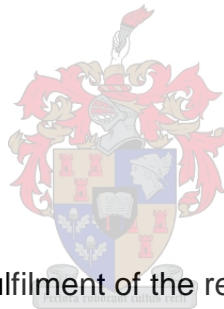


**Reasons of early sexual debut of “female” adolescents attending
Town-Two Clinic in Khayelitsha, South Africa**

By

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Master of Philosophy HIV/AIDS Management in the Faculty of Economics and
Management Science at Stellenbosch University.

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DECLARATION

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

December 2015

ABSTRACT

Introduction: There is an increase in the prevalence of HIV among young females compared to their male counterparts in South Africa (Shisana, 2012). Previous studies have shown early sexual debut is one of the contributing factors to acquiring HIV. Early sexual debut being defined as first sexual intercourse below the age of 15 years as illustrated in the literature (Aji et al., 2013). The aim of the study is to determine the contributing factors to early sexual debut by female adolescents in the ages between 13-19 attending Town-Two Clinic. To establish the knowledge of adolescent females about HIV & STI transmission, to evaluate what sexual and reproductive health education and management is required by adolescents attending the clinic, and to provide guidelines to deal with the concerns and needs of female adolescents attending Town-Two Clinic as well as reproductive health education.

Methods: This is an exploratory qualitative study. Twenty female adolescents between the ages 13-19 attending Town Two Clinic for family planning were voluntarily recruited. Data collection was done by means of a 20 minute interview; two participants were interviewed a day. The interview was semi-structured using open-ended questions. Socio-demographic data was obtained by means of a questionnaire; linked to the interviewee by means of a study code to maintain anonymity. Data analysis was done using inductive analysis and creative synthesis, which analyses the details of the information collected to discover important patterns, themes and interrelationships (Larry, 2014).

Results: The average age of the participants was 16 years. The youngest and eldest was 13 and 19 years old respectively; average grade was grade10. Majority of participants resided with their mothers (35%), 20% lived with both parents, 20% with their elder siblings, 15% with grandparents and 5% with other relatives. Participants (45%) reported they were sexually active; average age at first sexual intercourse was 14 years. The participants' acceptable age for sexual debut was 18yrs. Reasons contributing to early sexual debut were

identified as: peer pressure, easy access to alcohol, transaction and cross-generational sex, media and social networks, crowded living conditions, sexual abuse and lack of parental supervision and communication with children. The participants (95%) said they received sex education at school;. (65%) reported they were taught about safe sex practices and using a condom every time they have sex. Knowledge gaps; (60%) of the participants reporting they would like to receive more information and teaching about STI's, as they knew very little about them.

Conclusion: The study demonstrates the contributing factors to early sexual debut amongst female adolescents as: Peer pressure, easy access to alcohol, transaction and cross-generational sex, media and social networks, crowded living conditions, sexual abuse and lack of parental supervision and communication with children, and its risk to HIV infection. Appropriate and current sex education with regards HIV, STI prevention, testing and treatment is crucial. Parents play a vital role in educating their own children and need to overcome their socio-cultural views about sex. Interdisciplinary collaboration is needed between the health sector, education, law enforcement, church youth groups, media and social networks in developing effective programs for educating youth on HIV prevention, reproductive health and dangers of substance abuse.

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CHAPTER 1

INTRODUCTION

1.1 Introduction

A national HIV prevalence, incidence and behavioural survey conducted in 2012 revealed figures of the prevailing infection. The report stated the HIV incidence among the 15-24 year age group had increased by 1.49% which was estimated to be 139,000 new infections (Shisana, 2012). It further highlighted females in this age group had an incidence rate of 2.5% vs. 0.6% of the males (Shisana, 2012); rate is four times higher in females than males. Similar figures have been reported in Malawi where there are 3.3% more female than male adolescents, between the ages of 15 and 19 living with HIV (Dancy et al., 2014). The total number of adolescents living with HIV in South Africa is estimated to be 720,000 from the ages 15-24 (Shisana, 2012). The percentage of those individuals with HIV on antiretrovirals is only 14.3% (Shisana, 2012). Previous studies have shown early sexual debut is one of the contributing factors to acquiring HIV. Adolescent girls are an important population in the management of HIV. In rural Malawi, half of adolescents engage in sexual intercourse are before the age of 15 years (Dancy et al., 2014).

A medical officer reported working in a community-primary health care clinic in the heart of Khayelitsha, this problem is confronted on a daily basis. Khayelitsha means a 'new home' and is a township situated on the Cape Flats near Cape Town. It has a population of approximately 391 748 people; majority of them live in informal settlements. The population is mainly Xhosa speaking with most of them from various parts of rural Eastern Cape. Due to the high number of unemployment crime is rife and affects not only the local population but also the bordering areas. Currently there are support structures in place in this district for adolescents that are living with HIV in contrast to those that are negative or have not been tested. In the local clinic there is a trend where an increasing number of young adolescents' 12-14 yr. olds are

coming in for family planning. This reinforces prior knowledge and experience of early sexual debut of adolescents.

1.2 Research problem

There is an increase in the prevalence of HIV among young females compared to their male counterparts. Young girls seem to be engaging in sex at a much earlier age as evidenced by the number of them coming to the community health clinic for family planning. There is limited literature in this particular area near Cape Town for the exact reasons why there is an increasing incidence of early sexual debut in this group of the population. The problem this study pose to solve is: What are the contributing factors to early sexual debut among female adolescents between the ages 13-19 attending Town-Two clinic in Khayelitsha?

1.3 Aim

The aim of the study is to determine the contributing factors to early sexual debut by female adolescents in the ages between 13-19 attending Town-Two Clinic, in order to develop strategies to bring about behavioural change to prevent, decrease and delay their sexual exposure to HIV/AIDS.

1.4 The objectives

The objectives are:

- To determine the reasons behind early sexual debut, to establish the knowledge of adolescent females about HIV & STI transmission
- To evaluate what sexual and reproductive health education and management is required by adolescents attending the clinic
- To provide guidelines to deal with the concerns and needs of female adolescents attending Town-Two Clinic as well as reproductive health education

1.5 Significance of study

The purpose and significance of this study is to confront the problem of early sexual debut amongst adolescent girls who have been reported to be at a higher risk of HIV infection than their male counterparts. By investigating the reasons for early sexual debut strategies can be developed to encourage behavioural change amongst this vulnerable population. Female adolescents attending Town-Two Clinic will benefit from this study, as their sexual and reproductive health concerns and needs could receive attention and guidance addressed by appropriate health officials. The aim is to alleviate their fears by guiding them to fill any existing knowledge gaps. It will be endeavoured to bring about behaviour change and embed a theme of responsible sexual behaviour among adolescents and in doing so help decrease the incidence of HIV in this group. Adolescents attending Town-two clinic come from different schools and areas, there is the hope the impact of an adolescent based sexual and reproductive health promotion and education strategy will spread amongst this population. The aim is to make the clinic more attractive and accessible for young female adolescents.

