HIV/AIDS-RELATED KNOWLEDGE, ATTITUDES AND BEHAVIOUR OF FET COLLEGE STUDENTS: IMPLICATIONS FOR SEXUAL HEALTH PROMOTION.
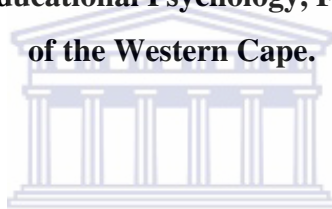
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Submitted in fulfillment of the requirements for the degree of Doctorate of Philosophy (PHD) in the Department of Educational Psychology, Faculty of Education, University of the Western Cape.

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DEDICATION

**I dedicate this thesis
to my Father in Heaven who has made this possible and my parents who have joined
him.**

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

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Signature: Colleen Gail Moodley   Date

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WESTERN CAPE

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I thank my LORD and GOD, JESUS CHRIST for his fountain of blessings and constant comfort and love that he bestows upon me at the best of times and at the worst of times.

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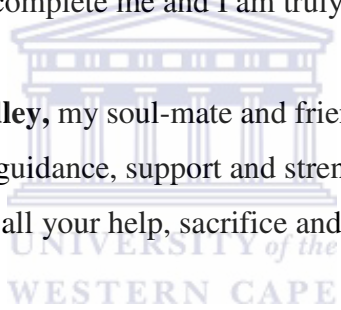
ABSTRACT

HIV/AIDS poses a major threat to South African youth with health promotion campaigns and participatory peer education approaches seemingly having had limited impact. Research contends that the education sector could play a role in promoting sexual health. This study investigated the HIV/AIDS-related knowledge, attitudes and sexual practices of 18-to- 24-year-old students at a Further Education and Training (FET) college. The relationships between participants' sexual practices and the variables: self-efficacy, self-concept, HIV/AIDS knowledge and gender were also investigated. Furthermore the study aimed to explore college students' perceptions and/or experiences of decision-making in relation to their engagement in safe or unsafe sexual practices.

A concurrent mixed model design was used for data collection with the qualitative component (focus group discussions) complementing and adding to information gathered quantitatively using self-administered questionnaires. Data of 554 students were included in the quantitative component.

The quantitative findings indicated high levels of HIV/AIDS knowledge, self-concept and self-efficacy. Risky sexual behaviour was measured in terms of condom use and the number of sexual partners in the 12 months prior to the study with males reporting significantly more risky sexual behaviour. More males (70% vs. 43 % females) reported no condom use when engaging in sex. More males (62 % vs. 28 % females) reported having had two or more sexual partners in the 12 months prior to the study. Results also suggested that an increase in knowledge of HIV/AIDS would predict an increase in the use of condoms particularly for males. Lower self-efficacy seemed to predict an increase in the number of sexual partners for males. The focus group discussions highlighted students' views of HIV/AIDS knowledge in relation to their sexual practices, attitudes and sexual decision-making. Influences such as personal factors (self–concept and self-efficacy), social factors (e.g. peer influences, gender, and status) and environmental factors (e.g. media) were investigated. Participants also commented on the effectiveness of HIV/AIDS campaigns and the adequacy in provision of health services at college and community level. From the findings, guidelines were developed which may be used to reflect on current intervention programmes and may be considered when developing future interventions programmes, policies, or campaigns in promoting safer sexual practices amongst youth as a means of addressing the HIV/AIDS pandemic.

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1   Introduction- Contextual information and rationale for the study

The rampant spread of the Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome (HIV/AIDS) globally seems unprecedented in the course of human history.   According to The Joint United Nations Programme on HIV/AIDS (UNAIDS) 38.6 million people are living with HIV/AIDS, almost double the number of 19.9 million in 1995.   Worldwide, there are also about 11000 new HIV infections and nearly 8 000 AIDS-related deaths per day (UNAIDS, 2008).

Research indicates that sub-Saharan Africa remains the region most affected by the HIV/AIDS pandemic.   The National HIV & AIDS and STI Strategic Plan (NSP) for South Africa 2007-2011 (2007) estimated that in 2006, more than 63% of HIV-infected people worldwide live in sub-Saharan Africa. This region accounts for 10% of the world's population, yet by 2005, 24.5 million of its people were infected with HIV/AIDS, including 2 million children younger than 15 years.   There were about 2 million AIDS-related deaths in 2005 and 2.7 million new infections in 2005.   The number of women with HIV in sub-Saharan Africa in 2005 numbered around 13.2 million, 59% of adults (UNAIDS, 2008).

South Africa too, has been severely impacted by the HIV/AIDS pandemic with future prospects looking bleak.   Ngwena (2003: 185) states that with the exception of India, South Africa has the largest number of people living with HIV/AIDS.   HIV/AIDS has become the biggest single contributor to morbidity and mortality in South Africa (Medical Research Council, 2001). About 5.54 million people were estimated to be living with HIV in South Africa in 2005.   Even more concerning is the disproportionate HIV prevalence in terms of gender.Women account for 55% of people living with HIV/AIDS in South Africa with 18.8% of the adult population (15-49 years) affected (NSP 2007-2011, 2007: 9).   AIDS is considered the main cause of premature deaths.

Mortality rates have increased by approximately 79% in the period 1997-2004, with a significantly higher increase in women than in men. Women, therefore withstand the worst of the HIV/AIDS pandemic. This phenomenon is very prominent in the age groups 20-24 and 25-29 years where the HIV prevalence rates are 23.9% for women to 6.0% for men and 33.3% for women to 12.1% for men, respectively. The peak age for HIV infection in women is 25-29 years while for men it is the 30-35 years age group (NSP, 2007-2011, 2007: 29).

The United Nations Population Fund (UNFPA, 2003a) reports that the world has its largest generation of adolescents in history, 1.2 billion, yet half of all new HIV/AIDS infections occur in people aged 15 to 24 years (youth). At the end of 2001, 11.8 million worldwide in this age cohort were living with (HIV/AIDS). Thus, young people, including young South Africans have also felt the impact of the HIV/AIDS pandemic. One study estimates that 10% of South African 15-24 year olds are HIV positive (NSP 2007: 37)., whilst another estimate is that overall HIV prevalence amongst this age cohort is about 8.7 % (Shisana et al., 2009). About 77% of all South African youth infected with HIV are female (NSP 2007-2011, 2007: 37).

The above discussion suggests that HIV/AIDS is posing a major threat to South Africans, especially the youth[1]. Therefore, it seems that the future course of the HIV/AIDS pandemic depends on the behaviours that young people adopt earlier in their lives. The South African government has recognised the need for intervention prior to the infection period. Therefore, one of the main aims of the NSP 2007-2011 (2007) is to reduce the rapid rate of new HIV/AIDS infections amongst people in the age group 15- 24 years.

The South African government has implemented extensive anti-AIDS and health promotion campaigns to encourage responsible sexual practices amongst youth.

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[1] For the purpose of this study, the term youth will be used interchangeably with the terms young people, adolescence, late adolescence and emerging adults to denote the participants in this study's age cohort 18-24 years. See Chapter 2 for the researcher's motivation to use these terms interchangeably when describing this age cohort.

However, given the above statistics these campaigns have failed to bring about positive behaviour change amongst young people (Visser, 1996; MacPhail & Campbell, 2001; Hartell, 2005). Government efforts to implement participatory peer education approaches have also had limited impact on the AIDS epidemic, which continues to rise (MacPhail & Campbell, 2001). Qakisa (2003) posits that most HIV/AIDS campaigns in South Africa have been unsuccessful in achieving their goal because of poor conceptualisation and narrow strategic approaches. Hartell (2005) advises that current promotion programmes need to be revised.

Researchers also hold various views on the focus of intervention programmes. Kaaya et al. (2002) contend that understanding why young people engage in sexual risk-taking assists in defining the objectives of intervention projects, such as what behaviour to address and which age groups and gender should be prioritised. Varga (1997) contends that intervention efforts should not only focus on sexual behaviour but must adopt an ecological approach. This means that there should be a focus on other issues like political, economic and socio-cultural determinants of high-risk sexual practices. Bremridge (2000) agrees with Varga and asserts that risk-reduction programmes that only provide information, without paying attention to the orientation and social context of the individual will not be adequate in bringing about change in sexual behaviour. She proposes that health communication theories be used in these campaigns to bring about positive behavioural change if designed properly. This is supported by Kotler and Kotler and Andreasen (2003:5) who assert that successful health promotion programmes have to adhere to criteria that are acceptable to the consumer (target audience). Programme developers should thus be au fait with social marketing principles.

1.2   Factors influencing sexual practices amongst youth

When considering the aforementioned views relating to intervention programmes, there appears to be a range of factors that influence young peoples' sexual practices. These factors include knowledge of HIV/AIDS, sexual decision-making, intrapersonal and external factors such as peer and family influence, and social factors such as poverty.

Zwane, Mngadi and Nxumalo (2004) found that factors such as socio economic status, relationships, family structure, pubertal maturity, various personalities and characteristics are linked to the timing and frequency of sexual activity. A brief discussion of the factors involved in influencing young people's sexual practices ensues.

Various researchers have tried to explain the relationship between HIV/AIDS knowledge and risky sexual behaviour. Possessing knowledge of a specific issue is seen to lead to informed decision-making. Thus, if the broader community and specifically youth were educated and made aware of HIV/AIDS, positive behaviour change would occur (Schell & Zeitlin, 2001; Strydom, 2003). Research indeed indicates that globally youth possess high levels of knowledge regarding the spread of HIV/AIDS but show gaps in their knowledge (UNAIDS, 2008). Studies conducted amongst South African youth also produced similar findings (Shisana et al., 2009).

Research clearly indicates that knowledge or education alone will not bring about the expected behaviour change in youth. It appears that although young people have obtained knowledge regarding sexual risk-taking they have not adapted their behaviour to suit the knowledge they have acquired. Various researchers have highlighted that youth still engage in high-risk sexual behaviour (Hubbs-Tait & Garmon, 1995; Taylor, Dlaminini, Kagoro, Jinabhai, & de Vries, 2003; Zwane et al., 2004; Hartell, 2005; NSP 2007-2011, 2007). Therefore, literature provides no definitive evidence that possessing knowledge of the consequences of risk-taking behaviour reduces high-risk behaviour. Literature further suggests that though youth possess knowledge they should be taught to implement this knowledge in sexual decision-making (Erulkar, Beksinska & Cebekhulu, 2001). Gordon (1996) contends that both the actual knowledge of the person and the ability to draw upon that knowledge affects decision-making.

Pettifor et al. (2005) contend that young peoples' behaviour place them at risk of contracting sexually transmitted infections (STI's). Included in these risky behaviours is the number of sexual partners. The greater the number of sexual partners an individual

has, the greater the likelihood of exposure to STI's as well as the inconsistent use of condoms and contraceptives.

Sexual decision-making is an important factor influencing sexual practices. In turn, sexual decision-making is influenced by other factors. For example, the developmental phase of an individual influences sexual decision-making. For instance, during the adolescent phase the individual's level of cognitive development influences the decisions of the individual to engage or not to engage in sexual practices (Louw, Van Ede & Louw, 1998). These authors have focused on the role that the cognitive development of young people plays in the choices made. They found that young people question their parents, judge political, social and religious systems, are idealistic and question values, norms, views and social systems. Youth are also introspective which leads to self-criticism as norms are usually measured by the standards of the peer group. This leads to the assumption that adolescents are less likely to accept what is presented as the norm and the plans of adults but are more likely to investigate and critically decide from their perspectives what is acceptable and what is not. Family and peers are therefore considered key socialising agents in the lives of adolescents (Fisher, 1987, Crockett & Randall, 2006).

Various researchers still differ concerning the factors that influence young people's sexual decision- making (Strydom, 2003: 4). Abott- Chapman and Denholm (1997) and Crockett and Randall (2006) contend that romance, love and trust are such over-riding needs in this developmental phase that they influence decision-making. Some researchers found that open communication about sexual issues promotes positive behaviour change, such as delay in sexual debut and increasing safer sexual behaviour (Haupt, Moonshi & Smallwood, 2004; Pettifor et al., 2004). A number of researchers have also investigated the role of egocentrism and feelings of invincibility that may influence young people's behaviours and relationships. Arnett (1996) found that the practice of having sex without contraception and sex with a casual acquaintance was higher for college students than any other age. Pettifor et al. (2005) found that the majority of South African youth do not consider that they are personally at risk for

contracting HIV. This indicates that if youth do not perceive themselves at risk they do not consider the need for protecting themselves.

Literature further suggests that intrapersonal factors play a role in sexual decision-making. Several studies indicate an association between self-concept and sexual-decision-making. Low self-concept has been linked to engaging in high-risk sexual behaviours (McNair, Carter & Williams, 1998). Hollar and Snizek (1996) found that high self-esteem could promote high-risk sexual behaviour. They found that college students who have high levels of self-esteem and HIV/AIDS knowledge tended to engage in high-risk, sexual practices. They posit that by engaging in high risk sexual behaviours an individual's self-esteem is increased which fulfils the need for acknowledgment thus increasing their status within the college culture. Other research however has found no or little association between self-concept and sexual decision-making. Langer, Warheit, and McDonald (2001) found no significant link between self-esteem and risky sexual behaviour when investigating a group of multi- racial university students. Literature thus seems to be inconclusive regarding the relationship between an individual's level of self-concept and their tendency to engage in high-risk sexual behaviours.

Various researchers also suggest a link between self- efficacy and sexual behaviour. In a South African study, Perkel (1992) found that a weak sense of self-efficacy was linked to poor knowledge of and negative attitude toward risky sexual behaviour, as well as a higher frequency of unsafe sexual practices in a study amongst 308 students at a South African university. Several studies indicate that a high perception of self-efficacy was positively related to a reduction in high HIV- risk behaviours. Seal, Minichiello and Omodei (1997) found that sexual self-efficacy (contrary to expectations) was positively associated with increased sexual risk with casual partners (but not with regular partners) among a sample of Australian female university students. Burns and Dillon (2005) and. Mashegoane, Moalusi, Ngoepe and Peltzer (2004) reported similar findings. Thus, literature seems to be inconclusive regarding the influence of self-efficacy on high-risk sexual behaviours.

Several researchers contend that socio-cultural determinants have an influence on adolescent sexual behaviour. Campbell and MacPhail (2002) found that gender norms restrict young women in exercising their negotiating powers to protect themselves in sexual encounters. The dominant social norms of masculinity portray young men as macho risk-takers and conquering heroes in the sexual sphere. Alternatively, women are expected to be passive to male advances. Qakisa (2003) agrees and asserts that women are taught to accept their sexual partner's behaviour and not question it. Qakisa's study indicated that 70% of rural women thought that men had a right to have multiple sexual partners and could refuse the use of condoms. Madise, Zulu and Ciera (2007) highlight the significance of ethnicity as a variable, and that social and cultural factors influence young people's sexual behaviour.

The use of drugs and alcohol has also been associated with young people's sexual decision-making. A study across nine European cities involving 1341 young adults with a median age of 21 years, indicated strong associations between sex and drugs and alcohol use in all cities studied (Bellis etal., 2008). Respondents' current drug and alcohol use was associated with having multiple sexual partners. This meant that the use of drugs or alcohol before intercourse could directly impair judgment. For example, adolescents and young adults may also drink or use drugs to engage in risk-taking (Bellis et al., 2008). South African studies on a similar age cohort concerning the use of drugs (Peltzer et al., 2009) and alcohol (Peltzer & Ramlagan, 2009) agree with the general finding that individuals using drugs and alcohol engage in sexual risk behaviours more often than those that do not use drugs or alcohol.

Several researchers have also considered religion as a factor in sexual decision-making. Extensive research has found that religiosity has been linked to sexual abstinence in youth. (Paul, Fitzjohn, Eberhart-Phillips, Herbison, & Dickson, 2000; McCree et al., 2003; Koffi, & Kawahara, 2008).

Literature has established a link between socio-economic conditions and sexual behaviour. Madise et al. (2007) conducted a study in four African countries. They used data from more than 19,000 adolescents to investigate whether poverty influenced sexual practices. Their findings indicate that poverty influences early sexual debut,

especially among females. The poor are also less likely to use condoms. Therefore, poverty, by influencing sexual behaviour and access to services, is able to influence the transmission of HIV infection.

1.3   The role of the education sector

The role of the education institution in promoting sexual health is crucial. Ngwena (2003) contends that the education sector is in a favourable position to monitor new HIV/AIDS infections in children and young people. He contends that learners are in a process of learning sexual behaviour and are more inclined to be receptive to adopt safer sexual practices than adults who have already established their sexual practices. This means that an entire generation of children and young people could be protected from being infected by HIV/AIDS; which in turn would contain the epidemic.

The Western Cape Education Department (WCED) and the Further Education and Training (FET) colleges have recognised the challenges South Africans face regarding the HIV/AIDS pandemic and have attempted to address the needs of young people at FET institutions through the introduction of student support services. The Department of National Education in South Africa has also ratified a policy aimed at addressing HIV/AIDS in schools as well as other institutions of learning (The National Policy on HIV/AIDS for learners and educators in public schools, and students and educators in Further Education and Training Institutions of 1999, (1999). Furthermore, the life skills programme has been incorporated into the college sector for the first time via the National Curriculum Vocation (NCV) programme that commenced in 2007. The NCV life skills programme covers the following topics over a three-year period: goal setting and planning; health and wellness; career planning and personal development; health and positive living; research skills; team work, leadership and managing diversity. The programme is aimed at providing a comprehensive package of the necessary life skills required to equip students to cope with life and in the world of work (The FET colleges Act no 16 of 2006).

However, there is a paucity of studies in the FET college sector investigating areas for intervention and identifying gaps in HIV/AIDS related knowledge, attitude and practices. Ferreira (2002) found that young people at FET colleges have insufficient knowledge, confidence and life skills to negotiate sexual issues, contraception, prevention of STI's and HIV/AIDS. The baseline survey and needs assessment of FET colleges, conducted by the Planned Parenthood Association of South Africa (PPASA) (2004) amongst 6 FET colleges in The Western Cape, attempted to investigate some of these aspects. The study's findings concur with Ferreira (2002), that students are aware of the dangers of HIV/AIDS but that there are still gaps in HIV/AIDS related knowledge. A very large number of respondents also reflected a sense of AIDS apathy. Thus, new and innovative messages and methods of training are required to communicate HIV/AIDS information. Furthermore, the most important needs of students and staff at FET colleges are continuous counselling for those affected and infected by HIV/AIDS, attending to the pregnancy and drug problems on the campuses, provision of voluntary counselling and testing (VCT) services and provision of condoms.
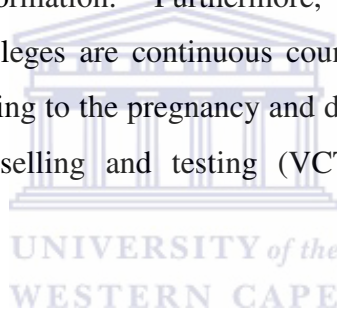
The above discussion gives an indication of the types of interventions needed in the FET college sector. It is against this background that the researcher explored the area of youth sexual behaviour and sexual health promotion in the FET college sector in an attempt to produce structured guidelines for promoting healthy sexual practices in this sector. These guidelines could be used to influence or direct the course of action for promoting responsible sexual practices. The guidelines are intended for policy makers and families, the youth and practitioners in the relevant fields like health, social development, recreation and education. These guidelines could also be used to contribute to health promotion in its entirety being infused within the FET curriculum.

MacPhail and Campbell (2001) contend that a key aim of sexual health promotion is, to provide the context for young people to renegotiate dominant high-risk behavioural norms and to establish new norms of behaviour. Bodiroza, a youth reproductive health and HIV/AIDS specialist for the United Nations Population Fund (UNFPA), aptly describes the manner in which this problem should be addressed. She states that by

focusing on and bringing to scale behaviour change interventions, thousands of young lives could be saved (UNFPA, 2003b).

1.4   Problem statement

Despite numerous interventions by many stakeholders, HIV/AIDS prevalence is still a major challenge to South African society, posing grave social and economic ramifications. Since the spread of HIV/AIDS is largely associated with a host of socio-political factors, HIV/AIDS is as much a social disease as it is a medical disease. Thus, more research is required to unravel and understand the many complex factors related to the spread of HIV/AIDS, including the many factors influencing the sexual behaviours of late adolescence/ emerging adults, a key target population in trying to arrest the course of the HIV/AIDS pandemic.

1.5   Significance

Studying the sexual behaviour patterns of youth is crucial, since their behaviours affect the future course of the HIV/AIDS pandemic. This research is relevant because it affords the researcher the opportunity to focus on the FET population, consisting overwhelmingly of youth. The researcher therefore hopes to engage with young people on issues related to their sexual behaviours. The institutionalized learning environment would be able to assist their student population in and outside the college environment in making informed sexual decisions that do not jeopardize themselves or their partners for HIV/AIDS, STI's and pregnancy. The study will be able to provide guidelines on sexual health promotion to all individuals, NGO's, community organisations and state departments dealing with young people

1.6   Aim of research

The aim of the research was to explore the knowledge of HIV/ AIDS and sexual practices of students (aged 18-24 years) at a FET college in the Western Cape. Both quantitative and qualitative methods were used in an attempt to produce structured

guidelines that could be used to influence or direct the course of action for promoting responsible sexual practices in this sector. The use of these different approaches served to enrich and cross- validate each other.

1.7   Objectives

1. To describe the levels of HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices of students at a selected FET college.

2. To describe and compare the gender groups in terms of HIV/AIDS knowledge, self-efficacy, self-concept, and sexual practices.

3. To investigate whether there is a relationship between HIV/AIDS knowledge, self-efficacy, self-concept, and sexual practices of students at a selected FET college.

4. To investigate whether there is a relationship between gender and sexual practices beyond that explained by knowledge, self-efficacy and self-concept.

5. To explore students at a selected FET college's perceptions and/or experiences of decision-making in relation to their engagement in safe or unsafe sexual practices.

6. To explore respondents' views on and their experiences of sexual health promotion in terms of HIV/AIDS.

7. To develop relevant sexual health promotion guidelines.

1.8 Definition of terms used in study

Adolescence: Ackermann (2001: 104-105) defines adolescence in terms of a developmental approach and describes this phase of development as a process of exploration where decisions are made concerning individual matters such as future goals, religion, politics, moral values, etc.. He further describes this phase as "the movement from relative dependence to relative independence and autonomy".

Ackermann contends that internal levels of psycho-social maturity determine the beginning and ending of adolescence. This is a crucial developmental process of transition that differs in duration for each person. He distinguishes between middle and late adolescence and considers middle adolescence (15-18 years) and late adolescence (18-22/25 years (Ackerman, 2001).

Super (1980) describes adolescence as occurring between the ages of 14 and 24, known as the *exploration* phase.The United Nations Population Fund (UNFPA) also defines adolescents as males and females between the ages of 14 and 24 (UNFPA, 2003b).

The World Health Organisation (in Population Report, 1995) defines adolescence as the progression from the appearance of secondary sex characteristics; development of adult mental processes and the transition from total socio-economic dependence to relative dependence.

Late adolescence is considered as the developmental stage between the ages of 18-24 years (Newman & Newman, 2006).

