sex for all the incorrect reasons. These findings are supported by Eden (1985) who states that lack of knowledge about contraceptives leads to poor contraceptive behaviour. It is clear that special efforts should be initiated to encourage the use of condoms.

4.4.7 Reasons why teenagers have sexual intercourse

Out of the total sample N=220, 11 (5%) respondents' reasons for having sexual intercourse were as follows:

- peer pressure
- to enjoy
- for fun
- to satisfy sexual feelings
- to prove their maturity
- for money
- being forced by their boyfriends

Fifty (22,7%) respondents gave the reasons as follows:

- immaturity
- there is no open discussion about sexual matters between themselves and their parents
- lack of information
- did not have enough love from their parents and

45 (20,4%) respondents gave their reasons as due to drugs and alcohol abuse, reading magazines and watching movies, especially "blue movies". Fourteen (6,4%) respondents stated "*old men*" are forcing young girls to have sexual intercourse with them.

The researcher's findings are supported by Seydel (1992) who lists various reasons for adolescents having sexual intercourse as being, to experiment, to have someone to care about them and to care about someone else, to feel grown up, to accommodate pressure and to feel good. Seydel (1992) further states that adolescents regarded sex as a form of recreation rather than reproduction. The term used for sex is to "*jol*". "*Jolling*" is associated with recreational activities such as drinking, dancing and going out. Seydel's findings correlate with the various reasons indicated by the respondents.

The researcher found that young people are under a lot of pressure to become sexually active and that just telling someone to "say no" to sexual intercourse is not enough. They need information and good reasons which enable them to convince their peers that they have a right to their choice.

4.5 SECTION D: CONTRACEPTIVE USAGE

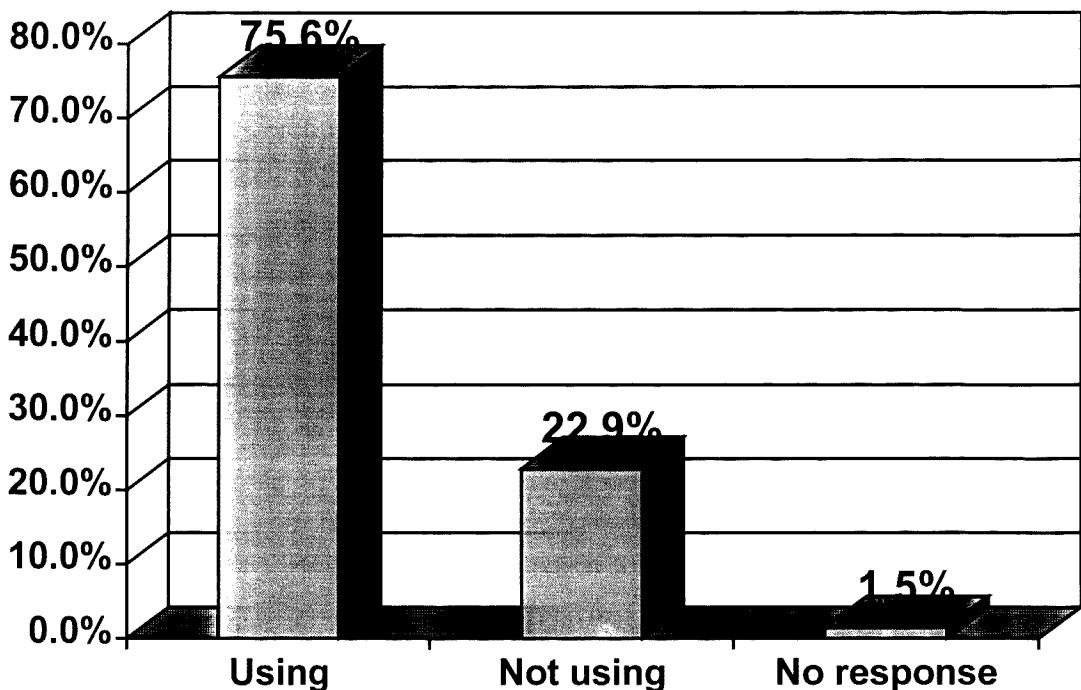
4.5.1 Contraceptive usage

Data analysis has demonstrated that the 131 (75,6%) sexually active

respondents were using contraceptives of which 99 (75,5%) were using condoms (see figure 4.5). In spite of the fact that they do use contraceptives the researcher could not prove that they use them consistently because data provided in questions 22 and 23 indicated that 30 respondents did not use condoms. It thus seems as if the real importance of using contraceptives is not fully internalized by adolescents.

According to Harris (1991), teenagers say that "*unexpected sex*" with no time to prepare is the most frequent reason for not using birth control. Harris (1991) agrees that teenagers often act impulsively and do not always think of the long-term consequences of their behaviour.

FIGURE 4.5
CONTRACEPTIVE USAGE



The findings also revealed that the older teenagers are more likely to use a contraceptive than younger teenagers. This was reflected by 59 (57%) out of 120 respondents, between the age group of 15 to 17 years who were not using contraceptives. These findings are supported by Hilton in (Stark, 1986) who points out that the older teenagers are more likely to use contraceptives when they initiate sexual activity.

4.5.2 Methods of contraception used

In response to the question which asked the respondents, what method of contraception they were using, 12 (5,5%) indicated that they were using the pill, 20 (9,1%) were using the injection, and 99 (45%) respondents were using condoms. Although 15 (6,8%) respondents indicated that they were not using contraceptives, they ticked condoms, in the question, which asked them about the method of contraception. Seventeen (7,7%) respondents indicated that they were not using contraceptives but ticked injection under method of contraception.