1.6 Research methodology

This was an exploratory qualitative study. Individual interactive interviews with each study participant were undertaken. The interviews provided an opportunity to gain in depth perceptions and views around early sexual debut as opposed to a questionnaire. Many behavioural studies are based on questionnaires and there is doubt whether the information acquired is always correct. Participants in a questionnaire may answer truthfully or may not. There may be incorrect ticking of answer boxes; they can be restrictive. The participant has to choose or tick a box of an answer already provided by the questionnaire. Thus there is little or no room to elaborate on their answer or offer new ideas. This was the motivation behind conducting a qualitative research study, investigating in-depth reasons behind adolescent's decision to have sex at an early age. An interactive interview with an adolescent, in a non-threatening environment assisted to gain an understanding how to prevent or

promote delaying sexual debut to a more mature age of the adolescent or young women.

Purposive sampling was selected to be the most appropriate approach for this particular study. The targeted participants in this study were female adolescents from the ages 13-19 attending Town Two Clinic. Whilst the young ladies were waiting their turn for their contraceptive consultation, an experienced health promotion counsellor gave a short dialogue on the study of "*Reasons for early sexual debut of female adolescents attending Town-Two Clinic*". Information on the reasons related to the study was presented. The importance of the study outcomes and its benefits to the youth and community was explained. Patients were thus invited to participate in the study. Patients wanting to enquire more or participate in the study were given the principal investigators contact details, which were also available on a Study Poster in the family planning room. The health promotion counsellor was suited for the recruitment process as this fell under her health promotion activities. There was no remuneration for the health promotion counsellor she volunteered and agreed to assist with this recruitment process.

Twenty study individuals were invited to participate voluntarily. Upon acceptance to participate, an appointment was arranged with the individual to carry out the interview. Informed written assent was obtained from participants' aged 13-17. The participant was able to choose whether or not to inform his/her guardian or parent about the study. This was done in order to minimize or prevent conflict between daughter and parent. It was known some parents may have been unhappy with their children discussing issues surrounding sex. The ethics committee granted a waiver for parental consent. Written consent was requested from all participants 18 years and older. Participants' identity in the study will be anonymous. Data collection was done by means of a 20 minute long interview; principal investigator conducted each interview; two participants were interviewed daily. The day of the interview changed each week according to chronological order, over a period of 15 consecutive weeks.

This is to ensure that participants do not meet one another and discuss the interview prior to being interviewed. The interview was semi-structured using open-ended questions to encourage discussion and elaborative responses. Socio-demographic data was obtained by means of a questionnaire; linked to the interviewee by means of a study code to maintain anonymity.

Data analysis was done using an inductive process and creative synthesis, which analyses the details of the information collected to discover important patterns, themes and interrelationships (Larry, 2014).

1.7 Ethical considerations

Participants were able to, at any time during the study period, terminate their participation without any negative consequences to them. There was no remuneration for participants. Participants' identity in the study was anonymous. Each participant's interview was allocated a study code; no names were used on either the questionnaire or the audio-recorded interview to ensure anonymity and confidentiality.

Participants invited to participate were between the age group 13-19. Thus for the under 18 there was in particular the issue of confidentiality. The adolescents may agree to participate in the study but not let their parents know as a result of the nature of the study. The participants may not want their parents/guardians be aware they are engaging in sexual activities. There may be a conflict of interests as the parents may see this study as harmful to their children as it deals in depth with sexual issues; known in most African cultures talking about sex is a taboo. Some parents may refute the research as they may see the proceedings of the process of gathering information as a medium of teaching their children about sex at a young age.

Limitations of the study

There are number of limitations that should be considered when reviewing this research project:

- A restricted sample in one community is included in the study
- The research focus only on the behaviour of girls and boys are ignored
- The sample size is small in the project

1.8 Outline of chapters

Chapter 1 is the introduction of the study outlining the research problem, the study aim and objectives and the rationale behind the study. Chapter 2 is the literature review on the research topic and identified problem. Chapter 3 is related to research methodology describing the selected study design, identification and selection of the study population, the process of data collection and analysis. Chapter 4 is discussion and reporting of the results obtained and their analysis. Chapter 5 is recommendations and conclusions made from the study.

1.9 Conclusion

The purpose of research was to assess a formulated and identified problem and to investigate how to appropriately and effectively acquire answers and solutions to the problem. HIV infection in the present youth and especially amongst female adolescents is on the increase in this particular community near Cape Town. It is the duty of health professionals to devise ways to counteract and prevent this condition from worsening. Making female adolescents the principal stakeholders in this project gives insight into their world and their challenges in their particular community. This allows them to be part of the process of finding a solution. This study aimed to come up with an appropriate strategy to implement relevant reproductive and sexual health promotion including HIV/AIDS prevention and eventually behaviour change amongst female adolescent.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Adolescents between the ages 12-24 in rural KZN had an HIV prevalence of 6.8% amongst girls and 2.7% in boys (Kharsany et al., 2014). This is in keeping with the National Department of Health findings, where female adolescents have a higher incidence of HIV infection than their male counterparts (Kharsany et al., 2014; Shisana, 2012). In rural Malawi 77% of female adolescent girls are unaware of HIV risk reduction behaviour (Dancy et al., 2014). Female adolescent are more likely to have partners that are 1-4 years older than themselves (Kharsany et al., 2014). This age and maturity discrepancy makes it even more difficult for adolescents to negotiate sexual practices. In this study population, HIV prevalence was higher in both girls and boys without a biological mother residing with them at home (Kharsany et al., 2014). Thus suggesting parental supervision and presence have a positive influence on prevention and/or delaying with sexual activities for various reasons not stated.

2.2 The situation in South Africa

HIV transmission is not a result of intra-school transmission thus suggesting inter-school transmission or school-community transmission (Kharsany et al., 2014). There seems to be a link between students having partners 1-5 yrs. older than themselves and HIV transmission, possibly as a result of school-community transmission. Contrary to this Marteleto (2013) reported in Cape Town, early sexual debut is related to having older adolescents at school mixing with younger adolescents due to some scholars not progressing to higher grades (Lam, 2013). Thus there are 18, 19 and 20 year old high school students, whom have been sexually active for some time mixing with 14,15, 16 year olds (Lam, 2013).

There seems to be a lack of perceived risk associated with HIV among adolescents and thus there is a low uptake of VCT. This contributes to the spread of HIV as adolescents engaging in sexual activities are unaware of their HIV status. There is lack of health seeking behaviour, as one may not feel ill for a long time. There needs to be more targeted interventions and preventative strategies for adolescents in schools, surrounding health facilities, churches and in the community as a whole.

Studies have shown the church has a vital role to play in preventative health promotion strategies. The church is highly valued in these communities. It has been advised the ministers of the church need to use the opportunity to address HIV and sexual issues as it affects all members of the congregation (Baldwin et al., 2008). Adolescents with regards to sexual education in low socio-economic backgrounds in Asian and Pacific Islands reported material on HIV and STI's presented to them was medical and clinical (Mueller, Bidwell, & Mann, 1997). They preferred a more psychosocial approach, which would enable them to relate and participate encouraging them to offer ideas and some of their own experiences (Mueller et al., 1997). A grey area exists where teachers are unsure when to start sex education. A question can be posed: At what grade is sex education at schools appropriate? It is well known children are having sex at a young age as young as 12 years when the individual is in grade 3 or 4. A study conducted in Nigeria showed in-school knowledge of sexual intercourse amongst adolescents in the lower grade was much lesser than their older counterparts in the higher grades (Esere, 2014). This poses a potential risk of restricting sex education to younger adolescents thus missing the opportunity to intervene before they become sexually active. A better intervention would be to offer sex education on safe sex practices and HIV/STI prevention prior to sexual debut.