Emerging adulthood: Arnett (2000: 469) refers to emerging adulthood as a phase that is "neither adolescence nor young adulthood but is theoretically and empirically distinct from them both".

Guidelines: The Collins English Dictionary (2003: 726) defines guidelines as "principles that are put forward to set a standard or to determine a cause of action" or as a series of experiences that staff must follow in order to attain an objective.

The National Qualifications Framework (NQF) & Curriculum Development, (1999:18) defines guidelines as "a basis for determining a course of action or list of suggestions in a document that is used to communicate the recommended procedure and process of a particular practice to achieve a certain goal".

Health promotion: Is defined in terms of the Ottawa Charter of the World Health Organisation in 1986:

Health promotion is the process in enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment.

Sexual health: "Sexual health refers to a state of physical, mental, emotional and social well-being linked to sexuality; not merely the absence of disease, dysfunction or infirmity" (WHO, 2002b). Satcher (2001:1) defines sexual health as follows:

Sexual health is not limited to the absence of disease or dysfunction, nor is its importance confined to just the reproductive years. It includes the ability to understand and weigh the risks, responsibilities, outcomes and impacts of sexual actions and to practice abstinence when appropriate. It includes freedom from sexual abuse and discrimination and the ability of individuals to integrate their sexuality into their lives, derive pleasure from it and to reproduce if they so choose.

A Health promoting educational institution: Is defined as an institution whose objective is to achieve healthy lifestyles for its entire population by developing supportive environments that contribute to the promotion of health. It provides opportunities for a secure and health-enhancing physical and social environment and requires commitment (The National Guidelines (2002) for the development of Health Promoting schools/sites in South Africa further (Health Promotion, task team, 2000).

In the Department of Education's report: Quality Education For All: overcoming barriers to learning and development; report to the National Commission on the special needs in education and training (NCSET) and National committee for Education Support Services (NCESS) (1997: 38), the concept **of health promoting sites** is defined as:

a place where all members of the learning community work together to provide students with integrated and positive experiences and structures which promote and protect their well-being. This includes the curricula in health, physical, social and emotional health, the development of health- promoting policies, the creation of a safe and healthy environment and support services and the

involvement of the family and the wider community in efforts to promote well-being. A health promotion site is a site that is constantly strengthening its own capacity as a healthy setting for living, learning, training and working.

Self-concept: Is defined as the totality of an individual's thoughts and feelings having reference to himself as an object (Gecas, 1982: 1).

Self-efficacy: Bandura (1977) proposed that an important source of motivation for any particular activity is the belief that one is competent to perform it at a reasonable level. This competence is defined as self-efficacy; a form of environmental mastery based on personal judgement of one's capabilities.

Self-esteem: Refers to the evaluation that the individual makes and maintains concerning himself/ herself: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy (Coopersmith, 1967: 4-5). Because self-esteem is a fundamental element of self-concept, both constructs are often used interchangeably and are given a range of labels: self-evaluation, self-respect, self-confidence, self-attitude, self-image, self-view, self-schema, self-worth, self-approval, and self-satisfaction, etc (Gecas, 1982)

Sexual behaviour: Varga (1997:51-52) refers to sexual behaviour as denoting physical actions associated with the act of sexual intercourse, penetration of the penis in the vagina or anus. Millstein, Petersen and Nightingale (1993) refer to sexual behaviour as a result of arousal that may be expressed individually or with another person and includes Masturbation. Sexual behaviour with a partner includes kissing, petting and sexual intercourse. For the purpose of this study, sexual behaviour refers to sexual intercourse with a partner or partners.

Sexual knowledge: In this study, knowledge is related to sexual behaviour and practices and refers to factors concerning HIV/AIDS such as modes of transmission, precautionary measures, risk behaviours and its implications. The concept of knowledge

differs from the concept of awareness and is highly complex (du Plessis, Meyer-Weitz, & Steyn, 1993).

Sexual practices: In this study, sexual practices refer to the number of sexual partners that participants are involved with as well as the use (or lack of use) of condoms when engaging in sexual intercourse.

Youth: The National Youth Policy 2008-2013 is used inclusively to refer to youth as young people within the age group of 14 to 35 years.

1.9   Outline of the thesis

The **first chapter** highlighted the need for investigating the sexual risk behaviour of youth , specifically emerging adults in a FET institution. Furthermore, the chapter outlines the statement of the problem as well as the significance of the study. The aims and objectives of the study and the definition of key terms used in the study are then discussed. Chapter 1 concludes with a brief outline of the study.

In **Chapter two** the relevant core concepts, such as sexual behaviour and sexual risk taking are clarified. Sexual decision-making and perspectives on the relationship between knowledge, attitudes and behaviour is examined. The life span and developmental tasks of participants in this study is explored. Empirical evidence concerning relevant theories; individual models used to investigate sexual –decision making are presented. These theories include the Health belief model, the AIDS risk reduction model, Theory of Reasoned Action, , Theory of planned behaviour, Social cognitive learning theory, Social Modelling/ Social learning Theory and Self-efficacy, The Trans-theoretical approach and the Conflict Theory of decision-making. Furthermore, theories concerning the influence of gender dynamics such as the Theory of Gender and power are discussed. In addition, Ecological systems models are discussed to underscore the view that individual models that explain sexual behaviour is embedded in the interactions between the broader environmental and social systems and the individual.   Factors that affect sexual decision- making such as self-concept and self-efficacy are also explored.

Chapter 3 describes the research method used in the study. The research sample, the research instruments used, and statistical methods used to analyze the data are presented. Furthermore, the ethical guidelines considered are outlined.

In **Chapter 4** the results and outcomes of the quantitative data collected are presented. The data is presented in the form of tables and graphs and use percentages, frequencies, means and standard deviations. The levels of HIV/AIDS knowledge, self- efficacy, self -concept, and sexual practices (condom use and number of partners in the 12 months prior to the study) in the sample are described. Further associations between gender, HIV/AIDS knowledge and self-efficacy, self- concept, and sexual practices (condom use and number of partners in the 12 months prior to the study) are reported.

Chapter 5   presents a discussion of the findings that emerged from the quantitative phase of the study. The discussion follows a thematic approach rather than a discussion of individual objectives as stated in chapter one and three.

Chapter 6 presents the results of the thematic analysis of the focus group discussions which aimed to address the fifth objective of the study. The focus group discussions explored the perceptions and experiences of decision making in relation to the engagement in safe or unsafe sexual practices of FET college students

Chapter 7 presents a framework depicting core findings indicating implications for policies and programmes for sexual health promotion. These findings are presented in the form of Sexual health promotion guidelines that emerged from the quantitative and qualitative findings of the study.

Chapter 8   The final chapter discusses the limitations of the study and concludes the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

As indicated in the first chapter, a discussion of literature related to this study serves to frame the study and clarifies core concepts relevant to this study. Although the researcher's interest for this study was primarily concerned with the relationship amongst personal factors like self-concept, self-efficacy and gender, in relation to sexual practices; these concepts are socially constructed and it was necessary to explore behavioural change theories related to sexual behaviour. Therefore, the discussion also includes theoretical perspectives that provide a holistic view of the sexual behaviour of youth, thus informing guidelines for the promotion of sexual health (the latter being the final objective of this study).

The discussion thus starts with a clarification of core concepts. Thereafter, an exploration of theoretical perspectives on the life stage and developmental tasks of participants and a summary of related theories and research on factors that may affect sexual decision-making follow.

2.2 Clarification of key concepts

2.2.1 Sexuality

Sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual (WHO, 2002b).

Varga (1997: 52) posits that sexuality encompasses physical capacity for arousal and pleasure as well as personalised and shared social meanings attached to sexual behaviour and the formation of sexual and gender identities. Dixon-Mueller (1993: 273) defines sexuality as a concept including personal feelings, desires and beliefs as well as socially accepted attitudes, norms and meaning with regard to interaction with other individuals regardless of their gender. Sexuality includes all dimensions of personality and does not only pertain to an individual's ability for erotic response. It refers to all aspects of being sexual and incorporates an individual's biological, psychological, behavioural, clinical and cultural dimensions (Millstein et al., 1993).

Asia (2004: 30) contends that double standards still exists regarding the concept of sexuality for the different genders, claiming that sexual desire is considered salient for males and is ignored for females. It is also seldom discussed in the case of females but emphasis is rather placed on the consequences of such behaviour, such as pregnancy. The issue of gender   and sexual behaviour will be examined later in this study.

Sexuality is a more comprehensive concept than sexual behaviour. It also includes physical capacity for arousal and pleasure (libido) as well as personalised and shared social meanings attached to sexual behaviour and the formation of sexual and gender identities. Therefore, the salience of sexuality in behaviour research is highlighted by the following statement "Without the focus on sexuality as the basis of sexual behaviour, interventions targeting sexual behaviour change are likely to be insignificant, temporary and ineffective in the long term" (Varga, 1997: 52).

Given the age cohort of this study's population, it may be pertinent to highlight the concept adolescent sexuality. **Adolescent sexuality** is viewed as part of the broader context of adolescent developmental or transition tasks. The conceptualisation as part of a developmental or transition process, underscores the importance of adolescent sexuality. Therefore, adolescent sexuality has to be understood as a process or series of varying and overlapping behaviours, attitudes and experiences. In addition, adolescent

sexuality is understood to be part of a context of behaviours and developmental processes (Bremridge, 2000: 9).

2.2.2   Sexual behaviour

Various researchers define sexual behaviour differently. Sexual behaviour is viewed as one aspect of human sexuality (Lesch, 2000). Varga (1997:51-52) explains sexual behaviour as denoting physical actions associated with the act of sexual intercourse such as penetration of the vagina or anus.   By definition, sex necessitates the participation of at least two people.   Thus, sexual behaviour is a product of the combination of partners' sexuality, decision-making, and negotiation (Dixon-Mueller, 1993).   However, Millstein et al. (1993) contend that sexual behaviour results from arousal that may be expressed individually or with another person.   Therefore, masturbation is considered a form of individual response where the adolescent is free to choose whether to masturbate or not. Dixon-Mueller (1993: 273) distinguishes sexual behaviour as actions that are empirically observable (in principle at least) what people do with others or with themselves, how they present themselves sexually. This includes acts and verbal communication leading up to intercourse described as foreplay. The actions involved that lead to sexual intercourse, is also viewed as sexual behaviour. Therefore, sexual behaviour with a partner includes kissing, petting and sexual intercourse (Millstein et al., 1993).

Various researchers have used a range of theories to investigate the various aspects of sexual behaviour of individuals in the age cohort 18-24 years. The latter part of this chapter will discuss some of the research conducted in relation to the behaviour change theories and models used.

2.2.3   Sexual risk-taking

Moore, Gullone and Kostanski (1997: 370) define risk as behaviour for which the outcome is uncertain and which involves potential negative consequences.   Gordon (1996: 562) describes a risk taker as one who knowingly risks harm by engaging in a

particular activity. Furthermore, if an individual does not view the activity as harmful then engaging in it cannot be labelled as harmful. Risk behaviour is also defined as "a way of conducting oneself in an intense or extreme way thus increasing the chance of exposure to mischance alcohol and drug abuse" (Gordon, 1996: 562). Included in this definition is anal sex with or without a condom, having sex with multiple partners, or having sex with someone who has had several sexual partners themselves including casual sex or sex with a prostitute (Lesejane, 2004: 14).

Risk-taking behaviour is regarded as behaviour that could endanger the physical and psychological well-being of the adolescent. These could cause the adolescent to engage in substance and drug abuse, physical violence, suicidal behaviour and unprotected sexual intercourse (Jessor, 1998).

In this study, the term "risk" refers to activities that place an individual or group directly or indirectly at risk for contracting HIV/AIDS or an STI. These direct risk behaviours include not using a condom when having sexual intercourse, having multiple sexual partners and sharing drug needles. Jessor (1998) and Lesejane (2004) consider alcohol use, smoking, the use of illicit drugs, and other such activities, as indirect risks that may lead to impaired judgment. These could adversely affect sexual decision-making. Researchers have found a link between risk–taking behaviour, egocentricism, impulsiveness and sensation seeking during the adolescent and emerging adult phase of development. Sensation seeking is defined as the search for new and extreme experiences and increases as young people develop from adolescents into emerging adults (Arnett, 2000). This may partially explain why adolescents and emerging adults engage in sexual risk-taking behaviour. Therefore, adolescent egocentricism may influence adolescent and emerging adults' behaviours and relationships, which in turn affect decision-making (Arnett, 1996; & Elkind, 1978). These concepts will be discussed in more detail in Chapter 6 of this study.

Research concerning the effects of risk taking behaviour is extensive. International studies have consistently shown a general trend of high sexual risk-taking behaviour in this particular age cohort (18-24 years) (Kirby, 1992; & Anarfi, 2003). The WHO

(2002b) identified unsafe sex as the second most important risk factor for disease, disability, or death in the poorest communities and the ninth in developed countries. In the American context, young adults aged 15–24 years acquired 48% of STI infections. South African studies have found similar findings (Ngwena, 2003; Taylor et al., 2003; Pettifor et al., 2004; Hartell, 2005; & NSP, 2007-2011, 2007). Therefore, STI's seem to be largely infections of youth. This is mainly because their sexual relations are often unplanned, sometimes because of pressure or force, and typically occur before they have acquired the experience and skills to protect themselves. In terms of gender, after pregnancy-related causes, STI's are the second most important cause of healthy life lost in women (Glasier et al., 2006).

The influence of factors such as alcohol and drugs also add to sexual risk-taking. Various researchers concur on the negative effects of alcohol and drugs. Smith and Rosenthal (1995) found that adolescents who engage in sexual risk behaviour also engage in additional risk behaviours such as alcohol and drug abuse. Substance use among teenagers and college students has been related to risky sexual behaviour. In a sample of college students ages 17 to 24, 47 % of men and 57 % of women indicated that they had sexual intercourse one to five times while under the influence of alcohol (Butcher, Thompson, & O'Neal, 1991). Heavy use of alcohol has been correlated with increased casual sex without condoms and with increased numbers of sexual partners among 18-to-21-year-olds (McEwan, McCallum, Bhopal & Madhok, 1992).

2.2.4   Sexual decision-making

Sexual decision-making is defined as decisions, preferences and resolutions made by an individual concerning the conditions under which sexual intercourse occurs, such as timing of intercourse or use of contraception. **Sexual negotiation** is a term often used synonymously with sexual decision- making and is defined as the verbal and non-verbal interaction and dynamics between partners in deciding how and when intercourse will take place (Varga, 1997: 52).

Acknowledging that the developmental stages for emerging adulthood and adolescence overlap, it is important to examine and understand **adolescent decision-making.** Adolescent decision-making is perceived as different from that of adults when it comes to risky behaviour (Rolison & Scherman, 2002: 588). Research in adolescent decision-making indicate that adults and adolescents older than 15 years possess similar decision-making abilities but consider the consequences of decisions concerning sexuality differently. This may lead to adolescent risk–taking behaviour (Millstein et al., 1993; & Rolison & Scherman, 2002). Furthermore, these studies show that with age the adolescent is able to increasingly regard other's perspectives and comprehend concepts of mutuality in a relationship with peers. Adolescents who are able to apply these concepts in a relationship are able to communicate successfully, with a partner regarding sexual activity and contraception (Millstein et al., 1993).

Adolescents and adults differ in terms of their decision-making because they differ in their approach to various options as well as identifying the consequences of an option. Adults and adolescents also differ in terms of placing values on possible consequences and assessing the likelihood of consequences. Therefore, adolescents may use a different decision rule since, unlike adults; they may not perceive the same type of behaviour to be risky. The aforementioned implies that adolescent sexual decision-making may be either impulsive or spontaneous decisions. In view of this, it is important to examine impulsive decision-making as well as theoretical models that may be able to give insight into sexual decision-making.

Conceptions of impulsivity suggest that impulsive individuals act spontaneously meaning that they do not consider consequences. Rational decision-makers use beliefs about the consequences of their actions whilst impulsive decision-makers use non-cognitive cues, including affective and psychological cues as opposed to merely ignoring consequences, in making decisions (Donohew, Zimmerman, Cupp, Novak, Colon & Abell, 2000: 1079).

Various theories are relevant to sexual decision-making. Some of these theories are:
The Health Belief Model, The AIDS Risk Reduction Model, Theory of Reasoned Action, Theory of Planned Behaviour, Social Learning /Social Cognitive Theory and

the Transtheoretical Approach. Theories concerning the influence of gender dynamics such as the Theory of Gender and Power, Social Constructionist Theory and the Social Cognitive Theory of Gender-role Development and Functioning as well as Bronfenbrenner's Ecological systems theory. The aforementioned theories will be elaborated on later in this chapter.

2.2.5   Perspectives on the relationship between knowledge, attitudes and behaviour

Knowledge is defined as facts, information and skills acquired by a person through their experiences or the education they received and the theoretical or practical understanding of an issue (Pearsall, 1998). As previously stated in Chapter 1, Strydom (2003: 4) asserts that researchers are continuously trying to explain the gap between knowledge and behaviour change through various theoretical perspectives. Numerous studies (Ntozi & Kirunga, 1997; Bremridge, 2000; Lesch, 2000; Harrison, Smit & Myer, 2000; Smith, 2003; Goodwin, Kozlova, Nizharadze & Polyakova, 2004; & Grotzinger, 2006) reveal that there are diverse assumptions concerning the influence of knowledge on behaviour change. Knowledge is related to sexual behaviour and practices and refers to factors concerning HIV/AIDS such as modes of transmission, precautionary measures, risk behaviours and its implications.

The concept of knowledge differs from the concept of awareness and is highly complex (du Plessis et al., 1993). Various factors, such as selective perception, the interpretation of messages and selecting different sources of information, influence knowledge and the concept of awareness. There is therefore, no simple correlation between knowledge and behaviour (du Plessis et al., 1993).

Knowledge influences behaviour but is also linked to attitudes. Attitudes are the manner in which one thinks or feels about the way something or someone behaves (actions) (Pearsall, 1998). Parsadh (2004: 22) defines attitude as a person's assessment of a particular behaviour that also activates behaviour. These are salient concepts in this study and to acknowledge the relationships between these concepts is essential. Ntozi et al. (1997) found that attitudes are significantly associated with the number of

people who participants knew to be ill with AIDS. These researchers found that the individual's attitude is essential in the prevention of a disease, particularly when focusing on the degree of susceptibility, seriousness of illness, benefit and barriers to taking action.

Goodwin et al. (2004) contend that peer pressure influences beliefs such as "condoms are a threat to manhood" and serve to weaken the relationship between any increase in knowledge and subsequent safer sexual practices. Other research agrees that peer pressure has an influence on behaviour change among adolescents particularly in relation to initial sexual engagements, attitudes towards HIV/AIDS and condom use, and safer sex practices (Bremridge, 2000; Lesch, 2000).

However, Smith (2003) suggests that fear and concern motivate behavioural change and lead individuals to worry/care about themselves. The author found that when levels of worry are decreased, an individual's concern/worries about contracting HIV/AIDS are influenced by the behaviour and worries of other people in their lives. Other research contends that information, education and communication form a strong basis for HIV prevention and studies show that these have an influence on knowledge and attitudes, with lesser influence in actual behaviour change. There is "currently a substantial gap between high levels of knowledge and low levels of preventative practice" (Harrison et al., 2000:285-286).

A crucial factor and of particular interest to this study, relates to young adults' engagement in risky sexual practices and the link to their self-concept. The following discussion will explore self-concept and its influence on sexual decision-making.

2.2.6   Self-concept

Self-concept is generally defined as *the totality of an individual's thoughts and feelings having reference to himself as an object* (Gecas, 1982: 1). Self-esteem refers to the evaluation that the individual makes and maintains concerning himself/ herself. It conveys an attitude of approval or disapproval, and shows the extent to which the

individual believes himself to be capable, significant, successful, and worthy (Coopersmith, 1967: 4-5). As self-esteem is a central dimension of self-concept, both constructs are often used synonymously and are given a variety of labels such as self-evaluation, self-respect, self-confidence, self-attitude, self-image, self-view, self-schema, self-worth, self-approval, and self-satisfaction (Gecas, 1982).

Different views exist concerning the nature and development of self-concept. Self-concept is described as the cognition and evaluation of specific aspects of the self, the ideal self and the overall self-regard, including gender identity, family status, personal goals, and self-esteem. Self-esteem is the most significant element of the self and evaluates the self-concept (Räty, Larsson, Söderfeldt & Wilde- Larsson, 2005). Byrne and Shavelson (1986) contend that self-concept is one's perception of self, and this perception stems from how one perceives the general social environment, particularly significant others. Sharpes and Wang (1997) contend that self-concept is a psychological dimension that indicates how good we feel about ourselves. It is considered a salient factor in determining the nature of human behaviour that is solidified in adolescence.

However, Sharpes and Wang (1997) also contend that there is no clarity whether self-concept is a construct from the cognitive sciences, an active part of personality or of the ego and unconscious, or a physiological process as indicated from neurological research. It is also unclear whether the psychological construct of self is related to other concepts, such as personal identity, self-esteem, and the ego, as sometimes these refer to the whole person or a structure or element within a person. These authors further contend that self-concept is developmental and that adolescent perception of personal, relational, and academic self-identity occurs uniformly across cultures and environmental circumstances.

As the current study particularly deals with sexual decision-making, the discussion of sexual self-concept is of importance.

Sexual self-concept is an individual's evaluation of his or her sexual feelings and actions. Developing a sexual self-concept is a key developmental task of adolescence (Chilman, 1983). Andersen and Cyranowski (1994) define sexual self-concept as an individual's overall concept of the self as a sexual person, including both positive aspects (such as, passion, arousability, and agency) and negative aspects (such as, anxiety, negative affect, and embarrassment). During adolescence, young people tend to experience their first adult erotic feelings, experiment with sexual behaviours, and develop a romantic relationship. This developmental task in relation to new sexual and romantic experiences renders adolescence a period in which young people are actively constructing a sense of themselves as sexual beings.

Research indicates mixed findings concerning the effects of self-concept and self-esteem on sexual behaviour.

Self-concept is usually described in terms of high versus low or positive versus negative (Sharpes & Wang, 1997). Various studies have linked low self-concept to sociological conditions and a wide range of personal and social disorders. International studies link low self-concept with suicide (Emery, 1983; Walker & Mehr, 1983), criminal activity (Krueger & Hansen, 1987), alcoholism and teenage pregnancy (Patten, 1981; & Zongker, 1977), drug abuse (Reardon & Griffing, 1983) and welfare dependency. Some researchers link low self-concept to economic problems (Sharpes & Wang, 1997). Low self-esteem has been considered an important symptom of depression (Cole, Maxwell & Martin, 2001: 72) and self-esteem has been found to be the most important factor for retaining psychological and social health during adolescence (Torres & Fernández, 1995; Räty et al., 2005). Some South African studies have also found that low levels of self-concept are associated with a wide variety of negative behaviours such as academic failure, violence, sexual risk-taking, depression and suicide (Bremridge, 2000; Lesch, 2000; Eaton, Flisher & Aaro, 2003; Bryan, Kagee & Broaddus, 2006).

Conversely, researchers exploring the relationship between protective factors and problem behaviours found that adolescents who display high levels of self-esteem, connectedness to school, or participation in pro-social activities are less likely to engage

in behaviours that compromise their health or well-being (Resnick & Bearman ,1997; Jessor, 1998).