Out of 120 respondents, who were between 15 to 17 years, 69 (57,5%) respondents were not using contraceptives. Brunner (1997) believes that early adolescents are reluctant to use contraceptives because of immaturity but late adolescents, aged 18 to 20 years are more likely to use contraceptives because of more developed thought processes especially abstract thinking.

Data analysis revealed that condoms are the most commonly used contraceptives. This is advisable because condoms can protect the individual against STD/AIDS and pregnancy.

TABLE 4.10
METHODS OF CONTRACEPTION

	N	%
Pills	12	5,5
Injection	20	9,1
Condom	99	45
Not applicable	89	40,4
Total	220	100,0

4.5.3 Sources of contraceptives

Out of the 131 (59,5%) respondents who were using contraceptives, 65 (49,6%) respondents indicated that their source of contraceptives was the hospital and clinic, 58 (44,3%) got their contraceptives from clubs. The findings revealed that government hospitals followed by clinics were the major sources of contraceptives.

4.5.4 Accessibility to contraceptives

In response to the question which asked the respondents whether it was easy to obtain contraceptives, 108 (66,3%) respondents out of 163 reported that it was easy to obtain contraceptives, 55 (33,7%) respondents indicated that it was not easy to obtain contraceptives. The respondents who experienced problems in getting contraceptives mentioned the following problems:

- One has to pay to get condoms, for example from the pharmacy
- Refusal of nurses at clinics to issue contraceptives without parental consent
- Clinics situated too far away and transport problems
- Respondents too shy to go to the clinics for contraceptives
- Not interested in sexual activities

4.5.5 Parents' awareness regarding their children's use of contraceptives

Out of 131 respondents, who were using contraceptives, 68 (52%) respondents' parents were aware that they were using contraceptives, 48 (70,5%) out of the 68 mentioned that only their mothers were aware that they were using contraceptives, 63 (48%) respondents indicated that their parents were not aware they were using contraceptives. See table 4.11.

The findings revealed that the adolescents who mentioned that their mothers are aware that they are using contraceptives, were all girls. This is an indication of good communication between mothers and daughters, whereas the findings also revealed that fathers are not involved in their adolescents' sexual education. The researcher agrees with Olivier (1994) who states that fathers generally do not discuss sex with their children. This lack of openness and open discussion may lead to problematic sexual behaviour on the part of adolescents as discussed in Chapter 2.

TABLE 4.11
PARENTS AWARENESS OF TEENAGERS' USE OF CONTRACEPTIVES

	N	%
Yes	68	52
No	63	48
Total	131	100,0

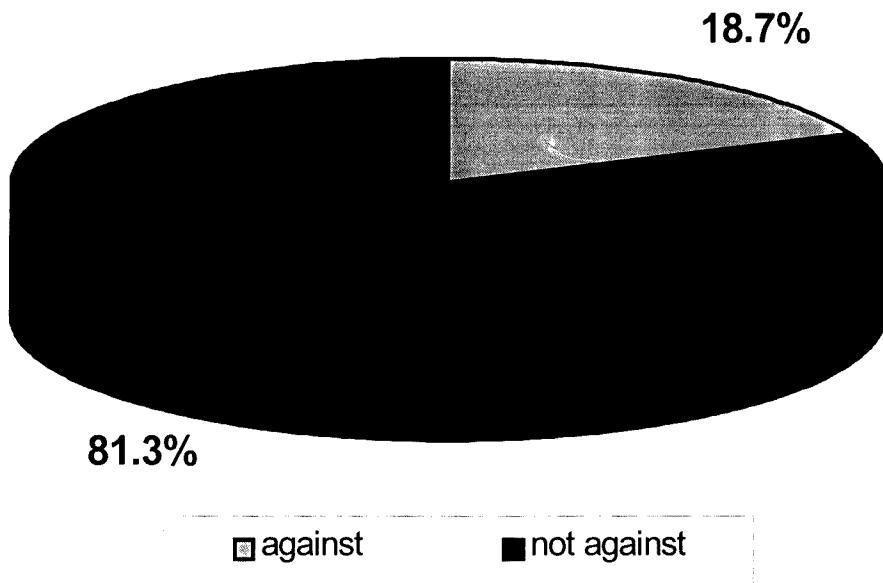
4.6 SECTION E: SEXUAL HEALTH INFORMATION

4.6.1 Discussion of sexual matters with parents

Of the total sample N=220, 179 (81,3%) indicated that sexual matters should be

discussed freely and openly with parents, 41 (18,6%) were against discussion of sexual matters with parents, see table 4.14.

FIGURE 4.6
THE NECESSITY OF DISCUSSING SEXUAL MATTERS WITH PARENTS



4.6.2 Reasons for the importance of discussing sexual matters with parents

The following reasons were given by the 179 respondents for discussing sexual matters openly and freely with their parents:

- parents are the source of information
- parents will discuss sexual matters with them
- they will learn more and gain experience
- discussion of sexual matters will decrease the number of pregnancies
- discussion of sexual matters will enable them to differentiate between advantages and disadvantages of sexual activities

- discussion with parents about sexual matters will enable them to prevent sexually transmitted diseases and HIV/AIDS which is a killer disease
- parents should advise them about sexual issues at an early age
- to prevent conflict in the family
- parents need to be open and not hide the truth about sexual matters

Four (1,8%) respondents failed to give their reasons.