2.3 Early sexual debut

Early sexual debut is known to be one of the contributing risk factors for the acquisition of HIV infection but the reasons why this is a risk have not been

fully explored (Stöckl, Kalra, Jacobi, & Watts, 2013). Stockl identified four possible pathways in which sexual debut may contribute as a risk factor to acquiring HIV (Stöckl et al., 2013). These include; early sexual debut means the women has a longer period of exposure to the risk of acquiring HIV (Stöckl et al., 2013). Early sexual debut of girls may predispose them to engage in risky sexual behaviour with increased exposure to STI's, PID and HIV (Stöckl et al., 2013).

The female reproductive organs and immune system may be biologically immature and thus be more prone to tears and infections thus increasing the risk of acquiring HIV (Stöckl et al., 2013). The last pathway explained is the girls who have an early sexual debut are more likely to have partners who are much older, whom have had a longer exposure to HIV infection and may have multiple sexual partners (Stöckl et al., 2013). The evidence from the review revealed there was a consistent association between early sexual debut and the risk of HIV infection (Stöckl et al., 2013).

There was conflicting evidence to the second pathway, which infers early sexual debut predisposes to risky sexual behaviour, as there was no significant association between the two variables (Stöckl et al., 2013). There was no significant evidence for the pathway suggesting early sexual debut is linked to older partners with higher risk of HIV infection (Stöckl et al., 2013). Further there was no data with significant findings relating early sexual debut to HIV infection as a result of an immature reproductive system and/or immunity (Stöckl et al., 2013).

There are other reasons leading to early sexual debut and its correlation to HIV infection; socio-economic status is one contributing factor. A child growing up in poverty in many instances are not well educated as there may be no money for bus, taxi fare, uniform or books thus they drop out of school. There is the possibility they then lack knowledge of HIV and how to prevent themselves from being infected (Ross. Dick, 2006); they may fall prey to men

who entice them with basic support such as food, shelter and material objects and become coerced to engage in unprotected sex (Ross, 2006).

2.4 Adolescent sexual behaviour

A study conducted in Nigeria looked at adolescent's sexual behaviour over the last 12 years (Aji et al., 2013). The authors reviewed journal articles on the subject of adolescent sexual behaviours and practices in Nigeria from the year 2000 to 2011 (Aji et al., 2013). The study reported adolescents wanted to receive sex education from their parents (Aji et al., 2013). Parents were noted to be reluctant to talk about sex with their children as they felt this might encourage them to be sexually active (Aji et al., 2013). The literature revealed other sources of information about sex and sexual behaviour came from television, peers, older classmates, newspapers, magazines, teachers, health care providers and sometimes parents (Aji et al., 2013). A study conducted in rural America with African Americans, revealed adolescents preferred acquiring knowledge about HIV from peer-led mentors (Baldwin et al., 2008).

Comparing knowledge on HIV and STI's of adolescents led by peers and those led by adult mentors, they found the adult led group improved on their knowledge much more than the peer led group (Baldwin et al., 2008). They attributed this to possible inexperience of peer mentors and inability to answer or address difficult questions (Baldwin et al., 2008).

The median age of sexual debut was 15 years in keeping with most literature definitions for early sexual debut. They reported the method of sexual intercourse was mainly penetrative vaginal-penile intercourse but there was a moderate amount of adolescent's who engaged in oral and anal intercourse (Aji et al., 2013). Studies have reported unprotected anal intercourse whether receptive or insertive has the highest risk of HIV transmission (Dancy et al., 2014); guidance pointed towards educational material addressing methods of protection in various sexual acts. There is no difference whether it is anal intercourse between a heterosexual or homosexual couple (Dancy et al.,

2014). There was no data on MSM or WSW as this information was not divulged by participants because of the strict cultural and legal views about this key population (Aji et al., 2013). Men having sex hide their sexual orientation and find it difficult to get information on ways to protect themselves from contracting HIV and STI's (Ross and Dick, 2006).

Abstinence has been advocated and encouraged at school as one of the primary interventions to delay sexual debut (Aji et al., 2013). In an ideal world this would work but researchers have to be realistic of reality and the changing norms of the 21st Century. There is evidence identifying children are engaging in sex even at an age of 9 years. Health minders should be proactive and accept reality as it appears and work with them. Instead of only advocating abstinence, responsible sexual behaviours should be promoted with the correct use of contraceptives and barrier methods to decrease and prevent the transmission of STI's including HIV. In rural America it has been reported adolescents engage in risky sexual activities due to boredom and lack of recreational activities (Baldwin et al., 2008). Therefore communities and local government with other private stakeholders should explore increasing sport clubs, hold tournaments and keep children occupied and off the streets.

2.5 HIV prevention steps

The following literature review is on the 6-step approach to HIV prevention in counselling for adolescents (Pinto, 2009). The approach is a patient centred intervention looking at sexual behaviour with the aim of risk reduction and prevention of HIV and other STI's among adolescents. Pinto (2009) indicate the first step explores the patient's own ideas and beliefs around sex and their perception of what it means to be sexually active. The second looks at the patient's existing knowledge of HIV. This helps identify what knowledge gaps if any, exist and thus educational material is generated according to the individual's needs. The third step investigates the patient's own barriers to responsible sexual behaviour. This explores issues surrounding condom use, contraceptives, possible substance use/abuse, gender inequality and inability

to negotiate sexual practices. The fourth step explores whether the patient sees himself or herself as partaking in risky behaviour. The fifth step is to use what has been learnt about the patient from the previous steps and combine all the factors into developing an individualized approach to responsible sexual behaviour, recognition and evasion of triggering factors leading to risky behaviour. The patient thus creates his own way to deal with these triggers and implement ways to sustain responsible sexual behaviour. The sixth and final chapter review the conclusions and provide the recommendations.

2.6 Conclusion

Female adolescents have been identified as having a higher risk of HIV infection than their male counterparts. Literature suggests early sexual debut is a contributory factor to HIV infection. The reasons for early sexual debut, sex below the age of 15, are multifactorial. The factors may be intrapersonal, interpersonal and social. Thus strategies needed to decrease this trend have to be diverse and target the various factors that lead to early sexual debut.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The Stellenbosch Research Ethics Committee granted ethics approval: Human Research (Humanities). It was further granted approval by the National Health Research Ethics Committee (NHREC). The study was granted approval to take place at the premises of City of Cape Town's, Town-Two Clinic in Khayelitsha. The research committee headed by Dr Visser of City Health granted approval.

3.2 The Problem statement

The problem identified for this study was:

What are the contributing factors to early sexual debut among female adolescents between the ages 13-19, attending Town-Two clinic in Khayelitsha?