Concerning gender differences, research indicates that adolescent females have more problems and experience a poorer sense of well-being compared with adolescent males. They are at an increased risk for physical complaints, depression, lower self-esteem, and internalizing problems. (Sharpes & Wang, 1997; Torres & Fernández, 1995; & Räty et al., 2005).

Studies relating to adolescent self-concept and self-esteem indicate the importance of evaluating self-concept in addition to behaviours (Breakwell & Millward, 1997). Theory and research suggest that self-concept plays an integral role in the decision to repeat behaviours after experiences of success and failure, through its effect on motivation (Rodriguez, & Audrain-McGovern, 2005: 256).

However, Goodson, Buhi and Dunsmore (2006) refute these findings. When reviewing literature on the relationship between self-esteem and sexual behaviour, they found little supporting evidence to show that self-esteem plays a role in behaviour change. They questioned why health promotion and educational programmes continue to target self-esteem enhancement as a means to promote healthy decision-making and behaviour. These researchers advised that given the absence of empirical evidence on this issue that practitioners' emphasis on self-esteem could be dismissed as innocuous. Similarly, a synthesis of literature focusing on self-esteem and numerous outcomes found that self-esteem does not have the protective effect as touted by health promotion professionals. Instead, high self-esteem may promote experimentation in the case of sexual activity or drinking, while its general protective effects are "negligible" (Baumeister, Campbell & Krueger, 2003: 1). A similar review examined whether low self-esteem led to various types of violence and aggression, and found no evidence supporting a causal relationship. In contrast, researchers concluded that violence may result from threatened egotism or "highly favourable views of the self that are disputed by some person or circumstance" (Baumeister, Smart & Boden, 1996: 26).

Since one of the objectives of this study is the influence of self-efficacy on sexual practices, the concept self-efficacy should be clarified.

2.2.7 *Self-efficacy*

One of this study's objectives is to explore the influence of self-efficacy and decision-making on sexual behaviour. According to the self-efficacy construct, a person's expectations about whether he/she should and can execute competent behaviour will determine initiation and persistence in achieving a desired goal (Bandura, 1977; Bandura, 1990; & Levinson, 1986). Self-efficacy is not a behavioural change theory but is an important element of many of these theories, including the Health Belief Model and the Theory of Planned Behavior (Bandura, 1977). Bandura's Social Learning Theory and Social Cognitive Theory highlight how general social influences, such as peer influences, social norms, media and support influence the individual. Bandura defines self-efficacy as a belief that one can perform a specific behaviour (Bandura, 1978: 240). Self-efficacy refers to an individual's belief in his/her personal ability, regardless of knowledge or skills. This determines what course of action the individual will choose, how long it will continue in the face of resistance and his/ her resilience to persist after crises. Self-efficacy is therefore, not concerned with the skills one possesses but with the judgements of what one can do with whatever skills one possesses. This judgement determines the amount of effort one would spend on a task and how long one would persist with it. Individuals who possess strong self-efficacy beliefs exert greater efforts to master a challenge while those with weak self-efficacy beliefs are inclined to reduce their efforts or even give up. (Bandura, 1978: 241). This assumption implies that people who believe in the efficacy of their own actions are more likely to engage in health-promoting behaviours (Mirowsky & Ross, 2003).

Social Learning theory/ Social Cognitive Theory will be discussed in more detail later in the chapter. Several studies have found moderate to strong associations between the variables self-efficacy and sexual risk behaviours, with lower self-efficacy in adolescents related to engaging in high-risk sexual practices (DiClemente, Lodico, & Grinstead, 1996; Reitman, St. Lawrence, & Jefferson ,1996; Buunk, Bakker & Siero,

1998; Van Dyk, 2001). In contrast, other investigators report less powerful relationships among self-efficacy, intentions, and condom-use behaviour (Morrison, Rogers & Baker, 1995).

Self-efficacy is proposed to influence behaviour (Bandura, 1977) and specifically, condom self-efficacy is proposed to influence condom use (Bandura, 1990). **Condom self-efficacy** would be one's confidence in one's ability to use condoms. Previous research findings support that there is a relationship between adolescents' and young adults' condom self-efficacy and condom use. Condom self-efficacy was reported to be related to intentions to use condoms (Brafford & Beck, 1991; Jemmott & Jemmott, 1991; Basen-Engquist & Parcel, 1992) as well as the actual use of condoms (Basen-Engquist & Parcel, 1992). O'Leary, Maibach and Ambrose (2000) found that condom self-efficacy predicts condom use behaviour change. Furthermore, intentions to use condoms were increased by strategies to increase condom self-efficacy (Jemmott & Jemmott, 1991). Research conducted on the relationship between self-efficacy and condom use suggests that those individuals with higher levels of self-efficacy are more inclined to use and/or intend to use condoms. These results concur across diverse populations (Dilorio, Dudley ,Soet, & McCarty,2004; Halpern-Felsher, Kropp, Boyer, Tschann & Ellen, 2004). However, Hanna (1999: 59) asserts that to further study the relationship between condom self-efficacy and condom use, a reliable and valid self-efficacy scale that measures a broad range of specific behaviours for condom use is needed. Several adolescent and young adult condom self- efficacy measures have been developed. However, they have limitations. These limitations include the lack of specific behaviours involved in condom use, younger adolescents are not included in samples, and acceptable psychometric properties are not reported. Therefore, research needs to include instruments that are more rigorous in terms of validity.

2.3   Clarifying the definition of the population's age cohort in terms of certain developmental theoretical perspectives.

This study focuses on the sexual behaviour of students in the FET sector, spanning the age cohort 18 to 24 years.   Literature suggests that an individual's stage/phase of development also influences the individual's behaviour. It would therefore be prudent to consider the categorisation of this age cohort within certain developmental theories.

Different developmental theories differ in their focus (depth) and range (age periods). For example, Erikson's theory of psychosocial development (1968) identifies eight stages across the lifespan, with each stage involving the resolution of a crisis in the individual's human relationships. This study's population therefore spans two of the stages in Erikson's theory of psychosocial development. The stages are identity versus role confusion (**adolescence** [12 to 19 years]) and intimacy versus isolation (**early adulthood** [20-40 years]). Super (1980) on the other hand, refers to the developmental period between the ages of 14 and 24 years, as the *exploration* phase, and *establishment* is the early adulthood phase, which occurs between the ages of 25 and 44 years.

Newman and Newman (2006) refer to the developmental stage between the ages of 18-24 years as **late-adolescence** and view this stage as an extension of adolescence. According to Ackermann (2001), the age range 12/13 to 22 or 25 years is associated with the developmental phase of **adolescence**. He further categorizes adolescence into early adolescence (12-15 years), middle adolescence (15-18 years), and **late adolescence (18-22/25 years)**. Ferreira (2002: 87) also states that FET college students are in the **late adolescent phase** of human development. Thus, Newman and Newman (2006), Ackermann (2001) and Ferriera (2002) describe this study's participants as being in the **late adolescent** phase of their development. In contrast, Arnett (2000) describes this phase (18 -24 years) as the **emerging adulthood phase.**

This study's population therefore also falls within Arnett's (2000) Theory of Emerging Adulthood, which also focuses on the individual's development during the years 18 to 25. He described this phase as the **emerging adulthood phase**. Until recently, most of

the research on adolescent development has focused on early and middle adolescence, with less research focusing on transitions out of adolescence. Thus, the value of distinguishing between late adolescence and emerging adulthood remains to be empirically determined. Emerging adulthood is described as a new conception of development for the period from the late teens through the twenties, with a focus on ages 18-25 years involving exploration in a number of areas, including identity and romantic relationships (Arnett, 2000).

The concept **youth** also applies to this study's population. The WHO defines youth as individuals between the ages of 15 and 24 years. Similarly, The National Youth Development Framework, approved by the South African Cabinet on 21 November 2001, defines South African youth as all those between the ages of 15 and 28 years to facilitate the implementation of youth programmes (Youth Development Network, 2004).

The above indicates that different theorists use diverse labels to define this age cohort, reflecting the difficulty in finding a uniform definition for the age cohort 18-24 years. Thus, for the purposes of this study, the researcher takes cognisance of this difficulty, and will therefore refer to the study's participants interchangeably as **youth**, **young people**, **adolescents**, **late adolescents and emerging adults.**[2]

2.4   Developmental theories applicable to the study's population

Given the discussion in section 2.3 above, this study's participants are in the developmental phase that marks the individual's transition from childhood to adulthood. Major physical changes of puberty and important cognitive and social developments occur in the individual during this stage (Burger in Ferreira 2002: 88). Ferreira further states that the personalities of college students can also undergo change during this late adolescent phase. Many students are seen to grow in identity, flexibility, openness, and integration of personality by having to cope with new and increasing experiences. He

[2] The reader should note the lack of uniformity amongst developmental theorists in categorising the age cohort 18-24 years, especially when reading the developmental theories discussed in this study. The different theorists may be discussing the same age group but using different labels.

also contends that the manner in which they are able to cope successfully depends on the student's individual strength and flexibility. Gullota, Adams and Markstorm (2000) underscore this point by describing the period spent by students at college as the stage when he/ she is in transition to adulthood, marked by major physical, sexual and emotional development. The participants in the current study are therefore in a phase of development where they are in a process of self-discovery and where external (social) as well as internal (psychological) factors play a role in affecting their sexual decision-making.

Although there are different developmental theoretical perspectives relating to this study's population, the limitations of this study has prompted the researcher to focus on two developmental theoretical perspectives, namely Erikson's theory of psychosocial development (1968) and Arnett's theory of emerging adulthood (2000). The researcher is of the view that Erikson's theory of psychosocial development and Arnett's theory of emerging adulthood would give a good description of development during the phase 18-24 years. A brief discussion of each theory follows.

2.4.1   *Erikson's theory of psychosocial development*

Erikson (1968) contends that during the course of one's life the individual faces eight crises in their human relationships. These crises are related to the eight stages of the lifespan, each defined in terms of a developmental task that is considered important for that period. These crises are not considered crises in the fatalistic sense, but are critical times in the development of challenges. When these challenges are successfully resolved, it leads to the gaining of virtues. This is an indication of the growth of ego strength and not an evaluation of the individual. Each developmental crisis that relates to biological maturation has a social dimension that crystallises around an emotional conflict. Erikson is a theorist of affect and states that it is emotions in their productive and resolving roles that form the building blocks of human behaviour and eventually the individual personality. During each stage of life, the individual faces distinctive developmental tasks. Because of the endless possibilities of exploring various ways of being, adolescence is considered as the optimal time for the deconstruction of the childhood identity and the reconstruction of a feasible adult identity. It is thus the chief

task of the individual during the adolescent stage to resolve the conflict of identity versus identity confusion in order to become a unique adult with an important role in life. Erikson's epigenetic principle holds that every stage in the individual's development is instrumental to future stages and re-frames all earlier ones. A brief description of Erikson's eight stages of psychosocial development across the lifespan follows.

Stage 1: basic trust versus basic mistrust (birth to one year).

Infants gain a sense of confidence or trust that the world is good through affectionate responsive care. Mistrust develops when infants have to wait for lengthy periods to receive comfort and are treated callously. Failure to develop trust may adversely interfere with the infant's sense of security and jeopardize his/her ability to successfully master the challenges of the stages that follow (Erikson, 1968).

Stage 2: autonomy versus shame and doubt (one year to three years)

With the use of new mental and motor skills, children want to make decisions and choices for themselves. The development of autonomy occurs when the child is not shamed or forced to do something and when the child is permitted a reasonable measure of free choice. Shame and doubt are the main factors that jeopardize the development of autonomy. Erikson described recognition from significant others as the critical interpersonal process during the consolidation of identity in adolescence and young adulthood (Erikson, 1968).

Stage 3: initiative versus guilt (three years to six years)

When children achieve a sense of autonomy, they are able to develop their limited explorations of the previous phase by moving on to a new set of environmental challenges through increasing social and spatial spheres. If a child's conflicting feelings of love and hate and conflicting impulses are disregarded, underestimated or ridiculed, it could result in destructive feelings of guilt (Erikson, 1968).

Stage 4: industry versus inferiority (six years to 12 years)

When children enter school, they have to believe in their ability to learn the basic intellectual and social skills. Inability to feel competent could result in a sense of inferiority. The child who constantly fails in school risks feeling isolated from society or in an attempt to gain acceptance from others, will carelessly conform to the desires or requests of others (Erikson, 1968).

The following two stages, stages 5 (identity vs. role confusion) and 6 (intimacy versus isolation) of Erikson's theory are of particular relevance to this study.

Stage 5: identity versus role confusion (twelve to nineteen years)

This stage in Erikson's theory is most relevant for understanding the physical changes of puberty and the psychosocial changes in adolescence. If this crisis is successfully resolved, it results in the development of the virtue of fidelity, the ability to uphold certain values despite inescapable conflicts and inconsistencies (Seifert & Hoffnung, 1997: 37). Identity depends on a reliable assimilation of who you are. This is based on the many different roles one fulfils. When roles are not integrated, this results in role confusion. The areas of identity development that undergo a tremendous amount of stress during adolescence are sexual, intellectual, physical, career and religious areas. Those children who are deprived of family support and adult role models they desire, may be unable to successfully resolve the crisis. Erikson contends that the inability to resolve the crisis at this stage could be linked to behaviours such as substance abuse and antisocial personalities. He further states that a negative identity could be the cause of the roles of deviance and extreme conformity, or an identity found undesirable by society. In this phase, the adolescent is in the process of establishing his/her own value system as part of the development of his/her identity. Therefore, the extent to which the adolescent achieves this is important. The adolescent must also deal with increasingly strong sexual urges. Adolescents have to place themselves within a very different social matrix in comparison to the one they inhabited as children. Adolescents receive mixed messages about their sexual development from their parents, the media, the music industry and peers. These messages could promote a false sexual identity that results in accelerating their sexual development to that of an adult (Erikson, 1968). Researchers agree that during adolescence, young people form their sexual identity (SIECUS Report

Supplement, 2001) and that developing healthy sexuality during adolescence is a critical developmental task (Chilman, 1983; Gagnon & Simon, 1987; Tolman, 2002).

Stage 6: intimacy versus isolation (early adulthood: age 20-40 years)

Erikson (1968) refers to this period as a psychological conflict of early adulthood, reflected in the young person's thoughts and feelings about making a permanent commitment to an intimate partner. Erikson posits that a successful resolution of intimacy versus isolation prepares the individual for the middle adulthood stage, which focuses on generativity, this means caring for the next generation and helping to improve society (Erikson, 1968).

Stage 7: learning generativity versus self-absorption (middle adulthood [40-65 Years])

The significant task developmental phase is to perpetuate culture and transmit values of the culture through the family (taming the kids) and working to establish a stable environment. Caring for others is important to create something that contributes to societal improvement. This Erikson calls generativity. During this stage, individuals often fear inactivity and meaninglessness. (Erikson, 1968).

Stage 8: integrity versus despair (late adulthood, from 65 years)

This stage involves reflection on the type of person they have been. Individuals need to feel that they are happy and content, feeling fulfilled with a deep sense that life has meaning and they have made a contribution to life, a feeling Erikson calls **integrity**. Their strength stems from a wisdom that the world is very large and the individual has acquired a detached concern for the whole of life, accepting death as the completion of life (Erikson, 1968). On the other hand, some adults may reach this stage and despair at their experiences and perceived failures. They may fear death as they struggle to find a purpose to their lives. Alternatively, they may feel they have all the answers (not unlike going back to adolescence) and end with a strong dogmatism that only their view has been correct (Erikson, 1968).

2.4.2 Erikson's views on identity development and self-concept

Erikson (1968) contends that the primary task of the adolescent stage of life is to resolve the conflict of identity versus identity confusion. He further contends that identity development and self-concept take place during adolescence. The aim of this phase is to ask and answer the question "who am I"? Moreover, what do I want from life? Wong et al. (1999: 898) describes identity development by stating that prior to adolescence the child's identity is like pieces of a puzzle scattered across a table. During adolescence, both the cognitive and the social development as well as social experiences encountered, drive individuals to combine the puzzle pieces. In this manner adolescents reflect on their place in society, on the way other individuals view them and on their options for the future. Social forces play an important role in the individual's sense of self. The people with whom the adolescent interacts, serves as mirrors that reflect information back to the adolescent concerning whom he/she is and who he/she should be.
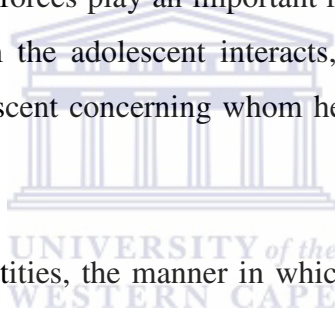
With the development of identities, the manner in which adolescents view themselves (self -concept) changes. Adolescents' self-descriptions become less concrete and more abstract. They include less physical and more psychological components and tend to demonstrate a greater awareness of themselves and they include descriptions of themselves. Adolescents also include descriptions of themselves in terms of their social competencies such as whether they are friendly, helpful or kind. However, the way in which an identity is established, will differ from culture to culture. The ultimate aim is therefore, to become a unique adult with an important role in life (Erikson, 1968).

Erikson's psychosocial perspective therefore considers adolescence as a developmental phase associated with the development of industry, identity and intimacy. It is imperative that the family with adolescent members provides the foundation for positive development. The broader social and cultural environments also influence the positive development of the adolescent. If the adolescent is able to resolve dilemmas in a positive manner, it will result in a fully functioning, capable and mature adult able to make rational decisions. Traumatic events could worsen the difficulty of these

developmental challenges and can lead to impairments in behaviours, thoughts, and feelings (Wolfe, Wekerle, Reitzel-Jaffe, & Lefebvre, 1998: 62). It is likely that any disruption to an individual's self-concept, their trust within a relationship and their sense of power and control over what happens to their body will lead to ill effects (Ackard & Neumark-Sztainer, 2002: 456). Erikson thus provides a useful framework for the explanation of the process of psycho -sexual maturation in terms of a developmental perspective. This correlates with the perspective of adolescence as a path of transition from childhood to adulthood (Erikson, 1968).

2.4.3   Arnett's Theory of Emerging Adulthood

Arnett refers to the age cohort 18-25 years as emerging adulthood. As mentioned earlier, this age cohort falls within Arnett's developmental theory of Emerging adulthood. Arnett's theory of Emerging Adulthood (2000) contends that Emerging adulthood is theoretically and empirically different from adolescence and young adulthood. The Emerging adulthood phase is marked by relative independence from social roles and from normative expectations. Emerging adults have left the dependency of childhood and adolescence, but have not yet entered adulthood. Emerging adults often explore a range of possibilities in terms of life, love, work, and worldviews. Emerging adulthood is a period when many different directions are possible, when few definite decisions are made about the future. Emerging adulthood is the period when "the scope of independent exploration of life's possibilities is greater for most people than it will be at any other period of the life course"(Arnett, 2000: 469).

Arnett argues that it makes little sense to group the late teens, twenties, and thirties together and call the entire period "young adulthood." He found that the majority of young people aged 18-25 do not believe they have reached full adulthood while the majority of people in their thirties believe that they have. This reflects a subjective sense of most emerging adults that they have left adolescence but have not yet completely entered young adulthood. These young people see themselves as gradually making their way into adulthood, so "emerging adulthood" seems a better term for their subjective experience. The term "emerging" captures the dynamic changeable, fluid quality of this

period (Arnett, 2000: 471). Therefore, based on the above discussion, Arnett argues that young adulthood is a term better applied to the thirties, where individuals are still young but are definitely adult in a way that individuals aged 18-25 years are not.

Arnett contends that for most people, the late teens through the mid-twenties are the most "volitional" years of life. However, factors such as cultural influences can curb the degree to which adult commitments and responsibilities are delayed while the role experimentation that began in adolescence continues and intensifies. He further contends that in the case of love and work, the goals of identity explorations in emerging adulthood are not restricted to direct preparation for adult roles. On the contrary, the explorations of emerging adulthood are partially explorations for their own sake, part of obtaining a broad range of life experiences before taking on enduring and limiting adult responsibilities.

The absence of role commitments in emerging adulthood makes it possible for a level of experimentation and exploration that is not likely to be possible during the thirties and beyond. For individuals who wish to have a variety of romantic and sexual experiences, emerging adulthood is the time for it, because parental surveillance has diminished and there is yet little normative pressure to enter marriage. Arnett (2000) suggests that the context of diminished parental surveillance and little pressure for marriage during these years could contribute to risky sexual behaviours. Arnett further argues that significant identity exploration takes place during this period of greater freedom and fewer constraints. He posits that risky behaviours in young adulthood "can be understood partially as one's reflection of the desire to obtain a wide range of behaviour before settling down" (Arnett, 2000: 475).

Arnett considers the phase before the emerging adulthood phase to be the adolescent phase. During adolescence, dating often takes place in groups, as adolescents engage in shared recreation such as parties, dances, and hanging out (Arnett, 2000: 473). However, during the emerging adulthood phase, explorations in love become more intimate and serious. By emerging adulthood, dating is more inclined to occur in couples, and the focus moves from recreation to exploring the potential for emotional

and physical intimacy. Romantic relationships in emerging adulthood last longer than in adolescence, are more likely to include sexual intercourse, and may include cohabitation. Thus, in adolescence, explorations in love tend to be hesitant and transitory. In contrast, explorations in love in emerging adulthood tend to involve a deeper level of intimacy and the implicit question is more identity focused. (Arnett, 2000: 473).

Park, Mulye, Adams, Brindis and Irwin (2006) also highlight the separation of this developmental phase from that of adolescence. They refer to this phase (18-24 years) as young adulthood and agree with Arnett that this phase involves exploration and steps toward independence, with varying levels of adult supervision, roles and responsibilities, making this period unique in the lifespan and therefore a phase separate from adolescence. They posit that the health issues of young adulthood have received relatively little attention compared with those of adolescence, although the critical issues in young adulthood parallel those of adolescence. Young adults often fare worse than adolescents on health indicators, with many measures of negative outcomes. Another problem is the inconsistent age grouping for young adults. Despite the high prevalence of many health problems during young adulthood, data sources often group young adults with older adults. These authors stress that people in their late twenties differ from those in their early twenties on many markers of health, as well as social indicators, such as employment status and educational enrolment.

2.5 Behaviour Change Theories

2.5.1 Introduction

Numerous researchers have attempted to investigate, explain and influence the sexual behaviour of individuals in the age cohort 18-24 years. A range of theories has been used to assist them in this task (Glanz & Rimer, 2005: 4). These authors further state that "Researchers and practitioners use theory to investigate answers to the questions of "why," "what," and "how" health problems should be addressed. By seeking answers to these questions, they clarify the nature of targeted health behaviours. That is, theory guides the search for reasons why people do or do not engage in certain health

behaviours" (Glanz & Rimer, 2005: 5). Theories of behaviour change may provide a valuable means for the development and implementation of interventions, and for promoting and understanding behaviour and the underlying processes involved. Each behaviour change theory or model attempts to explain behaviour change by focusing on different aspects. (Glanz, & Rimer, 2005: 21). Taking cognisance of this, the following discussion will explore behaviour change theories that have been used to explore and explain sexual behaviour.