The following reasons were given by those who were against discussion of sexual matters with parents:

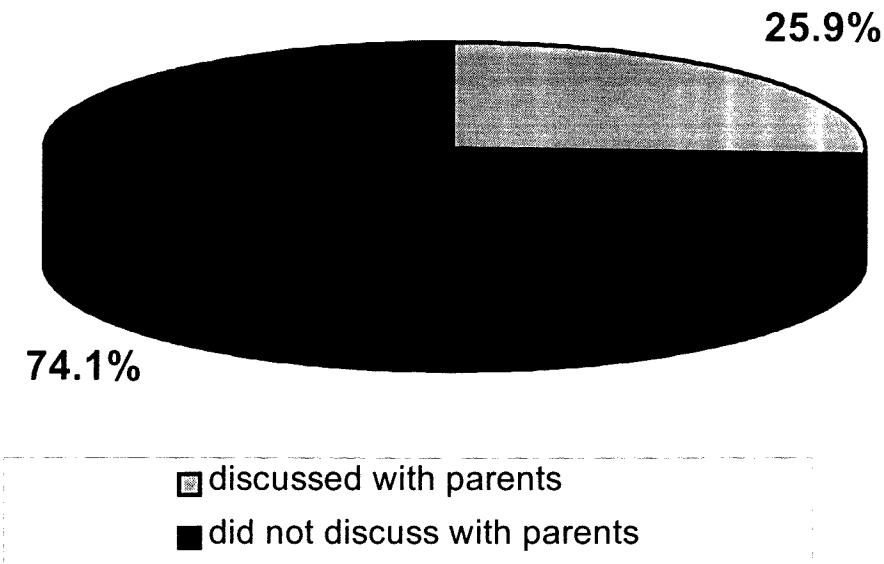
- they felt they were too young to discuss sexual matters with their parents
- parents would hate them and beat them up
- it is a taboo in our culture to talk to parents about sexual matters
- some parents do not care for their children
- parents are too reluctant to discuss sexual matters with their children

The research findings revealed the need for parents and their children to discuss sexual matters. Pretorius (1989) also points out that the family is the home from which the child starts out his lifelong journey through society. Fisher (1986) feels that children who can talk to their parents about sex are less likely to engage in sexual activity and are more responsible in their approach to sexuality.

The majority, 163 (74,1%) of respondents reported that they had not discussed sexual matters with their parents, while 57 (25,9%) indicated that they had discussed sexually related matters with their parents.

The findings of this research revealed the link between early indulgence in sexual intercourse and lack of open discussion of sexual matters between parents and their children. The negative effects of the failure of parents to discuss sexual matters with their adolescent children has been discussed in Chapter 2.

FIGURE 4.7
DISCUSSION OF SEXUAL MATTERS WITH PARENTS



Reasons for the lack of discussion between parents and adolescents could, according to Van Rooyen and Louw (1994), be that parents perceive themselves as being unable to provide adequate education, because they feel they do not know enough about human sexuality or they do not know how to explain what they do know. It seems as if most parents feel incapable and embarrassed about any effort to talk openly with their children about sex. Fisher (1986) points out that children who can talk to their parents about sex are less likely to engage in sexual activity, and are more responsible in their approach to sexuality. Their behaviour is a reflection of their parents' values.

These findings suggest that open discussion of sexual matters between parents and their children should be encouraged in order to promote sexual health.

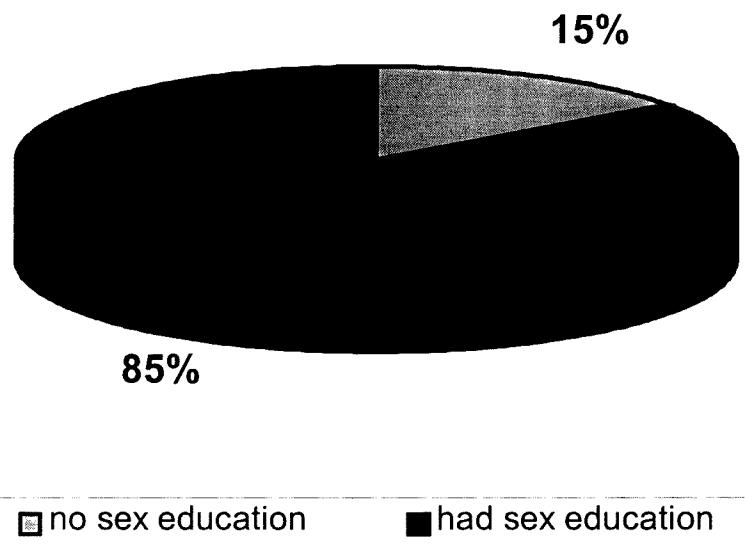
4.6.3 Sex education at school

187 (85%) respondents indicated that they had sex education lessons and the

minority 33 (15%) indicated that they did not have sex education lessons at their schools, see figure 4.8.

It is interesting to note that those adolescents who indicated that they used contraceptives also indicated that they received sex education in grades 7 to 9. This supports the statement that correct information at an early stage could promote good sexual health.