3.3 Objectives of the study

The objectives of the study were:

- To determine the reasons behind early sexual debut, to establish the knowledge of adolescent females about HIV & STI transmission
- To evaluate what sexual and reproductive health education and management is required by adolescents attending the clinic
- To provide guidelines to deal with the concerns and needs of female adolescents attending Town-Two Clinic as well as reproductive health education

3.4 Methodology

The methodology of a study forms the foundation to solve the formulated problem developed from theoretical considerations. The objectives were used provide a basis upon which the research will be based to produce an answer to the formulated problem.

3.4.1 Qualitative research

Qualitative research methods are characterized by the aim of a study, which thus share the understanding of human behaviour in a social setting and translates the data into understandable units expressed in words. This was an exploratory qualitative study using interactive interviews with each study participant were undertaken. Using this method delivered in-depth perceptions and views around early sexual debut as opposed to a questionnaire. Many behavioural studies are based on questionnaires but there is doubt whether the information acquired is always correct. Participants in a questionnaire may answer truthfully or may not which is at times evidenced by incorrect ticking of answer boxes; they can be restrictive. The participant has to choose or tick a box of an answer already provided by the questionnaire consequently there is little or no room to elaborate on their answer or offer new ideas. This was the basis and motivation for conducting a qualitative research investigating in-depth reasons behind adolescent's decision to have sex at an early age.

3.4.2 Sampling

A sample collects data from a representative section of a population with the aim to gain information that could be interpreted and assist in solving a problem. A decision was made to employ purposive sampling for the study, which represents a group of different non-probability sampling techniques. The objective of purposive sampling is not to make generalizations from the group of selected respondents. The intension is to focus on a distinctive element of a population that could be of interest to the researcher.

3.4.3 The interview process

The targeted participants in this study were female adolescents from the ages 13-19 attending Town Two Clinic. Whilst the young ladies were waiting their turn for their contraceptive consultation, an experienced health promotion counsellor gave a short dialogue of the study on "Reasons for early sexual debut of female adolescents attending Town-Two Clinic"; information on the reasons for the study was presented. The importance of the study outcomes

and its benefits to the youth and community was explained and they were then invited to participate in the study. Patients were given the principal investigators contact details, which was also available on a study poster in the family planning room. This was done to offer a contact person should the participant enquire more information about the study. The health promotion counsellor was suited for the recruitment process as this fell under her health promotion activities.

Twenty individuals were invited to participate voluntarily in the study. Upon acceptance to participate, an appointment was arranged with the individual to carry out the interview. Informed written assent was obtained from the participants' aged 13-17. A written consent from their guardians/parents to participate in the study was not obtained as none of the participants' felt comfortable letting their parent or guardian know they were participating in a research study about adolescent's sexual behaviour. The ethics committee granted a waiver for parental consent as it may have caused conflict between daughter and parent. The participant may have refused participation if it was compulsory to obtain parental consent. Parental consent would have been ideal to obtain, however the participants did not want their parents to know they engage in sexual intercourse. Participants' identity in the study was anonymous because their names were not recorded on the forms.

3.4.4 Data collection

Data collection was done by means of a 20 minute long interview with each participant; they were given a study code to maintain anonymity. The interviews with each participant were audio recorded and given the same study codes. Two participants were interviewed on different days of the week. The day of the interview changed according to chronological order, over 15 consecutive weeks. This was done to ensure the participants did not meet one another and discuss the interview prior to being interviewed. The interview was semi-structured using open-ended questions to encourage discussion and elaborate responses.

3.4.5 Analysis of data

Socio-demographic data was obtained by means of a questionnaire; linked to the interviewee using a study code to maintain anonymity. Data analysis was done using inductive analysis and creative synthesis, which analyses the details of the information collected to discover important patterns, themes and interrelationships (Larry, 2014).

3.5 Conclusion

The data was collected during August 2015 at the determined location. A qualitative study was best suited for this research. The aim and objectives set out in this research were such that comprehensive information was needed to best address the various issues identified. The collected data was analysed and will be presented in the next chapter.

CHAPTER 4

DISCUSSION AND REPORTING OF RESULTS

4.1 Introduction

The data and information for the study was acquired through purposive sampling at a particular venue. The problem statement related to the study was formulated based on investigating the literature: What are the contributing factors to early sexual debut among female adolescents between the ages 13-19 attending Town-Two clinic in Khayelitsha?

4.2 Biographical information

The information was acquired from a written document completed by each respondent before the interview.

4.2.1 Age of participants

The average age of the participants was 16 yrs. The youngest and eldest was 13 and 19 years old respectively.

4.2.2 Education level

The average grade of the participants was grade 10. Youngest participants were in grade 7 and the eldest in 12. All the study participants were attending school and none were in paid employment in organisations.

4.2.3 With whom do they live?

Most of the participants resided with their mothers (35%). Some of them lived with both parents (20%) and others with their elder siblings (20%). There were those that lived with their grandparents (15%) and 5% with other relatives. Those not living with their parents (25%) reported their parents lived in rural Eastern Cape and they come to Cape Town for better education and opportunities. Some participants (10%) reported they did not live with their parent/s as their mother was deceased. While 5% reported their parents were never married and thus the mother lived with her other family.

4.2.4 Knowledge of parents

The majority of participants reported they knew both their parents (55%). The remainder of participants reported they had never met their fathers (20%) and others reported their fathers were deceased (20%). One participant reported she knew her father, however, her parents were never married and he was married and lived with his family.

4.2.5 Where do they live?

The socio-economic background of all participants was of a lower status. The majority of participants lived in a brick house (65%) and (35%) lived in an informal dwelling (shack). The average number of rooms per house was 3, including the open living room leading to kitchen. On average 4 people were living in a house; majority of participants (70%) reported sharing a bedroom with other family members. Those sharing a room (55%) also shared a bed with another family member. While some sharing a bed; 10% shared with an adult of the same sex and 45% with their sibling of either sex.

4.2.6 Who is the breadwinner?

The participants (35%) reported the breadwinner in their families was their single parent (mother). Some reported their elder sibling was the breadwinner (30%). Some indicated the household income came from both parents (15%) and others (15%) from their guardian (i.e. aunt and uncle). One reported the only income in the household was from her grandparent's old age grant.

4.3 Results from interviews

Various questions were posed to the respondents to gain their understanding of different topics related to the problem statement and objectives.

4.3.1 Sex and HIV Education

Most of the girls (60%) felt sex in general was a bad thing. Most elucidating sex was only appropriate in a marriage situation where the individuals were old

and loved one another and were mature to understand the consequences of their actions. Some felt sex was bad because children were too quick to experiment with it and are not able to deal with the consequences of their actions later. Some felt sex was bad as it is associated with diseases such as HIV, pregnancy and STI's. One participant of 16 said: *"I feel sex is bad as I fell pregnant at 14yrs after my first sexual encounter and we did not use a condom, I was too quick to have sex to please my boyfriend and didn't think of the consequences"*.

There were those girls (40%) that felt sex was a good thing. They felt sex was a natural act that is intended to happen between two individuals that love one another and are committed to each other. One participant aged 13 years said: *"Sex is good but not at my age, it is good only in married couples as it strengthens a marriage and it is good if the couple wants to fall pregnant"*.