Understanding the various theories used for explaining and interpreting the sexual behaviour of this age group (18-24 years) is essential. However, a discussion of all the behaviour change theories in research concerning the sexual behaviour of individuals in the age cohort 18-24 years is beyond the scope of this study. Thus, a brief discussion of a few behaviour change theories follows. Furthermore, research using these theories to investigate sexual behaviour of adolescents and emerging adults will also be highlighted.

2.5.2   *Health Locus of Control Theory*

Rotter, Seeman and Liverant (1962) define locus of control as the view an individual has of the events that occur in his/her life. There is an internal /external dimension to this trait. Internal control is the perception of positive and negative events resulting from one's own actions and thus under personal control. External control refers to the perception of positive and/or negative events being isolated from one's own behaviours in certain circumstances and therefore, outside of one's personal control. Conversely, individuals with an internal locus of control believe that they can influence and control their own health through personal behaviour. Individuals with an external locus of control believe that they have little control over their own health as it depends on external factors such as luck, chance, fate, other individuals or uncontrolled forces from "outside of themselves". Therefore, according to the Health Locus of Control Theory, individuals who believe they have no control over their own health (external locus of control) will be less likely to apply preventative and promotive behaviour than those who believe that they are able to do something to control their health (internal locus of

control). Thus, it can be assumed that individuals with an external locus of control will often do little to prevent illness or improve their health.

Various researchers have used this theory to investigate sexual behaviour. Van Dyk (2001: 90) found that individuals with an internal locus of control are more inclined to alter high–risk sexual behaviour, than those with an external locus of control. Van Dyk (2001: 89) further contends that in the prevention of illness and health promotion it is important to have the knowledge concerning the extent to which individuals have control over their own health.

The importance of culture on locus of control has been investigated in various studies. Mordaunt (2003:50) and Van Dyk (2001: 90) found that culture seems to influence locus of control. These authors contend that locus of control is not only considered a personal issue but also a cultural issue. Since South African society is a diverse blend of cultures, cultural influences on locus of control need to be considered when dealing with South African adolescent sexual behaviour (Van Dyk, 2001: 90). Van Dyk further contends that South Africa is a multi-cultural society viewed through a western lense. Western culture focuses on an internal locus of control while many indigenous African cultures have a collectivist worldview. This means the group interests takes preference over the individual interests. People from these cultures usually operate from an assumption of an external locus of control.

Many African cultures believe that disease is something beyond their control and ascribed to the ancestors and spiritual sources. Traditional Africans often use witch doctors and sorcerers to send illnesses to their enemies. These witches and sorcerers are also often blamed for illness such as HIV/AIDS and other misfortunes. Thus, in some rural areas HIV/AIDS is perceived as being caused by witchcraft and not the result of the individual's behaviour (Van Dyk, 2001). The identity of the traditional African is therefore rooted in his or her collective existence and all decisions including decisions concerning health are taken with the group's knowledge and approval.

It is impossible to assume that one can change individuals' locus of control or the underlying philosophical assumptions of a group of individuals (Boahene, 1996). Therefore, health professionals should acknowledge that traditional African culture has an external locus of control and they should learn to work with this rather than against it when developing methods to bring about change in high-risk sexual behaviour (Van Dyk (2001: 90). This is especially so for a multi-cultural environment such as South Africa.

2.5.3   Health Belief Model

This model suggests a direct link between an individual's preventive health beliefs and their preventive health behaviours (Rosenstock, 1974). Four specific categories of preventive health beliefs have been identified as highly predictive of preventive health behaviours. These are:

- Perceived susceptibility which refers to an individual's subjective perception of their risk of a given negative health outcome.
- Perceived severity which refers to individual's assesses the seriousness of a given negative health outcome.
- Perceived benefits which refer to an individual's view of the effectiveness of preventive health measures to reduce the risk of a negative health outcome.
- Perceived barriers which refer to an individual's analysis of the costs of undertaking the preventive health measure.

The model suggests that individuals engage in a form of cost-benefit analysis when making decisions about their health. For example, individuals who understand their personal risk to a disease such as influenza and believe that vaccination will help them to avoid that risk, will be more likely to actually be vaccinated compared to those individuals who do not feel a personal sense of risk (Rosenstock, 1974).

The Health Belief Model (HBM) is one of the most widely used approaches to understanding individual health behaviour (Janz & Becker, 1984). Studies conducted in

Sub-Saharan Africa (Agha, 2002) indicate that it is a good means of explaining intentions and behaviour.

Various other researchers have used the HBM to examine the prevalence of condom use in preventing the spread of HIV/AIDS (Hiltabiddle, 1996; Laraque, Mclean, Brown-Petersied, Ashton & Diamond, 1997; DiFranceiso et al., 1998). Research to gauge various predictors of condom use among adolescents in Harlem, United States of America, indicate that there are specific motivating factors such as the desire to delay parenthood, a perceived benefit and to be most predictive of consistent condom use (Laraque et al., 1997). Another study examined the number of partners as a proxy for exposure to STI's (Levinson, Jaccard & Beamer, 1995). Netswera (2002) used The HBM to investigate youths' exposure to sex risks and their stability in sexual relationships. His findings suggest that there is a need to increase HIV/AIDS campaigns and sexuality education and to educate youth regarding the dangers of unprotected sex. Mashegoane, Moalusi, Ngoepe and Peltzer (2004) investigated the role of social norms in the prediction of the intention to use condoms among South African university students. Their findings suggest that self-efficacy is a salient aspect of safe sex behaviour in youth. The HBM together with the Theory of Planned Behaviour have been applied to sexual risk-taking among female college students (Swenson, 2008).

The components of the HBM generally reflect the goals of social marketing efforts. These are to raise awareness, reduce barriers to safer sex and increase perceived benefits of prevention. The Health Belief approach to adolescent sexual decision-making has the ability to be integrated into sex education curricula. However, this model may underestimate the influence of the cultural context in which decisions about sex take place. Janz and Becker (1984) caution researchers that though the health risk perspective may be the most prominent framework on which adolescents rely when making decisions about sexual behaviour; it is not the only influence. In addition to school/ college-based sex/life orientation programmes, young people use various sources (including parents, peers, and various forms of media) to make decisions about their sexual behaviour. Unfortunately, adolescents' worlds are saturated with

information related to sex, most of which ignores the consequences of sexual risk behaviour.

2.5.4 AIDS Risk Reduction Model

Catania, Kegels and Coates (1990a) combined elements from the HBM and Social Cognitive Theory to describe processes through which individuals change their behaviour. The AIDS Risk Reduction Model (ARRM) has been designed to understand and predict behaviours that cause AIDS infection. Hence, the analytical framework that it offers can be considered to be the most relevant in studying high-risk sexual practices and how and why individuals adopt preventive behaviours. The ARRM therefore, is consistent with the notion of empowerment, which has come to guide the approach to health intervention. This means that the individual has to commit and take responsibility for behaviour change. There are three sets of processes or stages in the ARRM. These are:

- Recognition and labelling of one's sexual behaviour as high risk for contracting HIV.

- Making a commitment to reduce high risk behavioural and /or to increase low risk activities. This requires that the individual takes ownership of the problem as well as the responsibility for doing something about it.

- Seeking and enacting strategies to obtain these goals.

The ARRM is ideally suited for longitudinal studies and used to identify why people fail to progress through the various stages. This allows for effective intervention as it allows one to recognize the position of the person in the process and address the particular needs for that stage (Catania et al., 1990a).

Various researchers have used this model in investigating sexual behaviour. Sheer and Welch Cline (1995) found that individuals who engage in risk taking behaviour on a more frequent basis and with greater impulsivity may not use condoms but are more

likely to have higher numbers of partners and may engage more frequently in unprotected sexual intercourse when their partner's HIV status is unknown. Halpern-Felsher et al. (2001) found that habit, or patterns in past behaviour, such as previous condom use, are important predictors of perceived risk and future behaviour. Macintyre, Brown and Sosler (2001) did a cross-sectional study in Uganda, Kenya and Zambia. Their findings show that knowing somebody with AIDS was predictive of protective sexual behaviour, as were knowledge of HIV prevention methods and correct beliefs regarding AIDS patients. The authors concluded that knowledge of someone who had AIDS or who had died of AIDS may increase an individual's awareness of the consequences of HIV/AIDS and may lead to safer sexual practices.

Conner, Stein and Longshore (2005) investigated prevention programmes. They found that safe sex intentions predicted safer behaviour in a low-risk group and self-efficacy predicted condom use in a high-risk group. Therefore, different ARRM constructs may be more salient and relevant for high versus low-risk seekers. Kiene and Barta (2006) evaluated the effectiveness of a custom computerized HIV/AIDS risk reduction intervention amongst college students. Results indicated that delivery of brief individually tailored HIV/AIDS risk reduction interventions via computer might be an effective HIV/AIDS prevention approach for young people.

A general limitation of the ARRM model is that it focuses on the individual. Researchers suggest that the ARRM should consider the socio-cultural issues that influence and may impede an individual's behaviour choices and ability to act on them (Denison, 1996).

2.5.5   *Theory of Reasoned Action*

Similar to the HBM the Theory of Reasoned Action (TRA) is based on cognitive determinants to produce behaviour change. The TRA is a cognitive theory designed to predict and explain any human behaviour that is under the individual's own free will. The TRA is concerned with the relationships between beliefs, attitudes, subjective norms, intentions and behaviour. The individual's intention to perform the behaviour is

what is considered to predict the behaviour. Intention is considered a function of attitudes towards the performance of the behaviour and the subjective norms. Thus, the TRA advocates that a change in one's thought patterns regarding life events and personal choices, determines change in behaviour ((Melkote, Muppidi & Goswami, 2000).

Research conducted on sexual behaviour using this theory, include Bosompra (2001) who examined the applicability of the TRA to the study of condom use intentions of Ghanaian university students. The findings suggest that AIDS education interventions targeting university students should not only focus on individuals but also their sexual partners and their broader social networks in order to enhance perceptions of peer acceptance of condom use. Furthermore, AIDS educators in Ghana's universities need to focus on two issues: students' perceptions of what their significant referents (sexual partners, close friends, parents and medical doctors) consider consistent condom use and their perceptions of the outcomes of consistent condom use, particularly the negative outcomes (disadvantages).

The TRA similar to the Theory of Planned Behaviour (TPB) (which will be discussed next) are valuable in providing an understanding of the individuals' intentions concerning sexual behaviour. However, a major criticism of these theories is that they fail to incorporate the influence of the social, economic and power relations between genders in society. The TRA together with the TPB is therefore, steeped in predictive assumption that views the individual at the centre of cognition and action. These theories are limited to behaviours over which individuals have a high degree of volitional control. The overly cognitive and rational stance of these theories is in direct opposition to the dynamics of a heterosexual relationship that is considered necessary determinants of sexual risk taking behaviour (Chitamun & Finchilescu, 2003: 159).

2.5.6   The Theory of Planned Behaviour
The Theory of Planned Behaviour (TPB) is an extension of the TRA and incorporates the construct, perceived control. Individual beliefs concerning the extent to which they

are able to affect the intended behaviour is included as an explanatory variable, together with attitudes and subjective norms. (Ajzen, 1991).

Various researchers used this theory to investigate the factors involved in decisions to engage in sexual activity and investigated the factors influencing South African female students' decisions to engage in premarital sexual intercourse. They found that both attitudes and subjective norms were found to be predictors of intentions, with attitudes being the stronger predictor. Further analyses showed that beliefs about the outcome of premarital sexual relations and the evaluation of these outcomes were supported (Chitamun & Finchilescu, 2003). However, contrary to the theory, subjective norms were not correlated with motivation to comply with the perceived views of salient referents. Mccabe and Killackey (2004) used a longitudinal exploration of sexual decision- making in a group of young adult women aged between 18 and 21 years. They found that intention to engage in sexual behaviour was reasonably well predicted using the constructs of TPB. Cha, Doswell, Kim, Charron-Prochownik and Patrick (2007) used this theory to investigate Korean college students' sexual behaviour. Their findings indicate that premarital sexual attitude, that is, abstinence, self-efficacy and referent group norms were significant predictors of intention of premarital sex for male students, but only attitude and norms predicted intention of premarital sex for female students. Furthermore, findings indicate that the TPB may be an effective theory to guide the development of theory-driven sexual abstinence interventions to reduce risky sexual behaviour for Korean males, while the TRA may be an effective theory for Korean females. The value and criticism of the TPB has been discussed under the TRA.

2.5.7   *Social Learning/Social Cognitive Theory*
Social Learning Theory emerged from the Theory of Behaviourism. Several kinds of social learning theory emerged, the most influential being Bandura's theory (1977) which emphasized observational learning. Bandura later revised his theory and emphasized how the individual thinks about himself and other people (Bandura, 1989; & Bandura, 1992). Bandura then called his theory a social cognitive instead of a social learning approach. Melkote et al. (2000) consider social learning theory to be synonymous with Social Cognitive Theory (SCT). According to them, this theory

explains human behaviour (and behaviour change) in terms of continuous reciprocal interaction between cognitive, behavioural and environmental influences. Bandura (1990) contends that to engage in a certain type of conduct, the individual must possess the information about it and the skills to manage the self and others in relation to it. Two important elements of this theory are social modelling and self-efficacy.

The basis of social modelling is that individuals subconsciously do what is considered normal by observing other individuals' actions. Thus, the importance of observing and modelling the behaviours, attitudes, and emotional reactions of others, is emphasised. Furthermore, if role models are able to solve a problem successfully, observers will develop a stronger belief in their own abilities. Thus, if one observes significant others as being able to conquer obstacles then there would be no doubt as to ones ability to cope in similar circumstances. (Melkote et al., 2000). Bandura (1977) contends that learning would be difficult and dangerous if individuals had to rely only on their own actions to inform them what to do. Fortunately, most human behaviour is learned observationally through modelling. Thus, by observing others one forms an idea of how new behaviours are performed, and on later occasions this coded information serves as a guide for action. Therefore, an individual is more inclined to evaluate his/ her abilities, by observing the coping mechanisms of his /her significant family members, role models and peers.

Behaviour change is also influenced by the individual's level of self-efficacy. This means than an individual must be able to possess a self-belief in his/her ability to practice the behaviours of which one is capable. Thus, the self-efficacy mechanism is essential in human activity. The self-perceptions of efficacy influences the individual's thought patterns, actions and emotional arousal. The importance of social influence factors is acknowledged in this theory. However, the influence of social factors on sexual behaviour is given secondary importance over the view that the individual decision maker largely determines the course of action.

Self-efficacy and social modelling have been used extensively in AIDS prevention campaigns (Mordaunt, 2003: 44). Social Learning Theory (SLT) has been used by various researchers to investigate sexual behaviour. For example, Buhbe (2001)

determined whether a model based on Rotter's (1954) Social Learning Theory could predict self-report intention to engage in unprotected vaginal intercourse among young adult women on the pill. Results indicated alcohol had no impact on behavioural intent and that issues of relationship quality, gender socialization and STI knowledge were discussed. Basen-Engquist (1992) tested a model of safer sex behaviour using variables from SLT, the HBM, the TRA and theories of cognitive coping style on undergraduate university students. Cecil and Pinkerton (2000) determined whether magnitude and confidence represent operationally distinct dimensions in undergraduate university students. The study's findings indicated an overlap between the dimensions of confidence and magnitude, but also substantial differences. Kennedy, Nolen, Applewhite, Waiters and Vanderhoff (2007) developed, administered and assessed a brief male-focused and behavioural-driven condom promotion programme for young adult African American males in an urban setting. Mitchell, Kaufman and Beals (2005) used Social Cognitive Theory to establish latent growth curve modelling with American Indian adolescents and young adults to explain the relationship between youths' confidence in resisting risk and the number of sexual partners they had.
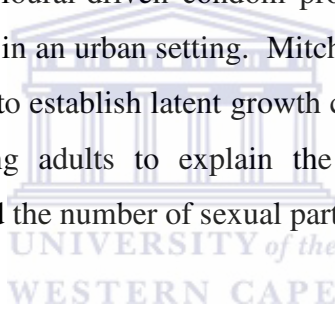
Critics of SLT / SCT contend that behaviour has been found to be more consistent than the theory suggests. This theory focuses a great deal on the situation. Some researchers have argued that the theory ignores the influence of biological or hormonal processes. Probably of most significance is the criticism that the theory is not unified. Concepts and processes such as observational learning and self-efficacy have been highly researched but there has been little explanation about the relationship among the concepts (Glanz & Rimer, 1995).

2.5.8 The Transtheoretical Model

According to the Transtheoretical Model also known as the Stages of Change Model of Prochaska and DiClemente (1984:24-29) behaviour change involves movement through four stages of change. The first stage of pre-contemplation is where individuals are unaware of having a particular problem and do not intend to change their behaviour (for example, they would not consider the use of condoms). The second stage is the

contemplation stage. During this stage, the individual realises that a personal problem exists. For example, they are aware of the dangers of unsafe sex and seriously consider the use of condoms but have not yet made a serious commitment to change. The action stage is the third stage and involves individuals changing their overt behaviour and the environmental conditions that affect their behaviour. In this stage, individuals are acting on their beliefs in personal self-efficacy. For example, people start using condoms and believe in their ability to maintain their behaviour. The last stage of behaviour change is maintenance. During this stage, individuals strive to maintain their newly acquired behaviour and to prevent the reoccurrence of the behaviour from which they made their change. Maintenance is not an abstinence of change but a continuance of change. For example, individuals make use of condoms but still have to work very hard to maintain the behaviour and to prevent reoccurrence of unsafe sexual practices. The problem will only stop when individuals no longer experience any temptation to revert to the problem behaviour and if they no longer have to make any efforts to prevent themselves from relapsing.

Various researchers have used the Transtheoretical Model to investigate sexual behaviour. Parsons, Halkitis, Bimbi and Borkowski (2000) found that adolescent college students weigh the perceived pros of having unprotected sex (not using a condom) as a significant factor in their non-use of condoms. Coury-Doniger, Levenkron, McGrath, Knox and Urban (2000) developed a behavioural counselling intervention, named Rochester STD/HIV Behavioural Counselling, for front-line providers who deliver STD/HIV prevention interventions to at-risk individuals in both clinical and community-based settings. Rodgers, Courneya and Bayduza (2001) established that the principles of the Transtheoretical Model apply to diverse populations. The study examined self-efficacy and processes of change of the Trans-theoretical model across three populations, namely; high school students, university undergraduate students, and employed adults. Results suggest that the underlying principles of change in the Trans-theoretical Model are similar across all populations. Prochaska et al. (1994) examined stages of change and decisional balance across 12 problem behaviours. This study found that progress from the precontemplation to contemplation stage involves an increase in the evaluation of the pros of changing the problem behaviour while progressing from the contemplation to action stage involves a

decrease in the cons of changing the behaviour. The finding is significant for programmes that use the Transtheoretical Model as the framework for the intervention.

There is a large body of evidence supporting the Transtheoretical Model, verifying the constructs, and showing support for application to changing health behaviour. However, there are an increasing number of studies criticizing the model concerning conceptual, methodological, and analytical concerns. Some critics reject stage-based theories of human behaviour on conceptual grounds (Bandura, 1997; Kraft, Sutton & Reynolds, 1999) while others see methodological or analytical flaws and concerns over existing evidence (Macnee & McCabe, 2004; Sutton, 2001). The Transtheoretical Model has been criticized for the fact that human functioning is too flexible and multidimensional to be categorized into discrete stages (Bandura, 1997). Kraft et al. (1999) found no theoretical reasoning or empirical findings to show that the six-month period is appropriate for defining stages. Kraft and colleagues also suggest that the Transtheoretical Model could be refined to include two stages only, namely; pre-contemplation and one that includes the rest of the stages. This judgment was made due to the clear differences found between pre-contemplation and the rest of the stages on pros, cons and confidence. Macnee and McCabe (2004) question the applicability of the model to specific populations. Another concern examined by Sutton (2001) suggests that there are some serious problems with the existing methods used to measure the stages of change. Sutton further states that the use of algorithms based on arbitrary periods, is logically flawed.
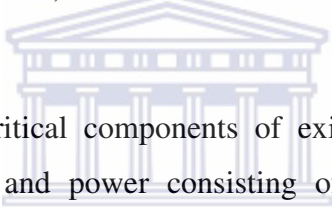
2.5.9   Theory of Gender and Power

The importance of gender in the dynamics of sexual relationships has been highlighted by The WHO. Gender is used to describe those characteristics of women and men, which are socially constructed, while the concept "sex" refers to those, which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles. Gender identification includes understanding that a person is male or female as well as understanding the roles, values, duties, and responsibilities of

being a man or a woman (WHO, 1998). The various concepts related to gender are discussed in Chapter 5.

Unlike the psychosocial theories which are gender-blind, the Theory of Gender and Power is a social structural theory addressing the wider social and environmental issues surrounding women, such as distribution of power and authority, affective influences, and gender-specific norms within heterosexual relationships (Connell, 1987).

Programmes using The Theory of Gender and Power assess the impact of structurally determined gender differences on interpersonal sexual relationships (perceptions of socially prescribed gender relations). A detailed discussion of the theory follows.

Connell (1987) shaped the critical components of existing theories and formed an integrative theory of gender and power consisting of three salient structures that characterise the gendered relationships between men and women. These are the sexual division of labour, the sexual division of power and the structure of cathexis. Division of labour and the sexual division of power were recognized as salient factors that partially explain gender relations. However, Connell devised the third factor, cathexis to address the emotional components of relationships. These three factors are overlapping but yet distinct and explain the culturally bound gender roles assumed by men and women. Connell contends that these structures are inter-related and cannot be separated, neither is there one structure that takes precedence over others. These three structures exist on two levels, namely the societal and the institutional level of which the societal level is the higher. They are founded in society through several abstract, historical and socio -political forces that separate power and assign social norms on the gender-determined roles. As society changes, these structures remain intact at the societal level over time. The three social structures also operate at the lower institutional level. Social institutions include (but are not limited to) schools, work sites /industries, families, relationships, religious institutions, the medical system and the media. These structures are maintained within the institutions' social mechanisms such as unequal pay for comparable work, discriminatory practices at school and the work

place, the imbalance of control within relationships and in the work place, the stereotypical and/or degrading images of women portrayed in the media. These and other social mechanisms limit women's way of life by producing gender-based inequalities in women's economic potential, control of resources and gender-based expectations of women's role in society. Institutional changes occur more rapidly than societal changes, but changes at the institutional level are also very gradual (Wingood & DiClemente, 2000).

Based on this theory, it is the gender-based inequalities and inconsistencies in expectations that produce the exposures or risk factors that adversely influence women's health. These structures and the manner in which they affect risk factors will be discussed in more detail.

Various researchers have used the theory to investigate the role of gender and gender roles in sexual behaviour choices. Wingood and DiClemente (1995) found that using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction.

Wingood and DiClemente (2000) also applied the Theory of Gender and Power to examine HIV related exposure, risk factors and intervention programmes for women. These researchers contend that the sexual division of labour refers to assigning women and men certain occupations. This also involves assigning women different and unequal occupations to men. This in turn affects women, since the nature and organisation of women's work limit their economic potential and restricts their career paths.