**FIGURE 4.8
SEX EDUCATION LESSONS**

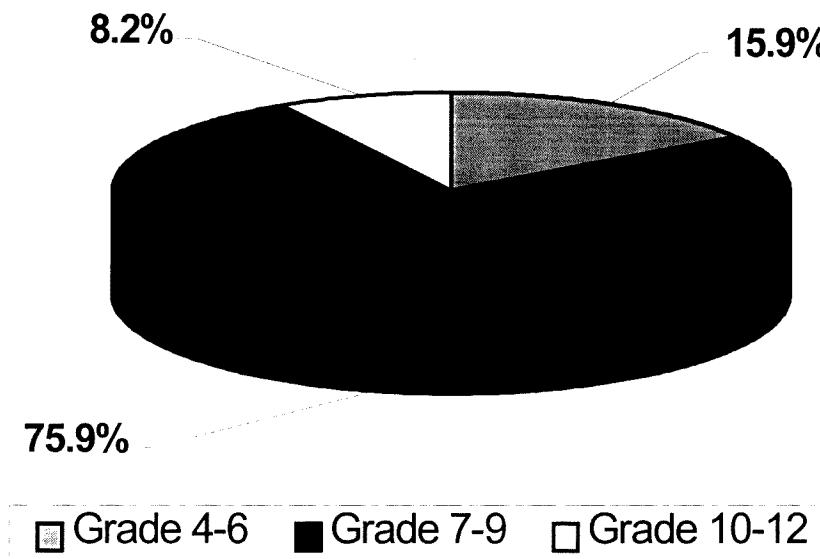


4.6.4 The grade when first sex education was received

Out of the total number N=220, the majority 167 (75,9%) respondents indicated that they were in grades 7 to 9, 35 (15,9%) indicated that they were in grades 4 to 6, and 18 (8,2%) indicated that they were in grades 10 to 12 (see table 4.1).

It is a myth that a child is too young to talk about sexual matters. The earlier that one begins with sex education, the better. The researcher also suggests that by keeping children sexually ignorant they are exposed to greater danger and anxiety.

FIGURE 4.9
THE GRADE WHEN FIRST SEX EDUCATION WAS RECEIVED



4.6.5 Sources of information on sexual matters

In addition to efforts undertaken to detect the level of knowledge respondents possess, an attempt was made to identify the source of sexual information. It is important to note that in response to question 36 the respondents have ticked more than one source of obtaining sexual information as reflected in table 4.12. It is apparent that the schools are the most prevalent source of information on sexual matters. Other sources in order of frequency were peers, friends, radio, health workers, parents and television.

Out of 220 respondents only 57 (25,9%) respondents indicated that they obtained information from parents. This supports the findings previously

mentioned that parents do not participate in providing sex education to their children. The above findings confirm that the most prevalent sources of information about sexual matters are schools, peers, friends and the radio. Peers were found to have contributed information, although, Harrison (1998) confirms that numerous teenagers remain considerably misinformed about contraception and the biological factors of pregnancy because of misinformation from their peers.

TABLE 4.12
SOURCES OF INFORMATION ON SEXUAL MATTERS

	N	%
Parents	57	25,9
School	83	37,7
Health workers	66	30,0
Peers	70	31,8
Radio	70	31,8
Television	53	24,0
Magazines	60	27,2

4.6.6 Additional information on adolescents' sexual health

The subjects were asked if they had any additional information about adolescent sexual health. Some of the points mentioned are as follows:

- sexual health means using condoms when practicing sex (safe sex)
- say "no" to sex
- have one faithful sexual partner
- be aware of sexually transmitted diseases and HIV/AIDS
- sexual information should be accessible to everybody by means of the media
- parents should be actively involved in sex education of their children

- sex education should be introduced as early as possible
- health workers should visit schools as many times as possible
- go for HIV test before getting married
- enough condoms should be distributed all over the country
- female condoms (femidoms) should be available free of charge
- youth to participate in dramas, concerts and conversations that promote sexual health
- young people should be allowed to visit AIDS patients in hospitals, to see how dangerous AIDS can be
- strive for a reduction of teenage pregnancies
- avoid alcohol and drug abuse

The findings revealed that teenagers in this geographical area (Oshana region) lack information on how to promote adolescent sexual health. The researcher agrees with Oliver (1989) who states that although teenagers may know about sexual intercourse, their knowledge of human sexuality may still be very limited and hopelessly inadequate.

4.7 FOCUS GROUP INTERVIEWS

Focus group interviews were conducted in a separate quiet classroom. Twelve students from each selected school were used for focus group interviews; the respondents who participated in the interviews were excluded from completing the questionnaire. Three focus groups interviews were conducted.

Permission to conduct interviews was requested and obtained from the participants. Participants were assured that all information obtained in the interviews would be treated confidentially.

The interviews were conducted both in English and Oshiwambo, in order to

clarify some points. Interviews were tape-recorded and handwritten notes were taken. Data saturation was obtained. During the interview certain key words were used. The questions for the interviews were:

- What are your views about adolescent sexual health?
- What are your views about the consequences of teenager pregnancies?
- What strategies should be used in order to improve adolescent sexual health?

4.7.1 Respondents' views on adolescents' sexual health

In response to the question, which asked the participants their views on adolescent sexual health, the participants in three secondary schools had similar views. These can be summarised by the following comments:

"Mhh... adolescent sexual health is very poor, because teenagers are very sexually active. They like boyfriends, and the boyfriends have many girlfriends."

"Young people are dying because of AIDS, this is indicative of not using condoms."

"Parents are reluctant to discuss sexual matters with their children about sex and to encourage the use of condom."

"Rape of children by older men is very high in our country. Rape is very bad because it can cause a permanent psychological damage."

"The government must give heavy punishment to the rapist."

"Sexual abuse of young girls by older men is very high."