The participant's reported their views and beliefs expressed mostly stem from various sources, teachings at school, parents and some from their own observations in their society. One participant aged 15yrs said her beliefs stem from her own thoughts and observations in her community, as she sees young girls becoming pregnant at a young age, which is something that has almost become the norm. None of the participants reported their views and beliefs surrounding sex stem from their religious backgrounds or culture.

Most of the girls reported they received sex education in Life Orientation classes at school. Only one girl reported she did not have sex education at her school. Most of them (65%) reported they were mostly taught about safe sex practices and using a condom every time they have sex. They were taught this would protect them from contracting diseases such as HIV and sexually transmitted infections (STI's). The other (35%) were mainly taught about preventing teenage pregnancies and using contraceptives.

Although many of the girls reported they were taught about HIV and STI prevention. Some of them were not clear on what HIV was and most of them lacked knowledge about STI's. The majority of girls (75%) reported HIV was an infection you get when you have sex without a condom. The general consensus was sex without a condom (irrespective of knowing the other partners status) equated to HIV infection. None of the participants specified having sex with an individual known with HIV without a condom exposes one to the infection. Only 3 participants explained other modes of HIV transmission. One participant, aged 15yrs said: *"You get HIV by sharing needles, having sex without a condom and from a mother to her baby during childbirth."*

Amongst the 20 participants, 4 girls (20%) did not know or had limited knowledge about HIV. One participant aged 13yrs, in Grade 7 said: *"I don't know anything about HIV and STI's. We don't get taught about this at school."* Two participants both aged 17yrs, said: *"I don't know much about HIV"*.

A girl elaborated she did not know much about HIV because they do not spend much time on HIV and STI's in "Life Orientation" and the little she knows is from conversations with her friends. One participant aged 16 yrs. said: *"HIV is something you get if your blood mixes with someone's blood that is HIV positive. Sometimes people get HIV from sharing toothbrushes."*

There are many knowledge gaps pertaining the HIV and prevention which were identified in the interviews. The majority (60%) of the participants reported they would like to receive more information and teaching about STI's, as they knew very little about them. The rest of the participants (30%) reported they wanted to know more about both HIV and STI's. Two participants were not quite sure what they would like to know.

One participant of 16 years asked: *"What does one do when they get infected with HIV or an STI? Where can we go for help and what can we do to prevent"*

further infection? Do we get counselling after being told you have an infection?"

A 16 year old said: *"I don't know much about STI's. I would like to know what the symptoms of an STI are. How does one get infected with an STI? I wish I could more information about STI's at school from our teachers."*

4.3.2 Conversations related to sex at home

Reviewing the research it became apparent parents as well as adolescents are reluctant to engage on the topic about sex and issues surrounding the topic (Aji, Mo, Co, & Of, 2013). In this study 55% of the participants reported they do speak to someone about sex and boyfriends at home and 45% said they did not engage at all concerning the topic. The participants that did speak to someone, 30% reported they spoke to their mothers about sex and boyfriends. Others (25%) spoke to their elder siblings and 10% to other relatives (grandmother, aunt).

The participants that did not speak to their family members related they felt too shy and embarrassed to speak to their mothers or fathers about sex and boyfriends. They felt their mothers in particular were too 'strict' and unapproachable with the topic of sex. They reported they were scared of what their mother's reaction would be if they brought up the subject of sex. One 19 year old said: *"I'm not free to speak about sex to my mother because I'm scared of what she would say to me"*.

Another participant of 15 years said: *"My mother doesn't speak to me about sex. She just tells me that I'm old now to go to the clinic and get an injection (contraceptives). Maybe she shy's away from speaking about sex to me because she doesn't want me to know too much about sex. I'm also not ready to speak to my mom about sex and boys, I don't know what her reaction would be"*.

4.3.3 Role of the Church

Most of the 20 participants, 17 (85%) reported they attend church. While of the 17 that did attend church reported the minister's wife or other young mother in the church would discuss issues around sex and teenage pregnancies in the 'youth group'. Many of these participants felt free to discuss sex in the youth groups as they were amongst their peers and felt free to discuss issues with a church elder (mother) to guide them.

The contents of the discussion varied between participants. One participant of 17 year said: *"We speak about matters concerning youth such as sex. The mothers hold the sessions and I feel free to speak about sex in the youth group because all of us are roughly the same age with similar experiences. The mother who facilitates the group discussions is open and non-judgmental"*.

A 15 year old said: *"We discuss challenges facing youth and talk about things that uplift and groom youth into responsible adults. They teach us that sex is wrong when practiced by children. We don't go too deeply into discussions about sex as it doesn't build or make people become better people."*

A response from a 17 year old said: *"The pastor tells us not to have sex as it makes our bodies impure and dirty"*.

Another participant also aged 17yrs reported in her church they do not have discussion around sex at church and this kind of topic is reserved for adults not youth.

A response from a 16 year old said: *"We speak about sex at church but don't go into in-depth discussions as we are told sex is bad. If one goes to church and listens to Gods word they know that one must wait until they are married. I don't feel comfortable speaking about sex at church because people may judge you and may think you are too inquisitive and know too much."*

One participant aged 13yrs said: *“At church we are divided into two different groups, one for young teenagers and the other for the older youth. In my group we don’t discuss sex as they say we are too young. In the other youth groups they do. I think that maybe they should start discussions about sex and HIV should be started in the younger teenagers group as well so that we are aware of the various issues around sex, HIV and pregnancies.”*

The majority of the participants (60%) felt most comfortable speaking to their friends and boyfriends about sex. Some (20%) felt easier to speak to their siblings and 20% to their mothers. Amongst friends when the topic of sex arises most of the participants (35%) revealed they usually spoke about sex in general and what they did when they were together with their boyfriends. One participant of 17 years: *“My friends and I talk about what we do when we are with our boyfriends. We give each other advice about what we do when we’re with our boyfriends. We talk about the different sex positions and various things one can do.”*

Most of them (45%) spoke about safe sex practices and condom use. One participant aged 15yrs said: *“We talk about sex and that we must use a condom when having sex. Its common talk and it’s not an unusual topic talking about condom use.”*

A 19 year old said: *“We talk about sex all the time and condom use and what can happen to one if they don’t use a condom.”*

One participant aged 15 years. said: *“We talk about sex and that it is something one should do when they are ready and not be forced into it.”*

4.3.4 Sexual activity

Almost half of the 20 participants (45%) reported they were sexually active while of those 60% were in relationships. The average age at first sexual intercourse was 14 years. This confirms the growing prevalence of early

sexual debut amongst female adolescents in this setting. Early sexual debut being defined as first sexual intercourse below the age of 15 years as illustrated in the literature (Aji et al., 2013). The youngest age at sexual encounter was 11 years, this participant is now 19 years old; her period of sexual exposure is 8 years under the age of 20. The oldest age at first sexual encounter was 16 years.