Wingood and DiClemente (2000) further examined the sexual division of power. Power refers to having power over others and exists at the interpersonal level and occasionally at the institutional level. Women in relationships where there is an imbalance of power are inclined to depend on their male partner, as men are often the ones who bring more

financial assets (such as money, status) into the relationship at a social level. The sexual division of power results in negative health outcomes for women. The disempowering of women on an institutional level occurs through the manner in which the media portrays them.

The third factor, cathexis refers to the structure of affective attachments and social norms. At the societal level, this structure determines appropriate sexual behaviour for women and is characterised by the emotional and sexual attachments that women have with men. This structure limits the expectations that society has about women concerning their sexuality. This in turn shapes the perceptions that women have of themselves and others and thus limits women's experience of reality. This structure also explains the link between women's sexuality and other social concerns related to impurity and immorality. On an institutional level, this structure is maintained by social mechanisms such as sexual stereotyping of women. These biases produce cultural norms, the enforcement of strict gender roles and stereotypical beliefs such as the belief that women should have sex only for procreation, creating taboos for female sexuality (Wingood & DiClemente, 2000).

According to the structure of cathexis (structure of social norms and affective attachments), women who are more accepting of conventional social beliefs are more likely to experience adverse health outcomes. Wingood and DiClemente (2000) hypothesised that women with more social exposures and more personal risk factors will be more burdened by the structure of social norms and affective attachments than those not having these exposures and risk factors, and subsequently, will experience poorer health outcomes. Wingood and DiClemente (2000) identified the concepts of social exposures and personal risk as women who have older partners, women who wish to conceive or whose partner is interested in conceiving children, family influence that is not supportive of HIV prevention, a distrust of the medical system, conservative cultural and gender norms and religious beliefs that prohibit the use of contraception. Furthermore, these authors defined the personal risk factors as women having limited

knowledge of HIV prevention, negative attitudes and beliefs about condoms and history of depression or psychological distress.

Gender and sexuality are thus largely interrelated, therefore a great segment of the "hidden" message young people receive concerning sexuality reflects normative views of gender. This link between gender and sexuality becomes particularly salient at adolescence, as conformity to traditional gender ideals becomes more rigorously enforced after puberty (DeGaston, Weed & Jensen, 1996). Attitudes and experiences of sexuality become "gendered" in that the cultural expression of sexuality is directly associated with the appropriate performance of gender. Therefore, ideals of gender and sexuality reflect cultural messages that merge to produce what may be termed "gendered sexuality." For example, the traditional, normative performance of gender places women in the submissive position relative to men (in certain cultures). This submissiveness has implications for decision-making in heterosexual relationships, as women (in these cultures) are often unable to express their concerns and desires fully. Moreover, the traditional performance of gender exercises considerable social power outside of these relationships for example, the emphasis placed on male sexual conquest may encourage men to make unhealthy decisions by encouraging sexual promiscuity (Tanenbaum, 2000). This gendered sexuality perspective may be instrumental in discovering why the health risk perspective is not as effective, and may help to explain the consistent finding that many young people risk their sexual health regardless of the sexual health information they possess.

Because AIDS is a condition that links sex, gender and disease, a social structural framework such as the Theory of Gender and Power that addresses norms governing social sexual relations may serve as a useful guide for designing HIV interventions for women.

2.5.10 Social Constructionist Theory
Social Constructionist Theory recognises that norms for masculinity and femininity, roles allocated to women and men and sexual scripts vary widely across societies. At its basic level social constructionist, theorists believe that sexuality is defined in a

backdrop of temporal and cultural factors. In effect, physically similar sexual acts, such as sodomy, have different meanings and significance throughout various cultures and historical periods. Another shared belief of social constructionists is that humans have nothing which is innate, or immutable. Humans are a very plastic species - in other words, the individual is constructed from the society and times in which he lives. Thus, sexual behaviour is a product of social conditioning rather than biological factors. (Vance, 1999).

The extensive connection between gender and status has served as the source for several theories of how gender influences the use of power. Bussey and Bandura (1999) developed a Social Cognitive Theory of Gender-role Development and Functioning. This theory explains how gender conceptions are produced from the complex blend of experiences and how they function in relation to motivational and self-regulatory mechanisms to direct gender-linked behaviour throughout the life course. Feminist theories also highlight gender and power as salient issues that influence society.

The theories of gender acknowledge that human differentiation based on gender is a phenomenon that affects nearly every facet of individual's daily lives. However, there are criticisms leveled at these theories.

Chafetz (2004) highlights the problems facing gender in theory. She contends that there are no clear coherent definitions of sexual terms and theoretical questions. Furthermore, the loyalty of scholars to particular theoretical camps, results in the generation of very few integrated theories that incorporate a variety of perspectives at diverse levels of analysis. Chafetz also points to the paucity of examining phenomenon using theoretical approaches or explanations of a given phenomenon.

The following ecological systems theory is presented to support the argument that individual models that explain sexual behaviour is firmly rooted in the interactions between the broader environmental and social systems and the individual.

2.5.11   Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's Ecological Systems Theory (1979) asserts that individual behaviours are influenced by factors within the immediate environment, as well as factors emanating from the larger surroundings. The environment is described in terms of multilevel nested systems: microsystems, mesosystems, exosystems, and macrosystems. This theory locates the individual as part of the microsystem, which consists of the individual's pattern of activities and interpersonal interactions with other persons such as parents, siblings, other family members, or peers. The mesosystem comprises the interactions between various settings in which the individual actively participates, such as interactions between family, work and social life. The exosystem refers to interactions between various settings that do not involve the individual as an active participant but in which events occur that affect processes within the microsystem. Exosystem factors include programmes, policies, and regulations. The macrosystem comprises characteristics of a given culture, subculture, or belief systems and patterns of social interactions that are embedded in each of these systems. These systems interact to influence the individual and are likewise influenced by the individual.

Various studies have used Bronfenbrenner's Ecological Systems Theory to investigate sexual behaviour. For example, Newman (2000) found that gendered mechanisms of risk may differentially affect HIV risk among African American adolescents. These include sexual activity, condom use, alcohol and other drug use during sex, partner age differences, and risk and condom perceptions. The study's findings suggested gendered differentially tailored interventions could be implemented for urban African American adolescents. The findings also support strengths-based interventions that address the social context of HIV risk behaviour. Furthermore, the results suggest a risk and resiliency approach to the social ecology of HIV-related sexual behaviour, which may facilitate interventions along the pathways of vulnerability that place youth at risk for HIV/AIDS.

Voisin, DiClemente, Salazar, Crosby and William (2006) examined factors that are independently associated with STD risk behaviours among sexually active detained female adolescents. Findings indicated that factors such as greater substance use,

stronger risk-taking attitudes, lower perceived parental monitoring and familial support, gender roles supporting male dominance, risky peer norms, and lower student-teacher connectedness, were independently associated with increased STD risk behaviours. A multi-systemic approach to STD prevention among this population was suggested. Harding (2003) investigated decision-making across the lifespan. She investigated how adolescents make decisions and the educational strategies that can be used to support them in making positive choices. Cocoran, Franklin and Bennett (2000) investigated the combination of factors that successfully predicted pregnancy in adolescence.

The shortcomings of ecological theory are that it does not explain why things happen or why connections exist, nor is ecological theory adequately prescriptive to inform practice directly. Critics claim that it is overly inclusive, giving little guidance concerning what should be considered important to include in a general schema. Furthermore, it does not criticize the entropy of systems that are not viable, leaving unquestioned the value of some systems as they exist. Finally, it is overly generalized, and the language is too complex. These objections suggest that ecosystems or ecological theory, as originally developed, exaggerate the importance of the parts of a system, making it appear that homeostasis (system stability) is preferable to conflict and change and leaves unchallenged underlying assumptions such as hierarchies and institutions (Ungar, 2002: 484).
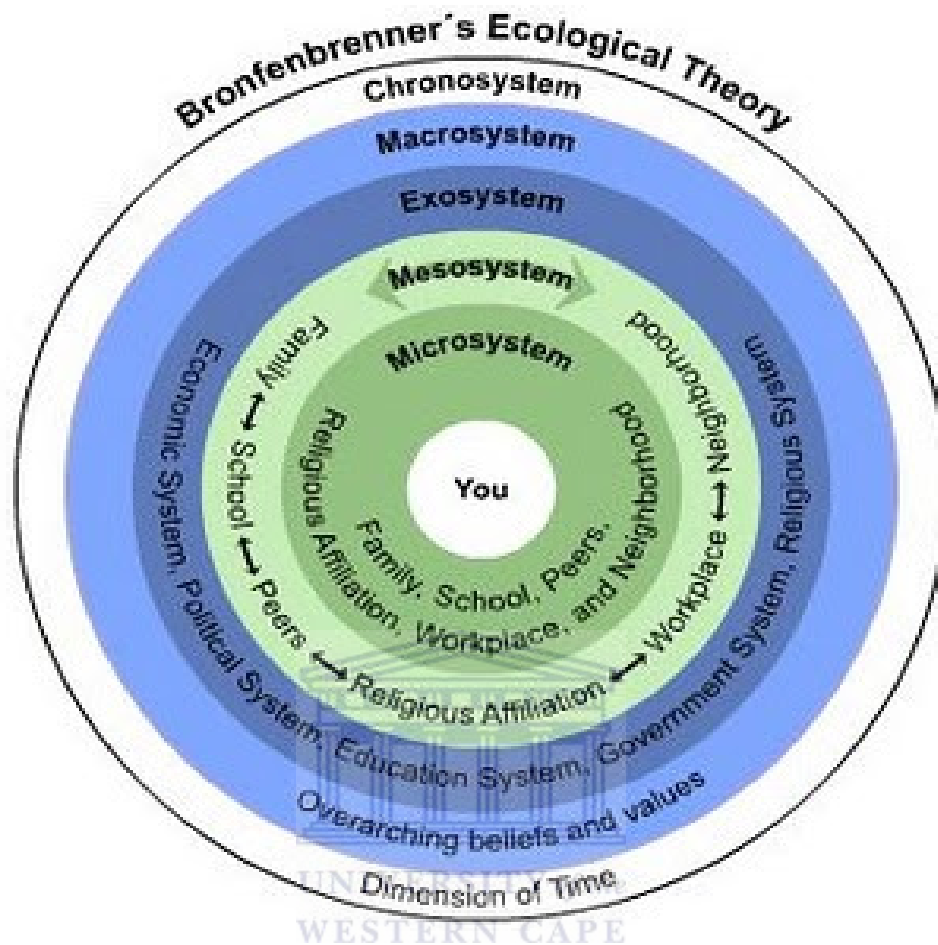
Figure 2.1 Bronfebrenner: Ecological Theory (Bronfenbrenner, 1979).

2.5.12 Summary of Theoretical Perspectives

A synopsis of the above discussion indicates that some similarities exist between the behavioural change theories and models used to understand sexual behaviour. Several behavioural change theoretical approaches emphasize the role of the perceived outcomes of behaviour (although the terminology differs for this construct), including perceived benefits and barriers (Health Belief Model) and outcome expectations (Social Cognitive Theory and Theory of Planned Behaviour). Several approaches also emphasize the influence of perceptions of control over behaviour.   This influence is given various labels such as self-efficacy (Health Belief Model and Social Cognitive Theory) and perceived behavioural control (Theory of Planned Behaviour). Other theories highlight the role of social influences, as in the concepts of observational learning (Social Social Learning Theory/Cognitive Theory), perceived norm (Theory of

Reasoned Action and Theory of Planned Behaviour) and social support, and interpersonal influences (Bronfenbrenner's Ecological Systems theory). However, most of the theories do not attend to the influence of the environment on health behaviour (Glanz & Rimer, 2005).

2.6 Conclusion

This chapter aimed to highlight literature relevant to the goal objectives of this study. Relevant core concepts, such as sexuality, sexual behaviour and sexual risk-taking. Sexual decision-making, perspectives on the relationship between knowledge, attitudes and behaviour were discussed. Factors that affect sexual decision-making such as self-concept and self-efficacy were also explored. Thereafter, developmental tasks of participants in this study were examined in terms of some developmental theoretical perspectives. Behaviour change theories were examined and empirical evidence related to relevant theories used to investigate sexual decision- making, were presented.

The most prominent individual models discussed were the: The Health Belief Model, The AIDS Risk Reduction Model, Theory of Reasoned Action, Theory of Planned Behaviour, Social Learning /Social Cognitive Theory and the Transtheoretical Model. Theories concerning the influence of gender dynamics such as the Theory of Gender and Power, Social Constructionist Theory and the Social Cognitive Theory of Gender-role Development and Functioning as well as Bronfenbrenner's Ecological systems theory. These theories were discussed to underscore the view that individual models that explain sexual behaviour is embedded in the interactions between the broader environmental and social systems and the individual.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology used in the study. The objectives of this study (as previously stated in Chapter 1) point to the selection of a combined quantitative – qualitative approach for enhancing the understanding of young people's sexual risk-taking behaviour and its consequences. King, Keohane and Verba (1994: 5) state that the best research often combines the features of both approaches. They further state that by understanding both styles, one learns the range of research and can use both in complementary ways. Other aspects discussed in this chapter include the research setting, population and sample, the data analysis and the ethical considerations.

3.2 Objectives of the study

1. To describe levels of HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices in the sample.

2. To describe and compare the gender groups in terms of HIV/AIDS knowledge, self efficacy, self concept, and sexual practices.

3. To investigate whether there is a relationship between HIV/AIDS knowledge, self-efficacy, self-concept, and sexual practices for the sample as a whole.

4. To investigate whether there is a relationship between gender and sexual practices beyond that explained by knowledge, self-efficacy and self-concept.

5. To explore respondents' perceptions and/or experiences of decision-making in relation to their engagement in safe or unsafe sexual practices.

6. To explore respondents' views on and their experiences of sexual health promotion in terms of HIV/AIDS.

7. To develop relevant sexual health promotion guidelines.

3.3   The research setting

The FET sector consists of a diverse and essential part of education and training system. This sector is larger than the higher education and training (HET) sector in terms of the number of student enrolments and total expenditure. It also consists of a more diverse, and heterogeneous population (Ferreira, 2002: 49-50). The FET sector is unique in that it provides training to students over a large age range from 16 to 60 years. This differs radically from the HET sector (universities) where most students commence their studies at age 18/19 years. Due to extensive government funding for the FET's new National Vocation Certificate (NCV) courses (commenced January 2007) an even larger number of younger students will probably enrol at FET institutions in future.

The Human Capital Development Strategy (2006) and the WCED Strategic Plan (2006) refer to the FET sector as a sector that is important in the country's national objective of sustainable growth and development. It is expected that FET colleges will provide certain critical skills for economic growth and development and to contribute towards developing civil society. In order to form a relationship between education and the economy, it is important for FET institutions to develop collaborative partnerships with industry, non-government organisations and community organisations and government. This will ensure that relevant programmes are initiated and delivered thus bridging the gap between education and the world of work.

The FET sector in the Western Cape comprises of 5 colleges. The researcher deemed it appropriate to select the college with the largest number of students.

3.4   Research population and sample

The selected FET college consisted of 8 campuses with approximately 5000 students in the 18-24 year age group. One of these campuses had a negligent number of students that indicated their willingness to participate in the study.   Therefore, the preliminary sampling frame comprised of 7 campuses with approximately 4000 students.   To

determine the sample size needed for representivity Yamane's formula was used. This formula is as follows: $n = \dfrac{N}{1 + N(e)^2}$

Whereby n is the sample, N the study population and e, a constant equal to 0.05 (Yamane, 1967; Israel, 1992). Using this formula, the study sample had to be approximately 363 participants. Research however, indicates that in large scale sexuality surveys it is frequently found that between 30% and 40% of individuals selected for the sample are not successfully recruited and published studies reporting participation rates of less than 50% are not uncommon (Wiederman & Whitley, 2002: 105).

Therefore, it was deemed appropriate to over-sample, resulting in 1600 students, stratified according to campus being approached. This type of sample enables the researcher to generalise the findings to the designated population.

Of the students selected 1046 agreed to participate in the study. However, 492 questionnaires were found to be invalid and omitted from the study. The invalid questionnaires consisted of 76 respondents who did not fit into the age cohort 18-24 years and a further 416 respondents who did not fully complete the questionnaire (i.e. scales were incomplete). Incomplete questionnaires were treated as a non-response.

Thus, data of 554 participants representing the age cohort 18-24 years was used in the final analysis. This sample consisted of 239 (43%) males and 315 (57%) females. The ages of participants ranged from 18 to 24 years, with the mean age being 20 years. Table 3.1 illustrates the demographic information of the sample.

Table 3.1: Frequency distribution of selected demographic characteristics of the study sample (n=554)

Variable	Total n (%)	Males	Females
Age:			
<21 years (18-20)	343 (62%)	142 (41.4%)	201 (58%)
Over 21 years (21-24)	211 (38%)	97 (46%)	114 (54%)
Population group:			
South African Asian/Chinese	6 (1%)	2 (33.3%)	4 (66.7%)
South African Black	218 (39%)	78 (33.8%)	140 (64%)
South African Coloured	224 (40%)	105 (46.9%)	119 (53.1%)
South African Indian	7 (1%)	3 (42.9%)	4 (57.1%)
South African White	87 (16%)	46 (52.9%)	41 (47.1%)
Foreigner	12 (2%)	5 (41.7%)	7 (58.3%)
Marital Status:			
Single	546 (99%)	238 (43.6%)	308 (56.4%)
Married	8 (1%)	1 (12.5.4%)	7 (87.5%)

3.5   Research design

According to Johnson and Christensen (2004:275), research design refers to the outline, plan or strategy used to search for answers to the research question. This consists of the proposed, the operalisation of the variables and the contribution of the research participants. The entire process is viewed as an escalation upwards to attain ultimate knowledge. In this study, a **combined quantitative-qualitative approach** was used (See figure 3.1). Quantitative research answers the questions "What and How Many?" whereas qualitative research answers the questions "How and Why?" Both methods are important in understanding a phenomenon. A concurrent mixed model design was used for data collection. According to Tashakkori and Teddlie (2003), a concurrent mixed model design is a mixed methods design wherein there are two relatively independent phases: One consisting of the quantitative question(s), data collection and analysis techniques and the other comprising of qualitative question(s), data collection and analysis techniques.

Figure 3.1   Research design flowchart
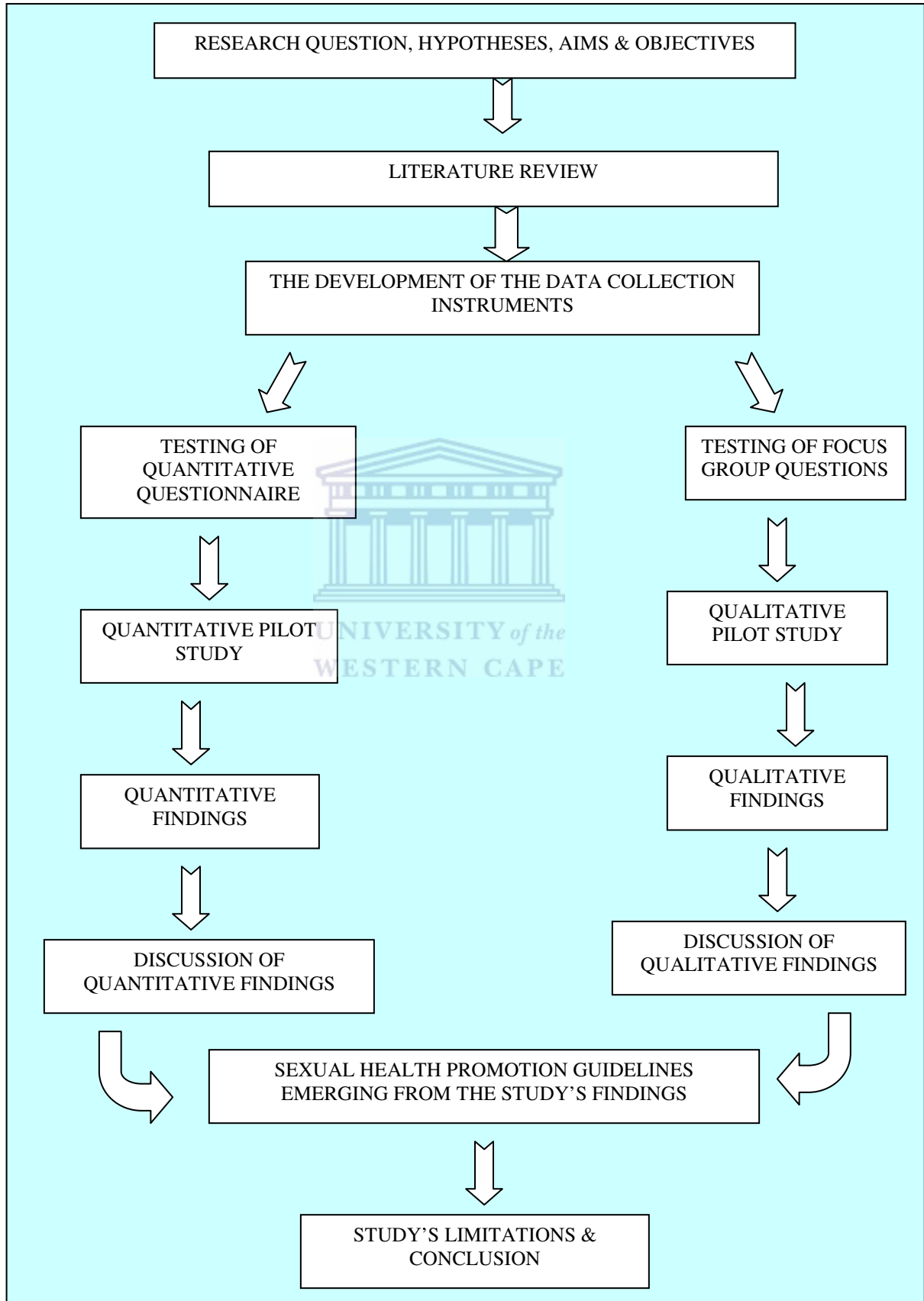
The quantitative method was deemed more appropriate to answer the first four research questions as the purpose of these questions were to describe, compare and investigate phenomena. (Domoholdt, 1993). In this study, the phenomena refer to levels of HIV/AIDS knowledge, self- efficacy, self-concept, sexual practices, and gender. The qualitative method was deemed more appropriate for the fifth and sixth research questions. Arnett (2004) contends that the qualitative methods provides participants with opportunities to tell their stories outside the confines of a structured measured scale, thus providing depth and clarity to the understanding of sexual behaviour and sexual health promotion. Furthermore, Arnett (2004:327) states that qualitative interviews with emerging adults are valuable not only as a means to an end but also in their own right. A striking ability of emerging adults is their capacity for social self-recognition that is their insightfulness into the lives and behaviour of themselves and others.

There are possible limitations in using the concurrent mixed model design. One such limitation could be the sample size differences because quantitative and qualitative data are usually collected for different purposes (generalization vs. in-depth description, respectively). Another possible limitation is the challenge faced by the researcher in integrating two data sets meaningfully in the interpretation of the findings (Creswell & Plano Clark, 2007: 66-67).

3.6   Methods of data collection

The study involved questionnaires and focus group discussions as methods of data collection. The data collection was conducted in several stages. These stages included both quantitative and qualitative phases. A brief motivation for the choice of instruments and the properties of each are outlined below.