"Adolescent sexual health means freedom from sexual problems, like STD, HIV/AIDS, teenage pregnancy."

"Using condoms, sticking to one faithful partner."

"Personal hygiene is very important to prevent infections."

The above comments by participants highlighted that teenagers are sexually active, having more than one sexual partner. This is supported by data obtained in this research when 131 (59,5%) respondents indicated that they are sexually active. The findings also revealed that only boys have more than one sexual partner. It is clear that teenage sexual activity can lead to complications like teenage pregnancy with its adverse effects and STD/HIV/AIDS.

The above findings are supported by Harrison (1998) who states that adolescents are sexually active, and this increase in sexual relationships also results in an increase of teenage sexual problems like sexually transmitted diseases, HIV/AIDS and teenage pregnancies.

AIDS seems to be a problem in Namibia as it was also mentioned by respondents, who were involved in the completion of the questionnaire. The adolescents were aware of this disease and expressed the need for more organised and planned information about sexual health.

Parents are reluctant to discuss sexual matters with their children. This is supported by Van Rooyen and Louw (1994) in Chapter 2 and also by respondents who were involved in the completion of the questionnaire. It is clear that some parents don't like to discuss sexual matters with their children, but the adolescents expressed the need for such discussions to take place.

The researcher feels that it is important for parents to build up an open parent-child communication about sexual matters. Fisher (1986) points out that children

who can talk to their parents about sex are less likely to engage in sexual activity and are more responsible in their approach to sexuality.

The incidence of teenage pregnancies is high in Namibia (see Chapter 1). Teenage pregnancies are also mentioned by 43 (20%) respondents who were involved in the completion of the questionnaire. They indicated that they had been pregnant before. Teenage pregnancy is one of the most disturbing and complex social problems which faces our communities today.

Focus group participants also pointed out that sexual abuse of young children by older men is a problem in the area.

4.7.2 Respondents' views on the consequences of teenage pregnancies

All the focus group participants mentioned similar consequences of teenage pregnancies. These were:

- "*Both boys and girls get expelled from school, girls lose the opportunity to finish education.*"
- "*It is difficult, because you will be a young mother, without work.*"
- "*The girl may undergo an operation, because she is not big enough to push through because she is not finished her own growing.*"
- "*Baby may be born very weak or small, too early; it is a problem because small babies are much, much more likely to be very sick, and to die.*"
- "*Some parents becomes angry, girls gets thrown out of the home, sent back to stay with their grandmother, parents fight, blaming each other for not providing information etc.*"
- "*The teenagers are in risk of sexual transmitted diseases, HIV/AIDS.*"
- "*Suicide - could be a consequences as the girl does not know how to deal with the problem and fear the reaction of her parents, friends, school and takes her life due to shame, fear and confusion.*"

- "*They become alcoholics, spend days and nights in shebeens and become an alcoholic eventually.*"
- "*They may die from illegal abortion.*"

With regard to the respondents' views on the consequences of teenager pregnancies, this research supports the observation that a teenage pregnancy has devastating effects on the teenager, the baby, the father and society. The consequences can be summarised as follows:

a) Family problems

Teenage pregnancy can cause family problems. Some parents become angry and girls get expelled from home. Parents may start fighting, blaming each other for not providing information. This was also mentioned by the respondents who were involved in the completion of the questionnaire. They mentioned that the prevention of teenage pregnancies should be encouraged in order to prevent the above-mentioned problems.

b) Educational problems

Educational problems are common after a teenage pregnancy, as was mentioned by respondents who completed the questionnaire. This is also supported by Nass and Fisher (1988) who mention that most mothers who keep their babies drop out of school and lose their educational opportunities. According to Elsler and Lamb (1990) the premature transition to parenthood also adversely affects educational and vocational attainments.

c) Health problems

Focus group participants also pointed out health problems as consequences of teenage pregnancies. They also stated that they are more at risk of acquiring sexually transmitted diseases, HIV/AIDS, which has become a major cause of ill health and death in our country. This is

also supported by Masters (1986) who states that teenage mothers tend to have more medically complicated pregnancies, including antepartum haemorrhage, anaemia, cephalopelvic disproportion, pregnancy induced hypertension, eclampsia and abortions.

d) Unemployment

The majority 20 (55,5%) respondents out of 36 believed that teenage mothers become poorer, unemployed and alcoholics.

e) Suicide

A sad complication is that some pregnant teenagers commit suicide. This was mentioned by focus group interview participants. Teenagers tend to feel that the situation is the end of the world for them and from there it was not difficult to commit suicide.

f) Death

Death can be the consequence of an illegal abortion, which a girl attempts in desperation or under pressure from boyfriends or peers. Harrison (1998) points out that teenagers take various substances, often rat poison, or put objects into the vagina, or hit the stomach in the hope of inducing an abortion. This is mentioned in Chapter 2.