The first sexual encounter more than half (55%) of the participants did not use a condom; 44% did use a condom. This supports the claim the highest incidence of new HIV infection is amongst adolescent females as illustrated by the lack of condom usage. The participants that did not use condoms elaborated on their reasons. Three participants aged 16, 18 and 17 years reported they did not know why they did not use a condom; did not think it through. One participant of 17 said: *"I don't always use a condom because it bores me. Sometime it just happens that my boyfriend and I don't use a condom. I personally don't feel a difference or have a preference of having sex with or without a condom. So I cannot say I prefer sex without a condom because it feels better. We just sometimes forget."*

A further 17 year old said: *"It's boring using a condom and sometimes I just don't feel like using it."*

All the participants in relationships reported they felt free to negotiate sex with their partners. They all felt free to discuss issues such as sex, condom use and refusal to have sex when not in the mood. A response from 15 year old who is in a relationship but not sexually active said: *"We do talk about sex with my boyfriend. He sometimes gets upset and angry when I tell him I'm not ready to have sex with him."*

Related to the same point an 18 year old said: *"I insist on using a condom with my partner, yes he gets upset and sulks but I tell him that I'm doing it to protect myself and I'm not going to please him."*

One participant aged 16yrs said: *“If I’m not in the mood to have sex he understands but I feel I cannot talk to him or enforce condom use because he gets upset.”*

A 17 year old respondent said: *“Sometimes I do feel pressured to have sex with my boyfriend and not to use a condom.”*

More than half (55%) of the participants in relationships reported they did at times feel pressured into having sex by their partners. One participant aged 15 said: *“Yes I sometime feel pressured to have sex, but I tell him I’m not ready. This is because I can see that he’s not faithful and has other girlfriends. And personally I’m just not ready to have sex yet. He does get angry and upset but I stand by my decision.”*

Eleven of the 20 participants (55%) reported they were still virgins. Only one was currently in a relationship being a virgin. The average age of those that were virgins was 15yrs. There were three participants of whom two aged 15 and one aged 17 reported they were not sexually active because they had not met the right partners to consider losing their virginities to. Another 3 participants reported they were still virgins because they just did not desire to have sex and were not in relationships. This illustrates the protective factor of not being in a relationship as it seems to delay sexual debut.

Some of the participants (36%) that were virgins reported they delayed having sex because they were scared of the diseases such as HIV that one can potentially get from having sex without protection; they were scared of falling pregnant. These participants represent only (20%) of the entire study population. A response by a 15 year old was: *“I want to stay a virgin until I’m 18yrs. old or until I get married. I’m also scared of getting HIV. Some guys trick you into having sex without a condom and then you get exposed to HIV.”*

Another participant aged 16 years said: *“I grew up being told that sex is bad. I don’t desire or have a need to have sex. Being a virgin protects me from getting diseases such as HIV and STI’s.”*

Two participants both aged 13 years said they were too young to have sex and want to remain virgins. Almost all the participants in the study, except for 2, thought abstinence by female adolescents was difficult in their community. The main reason was peer pressure from female friends and boyfriends. Teenage alcohol abuse was another inhibiting factor for abstinence.

4.3.5 Early Sexual Debut

The reasons behind early sexual debut of female adolescents were multifactorial. Early sexual debut defined as age at first intercourse to be less than or equal to 15 years. There were varying responses from the participants, the recurring themes were: Peer pressure, gender inequality, alcohol access and abuse, transactional sex, media and social networks, crowded living conditions, poor communication with parents, rape and abuse.

- Peer pressure

This was the most common reason expressed by the participants for engaging in sex. Peer pressure was describes as children having sex in order to try fit in with a particular group of friends. Some children were looking for ways to be popular and gain attention from boys therefore end up engaging in sexual activities. Others are coerced into sex in order to please their partners. The latter being a characteristic of gender inequality. One participant of 17 years, said: *“Some children have sex without a condom because they are still young and don’t know what’s right or wrong when having sex. Some are pressured into sex by their boyfriends.”*

Another 16 year old participant said: *“At the age of 12 or 13 some children are in high school and start mixing with older children and get influenced into doing things that they don’t fully understand or ready for. Guys in high school like the*

younger girls because they are easily influenced and fresh out of primary school and haven't been touched. And being young and in high school you want to fit in and end up having sex with an older boy because you like the attention."

A 15 year old said: *"Friends will tell you that having sex is nice and brag about how many rounds they had with their boyfriend, and then you also feel you'd like to try it. Also want to fit in."*

A 13 year old related: *"Sometimes people start dating when they are young, and they date older guys. Guys always want sex and they feel that to show that they love their boyfriend they must have sex with them. She goes against her own will to please her boyfriend and peers."*

- Easy access to alcohol

This was another reason given for adolescents engaging in sex at an early age. One adolescent aged 18 said: *"Some of them are abusing alcohol and they mingle with adults in the shebeens. They are let into the shebeen because there is no regulatory figure or bouncer at township shebeens and these children sit and drink with older men. They also look older than they are and therefore men think they are older."* Another participant aged 13yrs said: *"Some children are sent by their parents to bottle stores and shebeens to go buy alcohol for their parents. And sometimes they go buy for themselves because they are used to going to these places. There are no regulations in place in townships to prevent selling alcohol to minors and minors accessing taverns and shebeens."*

- Transactional sex and cross-generational sex

This has been reported as a contributing factor to exposure to HIV and other STI's. One participant aged 13 said: *"Some of them are selling their bodies and indulge in alcohol. When they are drunk it's easy for men to take*

advantage of them and they have unprotected sex.” Another participant aged 17yrs said: *“Some children are enticed by older men with money.”*

- The media (mainly television) including social media and networks

A participant aged 16 years said: *“Some children are influenced by what they see on TV. Others watch pornography on their cell phones and want to experience sex.”* Another participant of 18 said: *“Some of them are imitating what they see at home or on TV.”*

- Crowded living conditions

This can also contribute to early sexual debut. Children may see parents having sex and want to mimic the act with other children. One participant of 19 said: *“Its things that they see and observe from adults. And being friends or hanging around people that are older than them. And they get influenced into having sex without fully understanding sex and its consequences.”* Another participant aged 15yrs said: *“Others are exposed to sexual acts by seeing what adults do and also want to experiment.* Another participant of 19 years said: *“Its things that they see and observe from adults. And being friends or hanging around people that are older than them. And they get influenced into having sex without fully understanding sex and its consequences.”*

- Lack of parental supervision and communication with their children

This was also a factor contributing for early sexual debut, expressed by the participants. One participant of 16 years said: *“Lack of guidance by parents. Parents don’t talk to their children about sex and thus children get the wrong information from their friends.”*

Another participant aged 15yrs said: *“There is no support or discipline from parents. Parents don’t guard their children. Children are not supervised and they do anything and everything without being reprimanded. Some parents don’t speak to their children about sex and the dangers of HIV. Some parents*

aren't open. They don't guide their parents, some parents are strict and always lock up their children in the house. And when those children break free they want to go out and try everything."