3.6.1   Quantitative phase: questionnaires

The quantitative data were collected with a self-administered questionnaire consisting of 5 sections **(Addendum E).** The sections were adopted for use in the study after the

researcher conducted a detailed literature review. The items included both closed and open-ended questions as well as multiple -choice questions. This was done to ensure that relevant information was collected and to establish reasons why certain experiences relating to sexual behaviour, occurred or did not occur. This compares well with guidelines provided by Neuman (2003: 268-279). In line with the normal requirements in questionnaire construction, the questionnaire was formulated in simple (unambiguous) English. This consideration was crucial since many of the participants were in fact second and third language English speakers. A cover page introduced the study to the participants. Aspects of confidentiality, voluntary participation and anonymity were also presented on the cover page.

Section 1: Demographic information was requested of the participants. These items included gender, age, race and marital status.

Section 2: **Sexual practices**. Items in this section included questions related to sexual practices in terms of condom use, and the number of sexual partners in the 12 months prior to the study. To establish the use of condoms, the following item was used: *Do you make use of any contraceptive/ safe sex/ family planning methods*? This was followed by the item: *If yes, what methods do you use?* Participants' responses were categorised in terms of whether they used condoms or not (into a *yes* or *no* category). All respondents who indicated that they had used condoms were selected and scored. It was accepted that female participants who had indicated that condoms were used during sexual intercourse, were referring to the use of condoms by their male partners.

The number of sexual partners in the 12 months prior to the study was assessed by scoring the responses to the item: *How many sexual partners did you have in the last twelve months?* For the purpose of analysis the responses were then categorised in terms of <2 sexual partners and > =2 sexual partners.

The measuring of these variables is supported by literature indicating that the risks of contracting HIV/AIDS, STI's and adolescent pregnancy is reduced by limiting the number of sexual partners and having protected sex (Zanera & Mitika, 2005: 198).

Section 3: **Knowledge of HIV/AIDS**. The items used in this section were taken from the HIV/AIDS Knowledge Questionnaire (HIV-KQ-18). It is a self-administered measure and is used to measure respondents' HIV-related knowledge, particularly in relation to sexual transmission. It consists of 18 forced-choice statements designed by Carey and Schroder (2002) for the Center for Health and Behavior at Syracuse University, New York. The responses were measured on a four- point Likert scale (definitely true, true, false and definitely false). Examples of the items include the following:

Coughing and sneezing do not spread HIV.

A person will not get HIV if she or he is taking antibiotics.

Only those respondents who answered all items on the scale were selected. The maximum total score for the HIV-KQ-18 was 72. The scores are calculated and interpreted as having a midpoint of 36. Scores below the midpoint indicated low knowledge and those above the midpoint indicated high knowledge. Chronbach's alpha method of internal consistency analysis was used to measure the reliability of the HIV Knowledge Questionnaire used in this study. The alpha coefficient of the HIV-KQ-18 for this study was 0.63. Streiner and Norman (2003) recommend an alpha coefficient of at least 0.70 but no higher than 0.90. Thus, this is low reliability but is considered an acceptable level of internal consistency for research purposes (Anastasi, 1988).

Section 4: **Levels of self-efficacy**: The levels of self-efficacy in the population were measured because literature indicates that individuals who attribute their actions to self-efficacy are more inclined to engage in health promoting behaviour, such as safe sexual practices (Mirowsky & Ross, 2003). The Sexual Risk Behaviour Belief and Self–efficacy Scale (SRBBS) measure psychosocial variables affecting sexual risk-taking behaviour, including attitudes, norms, self-efficacy and barriers to condom use. Participants' levels of self-efficacy (in relation to sexual practices) were measured using an adapted version of the Basen-Enquist, Mâsse, Coyle, Kirby, Parcel, et al.(1999) Sexual Risk Behaviour Belief and Self–efficacy Scale (SRBBS), derived from the Theory of Reasoned Action, social learning theory and the Health Belief Model.

The SRBS Self-efficacy was measured by questions which consisted of various statements pertaining to participants' ability to control events concerning safer sexual practices. These statements concerned participants' self-efficacy with regard to, their ability to refuse sex, communication concerning condoms and their use of condoms. Respondents were asked to indicate their level of certainty using a Likert scale (absolutely sure, sure, unsure or absolutely unsure, scored from 1-4 respectively) regarding various statements about their perceived self-efficacy to control certain events concerning safer sexual practices. The manner in which the statements were constructed, resulted in a high score denoting low self-efficacy while a low score denoted high self-efficacy. Examples of the items include the following:

Imagine that you met someone at a party. He/she wants to have sex with you. Even though you are very attracted to each other, you're not ready to have sex. **How sure are you** *that you could keep from having sex?*

Imagine that you and your boyfriend/girlfriend decide to have sex, but he/she does not want to use a condom. You do not want to have sex without a condom. **How sure are you** *that you could keep from having sex, until your partner agrees to use a condom?*

Imagine that you are having sex with someone you have just met. You feel it is important to use condoms. **How sure are you** *that you could tell the person that you want to use condoms?*

The maximum total score for self-efficacy was 36. The scores are calculated and interpreted, those scores **above** the midpoint of 18 indicating **low** self-efficacy and those **below** the mid point indicating **high** self-efficacy. The adapted version of the self-efficacy scale yielded a Chronbach's alpha coefficient of 0.72 for internal consistency, a similar score to that reported in Basen-Engquist et al. (1999).

Section 5: Self–concept: The importance of self- concept is underscored by the literature. Self–concept is thought to influence behaviour. It is therefore important to investigate self-concept in studies relating to sexual behaviour (Rodriguez, Audrain-

McGovern, 2005; Sharpes & Wang, 1997). Sharpes and Wang (1997) concluded that self-concept is a psychological dimension indicating how good one feels about oneself. It is therefore a key factor in determining the nature of human behaviour, which is solidified during adolescence.

The self-concept items were taken from the AIDSCAP/WHO/CAPS Counseling and Test Efficacy Study questionnaire (AIDS Control & Prevention Project, 1997). It attempts to measure the individual's perception of him/herself and their perceptions on how others view them. It consisted of 8 questions. These items of the questionnaire examined the levels of participants' self-concept. Participants' responses were scored in terms of a four-point Likert scale (always, most of the time, seldom and never, with scores ranging from 1-4). The manner in which the items were constructed, resulted in a high score denoting low self-concept while a low score denoted high self-concept; **excep**t for 2 items. These two items were **reversed scored**. These two items were: "*You are inclined to feel that you are a failure*" and "*You have failed in your family's goals and expectations of you.*"

The maximum total score for the self-concept scale was 32.Those respondents who answered all the questions on this scale were selected and the scores were then calculated and interpreted. Those scores below the midpoint of 16 indicated high self-concept and those above the midpoint indicated low self-concept (Basen-Enquist et al., 1999).

The self-concept scale yielded a Chronbach's alpha coefficient of 0.64 for internal consistency. Similar to the internal consistency found for the HIV-KQ-18 in this study, the self-concept scale also yielded low reliability. However, it is considered an acceptable level of internal consistency for research purposes (Anastasi, 1998).

3.6.2   Quantitative phase: Pilot study

A pilot study was conducted to determine whether the questions in the questionnaire did not exceed the reading and vocabulary levels of the students and to ascertain the

duration of the administration. The questionnaire was administered to 20 students who were conveniently selected and had volunteered to participate. The aims and conditions of the research were discussed with prospective participants, including the important condition that student participation would be purely on a voluntary basis.

Students were requested to identify any questions that they had found difficult to understand. They were also requested to indicate any problems in general that they had experienced when answering the questionnaire.

According to Treece and Treece (1982) it is important to conduct a pilot study. They refer to the pilot study as a preliminary small-scale trial run of the research study. They further contend that pre-testing the research instrument by conducting the pilot study is important in ensuring the success of the investigation.

After the pilot study one adjustment was made to the questionnaire based on the feedback given during the pilot study. The adjustment was made to question 3.18, where the explanation of oral sex was included in brackets to ensure that there was no ambiguity in terms of participants' interpretation of the item.

3.6.3   Quantitative phase: Administrative procedure

The researcher obtained permission to conduct both the pilot study as well as the main study from the Chief Executive Officer of the FET institution, where the research population was found. Since the FET college is a public institution, permission to conduct the study was also requested from the Western Cape Education Department (WCED).

The questionnaires were group administered to students in various class settings. At the onset of each session, the purpose of the study was clearly explained to the students. Students were informed that their participation in the study was voluntary and that they held the right to withdraw at any time. Participants were requested to complete the questionnaires without indicating their names or any other information that could

identify them, thus assuring anonymity. Detailed instructions for the completion of the questionnaires were verbally given to students. This information was also available on the cover page of the questionnaire.

Various lecturers administered the questionnaires at the various campuses. This could have contributed to the high rate of non-response/incomplete questionnaires received. The average time required for the completion of the questionnaire was 55 minutes (1 period). Lecturers who administered the questionnaire had clear instructions and guidelines on how to administer the questionnaires (see Addendum D) and were available to give instructions and clarify any queries that students had. Extensive precautions were taken to protect the confidentiality of participants. Informed consent was obtained from all participants (see Addendums A and B).

The questionnaires were administered under examination conditions, thus students completed the questionnaire independently, honestly and without discussion. Taking into account that the questionnaire might have aroused more questions and could have triggered emotions, students were invited to contact the researcher telephonically or after the session/period of administration of the questionnaire, to discuss questions or counselling needs they required. A psychologist was available for this purpose as well as student support staff. Data was collected over a period of six months.

3.6.4 Qualitative phase: Focus groups

In this study, the qualitative approach used was focus group discussions. The researcher selected focus groups to gather information based on participants' interactions (Morgan, 1998). According to Creswell (1998: 240) focus groups are most relevant in multi-method studies that combine two or more means of gathering data in which no primary method determines the use of others. The researcher took cognisance of this, as the current study incorporates both quantitative and qualitative research methods. Furthermore, when considering the objectives of the study the researcher was of the opinion that the informal group situation of the focus group was ideal *in order to understand the reality and lived experiences as perceived by the group and individuals in the group* (Marshall & Rossman, 1999: 114) concerning their sexual behaviour and

views on health promotion. Brown (1999:113) indicates that the choice for the use of focus group technique is made on the basis that the focus group is able to generate rich and diverse views, opinions and experiences from multiple participants. The focus group discussions aimed to explore respondents' perceptions and/or experiences of decision-making in relation to their engagement in safe or unsafe sexual practices; and to explore respondents' views on and their experiences of sexual health promotion in terms of HIV/AIDS and formulating guidelines for the promotion of sexual health.

3.6.5   Qualitative phase: Pilot study

Participants were purposefully selected from the student population of eight campuses of the selected FET College. The pilot focus group comprised of those students who were in the 18-24 year age cohort, who volunteered to participate in the discussion. The researcher used purposive sampling methods, (specifically volunteer sampling) in selecting the participants. This method was used to acquire specific information from a clearly identified group who provided rich, in-depth information. Purposive sampling refers to a sample that consists of elements that most represent characteristics or attributes of the population (Singleton in de Vos, Strydom, Fouche, Poggenpoel & Delport, 2002: 207). A focus group pilot study was firstly conducted to gauge the suitability of such an approach and also to identify how the researcher could make improvements when conducting the research with the main focus groups. Voluntary participants consented in writing to take part in the study. Ten volunteers participated in the pilot focus group study to ascertain whether the instructions contained in the guidelines were clearly understood. The pilot study also afforded the researcher the opportunity to address any problems or make necessary adaptations before the actual research was conducted. The results of the pilot focus group clearly indicated that respondents understood questions posed. The results also yielded interesting candid discussion and eager participation. Consequently, no changes were made to questions posed to the participants of the pilot study.

3.6.6 Qualitative phase: Administrative procedures

After permission was obtained, the researcher conducted four focus groups discussions. The groups comprised of 12 participants aged 18- 24 years representative of students of the population across eight campuses. Literature does not concur as to the ideal size of a focus group. Some researchers refer to a group of six to twelve participants as the ideal size (Neuman, 2003: 396), while others suggest that six to eight is the ideal size (Millward in Breakwell et al., 1995: 280-281). In this study, each of the focus groups comprised of 12 participants. The groups were also represented by both males and females. In this study, one discussion per focus group was held, giving a total of four focus group discussions. Literature holds that the number of focus group meetings required for a particular study varies and is subject to the aims or purpose of the study (de Vos et al., 2002: 431; Marshall & Rossman, 1999: 114).

A semi-structured interview schedule was used to generate discussion on the following:
- Issues that influence experience and perception of sexual practices
- Sexual health, HIV/AIDS and STI's
- sexual health facilities on campus and in the community

Focus group discussions took place in classrooms at the various campuses. These venues were chosen by the researcher in terms of their location, where privacy was assured, interruptions and noise were reduced and students were seated comfortably. There were no interruptions during the discussions. Literature indicates that careful consideration should occur when selecting a venue because many factors could influence the choice of venue which in turn could influence the group dynamics (Schurink et al. in de Vos, Strydom, Fouche, Poggenpoel, & Shurink, 1998: 318). Furthermore, Krueger (1994) holds that focus group discussions should be held in a comfortable non-threatening environment, taking the comfort of participants into account.

The researcher ensured a high level of co-operation and participation thus facilitating the group rapport. Participants in all four groups were enthusiastic about their participation in the group discussion. This promoted group cohesion and afforded the

researcher the opportunity to examine their attitudes, behaviours and perceptions regarding their sexual practices and their opinions regarding sexual health promotion. Participants were informed of the nature and goal of the research. Krueger (l994: 108, 113) defines the focus group as a carefully planned discussion to obtain perceptions on a specific area of interest in a permissive, non- threatening environment. The researcher took cognisance of this and encouraged interaction between participants so that in-depth discussions could occur in an open, safe and non-threatening environment. Focus groups also allow one to observe interactions that could signify agreements and disagreements (Rossman & Rallis, 1998: 135). Brown (1999: 112) states that the use of focus groups to compliment or verify results provides greater depth or richness to these results. The researcher's use of focus groups enabled her to gain deeper insight into the lived experiences of young people.

The duration of the focus groups discussions conducted in this study was between 70-90 minutes. This concurs with what is proposed by Tang and Davis (1995) who contends that a focus group discussion needs to be one to two hours in duration. Having a focus group discussion of less than one hour poses the risk that the topic under enquiry might not be able to be fully explored. However, if the focus group discussion extends beyond two hours, both the participants and the facilitators may experience fatigue or disinterest. Tang and Davis (1995) suggested that the focus group discussion last approximately 90 minutes.

The focus group discussions were recorded, audiotaped and transcribed verbatim by an independent person with experience in transcription. Two tape recorders/ dictaphones and detailed notes were used in the event of tape recording problems. The transcripts were proofread to ensure that the transcriber did not exclude information (missing words or names, etc). The transcriber provided adequate space in the right margin to note non-verbal cues during the discussions. The aforementioned process concurs with what is proposed by Brown (1999: 121). Debriefing sessions were held immediately after the focus group discussions. During these sessions, notes were compared and discussed for their accuracy.

The researcher ensured that she implemented the following prior to the analysis of the data. All focus groups discussions were transcribed verbatim. The transcriber provided adequate space in the right margin to note non-verbal cues during the discussions.

3.7   Data analysis

Quantitative and qualitative data were analysed separately.

3.7.1   Quantitative data

Data was captured on a spreadsheet using The Microsoft Office Excel computer software programme in preparation for analysis. The data was recorded from question responses into meaningful variables. It was then imported into the Statistical Package for Social Sciences (SPSS) version 14.0 which was used for the analysis of the quantitative data.

Descriptive statistics were employed to summarize the demographic data of the study sample. The demographic data were presented using frequency tables and were expressed as frequencies and percentages. Furthermore, descriptive statistics in the forms of means and frequencies was used to describe levels of HIV knowledge, self-efficacy, self-concept and gender.

Chi-square test was used to ascertain if there was a significant relationship between gender and sexual practices reflected by condom use and the number of sexual partners in the 12 months prior to participation in the study. The following hypotheses were formulated:

H1:   There is a significant relationship between gender and condom use for late adolescents/emerging adults.

HO1:   There is no significant relationship between gender and condom use for late adolescents/emerging adults.
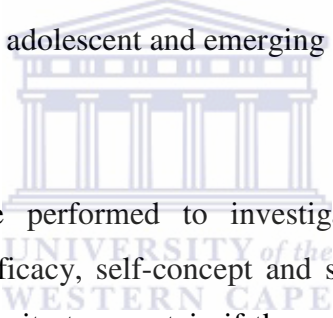
H2:   There is a significant relationship between gender and the number of sexual partners in the last 12 months for late adolescents/emerging adults.

HO2: There is no significant relationship between gender and the number of sexual partners in the last 12 months for late adolescents/emerging adults/youth.

Furthermore, a Hotteling's T²- test was conducted to establish if there was a significant difference between males and females for the predictor variables of knowledge of HIV/AIDS, self-concept and self-efficacy. The following specific hypotheses were formulated:

H1: There are gender differences in terms of HIV/AIDS knowledge, self-concept and self-efficacy of late adolescent and emerging adults.

HO1: There are no gender differences in terms of HIV/AIDS knowledge, self- concept and self-efficacy of late adolescent and emerging adults.

Two steps of analysis were performed to investigate the relationship between HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices. The first step was to investigate multicollinearity to ascertain if the variables were ideal to perform a multivariate analysis. The second step was to sequentially conduct various models by means of logistic regression analysis attempting to determine which model most accurately and parsimoniously predicted sexual practices identified by condom use and number of partners in the 12 months prior to participation in the study. Logistic regression was performed to establish whether there were any relationships amongst the predictor variables (HIV/AIDS knowledge, self-efficacy, self-concept) and the criterion variable (sexual practices in terms of condom use and number of sexual partners in the 12 months prior to the study) for the sample. The following specific hypotheses were formulated

H1:   The probability of sexual practices is a function of the intercept and HIV/AIDS knowledge, self-efficacy and self-concept for late adolescents/emerging adults.

HO1:   The probability of sexual practices (condom use and number of sexual partners in the 12 months prior to the study) is a function of the intercept only for late adolescents/emerging adults/youth.

To describe the effect of gender on the relationship between HIV/AIDS knowledge, self-efficacy, self-concept and sexual practice involved two steps of analysis. The first step was to sequentially conduct various models by means of logistic regression analysis to determine which model most accurately and parsimoniously predicted sexual practices identified by condom use and number of partners in the 12 months preceding the study.

Logistic regression analysis was conducted to establish the relationship between HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices for the sample. The following specific hypotheses were formulated

H1:   Gender significantly influences the relationship between HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices for late adolescents/emerging adults.

HO1:   Gender does not significantly influence the relationship between HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices for late adolescents/emerging adults.

3.7.2   Qualitative data

In the analysis of the focus group discussions the researcher considered the words of participants, the context of these words, internal consistency, the frequency of comments, the extensiveness of comments, specificity of comments and body language (that which was not said). This is in accordance with what is recommended by Morgan & Krueger (1998, vol. 6: 31). The researcher used content analysis. The analysis of the

focus groups discussions commenced with the verbatim transcription of the information from the dicta- phone recordings to produce a manuscript. Integration of the notes taken in the group discussions (where elements such as gesture and body language were noted) was added to the transcriptions, to verify accuracy.

Data analysis involves the processing of raw data (gathered during the study) into information that is meaningful and provides insight into the comments being studied. Roberts (2002:119) comments as follows about narrative analysis:

> *Through narrative, we come in contact with our participants as people engaged in the process of interpreting themselves and crucial events in their lives. We work with what is written, how it is said and what is not said, within the context of the specific assignment. We must then decode, recognize and re-contextualise or abstract the experiences in the interest of reaching a new interpretation of the raw data of experience.*

Barbour & Kitzinger (in de Vos et al., 2002: 318) state that qualitative analysis involves incorporating and comparing discussions of similar themes and investigating how these relate to the differences between individuals and groups.

The data was analysed in terms of Baptiste's model (2001) as this model provides a user-friendly explanation and structure for novice researchers. Using Baptiste's model (2001) data was analysed in terms of four phases within a framework of different strategies. The first phase of analysis included making decisions on the goals of the analysis, identifying appropriate and sufficient information, and the appropriate manner in gathering, recording, interpreting and conveying the information. This also involved the researcher doing a self-analysis in terms of the research ontology (reality as experienced by the researcher), the epistemology, nature and sources of information, axiology (the place and role of the researcher's values in the research), the role of the participants, the appropriate manner in which to use the research findings and causality (the meanings attached to associations drawn between people, ideas and/or events in research). This phase afforded the researcher the opportunity to pay attention to the

influence of her personal ideology and philosophical orientation on the information gathered and the data analysis.

This second phase commenced by reading through all the scripts and then selecting information rich in detail.   The classifying of data involved the tagging of data and the grouping of tagged data. In this manner, important information was selected. Numbers, symbols, phrases or terms were used to label the tagged data. The labeled and tagged data with similar characteristics were placed into a group or category and arranged into themes. In moving from coding to narrative, the researcher explored not only *what* was said in the data but also *how* it was said. Coffey and Atkinson (1996: 83) are of the opinion that form and content can be studied together and stress that the narrative approach looks at meaning and metaphors. This can alert the researcher to themes that coding and content analysis may not reveal. This phase allowed the researcher to select data and to place this relevant data into various categories/ themes.

The third phase does not entail the mere summarizing of concepts. There was also an integration of the similarities between the different concepts.   It involved an insightful and in-depth understanding of the concepts being studied.   This phase allowed the researcher to look holistically at the relationships between the various themes and sub-themes that had emerged.

The fourth phase dealt with the writing up of a report and forms an integral part of data analysis as it influences the nature of the analysis. Krueger (1994: 154), states that participants' quotations are not always given in a succinct manner and can sometimes be very crude. In this study, the researcher ensured that the quotations taken from the data was a reflection of what the participant stated. She ensured that it was an accurate account of the views of the participants.

Trustworthiness
Data verification in this study was done according to Krefting's guidelines and the Guba model in Krefting (1991) in order to ensure trustworthiness in the qualitative phase of

the study (Krefting, 1991). Guba's model is based on four aspects of trustworthiness, namely: truth value, applicability, consistency, and neutrality.

Truth value determines how confident the researcher is with the truth of the findings based on the research design, the participants, and the context. It is established through the strategy of credibility and by means of criteria actions/activities such as extensive field experience, time sampling, interviewing techniques, triangulation, reflexivity, and peer examination. Krefting (1991: 215) postulates that "truth value is usually obtained from the discovery of human experiences as they are lived and perceived by informants". It is therefore important that the researcher reports such subjective realities as accurately as possible. In this study credibility was enhanced by using the actual words of participants in the focus group discussions and thereby conveying situations as objectively and accurately as possible.

Applicability refers to the degree to which the findings can be applied to other contexts, settings or with other groups. It is established through the strategy of transferability and by means of the following criteria (actions/activities): nominated sample, comparison of the sample to demographic data, time samples, and a dense description. The researcher attempted to enhance the applicability of the study by ensuring that the research guidelines were as descriptive and clear as possible so that they were easily understood.

The applicability of this study was determined by providing adequate descriptive data in order to allow for comparisons (Krefting, 1991:216) and to ensure transferability for other studies dealing with young peoples' sexual practices in the FET college sector or educational institutions.