4.7.3 Strategies to improve adolescent sexual health

All focus group participants reported similar strategies for improving adolescent sexual health. Some of their comments are reflected below:

- *"I think we need information on how to prevent pregnancies at an early age and nurses should visit schools to give health education."*
- *"I would like our parents to be free to talk to their children about sexuality, ... but I think our parents don't know these things ... like condoms, they also need to be educated about these things."*

- *"Girls must not have boyfriends before the age of 18 years, or before they complete grade 12. I think after grade 12 they will have more information about sexual matters."*
- *"Say no to sex, have one faithful partner."*
- *"Old men not to rape children any more."*
- *"We need condoms to be available every where in Namibia, also at schools not only at hospitals."*
- *"A Condom is the only effective method that prevents sexually transmitted diseases, HIV/AIDS and pregnancies."*
- *"Young people should participate in religion."*
- *"Nurses at clinics should change their attitudes towards adolescents, because they don't like to give contraceptives like injection, or pills even condoms. They will ask you what are you going to do with this? You are still young. From there on you are going to fall pregnant or pick up STD/HIV/AIDS. Who is to be blamed? Nurses? Yes, nurses."*
- *"Young people are drinking alcohol too much, they must change, because they can do very bad things while drunk . . . like having sex with unknown people, being raped and raping."*
- *"HIV test before marriage is very important."*
- *"Parental guidance is very poor now a days."*
- *"Young people to participate in social activities, like sport, youth groups."*

With regard to the respondents' views about strategies to be used to improve adolescent sexual health, data analysis revealed that the majority 20 (66,6%) respondents who participated in the focus group interviews believed in the following strategies:

(i) Health education to be given by nurses at schools

Respondents believed that health education should be given by nurses. This was reflected by statements from some respondents who commented that: "Nurses should visit schools to give health education."

(ii) Parental guidance

Parental guidance was mentioned by some of the respondents. It is clear that parental guidance can play a big role in the adolescents' behaviour. The parents should make sure that their children receive correct information on sexual matters. They should also be taught about the consequences of early indulgence in sexual activities.

Respondents also believed that parent-child communication should play an important role in adolescent behaviour. This was also mentioned by respondents who were involved in the completion of the questionnaire and this suggests that lack of parent-child communication can lead to all the complications of sexual misbehaviour.

(iii) Availability of condoms

Availability of condoms at schools may prevent serious complications. This was reflected by statements from some respondents who commented that: "We need condoms to be available everywhere in Namibia, also at schools." It is clear that condoms may improve adolescent sexual health, because condoms can prevent pregnancies and at the same time protect against STD/AIDS. That is why it is advisable to use condoms as a contraceptive. This is supported by the positive response in the questionnaire that 120 (54,5%) of the respondents use condoms.

(iv) One faithful sexual partner

Having one faithful sexual partner plays a major role in improving adolescent sexual health, this was supported by 70 (31,8%) responses in the questionnaire stating that it is advisable for adolescents to have one faithful sexual partner. The findings also revealed that boys have more than one sexual partner. They should be aware of the consequences of having more than one sexual partner, particularly contracting STD and AIDS. It needs to be noted that boys form a high-risk group and should be targeted in special sexual health promotion programmes.

(v) Say "no" to sex before marriage

Saying "no" to sex before marriage will improve adolescent sexual health. This was mentioned by the majority of respondents who were involved in the completion of the questionnaire, when asked: "Any additional information on adolescent sexual health?" It was also mentioned by focus group interview participants. Respondents also believed that HIV tests should be done before marriage. This is important to ensure that both partners are not infected.

(vi) Negative attitudes of nurses should be changed

Negative attitudes of nurses at clinics were also mentioned by 55 (33,7%) respondents who were involved in the completion of the questionnaire. The following statements reflected this: "Nurses refuse to give us contraceptives, they said we must bring our parents." It is alarming that negative attitudes of nurses at clinics could discourage adolescents from this area from using family planning services. This could also cause adolescents to have negative attitudes towards family planning. This is thwarting the whole purpose of health care promotion in a very important sector of the community.

(vii) Avoid alcohol and drug abuse

Jessor (1998) also points out that the use or abuse of drugs and alcohol seems to be higher among teenagers indulging in sexual intercourse than among their non sexual active counterparts. It is clear that adolescents may indulge in sexual activity while under the influence of drugs or alcohol and therefore can contract sexually transmitted diseases.

(viii) Young people should participate in religion

The above information reveals an important aspect of adolescents' knowledge on how to improve their sexual health. Respondents believe that religion has an influence on young people's participation in sexual activities. They believe that religious affiliation and involvement inhibit

sexual behaviour that is unacceptable to their religious affiliation. Brock (1994) and Bodile (1994) also revealed in Chapter 2 that children who attend church regularly and have peers attending the same church, are less likely to be sexually active.

(ix) Social activities

Respondents also believed that being actively involved in social activities is one of the strategies to improve adolescent sexual health. Activities like sport, being members of youth groups and going to cinemas may keep them busy constructively instead of allowing them to loiter around and engaging in sexual activities, which may result in a variety of problematic situations they have to deal with at a very early age.

4.7.4 Respondents' attitudes towards sexual health

The researcher stated that the findings on the respondents' attitudes towards sexual health will be interpreted qualitatively. The focus group interviews revealed a sensitivity and awareness towards the problems and challenges regarding the sexual health of the adolescent.

It seems as if the adolescents have a positive attitude towards sexual health as supported by the following quotes from the focus interviews:

- *"Say no to sex, have one faithful partner."*
- *"We need condoms to be available every where in Namibia, also at schools not only at hospitals."*
- *"Young people should participate in religion."*

The researcher however wants to emphasize that this positive attitude could be changed by the negative attitude of nurses as experienced by the respondents in clinics and continuous lack of sex education by parents, health workers and schools. This could lead to a negative change in attitude in its cognitive, affective

and behavioural components.