One participant aged 16yrs said: *"I think parents are not open with their children about sex. They don't speak to their children. Children then get the wrong information from their friends."* Another participant aged 17yrs said: *"At home there is no supervision and children wonder around in the streets until late and come across bad influences and friends. There is lack of parental guidance."*

- Sexual abuse

Including rape is another factor that leads to female adolescents engaging in sex at a young age. One participant aged 13 years said: *"Some children are selling their bodies and indulge in alcohol. When they are drunk it's easy for men to take advantage of them and they have unprotected sex."* Another participant aged 15 said: *"Other children are raped at home by a relative and end up getting used to sex from a young age."*

4.3.6 Contraceptive use

The majority of the participants (85%) were on contraceptives. Those on contraceptives 95% were on an injectable contraceptive. The average age at contraceptive initiation was 15 years. Most participants (40%) were encouraged by their mothers to start using contraceptives. Two participants were advised by a nurse to start using contraceptives. Some participants (35%) decided to go on contraceptives on their own. One participant of 16 said: *"I decided to start using contraceptives because I felt that I'm at that stage where I might want to start having sex and I don't want to fall pregnant so instead of taking chances I decided to start prevention."*

Another participant of 13 years said: *"It was both my mother's choice and mine for me to start using contraceptives. If I had to be raped I wouldn't want to fall pregnant."*

A participant of 13 also echoed the above sentiment saying: *“I was advised by a mom and nurse who sometimes visit school to prevent unwanted pregnancy if I was to get raped. And I don’t want to get HIV.*

“One of the participants felt was not a good experience, said: *“Sometimes the nurse’s shout at you, they sometimes don’t have enough time to spend with us. They don’t explain all the different ways in which someone prevents pregnancies.”*

4.4 Conclusion

Just below half of the study participants (45%) reported they were sexually active. Their average age at first sexual intercourse was 14yrs. The participants’ perceived acceptable age for sexual debut was 18yrs. Reasons contributing to early sexual debut were identified as: peer pressure, easy access to alcohol, transaction and cross-generational sex, media and social networks, crowded living conditions, sexual abuse and lack of parental supervision and communication with children.

CHAPTER 5

RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

Early sexual debut is known to be one of the contributing risk factors for the acquisition of HIV infection but the reasons have not been fully explored (Stöckl, Kalra, Jacobi, & Watts, 2013). The aim of the study was to determine the contributing factors to early sexual debut by female adolescents in the ages between 13-19 attending Town-Two Clinic, in order to develop strategies to bring about behavioural change to prevent, decrease and delay their sexual exposure to HIV/AIDS.

5.2 Objectives of the study

The objectives were to determine the reasons for early sexual debut. Pinto's 6-step approach to HIV prevention in counselling for adolescents (Pinto, 2009) was adopted. It was found to be an ideal way to gain information, as it is client centred and lead by the client's own issues and perceptions. The healthcare provider guides the intervention towards the specific needs of the client. What may be appropriate and relevant to one client may not be applicable to the next one. This approach may not be appropriate for large interventions such as media HIV campaigns and governmental programs as those need to be generalized. This intervention was found to be appropriate for smaller groups such as adolescents that visit community health care facilities. This approach was utilized and tailored to get in-depth knowledge about the reasons behind early sexual debut among female adolescents attending Town-Two clinic. The information received from the interview process with individual participants was analysed and used to develop strategies and educational campaigns/interventions addressing the concerns and needs of adolescents attending Town-two clinic in Khayelitsha.

5.3 Discussion

Objective 1: *Reasons for early sexual debut*

Teenagers are sexually active 45% of participants reported they were sexually active; average age at first sexual intercourse was 14 years. This confirms early sexual debut amongst female adolescents in our setting. Early sexual debut being defined as first sexual intercourse below the age of 15 years as illustrated in the literature (Aji et al., 2013). Lack of condom use at first sexual intercourse reinforces statistical claims that female adolescents have a higher incidence of HIV infection than their male counterparts. More than half (55%) of the participants in this study reported they did not use a condom. Reasons for this were not clear but they reported they did not know why they did not use a condom, they didn't think it through. This reiterates the sentiments above that young girls engaging in sex without having thought about their actions can have negative, unanticipated consequences such as teenage pregnancy and exposes them to HIV.

Being single with no boyfriend seemed to have a protective effect on sexual activity and promoted virginity; 55% reported they were still virgins; of those that were still virgins only one was currently in a relationship. The average age of those that were virgins was 15 years. Other factors that promoted abstinence were a disinterest in sexual activities, fear of the diseases such as HIV and teenage pregnancy.

Various factors were expressed by adolescents living in the community for early sexual debut. Some of these factors have been discussed before in literature and others are new. The main reason behind early sexual debut expressed in the interviews was peer pressure from female peers as well as their male partners. Some of the participants (55%) that were in relationships reported they did at times feel pressured into having sex by their partners. This illustrates domination by the male partner in relationships and the submissive nature of female partners. Even though the participants felt free to negotiate

condom use with their partners they were not always successful in enforcing condom use are sometimes unable to overcome resistance from their partners. This portrays gender inequality and its roles in relationships. The age gap between the female adolescent and their partners also contributes to gender inequality. The average age gap in this study, between the participants and their partners was 3 yrs. Two participants had a 6 year age gap between themselves and their partner. There seems to be a link between students having partners that are 1-5 years older than themselves and HIV transmission, possibly as a result of school-community transmission. Marteleto (2013) reported in Cape Town, early sexual debut is related to having older adolescents at school mixing with younger adolescents due to some scholars not progressing to higher grades (Lam, 2013). Thus there are 18, 19 and 20 year old high school students, whom have been sexually active and at times being involved with 14,15, 16 year olds (Lam, 2013).

Another factor is the lack of parental supervision and guidance. More than half (55%) of the participants reported they do speak to someone about sex and boyfriends at home and 45% said they did not. Some of these participants that did speak to someone, (30%) reported they engaged with their mothers about sex and boyfriends. Reasons for the lack of mother and daughter communication were they felt too shy and embarrassed to speak to their mothers or fathers about sex and boyfriends. They felt their mothers in particular were too 'strict' and unapproachable with the topic of sex. They reported they were scared of what their mother's reaction would be if they brought up the subject of sex. This illustrates the similarities between the views of black South African adolescents and their Nigerian counterparts as well as similarities between their parental views when it comes to discussing sex with their children.

Another factor that has emerged but seldom discussed in literature is the access of children and adolescents to alcohol through taverns and shebeens. Laws do exist preventing traders selling alcohol to children. But there is no

reinforcement of these laws in our communities. There is no personnel in townships that check and restrict access of minors to taverns as seen clubs. Transactional sex has also been in this study mentioned as seen in literature.

Social media and social networks have also been mentioned as contributing factors to early sexual debut. Video clips of sexual acts occurring at school and sometimes rape have been captured on cell phones and they circulate amongst the pupils. These pornographic clips are easily accessible to children on their cell phones.

Crowded living conditions were expressed as a contributory factor to early sexual debut. As illustrated in the data collected in this study many of the participants live in crowded homes in informal settlements. The average number of rooms is 3 and housing an average of 4 people; 70% of the participants reported sharing a room with either siblings or an adult; 70% shared a room 55% also shared their bed.

Objective 2: *Establish the knowledge of adolescent females about HIV & STI transmission*

There is a need for better or further educating adolescents on sex, sexuality, HIV and STI's; 95% of participants said they received sex education at school under the subject "Life Orientation". Represented by 65% reported they were taught about safe sex practices and using a condom every time they have sex. They were taught this would protect them from contracting diseases such as HIV and sexually transmitted infections (STI's). Knowledge gaps were still identified in the interviews with 60% of the participants reporting they would like to receive more information and teaching about STI's, as they knew very little about them; 30% reported they wanted to know more about both HIV and STI's. This suggests the content of the material being taught at school with regards sex, HIV and STI's needs to be evaluated and improved.