Consistency of data refers to whether the findings would be consistent if the study were replicated with the same participants or in a similar context. It is established through the strategy of dependability and by means of the following criteria (actions/activities): dependability audit, dense description of research methods, stepwise replication, peer examination and code-recode procedure. Two strategies are suggested by Krefting (1991: 221) to enhance consistency. The first strategy would be the use of peers

experienced in methodology, to examine the research plan. The second strategy is the use of the code-recode procedure, which involves the researcher coding the data, then recoding it after a period of two weeks. The two sets of results are then compared to gauge the extent of consistency. The first strategy was applied to this study by using the study's promoter and other relevant academic staff at the University of the Western Cape. The second strategy was also applied because coded data was re-examined more than once to ensure that the coding was correct.

Neutrality refers to the degree to which the findings are a function of the participants and the conditions of the research, and not other biases, motivations and perspectives. It is established through the strategy of confirmability and by means of the following criteria (actions/activities): confirmability audit, triangulation and reflexivity. Both internal and external examiners will therefore examine this study's findings.

3.8 Ethical considerations

The researcher took the following steps to ensure that the ethical principles were adhered to: Prior to the commencement of the research, the researcher obtained permission to conduct her study at the FET institution (see Addendum F). Permission was obtained from the Chief Executive Officer of the FET college as well as the WCED. The researcher then approached students and discussed the goal as well as conditions of the research with them. These conditions included that student participation would be purely on a voluntary basis and that they could withdraw from the study at any juncture. Participants were also informed of the confidential nature of the study and their anonymity when participating in the study. The questionnaires were administered under examination conditions, thus students completed the questionnaire independently, anonymously, honestly and without discussion. Informed written consent was obtained from participants (see **Addendum A and B)** concerning their participation in both the completion of questionnaires (quantitative phase) and focus group discussions (qualitative phase). Furthermore, the researcher was also working under supervision and guidance of her supervisor and was aware of ethical

responsibilities. The services of a trained psychologist and student support counsellors were available to students who sought assistance and counselling after the sessions.

3.9   Summary

This chapter presented the methodological design of the study concerning the various stages of the research process. The research topic warranted the use of both the quantitative and qualitative approaches to provide an in-depth representation of young people's attitudes, perceptions, knowledge of HIV/AIDS, state of self–efficacy and self-concept as well as opinions concerning their sexual practices and views on and their experiences of sexual health promotion in terms of HIV/AIDS. In Chapters 4 and 5 the results of the quantitative and qualitative data analyses are provided respectively.

CHAPTER 4

QUANTITATIVE RESULTS

4.1   Introduction

This chapter contains the results of the statistical analysis that attempted to answer the hypotheses stated in chapter three. The chapter is organized in such a manner that it follows the listing of the objectives or hypotheses stated in the previous chapter. Each hypothesis or research objective will be restated followed by a summary of the results.

4.2   Objective 1:   This objective aimed to describe the levels of HIV/AIDS knowledge, self- efficacy, self -concept, and sexual practices of students at a selected FET college. Below follows a brief exposition of the reported prevalence in each of these categories. As stated in the previous chapter, descriptive statistics were employed to summarize levels of HIV knowledge, self-efficacy, self-concept and sexual practices.

Table 4.1 summarizes the prevalence of sexual practices, i.e. condom use and number of sexual partners in the past 12 months, of the study sample.

As illustrated in Table 4.1 the majority of participants indicated that a condom was not used when having sex, either by themselves or by a partner in the 12 months prior to the study. Furthermore, more than half of the participants indicated that they had less than 2 sexual partners in the 12 months prior to the study. These findings suggest that the majority of participants reportedly engaged in sexual risk-taking behaviour.

Table 4.1   Descriptive Statistics for sexual practices for the sample (n=554)

Sexual Practices Categories	N	%
Condom use		
Yes	252	45.5
No	302	54.5
Number of sexual partners		
<2 partners	316	57
≥ 2 partners	238	43
Total	554	100

Table 4.2 summarizes the descriptive statistics for the levels of HIV/AIDS knowledge, the levels of self-efficacy and self-concept of the study sample.

Table 4.2   Descriptive statistics for HIV/AIDS knowledge, self-efficacy and self-concept for the study sample (n= 554)

Variables	Mean	Minimum	Maximum	SD
HIV/AIDS Knowledge	57.80	30	70	5.51
Self-efficacy	14.90	9	35	4.23
Self-concept	13.98	8	26	3.24

HIV/AIDS Knowledge Maximum Total Score = 72
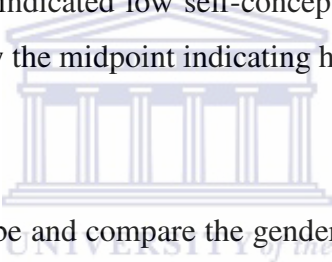
Self-efficacy Maximum Total Score = 36

Self-concept Maximum Total Score = 32

For HIV/AIDS knowledge, scores below the midpoint indicated low knowledge and those above the midpoint indicated high knowledge. The mean score for the study sample was 57.80 (SD=5.51) indicating that the level of knowledge regarding HIV/AIDS of the study sample was above average.

For self-efficacy scores **above** the midpoint of 18 indicated **low** self-efficacy and those **below** the mid point indicated **high** self-efficacy. The mean self-efficacy score for the study sample was below the midpoint, indicating that most of the participants felt that they had the ability to control events concerning safer sexual practices.

Scores on the self-concept scale below the midpoint of 16 indicated high self-concept and those above the midpoint indicated low self-concept. The mean self-concept score for the study sample was below the midpoint indicating high self-concept levels.

4.3   Objective 2: To describe and compare the gender groups in terms of HIV/AIDS knowledge, self-efficacy, self concept, and sexual practices. It was hypothesized that there is a significant relationship between gender and condom use and gender and sexual practises for the study sample.

Table 4.3 summarizes the prevalence of sexual practices, i.e. condom use and number of sexual partners in the past 12 months by gender.

The results in Table 4.3 indicate that more females (or their partners) than males reported the use of condoms when having sex. This finding highlights a large difference in male and female use of condoms when having sex. More than half of the male participants reported that they had sexual relations with two or more sexual partners in the 12 months preceding the study, whilst only a small percentage of females did. Thus, not only did males and their partners not use condoms when having sex, but they also had two and more partners in the 12 months prior to the study.

Table 4.3   Descriptive statistics of sexual practices for males (n=239) and females (n=315)

Sexual Practices Categories	Male		Female	
	n= 239	%	n= 315	%
Condom use				
Yes	71	30	181	58
No	168	70	134	42
Number of sexual partners				
<2 partners	90	38	226	72
≥ 2 partners	149	62	89	28
Total	**239**	**100**	**315**	**100**

Chi-square tests were done to determine if a significant difference in the incidence of condom use and number of sexual partners exist between males and females. The results of the analysis are summarized in table 4.4.

Significantly more males (70%) than females (43%) reported no condom use when engaging in sex (p<0.05). Furthermore, significantly more males (62%) than females (28%) reported having had two or more sexual partners in the 12 months prior to the study (p<0.05).

Table 4.4   Association between sexual practices and gender (n= 554)

	Male N=239		Female n= 315		Statistics		
	N	%	n	%	Chi-Square	df	P
Condom Use							
"Yes"	71	30	181	58	63.06	1	<.000
"No"	168	70	134	43			
Number of sexual partners							
<2 partners	90	38	226	72	6.71	1	<.010
>= 2 partners	149	62	89	28			

Table 4.5 summarizes the scores for the levels of HIV/AIDS knowledge, the levels of self-efficacy and self-concept by gender.

Table 4.5   Descriptive statistics for HIV/AIDS knowledge, self-efficacy and self-concept for the males (n= 239) and females (n= 315)

Variables	Mean	Minimum	Maximum	SD
HIV/AIDS Knowledge				
Male	57.70	30	68	5.84
Female	57.87	43	70	5.25
Self-efficacy				
Male	16.18	9	35	4.22
Female	13.92	9	34	3.97
Self-concept				
Male	14.04	8	25	3.22
Female	13.93	8	26	3.25

The mean scores in table 4.5 indicate that males and females attained similar mean score for HIV/AIDS knowledge and self-concept scores with similar variability (SD) and range scores for both groups. Females had higher self-efficacy than males in the study sample.

It was further hypothesized that HIV/AIDS knowledge, self-efficacy and self-concept differed significantly between males and females. Hotteling's T²- test was conducted to establish if there was a significant difference between males and females for the predictor variables of knowledge of HIV/AIDS, self-concept and self-efficacy. The results of these tests are summarized in table 4.6.

Table 4.6   Hotelling's T²- test results for the Sample (n= 554)

Variable	Gender: Male Mean (n = 239)	Gender: Female Mean (n = 315)	df	F	P
T² = .078	F (3, 550) = 14.35	p< .00			
Self-efficacy	16.18 (4.22)	13.92 (3.97)	1	41.60	.00*
HIV/AIDS Knowledge	57.70 (5.84)	57.87 (5.25)	1	.13	.72
Self-concept	14.04 (3.22)	13.93 (3.24)	1	.14	.71

*p<.05

Standard Deviations (SD's) are presented in parentheses.

The post hoc t-tests indicate that males (16.18) had significantly lower self-efficacy than females (13.92) (p<0.05). This scale was constructed in such a manner that a low score denoted high self-efficacy and a high score denoted low self-efficacy. No significant differences were found for HIV/AIDS knowledge and self-concept between males and females (p>0.05).

4.4   Objective 3: To investigate whether there is a relationship between HIV/AIDS knowledge, self-efficacy, self-concept, and sexual practices of students at a selected FET college.

The first step of the analysis that attempted to reach the third objective was to investigate multicollinearity to ascertain if the variables were ideal to perform a multivariate analysis. These are summarized in table 4. 7.

Table 4.7   Correlation matrix: self-efficacy, HIV/AIDS and self-concept

Variable	Self-efficacy	HIV/AIDS Knowledge	Self-concept
Self-efficacy	1.00	-.053	.234[**]
HIV/AIDS Knowledge	-.053	1.00	-.047
Self-concept	.234[**]	-.047	1.00

** $p < .01$ level (2-tailed).

The results in Table 4.7 show that the only significant ($p < .01$) relationship was between self-concept and self-efficacy (.234**). This moderate positive correlation suggests no evidence of multicollinearity and therefore the variables are ideal to perform the multivariate analysis.

The second step was to sequentially conduct various models by means of logistic regression analysis attempting to determine which model most accurately and parsimoniously predicted sexual practices identified by condom use and number of partners in the 12 months prior to participation in the study. Logistic regression was performed to establish whether there were any relationships amongst the predictor variables (HIV/AIDS knowledge, self-efficacy, self-concept) and the criterion variable (sexual practices in terms of condom use and number of sexual partners in the 12 months prior to the study) for the sample.

A three -predictor logistic model was fitted to the data to test the research hypothesis regarding the likelihood that HIV/AIDS knowledge, self-efficacy and self-concept would predict sexual practices (condom use and number of sexual partners in the 12 months prior to the study). Table 4.8 presents the logistic regression for the sample predicting condom use.

Table 4.8   Logistic regression for the sample (n=554) predicting condom use

-2LL null: 730.144				
-2LL research model: 721.102				
Final loss:	Chi² (3) = 9.042		p= .005	
	Variables in the equation			
N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept
Estimate	-2.509	.046	.023	.005
Standard Error	1.049	.016	.022	.028

The results of Table 4.8 indicate that the -2 times the log likelihood (-2LL) value was reduced from the base (intercept only) model at 730.144, to the full model (the model including all three predictors) at 721.102, a reduction of 9.042. The Chi-Square value was significant suggesting that the overall model was significantly different from the null model of the intercept only. This indicates that the predictors, as a set, reliably predict condom use.

Analyses undertaken to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy and self-concept) best predicted condom use are reported in table 4.9 below.

Table 4.9   Wald statistics for the Model

N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept
Wald's Chi-Square	5.723	7.925	1.112	.026
p-level	.017*	.005*	.292	.872
Odd's ratio (unit ch)	.081	1.047	1.023	1.005
-95% CI		1.014	.980	.950
+95% CI		1.081	1.069	1.062

An examination of the Wald statistics reveals that only the HIV/AIDS knowledge variable was significantly positive suggesting that having knowledge of HIV/AIDS could predict condom use. The odds that a person with higher HIV/AIDS knowledge will use a condom are 1.047 times greater than someone with less HIV/AIDS knowledge by one unit.

Table 4.10 presents the logistic regression for the sample predicting for multiple sexual partners in the twelve months prior to the study.

Table 4.10   Logistic regression for the sample (n=554) predicting for multiple sexual partners

-2LL null: 756.989				
-2LL research model: 721.008				
Final loss:	Chi² (3) = 35.981		p= 0.000	
	Variables in the equation			
N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept
Estimate	-1.282	-.010	.130	-.025
Standard Error	1.056	.016	.023	.028

* p< 0.05

The results of Table 4.10 indicate that the -2 times the log likelihood (-2LL) value was reduced from the base (intercept only) model, to the full model (the model including all three predictors). The Chi-Square statistic of the model was examined to determine if the overall model was statistically significant. The results revealed that the Chi-Square value was 35.98 (3), p = 0.000 (p<.05) suggesting that the full model was highly significantly different from the null model of the intercept only. This indicates that the predictors, as a set, predict whether a person would have >2 or < 2 sexual partners in a twelve month period preceding the study.

Analyses undertaken to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy and self-concept) best predicted multiple sexual partners are reported below in table 4.11.

Table 4.11   Wald statistics for the Model

N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept
Wald's Chi-Square	1.474	.408	31.104	.752
p-level	.225	.523	.000*	.386
Odd's ratio (unit ch)	.277	.990	1.139	.976
-95% CI		.959	1.088	.923
+95% CI		1.022	1.192	1.031

* p< 0.05

An examination of the Wald statistics reveals that only self-efficacy was highly significantly positive suggesting that an increase in an individual's self-efficacy would predict an increase in the number of partners an individual would have. Furthermore, the odd's ratio value for self-efficacy indicates a positive relationship with the number of partners of an individual. This means that, if an individual's self-efficacy score increases by one unit, the odds of having more than one sexual partner will increase by 1.139. Thus, it means that a person with lower self-efficacy has an increased probability to have more than one sexual partner.

4.5   Objective 4: To investigate whether there is a relationship between gender and sexual practices beyond that explained by knowledge, self-efficacy and self-concept.

A predictor logistic model was fitted to the data to test the research hypothesis regarding the likelihood that gender would have an effect on the relationship between

HIV/AIDS knowledge, self-efficacy, self-concept and sexual practices (condom use and number of sexual partners in the 12 months prior to the study).

Table 4.12   Logistic regression for the sample (n=554) predicting condom use

-2LL null: 730.144					
-2LL research model: 712.071					
Final loss:	Chi² (4) = 18.074			p=.001	
	Variables in the equation				
N=	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept	Gender
Estimate	-2.577	.046	.005	.009	.566
Standard Error	1.055	.016	.023	.029	.190

p< 0.05

Table 4.12 indicates that the -2 times the log likelihood (-2LL) value was reduced from the base (intercept only) model to the full model (the model including all four predictors. The Chi-Square statistic of the model was examined to determine if the overall model was statistically significant. The results revealed that the Chi-Square value was 18.073 (4), p = 0.001 (p<.05) suggesting that the overall full model was highly significantly different from the null model of the intercept only. Therefore, the hypothesis must be accepted and the null hypothesis rejected.

Analyses undertaken to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy, self-concept) and the effect of gender best predicted the use of condoms, are reported below.

Table 4.13   Wald statistics for the Model: Condom use

N=	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept	Gender
Wald's Chi-Square	5.963	8.070	.046	.100	8.868
p-level	.015*	.005*	.831	.752	.003*
Odd's ratio (unit ch)	.076	1.048	1.005	1.009	1.762
-95% CL		1.015	.961	.954	1.214
+95% CL		1.082	1.051	1.067	2.558

p< 0.05

An examination of the Wald statistics reveals that both knowledge of HIV/AIDS and gender were significantly positive suggesting that an increase in an individual's knowledge of HIV/AIDS would predict an increase in the use of a condom by that individual. Furthermore, the gender of the participant had an effect on the relationship between HIV/AIDS knowledge and condom use. The odd's ratio value for HIV/AIDS indicates a potential positive relationship with gender.

Thus, knowledge of HIV/AIDS remained a significant predictor of condom use even though gender was added to the model.

The odd's ratio value for HIV/AIDS knowledge indicates that with 1 unit increase in HIV knowledge the odds of a person using condoms increases with 1.048.   Further more, the results indicate that the odds of a male using a condom increases by 1.762

Table 4.14   Logistic regression for the sample (n=554) predicting for multiple sexual partners

-2LL null: 756.989					
-2LL research model: 674.300					
Final loss:	Chi² (3) = 82.689			p= 0.000*	
	Variables in the equation				
N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept	Gender
Estimate	-1.369	-.012	.094	-.016	1.270
Standard Error	1.098	.017	.024	.030	.189

p< 0.05

Table 4.14 indicates that the -2 times the log likelihood (-2LL) value was reduced from the base (intercept only) model (756.989) to the full model (the model (674.300) - including all four predictors). The -2LL value obtained in the present study indicated a satisfactory model fit. The Chi-Square statistic of the model was examined to determine if the overall model was statistically significant. The results revealed that the Chi-Square value was 82.69 (4), p = 0.000 (p<.05) suggesting that the overall full model with all four predictors was highly significantly different from the null model of the intercept only. This indicates that the predictors, as a set, reliably predict multiple sexual partners in a twelve-month period. As a result, the researcher must accept the hypothesis and reject the null hypothesis.

Analyses undertaken to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy, self-concept and gender) best predicted multiple sexual partners are reported below.

Table 4.15   Wald statistics for the Model: Multiple sexual partners in the 12 months preceding the study

N= 554	Constant	HIV/AIDS Knowledge	Self-efficacy	Self-Concept	Gender
Wald's Chi-Square	1.553	.482	15.483	.289	45.285
p-level	.213	.487	.000*	.591	.000
Odd's ratio (unit ch)	.254	.988	1.099	.984	3.561
-95% CI		.956	1.049	.928	2.460
+95% CI		1.022	1.152	1.043	5.154

p< 0.05

An examination of the Wald statistics reveals that self-efficacy has a significant relationship with multiple sexual partners suggesting that an increase in an individual's self-efficacy score (thus lower self- efficacy) would predict an increase in the number of sexual partners an individual would have had in the twelve month period prior to the study. This means that with each unit increase in the self-efficacy score, the odds increase of having more than one partner by 1.099. Therefore, if the individual has low self-efficacy, the possibility of having more than one sexual partner increases. Furthermore, the results indicate if you are a male, the odds of having more than one partner is 3.561 times higher than if you are female. Thus, self-efficacy remained a significant predictor with gender added to the model, but gender also affected the prediction significantly.

4.6   Summary

The data of the *quantitative part* in the study was analysed by means of the Statistical Package in the Social Sciences (SPSS) to provide information in terms of percentages, frequencies, means, standard deviation, Chi-square and correlations, which were used to describe the characteristics of the sample, to determine the significance of the nature of relationships and to test the hypotheses. The Chi-square test and the Pearson correlation were used to establish relationships or associations between the variables with regard to the nature and characteristics of the variables. A statistical procedure the Hotelling's T^2-test was carried out to compare the predictor variables. A three -predictor logistic model was fitted to the data to test the research hypothesis. The findings indicate that participants had high levels of HIV/AIDS knowledge, self-concept and self-efficacy with females having higher levels of self-concept and self-efficacy than males. The majority of participants engaged in risky sexual behaviour. Furthermore, results suggest that an increase in knowledge of HIV/AIDS would predict an increase in the use of condoms particularly for males. Findings further suggest that lower self-efficacy seemed to predict an increase in the number of sexual partners for males. Male participants were thus found to engage in more risky sexual practices by not using condoms regularly when having sex, and having had two and more partners in the 12 months prior to the study.

These results will be discussed in the next chapter.

CHAPTER 5
DISCUSSION OF QUANTITATIVE RESULTS

5.1   Introduction

This chapter presents a discussion of the findings that emerged from the quantitative phase of the study. The discussion follows a thematic approach rather than a discussion of individual objectives as stated in chapter one and three. The two themes discussed are: HIV/AIDS knowledge and sexual practices of the study sample. Factors influencing sexual practices such as gender, self-concept and self-efficacy and HIV/AIDS knowledge are also discussed in the second theme.

5.2   HIV/AIDS Knowledge

Youth world wide are increasingly affected by HIV/AIDS and those most affected are living in sub-Saharan Africa (Bankole, Ahmed, Neema, Ouedraogo, Konyoni, 2007). In South Africa, HIV/AIDS represents a devastating pandemic among its youth. It has been established that the age group 15-24 years is the most vulnerable as more than 15.6% of this age group is infected with AIDS (Coombe, 2002) and more than 60% of new infections also occur in this group (Hartell, 2005; Stephenson, 2000). Research in various parts of the world suggests that sufficient knowledge regarding HIV is a necessary first step, though inadequate in the prevention of the disease (Wong, etal., 2008). Kalichman (1998) highlighted that programs intending to decrease or assess risky sexual behaviour has consistently included some education about HIV as part of their interventions. Carey and Schroder (2008) also assert that researchers, interventionists and programme evaluators often make use of HIV/AIDS knowledge scales either to guide their curricula or to determine the effectiveness of their interventions. These are thus some of the reasons why these authors developed the HIV-KQ scale to ensure that researchers have reliable and valid tools to assess knowledge regarding HIV in clinical, educational and public health settings.

Various studies, both locally and internationally, have investigated HIV/AIDS knowledge amongst youth but revealed inconsistent findings.   Some studies suggest adequate to high HIV/AIDS knowledge amongst youth whilst others suggest the

opposite. To illustrate these contradictions, a study conducted amongst South African, Mexican and Thai youth found that they still lacked information about HIV and safer sex (UNFPA, 2003a:31). Conversely other studies (Reddy et al., 2003; Medical Research Council (MRC), 2003; Zwane et al., 2004; Pettifor et al., 2005, NSP 2007-2011, 2007: 41, Higher Education HIV, AIDS Programmes (HEAIDS), 2009; Reddy, 2009) found that South African youth have high levels of knowledge about HIV/AIDS. Studies conducted in first world countries reported similar findings of high levels of knowledge (Abbott-Chapman & Denholm, 1997, UNAIDS, 2008). However, literature also indicates that although possessing high levels of knowledge is important, it does not necessarily result in safer sexual practices (Pettifor et al., 2004; Hartell, 2005). Research relating specifically to HIV/AIDS knowledge among college students has consistently indicated that knowledge alone does not predict safe sexual practices (Opt & Loffredo, 2004).