4.8 SUMMARY

In this Chapter information obtained from the questionnaires and focus groups interviews has been presented statistically, analysed and interpreted. Both qualitative and quantitative research revealed similar findings in the study and recommendations will be made accordingly in the next Chapter.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This study was undertaken to:

- Identify the attitudes of adolescents towards sexual behaviour.
- Determine their knowledge base of sexual health.
- Determine what the practice of sexual health by adolescent's entail.
- Make recommendations where applicable.

Based on the findings, conclusions and recommendations are made so as to solve the identified problems.

5.2 CONCLUSIONS

5.2.1 In general a positive attitude towards sexual health was determined but it remains alarming that there is a small percentage of adolescents, who are involved in risky sexual behaviour. See data analysis of questions 20, 21, 22, 24 and focus group interviews.

5.2.2 It is of concern to the researcher that an average of only 79,3% of the respondents answered very easy questions on sexual issues correctly. 48 (21,8%) respondents also did not identify the most important mode of spreading STD's for example. It is clear from the research findings that the knowledge of adolescents' regarding sexual health is not optimal.

The following situations aggravate the situation:

a) **Parents' lack of participation in the sex education of their children**

Many researchers agreed that parental attitudes sometimes play an important role in adolescents becoming sexually active (Harris 1991). In this study it has been found that parents are reluctant to discuss sexual matters with their children according to the view of respondents. Gagnon (1987) stated that much of the information children get from their parents is observational and indirect because they don't get information from conversation. This results in serious implications as already discussed.

b) **Misinformation**

In this study it has been found that teenagers from this area have been misinformed about the use of condoms. This was pointed out during focus group interviews and also by the respondents who completed the questionnaires as follows: "We have been informed that condoms has caused AIDS". Morris *et al.* (1994) states that sexual information acquired from peers is likely to be inaccurate, and filled with misconceptions and myths.

c) **The need for health education**

The findings revealed the need for health education at schools. The respondents who were involved in the completion of the questionnaire pointed this out: "Health workers should give health education at schools".

The respondents also pointed out the need for sex education. "Sex education to be introduced as early as possible".

Health workers must know that for sex education to be acceptable to teenagers, it should fit into their subculture instead of expecting their life style to adapt to the functioning of services. They must remember that their role is to help adolescents to reach sufficient maturity to make their own decisions. They should present information to the teenagers through

group discussions, dramas etc.

Educational programmes for prevention of pregnancy among teenagers should include information on prevention of first and further pregnancies.

- 5.2.3 The research showed that adolescents are involved in risky sexual behaviour and do not practice safe sex. It was also proved that boys form a high-risk group regarding sexual behaviour. It is also a concern that the sexual abuse of adolescents by older men is a common phenomenon in this area.

5.3 RECOMMENDATIONS

Based on the research data, analyses and discussions, the following recommendations are made:

- 5.3.1 Parents should be responsible for the primary sex education of their children. The parents should prepare themselves physically, emotionally, mentally and socially to become ideal role models for their children. They must inform their teenagers in a supportive manner about sexuality and sexual health. Parents also need to be educated in this regard beforehand.

Increasing teenage knowledge of sexuality will lead to a decrease in sexual risk taking as inadequate information about sex could lead people to experiment and find out for themselves.

- 5.3.2 Health workers and teachers should be informed about the misinformation teenagers have about sexual health. They should provide accurate and up to date information about all aspects of sexual health. Accurate information leads to empowerment and enables more people to seek help if it is required. Regular refresher courses should be

held for healthworkers to enable them to give accurate and up to date information.

- 5.3.3 Well planned and organized sexual health education programmes should be launched in the communities and schools taking into account all socio-cultural related factors
- 5.3.4 Condoms should be available at schools and public places.
- 5.3.5 Adolescents should be actively involved in the promotion of their own sexual health.
- 5.3.6 The research findings should be made known to the institutions to enable them to start with remedial action.

5.4 SUMMARY

In this chapter conclusions and recommendations have been made in order to solve the problems. Recommendations identified in the research are based on the primary level of prevention and promotion of sexual health.

The research revealed valuable data, which if utilized correctly could contribute to adolescents taking responsibility for their own sexual health with a healthy community as the ultimate goal.

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ANNEXURE A

LETTER OF PERMISSION

PO Box 1500
Ondangwa
Namibia
9000

The Director
Ministry of Basic Education and Culture
Ondangwa West
Private Bag
Ondangwa
9000

Dear Sir/Madam

**PERMISSION TO CONDUCT RESEARCH ON ADOLESCENT SEXUAL
HEALTH**

Currently I am registered and studying for the Masters Degree in Nursing Science at the University of Stellenbosch in Cape Town. I hereby apply for your permission to conduct the said research at your school during the month of July 1999 to September 1999.

The objective of the research is an Adolescent Sexual Health investigation into the sexual knowledge, attitudes and behaviour of adolescents.

I believe that this research will highlight why unplanned, unwanted pregnancies, sexually transmitted diseases and abortion rate so high among teenagers.

The result of this research may improve sexual health amongst young Namibians.

Yours faithfully



ANNEXURE B

**LETTER OF CONFIRMATION FOR CONDUCTING A
RESEARCH IN A SELECTED REGION**



REPUBLIC OF NAMIBIA

MINISTRY OF BASIC EDUCATION AND CULTURE

ONDANGWA WEST

Tel: (06756) 40841
Fax: (06756) 40175/10544

Private Bag 2020
Ondangwa
NAMIBIA

Enq: Nghipondoka E A
Ref: 15/2/5

Prof. E B Welmann
Nursing Department
UNIVERSITY OF STELLENBOSCH

22 November 1999

ADOLESCENT SEXUAL HEALTH IN A SELECTED REGION IN NAMIBIA

This is to confirm that Linda N Lukolo conducted the above-mentioned study in our schools in Oshana Region from the month of July 1999 up to September 1999.