Objective 3: *Evaluate what sexual and reproductive health education and management required by adolescents attending the clinic*

The study identified when adolescents go to the clinic for family planning there are missed opportunities to educate adolescents on sexual and reproductive health by nurses. More than half (55%) of the participants reported they did not receive any form of sex education, HIV and STI information at the clinic when they came for family planning. The other 45% said they did receive some education and information in the form of posters and sometimes pamphlets. They sometimes received HIV and STI information when they went for VCT (voluntary counselling and testing) for HIV with a counsellor. All the participants reported they have had a HIV test at least once in their lifetime. Most of the participants (90%) reported they were worried and scared of contracting HIV. One participant of 15 years said she was not scared because there is now medication and therefore one can live a normal life. All the participants found going for VCT as a good experience even though it caused some anxiety when waiting for the results. This illustrates the success of voluntary testing and counselling drive by the department of health.

The majority of the participants represented by 85% were on contraceptives; average age at contraceptive initiation was 15 years. Most participants (40%) were encouraged by their mothers to start using contraceptives. Two participants were advised by a nurse to start using contraceptives. Some of them represented by 35% decided to go on contraceptives on their own. Those on contraceptives (95%) were on an injectable contraceptive. Most of them were unaware of other methods of contraceptives besides the injectable. Thus knowledge on the various methods of contraception available at the clinics was eagerly required. Almost all participants (85%) found the experience of going for family planning at the clinic a good experience.

- **Objective 4: *Provide guidelines to deal with the concerns and needs of female adolescents attending Town-Two Clinic as well as reproductive health education***

Implications & Recommendations

- Governing bodies at schools should hold parental seminars and guidance with regards speaking to their children about sex. Parents need to hold support groups where they share ideas on how to approach the subject of sex with their children. They need to be open and not be defensive and disciplinary when children enquire about issues of a sexual nature. Honesty is the best behaviour when it comes to discussing sex with children as they are not naïve.
- Parents need to know and be aware of what is on their children's cell phones.
- We live in a technological and digital age and new ways need to be invented to restrict and prevent access of pornographic material to children and adolescents. We can use this technology in a positive way to educate youth on sexual and reproductive health.
- Department of Social Welfare needs to be more active in schools as they have a vital role to play where dysfunctional family situations exist where children are vulnerable to abuse.
- There needs to be proper parental guidance when watching television at home. The media and TV stations can recommend parental guidance but parents do not use the facility.
- The department of education needs to regularly evaluate the content of sex education and HIV, STI information being taught to scholars and update it should the need arise.
- Sexual and reproductive education in primary school should be implemented. There needs to be a dialogue between child psychologists, social workers and the department of education where they reach consensus on which grade and age would be appropriate to initiate sex education, keeping in mind that children as young as 7 years have been reported to be sexually active.

- Teachers need training on the correct content and information about HIV protection and prevention as well as areas of support should an individual become infected or already be living with HIV.
- Outreach visits by nurses from clinics to the schools should be encouraged to hold information seminars with regards sexual and reproductive health, reinforcing HIV and STI prevention, recognition and treatment.
- TV station needs to screen series and movies with explicit sex during late evening times when children are supposed to be asleep.
- The role of churches in HIV and sex education needs to be encouraged. Church youth groups offer a great opportunity to deliver education and guidance to developing minds. Churches hold an importance stance in society and should use this to educate youth on safe sex practices.
- There needs to be better reinforcement of regulatory laws that prevent vendors selling alcohol to children; heavy fines or imprisonment of merchants who sell alcohol to minors
- Spot checks and raids of taverns and shebeens looking for minors indulging in alcohol.
- Prior to approving alcohol trading licenses to taverns and shebeens there needs to be an added prerequisite of personnel who will regulate entry into the facility and bounce and reject entry of minors to such establishments.

Recommendations from participants targeted at the Department of Health and Clinics. The following recommendations are from the participants themselves, as they expressed what information is important to them and how they would like to receive this information.

- “Nurse driven outreach programs visiting school on a particular day or days and hold educational seminars or lesson on sex, HIV and STI’s. We do not have adequate knowledge about STI’s and we would like to know more. And maybe on that day the nurses can do VCT’s and promote testing and also offer family planning.”
- “Nurses or counsellors to hold a short talk or discussion before we have our injections teaching us about sex and HIV and STI’s.”

- “Hold an event where you invite youth from the community to the clinic and teach them about STI’s and HIV. Inform youth about contraceptives and where to go for more information and education on sex, HIV and STI’s. Youth would attend such an event.”
- “Hold various projects and talks to educate youth more about sex and pregnancies. Hold informal talks in the clinic while we wait to be seen and maybe show various movies that educate about HIV prevention and preventing teenage pregnancies.”
- “Peer education. Have people our own age to talk about these issues. And maybe they will be able to relay the message better.”
- “Education in the form of a support group where youth are brought together in a room and discuss their experiences and share ideas on how to protect themselves. Have a nurse or doctor to explain things that we are not clear about when it comes to sex. Have posters that advertise support group times at schools.”

5.4 Conclusion

HIV is largely linked to behaviour; social science plays a major role in trying to change behavioural patterns. This study demonstrates the role of early sexual debut amongst female adolescents, as a contributing risk factor to HIV infection. Reasons contributing to early sexual debut were identified as: peer pressure, easy access to alcohol, transaction and cross-generational sex, media and social networks, crowded living conditions, sexual abuse and lack of parental supervision and communication with children.

South Africa has been dealing with HIV for the past 30 years. Various gaps in knowledge on HIV and STI’s were identified. Multidisciplinary recommendations have been identified and addressed. This study illustrates the importance of education. Education still holds a vital role in HIV prevention and treatment. There needs to be continuous provision of information which is up-to-date and appropriate to its target population. The health sector plays a vital role in educating all members of society on HIV and STI’s. Health sector

needs to collaborate with the Department of Education in developing effective programs for educating youth on HIV prevention and reproductive health. Parents play a vital role in educating their own children and need to overcome their socio-cultural views about sex. They are the first source of education for their children. They also need to live by example as they shape their children's behaviours, beliefs and views. Adolescents and the youth in general hold crucial sources of information for policy and program makers regarding issues that concern them. In the era of HIV, communication and education is imperative.

African countries can learn from one another by feeling comfortable and confident in adopting each other's HIV preventative measures and tailor them to the local setting. Our populations, socio-economic backgrounds, gender norms, cultural practices and beliefs are all similar. African researchers are in the best position to investigate these social norms and practices as they can identify with them and the population. African countries can bring about and implement new strategies to help reduce the incidence and prevalence of HIV among its people.

Revisiting the limitations

- The sample could be extended to include more communities to enable a comparison.
- Comparative studies could be conducted including boys of comparable ages.
- Larger samples could produce a wider range of responses
- This study could lead to further post graduate research

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