Thank you.

Yours sincerely

.....
L. Lukolo
DIRECTOR : MBEC

MINISTRY OF BASIC EDUCATION AND CULTURE
OFFICE OF THE REGIONAL DIRECTOR ONDANGWA WEST
1999 -11- 24
PRIVATE BAG X2020 ONDANGWA
REPUBLIC OF NAMIBIA

ANNEXURE C

RESEARCH QUESTIONNAIRE

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. How old are you?

12 - 14	1
15 - 17	2
18 - 20	3

2. Gender

Male	1
Female	2

3. What grade are you in?

Grade 8	1
Grade 9	2
Grade 10	3
Grade 11	4
Grade 12	5

4. Marital status of parents

Single	1
Married	2
Widowed	3
Separated	4

5. Occupation of mother

Not working	1
Teacher	2
Doctor	3
Nurse	4
Other, specify	5

6. Occupation of father

Not working	1
Teacher	2
Doctor	3
Nurse	4
Other, specify	5

7. Number of people in the immediate family (you included).

One	1
Two	2
Three	3
Four	4
Five	5
Six	6
Seven	7
More than 7	8

SECTION B: SEXUAL KNOWLEDGE

Indicate whether the following statements are True or False.

8. A girl can get pregnant even if she has sex once.

True	1
False	2
Don't know	3

9. Once a girl starts having monthly periods (menstruation), she can get pregnant, if involved in sexual intercourse.

True	1
False	2
Don't know	3

10. If a girl does not use contraceptives she is likely to get pregnant.

True	1
False	2
Don't know	3

11. A girl cannot become pregnant if she has intercourse during her menstrual period

True	1
False	2
Don't know	3

12. Have you been pregnant before?

Yes	1
No	2

13. If the answer to the question is "yes", how many times were you pregnant?

One	1
Two	2
More than two	3

14. Have you had an abortion?

Yes	1
No	2

15. If the answer is "yes", at what age?

Before 12	1
Between 12 and 14	2
Between 15 and 17	3
Between 18 and 20	4

16. Why did you have an abortion?

SECTION C: SEXUAL BEHAVIOUR

17. How do sexual transmitted diseases spread?

18. How can HIV/AIDS be prevented?

19. Have you ever been involved in sexual intercourse?

Yes	1
No	2

20. If the answer is "yes", at what age have you started with sexual intercourse?

Before 12 years	1
Between 12 and 14 years	2
Between 15 and 17 years	3
Between 18 and 20 years	4
None of above	5

21. How many sexual partners do you have?

One	1
Two	2
More than two	3
None	4

22. Do you have unprotected sexual intercourse? (without using condom)

Yes	1
No	2

23. Give the reason for your answer

24. What do you think is the reason for many teenagers having sexual intercourse?

SECTION D: CONTRACEPTIVE USAGE

25. Are you on contraceptives?

Yes	1
No	2

26. What kind of contraceptive are you using at the moment?

Pills	1
Injection	2
Condom	3
Intra uterine device	4
Other, specify	5

27. Where do you get contraceptives?

Hospital	1
Clinic	2
Clubs	3
Other, specify	4

28. Is it easy for you to get contraceptives?

Yes	1
No	2

29. Give the reason for the answer selected

30. Are your parents aware that you are using contraceptives?

Yes	1
No	2

SECTION E: SEXUAL HEALTH INFORMATION

31. Do you think that sexual matters should be discussed freely and openly with parents?

Yes	1
No	2

32. Give reasons for the answer selected above

33. Have your parents discussed sexual matters with you?

Yes	1
No	2

34. Have you had sex education lessons at your school?

Yes	1
No	2

35. What grade were you in when you first had a lesson in sex education?

Grade 1 to 3	1
Grade 4 to 6	2
Grade 7 to 9	3
Grade 10 to 12	4

36. What are your sources of getting information about sexual matters?

Parents	1
School	2
Health workers	3
Peers/friends	4
Radio	5
Television	6
Magazine	7
Other, specify	8

37. Please give me any additional information (about adolescent sexual health) you think is important for me to know.

Thank you very much for your co-operation!

ANNEXURE D

FOCUS GROUP INTERVIEWS

FOCUS GROUP INTERVIEWS

INSTRUCTIONS

- Everybody is expected to participate openly and freely in the discussion.
- There are no right or wrong answers.
- Information obtained will be treated confidentially.

QUESTIONS

- What are your views on adolescent sexual health?
- What are your views on the consequences of teenage pregnancies?
- What are the strategies to be used to improve adolescent sexual health?

KEYWORDS TO FACILITATE DISCUSSION

- Prevention of pregnancy
- Sexually transmitted diseases
- Acquired immune deficiency syndrome
- Sexual activities

ANNEXURE E

ABBREVIATIONS

ABBREVIATIONS

AIDS	- Acquired Immune Deficiency Syndrome
HIV	- Human Immune Deficiency Virus
NHIS	- National Health Information System
OPD	- Out Patient Department
PID	- Pelvic Inflammatory Disease
PHC	- Primary Health Care
STI	- Sexually Transmitted Infections
STDs	- Sexually Transmitted Diseases
UNICEF	- United Nations International Children's Emergency Fund
WHO	- World Health Organization
UNISA	- University of South Africa