The findings of the present study suggest adequate/high HIV/AIDS knowledge amongst the study sample of emerging adult students. On average, the participants of this study achieved approximately an 80% score on HIV/AIDS knowledge. Literature shows a big improvement with regard to the HIV/AIDS knowledge amongst students as Smith et al. (1998) reported scores of less than 50% in knowledge-based questionnaires just over a decade ago. This suggests that the concerted efforts put in place by governmental organisations to promote knowledge of HIV/AIDS and safer sexual practices seem to have had a positive impact. However, literature suggests that it is debateable whether improved knowledge has lead to safer sexual practices amongst South African youth (Erulkar et al., 2001). Phillips and Malcolm (2006) are of the opinion that although young people have the knowledge of risky sexual behaviour this does not necessarily result in the adoption of healthier sexual behaviour. Phillips (2006) asserts that the biggest obstacle to behaviour change is socially supported beliefs and that knowledge should be imparted to the entire at -risk group and larger communities in which the group is embedded. Although the results of the current study suggest that the emerging adult student population possessed adequate /high knowledge, there is still room for improving the situation through sex education programmes in educational institutions, peer education, mentoring and counselling programmes. College students' ideas on

sexual behaviour are influenced by peers (Bremridge, 2000; Lesch, 2000; Goodwin et al., 2004). Ferreira (2002) contends that using peer education involves training youth to educate and mentor other youth of a similar background, place of residence, occupation or interest area and is highly recommended in the college setting.

Contrary to most literature concerning HIV knowledge and gender (Eaton & Flisher, 2000; Pettifor, 2005; Hartell, 2005; Peltzer, &. Promtussananon, 2005; NSP 2007-2011, 2007), the results of this study show no significant differences in HIV knowledge across gender.   A similar result was found in a study involving the levels of HIV/AIDS knowledge of first-year University students in Malawi (Ntata, Muula, Siziya, & Kayambazinthu, 2008). The results of the current study suggest that although knowledge of the risks of HIV/AIDS may be an important element in condom use promotion campaigns, efforts should be made to understand and explore the complex structure of sexuality in adolescence.   Efforts should also be made to expand on the traditional belief that sexual behaviour is the consequence of rational decisions based on knowledge only (Sayles et al., 2006). Furthermore, the results of the current study may be due to programmes introduced in schools prior to students entering the FET college sector. These programmes may have been effective in imparting knowledge to everybody irrespective of gender.

5.3   Sexual practices

Sexual and reproductive health is affected by risk factors in numerous ways. Some of these risk factors include unprotected sexual intercourse and multiple sexual partners. These risk factors place youth at risk for HIV infection, STI's and unplanned pregnancies. Lefkowitz and Gillen (2006) found that emerging adults are more accepting of casual sex and feel less guilt about sex than do younger individuals feel. Eaton et al. (2003) argued that the high prevalence of HIV among young South Africans is fuelled by inconsistent condom use and multiple sexual partners. Condoms, abstinence, and or limiting the number of partners are considered the most common methods for preventing HIV/AIDS, although condoms are referred to far more frequently than the other methods (Pettifor, et al., 2005; Zambuko, & Mturi, 2005, Anderson, & Beutel, 2007). With specific reference to emerging adult students in South

Africa, the HEAIDS, (2009) findings conclude that both male and female students reported that they did not effectively manage the risks associated with their new-found freedom. The most prominent risk during this period is casual sexual intercourse without using condoms in the context of alcohol intake.

For the purpose of this study, sexual practices were explored in terms of number of sexual partners in the 12 months prior to the study and condom use.

5.3.1   Number of sexual partners

Lefkowitz and Gillen (2006) contend that though emerging adults engage in sex less frequently than other age groups, they report, on average, a greater number of sexual partners than do adolescents and young adults over the age of 25. Possibly, because of these casual relationships, emerging adults have an increased chance for sexual health problems and risks. Results from the current study highlight that college students risk their sexual health by having multiple sexual partners. Almost half (43%) of the study sample reported having had sex with more than two partners in the 12 months prior to the study.   A number of South African studies involving youth have explored risky sexual practices in terms of multiple sexual partners and found similar findings to those of the current study. Anderson et al. (2007) found in a study conducted in Cape Town, South Africa, that the key risk behaviour influencing risk perception for youth (aged 14-22 years) is early sexual debut and the number of sexual partners. The HEAIDS, (2009) findings show that 41% of emerging adult students had more than one sexual partner in the 12 months prior to their study. Arnett's theory of Emerging Adulthood (2000) is useful in understanding the relationships of individuals during the transition to adulthood. Arnett posits that emerging adulthood involves a period of exploration and personal growth.   This theory posits that the emerging adult need not feel isolated if they are unable to find a long-term romantic partner immediately; they could meet new people and explore different personalities.   Therefore, young adulthood is a phase during which individuals date several people, affording them the opportunity to discover the characteristics they want in a romantic partner. Arnett (2004) suggests that young adults date and have sexual intercourse with quite a few individuals instead of

committing to just one significant other, to find the best mate possible. Furthermore, sensation-seeking behaviour increases from adolescence into emerging adulthood. Therefore, adolescents with high levels of impulsivity or having a tendency towards sensation-seeking behaviours may place themselves at greater risk for contracting HIV/AIDS and STI's (Arnett, 2004). Lefkowitz and Gillen (2006) highlight the salience of identity issues in the sexuality of emerging adults.

A significantly higher percentage of males (62%) than females (28%) reported multiple sexual partners in the 12 months prior to the study. These findings are consistent with other studies involving emerging adults, conducted in South Africa. The National Communication survey on HIV/AIDS (NCS), (2009) found that multiple partners are highest among youth, especially among young men. Approximately one-third of men aged 16-24 have had more than one partner in the past year, in comparison to 6-9% of women in the same age group. The HEAIDS, (2009) findings also conclude that male higher education students were more likely to report having more than one sexual partner in the past month than females (19% versus 6% for females). In an American study of HIV risk behaviour among college students, Lewis, Míguez-Burbano, & Malow (2009) reported similar results. Pettifor, etal. (2004) contends that it is common to have a difference in the reported number of partners among males and females. The possible justification for this is that males' over- report and females under- report regarding the number of sexual partners they have. Lefkowitz and Gillen (2005) concur, these researchers noted that caution should be practiced when interpreting observed gender differences as they may simply reflect differences in reporting. They further suggest that it is crucial to acknowledge and understand the gender differences, but they should not be overstated. These findings imply that sexual and reproductive health programmes should specifically target both sexes equally during adolescence and not solely focus on females as do so many. Results of a survey (Lundgren, 2000) highlight the critical need for sexual and reproductive health programmes for male adolescents and young adults. Lundgren (2000) further proposes that these programmes involve their peers, parents, communities and social institutions. Programmes should also assist young men to find novel ways to express themselves and to change traditional gender roles. Sex and life skills education should be specifically provided for males. Young and

first-time fathers should be provided with special services. Programmes should also address male reproductive health issues, such as contraceptive use, STDs, forced sex, and unplanned pregnancy, as well as male perceptions of masculinity, responsibility and gender roles. Programmes avidly promoting self-efficacy for males should be implemented. Analyses undertaken to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy and self-concept) best predicted the number of sexual partners, show that only an increase in an individual's self-efficacy would predict a decrease in the number of sexual partners. Thus, the findings suggest that a person with lower self-efficacy has an increased probability of having more than one sexual partner.

Analyses to determine which of the predictor variables (HIV/AIDS knowledge, self-efficacy, self-concept and gender) best predicted the number of sexual partners showed that self-efficacy has a significant relationship with number of sexual partners. This suggests that lower self- efficacy would predict an increase in the number of sexual partners an individual would have had in the twelve-month period prior to the study. This means that if the individual has low self-efficacy the possibility of having more than one sexual partner increases. Furthermore, if you are a male, the odds of having more than one partner increases by 2.460. Thus, self-efficacy remained a significant predictor with gender added to the model, but gender also affected the prediction significantly. The findings therefore, suggest that for males there is a greater likelihood that lower self-efficacy would predict more sexual partners in comparison to females.

These results also support some theories on self-efficacy (Bandura, 1978) and the concept of personal control (Gecas, 1989) that purport that it is the interactive and the independent sources of information that influences an individual's perception of self-efficacy.

5.3.2   Condom use

The WHO acknowledged that unsafe sex (sexual intercourse without a condom) is the second most salient risk factor for disease, disability, or death in the poorest communities and the ninth in developed countries (WHO, 2002a). However, theory

supports behavioural instabilities as a typical behaviour pattern for the emerging adult developmental phase and attributes it to the process of identity exploration (Arnett, 2000). Inconsistent condom use is common for this developmental phase. Lefkowitz and Gillen (2006) report that emerging adults do not use contraception regularly or consistently when engaging in sex, though they are more likely to use a condom during first-time sex with a new partner.

South African research by The NSP 2007-2011 (2007), The National Communication Survey on HIV/AIDS (NCS), 2009 and the recently released results of the Higher Education HIV, AIDS Programmes (HEAIDS) survey (2009), found that condom use was high amongst South African youth and more specifically emerging adult students. Interestingly, the quantitative findings of this study suggest converse results as more than half of participants (or their partners) (54.5%) did not use condoms when having sexual intercourse in the twelve months prior to participation. Considering the brevity of the HIV/AIDS pandemic, these findings are alarming and show that the emerging adult participants engaged in sexual risk-taking behaviour despite possessing knowledge of the transmission of HIV. This also highlights the issue of invulnerability as demonstrated in the lack or reluctance of participants to use condoms and relates to the typical behaviour patterns of individuals in the emerging adult phase of development (Arnett, 2000). A possible intervention could be providing professional and youth friendly sexual health promotion services on campus. Youth-based contraceptive services in a specific locality are linked to lower pregnancy rates. Young people also feel uncomfortable accessing traditional health clinics (Meyrick & Swann, 2001) Young people highlight the importance of having a facility where there is respect, privacy, confidentiality, short waiting time, and affordable fees. Youth also prefer facilities that provide access to as many services as possible in one visit (Frontiers in Reproductive Health, Population Council, YouthNet, Family Health International, 2006).

In terms of gender, more female participants (58%) indicated that either they or their partners used condoms when having sexual intercourse than did males (30%). Interestingly, the gender difference in terms of condom use is also contrary to the findings of The NSP 2007-2011 (2007) and the NCS (2009). However, the findings of

this study are consistent with those of Lance (2001) where females were found to be more sexually responsible than males in terms of condom use. Literature suggests that there are various factors associated with the higher levels of condom use in females. Parsons et al., (2000) highlighted gender differences, concerning the perceived costs and benefits of unprotected sex. Females reported more benefits of condom use and costs of unprotected sex, fewer benefits of unprotected sex and costs of condom use, greater self-efficacy for practicing safer sex, and less situational temptation for unsafe sex. Roberts and Kennedy (2006) found that for female college students higher levels of condom use are associated with the ability to be assertive, intentions to use condoms, and avoiding substance use.

The findings of the current study suggest that having knowledge of HIV/AIDS could predict condom use. Lance (2001) found that students that perceived themselves as possessing high HIV/AIDS knowledge in general provided a high percentage of correct answers to items concerning safer sexual practices, than students perceiving their knowledge of HIV/AIDS as medium or low. The odds that a person with higher HIV/AIDS knowledge will use a condom are 1.047 times greater than someone with less HIV/AIDS knowledge. This prediction is further supported by the finding that when HIV knowledge was added to the other two predictors (self-efficacy and self-concept), it did not lead to an increase in correct predictions of condom use.

Results show that both knowledge of HIV/AIDS and gender were significantly positive suggesting that an increase in an individual's knowledge of HIV/AIDS would predict an increase in condom use by an individual. The odds ratio value for HIV/AIDS indicated a positive relationship with gender. This suggested that the gender of the participant affected the relationship between HIV/AIDS knowledge and condom use. Thus, knowledge of HIV/AIDS remained a significant predictor of condom use even though gender was added to the model. Furthermore, the results indicate that the odds of a male using a condom increases by 1.762. The findings therefore, predict the greater likelihood that for males, HIV/AIDS knowledge would be positively related to condom use in comparison to females. Lance (2001) found similar results, his study concluded that there was statistical significance for males, between knowledge of how one can prevent transmission of HIV and how often one has unprotected sex.

5.4   Levels of Self-efficacy

Literature highlights the salient role of self-efficacy in human behaviour. Various definitions of self-efficacy exist. Kleinke (1998) defines self-efficacy as an individual's view that his or her abilities and attempts play a key role in defeating difficult circumstances and coping with life trials. Bandura defines self-efficacy as a belief that one can perform a specific behaviour (Bandura, 1978: 240). Thus, self-efficacy refers to an individual's belief in his/her personal ability, regardless of knowledge or skills. Moreover, self-efficacy affects an individual's cognition, motivation, and frame of mind. On a cognitive level, individuals with self-efficacy beliefs know that one is able to achieve positive consequences of behaviour by applying the necessary skills, such as problem solving and goal setting. Self-efficacy is seen to motivate a sense of determination and fortitude when a person has to grapple with a complex task (Bandura, 1977).

When considering the potential significant role of self-efficacy on behaviour, the national survey of South African youth by Pettifor et al. (2004) may be of particular significance in relation to safe sexual practices amongst youth. These authors found that in youth (aged 15-24) high levels of self-efficacy were related to the control of particular events around safe sexual practices. Other studies show that individuals who believe in the efficacy of their own actions are more likely to engage in health-promoting behaviours. Thus, it follows that personal control should also be related to contraceptive use and the practice of safer sex (Mirowsky & Ross, 2003; Pettifor et al., 2004). Burns and Dillon (2005) found that greater probability of condom use was related to higher self -efficacy and future time orientation amongst African American college students. Therefore, studies are inconclusive on the relationship between self-efficacy and sexual practices. Various researchers have investigated the relationship between self-efficacy, knowledge and sexual practices. Self-efficacy was significantly related to multiple sexual partners, intention to use condoms, condom use, intention to abstain from sexual intercourse, intention to avoid drug use, and perceived knowledge about HIV/AIDS. Other research, (Brown, Jara, & Braxton, 2005) supports this. Their study found that students with high levels of AIDS risk knowledge also reported higher levels of condom perception and self-efficacy. Also, condom perception was a

significant predictor of AIDS knowledge, so sex education programs that stress the proper use of condoms may go a long way in benefiting urban college students concerning AIDS prevention (Goh & Primavera, 1996).

The quantitative results of the current study suggest that more participants (59%) were likely to have higher levels of self-efficacy with a mean score of 14.90. However, the results also suggest that gender differences exist. The mean scores of females were found to be slightly higher than those of males. Studies comparing levels of self efficacy by gender, show mixed results. Some females report higher levels of sexual self-efficacy (Parsons et al., 2000). Young women were significantly more likely than young men to abstain from sexual intercourse (Goh & Primavera, 1996). Other studies have found that college males report higher self- efficacy and condom perception than females (Brown et al., 2005; Farmer & Meston, 2006).

Rostosky, Dekhtyar, Cupp and Anderman (2008) are of the opinion that the difference in levels of self-efficacy for males and females could be due to various factors. These include differing social pressures and gendered expectations related to sexual behaviour that produce differing individual and interpersonal challenges to deal with and resist sexual risk for both adolescent males and females. However, youth should be empowered to resist unwanted sexual situations and to manage risky sexual situations.

5.5   Self-concept/self-esteem

Literature defines self-concept in numerous ways. Gecas (1982:1) defines self-concept as "the totality of an individual's thoughts and feelings having reference to himself/herself as an object". Self-esteem, on the other hand, refers to the assessment that the person makes and maintains of himself/ herself. It conveys an attitude of approval or disapproval, and shows the extent to which the individual believes himself to be capable, significant, successful and worthy (Coopersmith, 1967: 4-5). Since self-esteem is an essential facet of self-concept, both constructs are often used interchangeably and are given a range of labels such as self-evaluation, self-respect,

self-confidence, self-attitude, self-image, self-view, self-schema, self-worth, self-approval, and self-satisfaction (Gecas, 1982).

Arnett (2000), in accordance with the ideas of Erikson (1968) posits that identity development is one of the key psychosocial tasks of late adolescence and has significant implications for healthy psychological development throughout the life course. Arnett (2000, 2004) further contends that the most important and most distinct feature of the emerging adulthood phase is identity exploration. Arnett (2000) proposed that the behavioural instabilities experienced by emerging adults might be understood as part of a process of identity exploration. Identity formation involves experimenting with a range of life possibilities concerning: love, work, and worldviews prior to making lasting decisions.

It must be noted that in this study, when interpreting the scores for self-concept, a high score denotes low self-concept while a low score denotes high self-concept. The quantitative results show that generally, participants were likely to have higher levels of self-concept. In terms of gender, females indicated higher self-concept mean score levels than males. Some researchers have found that youth who exhibit high levels of self-esteem (as well as connectedness to school, or participation in pro-social activities) are less inclined to engage in health-compromising behaviours (Resnick & Bearman, 1997; & Jessor, 1998). Other researchers have found converse findings concerning the effects of self-efficacy and self-esteem on sexual behaviour (Morrison et al., 1995; & O'Leary et al., 2000). Studies are therefore inconclusive concerning the effect of self-efficacy and self-esteem on sexual behaviour.

Research is inconclusive concerning the association between gender and self-concept. Rostosky et al. (2008) found that adolescent males reported lower levels of sexual self-concept than adolescent females. This was in contrast to previous studies involving university students (Rosenthal et al., 1996). Various studies have investigated the association between self-concept and factors such as self-efficacy and HIV knowledge on sexual practices. Colon, Wiatrek and Evans (2000) found that though there was an association between self-esteem, social self-efficacy, sexual self-efficacy and HIV knowledge with African-American male adolescents' intention to use condoms, self-

esteem and sexual self-efficacy were the only significant predictors. Their finding suggests that greater ability to say no to sex and higher self-worth are linked to stronger intention to use condoms. Similarly Rosenthal, Moore, and Flynn (1991), found that males displaying high levels of self-esteem had confidence in their ability to assert themselves in sexual matters. Robinson et al. (2007) found that males were more inclined to endorse self-esteem enhancing reasons for having sex and those who did, have more sexual partners over their lifetime. These authors concluded that when self-esteem motivated sexual decision- making, youth were more likely to have a higher number of sexual partners and were less likely to use condoms consistently.

This therefore suggests that views expressed by Rostosky et al. (2008) who posits that adolescents' positive view of themselves as sexual beings may improve their ability to translate their knowledge of sexual risk into self-confident action concerning their sexual health has relevance to the findings of this study.

5.6   SUMMARY

This study investigated sexual practices amongst emerging adults in a FET college. The findings highlighted various factors related to sexual practices amongst emerging adults. It was found that participants had high levels of HIV/AIDS knowledge, self-concept and self-efficacy with females having higher levels of self-concept and self-efficacy than males. Furthermore, results suggest that an increase in knowledge of HIV/AIDS would predict an increase in the use of condoms particularly for males. Findings also suggest that lower self-efficacy seemed to predict an increase in the number of sexual partners for males. Male participants engaged in more risky sexual practices by not using condoms regularly when having sex, and had two and more partners in the 12 months prior to the study. The majority of participants engage in sexual risk –taking by having sexual intercourse without using a condom thus placing themselves at risk for contracting HIV/AIDS and STI's.

The following chapter outlines the results and discussion of the qualitative data.

CHAPTER 6
QUALITATIVE RESULTS AND DISCUSSION

6.1   Introduction

This chapter contains the results and discussion of the thematic analysis of the focus group discussions which attempted to address the fifth and sixth research objective as stated in chapter 3. These objectives aimed to explore students at FET colleges' perceptions and experiences of decision making in relation to their engagement in safe or unsafe sexual practices. In addition, it aimed to explore their views on and their experiences of sexual health promotion in terms of HIV/AIDS.

Core open- ended questions (listed below) were posed to the focus groups to facilitate free flowing responses (also see Addendum C).

- What are your views on factors that influence youths' decisions to engage or not engage in sexual risk behaviour that is detrimental to sexual health?
  (Sexual risk was explained as engaging in sexual intercourse without the use of a condom as well as having multiple partners.) Probing questions were asked to explore decisions on using or not using condoms.
- What are your experiences concerning the promotion of safe sex and sexual health to South African youth?
- What health facilities and services would you like to see provided to students at FET campuses?

Discussions related to these questions were initially focused on the experiences of youth in general. Later the discussions focussed on the experiences of youth in the FET setting.

Participants were very expressive and enthusiastic concerning their reasons for engaging or not engaging in risky sexual practices. They expressed themselves in a candid manner yet expressed concern for their actions. The themes and sub themes that emerged from the analysis will be outlined and illustrated with verbatim quotes.

6.2   Perceptions and/ or experiences of decision making in relation to engagement in safe or unsafe sexual practices

Responses elicited from focus groups regarding influences on sexual behaviour and decision-making revealed that no single factor was perceived to influence youths' decisions to engage in risky sexual practices (gauged in this study by condom use and number of sexual partners).   Numerous inter-related factors appeared to influence participants' sexual decision-making. These factors or themes comprised of personal/ individual factors, gender and power relations, views on condom use as well as social and cultural issues.   Each of these themes, in turn, incorporated a number of sub-themes. Table 6.1 below summarises the themes and sub-themes that emerged from the analysis of the question on factors that influence sexual behaviour and sexual decision-making.

The table structures the findings for the purpose of the discussion only and the researcher acknowledges the inter-relatedness of these issues. A discussion of each of the sub-themes follows.
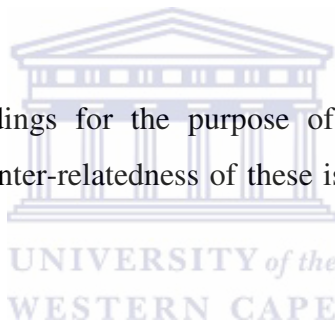
Table 6.1   Influences on sexual decisions to engage or not to engage in sexual behaviour that is detrimental to sexual health

Themes	Sub-themes
Personal/individual factors (intra-personal and interpersonal) in sexual decision-making	**Intra-personal:** • Self-concept or self-esteem • Need for acceptance by romantic partner (girlfriend / boyfriend) and peers. • Egocentricism and impulsiveness versus rational decision- making **Interpersonal:** • Romantic versus sexual relationships • Communication and sexual negotiation • Family relationships and communication
Gender and power relations	• The power or right of men to have sex in a relationship and to have multiple sexual partners (tolerance of male promiscuity) • The power of age (older male sexual partners) and transactional sex (the use of gifts and money) in sexual manipulation • Manipulation using the "love" word • Gender stereotyping and sexual behaviour
Views on condom use	Views on condom use
Social and cultural issues in sexual decision-making	• The influence of culture on safe sexual practices • The role of religion in sexual practices • Use of drugs and alcohol • The impact of environmental/external social and community factors: Poverty
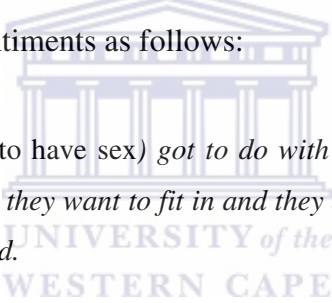
6.2.1 Personal/Individual factors

Personal factors included intra-personal and interpersonal sub-themes. The intrapersonal sub-themes were self-concept/ or self-esteem, the need for acceptance by romantic partner (girlfriend / boyfriend) and peers, as well as egocentricism and impulsiveness versus rational decision- making. The interpersonal sub-themes were romantic versus sexual relationships, communication and sexual negotiation, and family relationships and communication.

Self-concept/ self-esteem

It is important to note that in this study participants used the term self-concept and self-esteem interchangeably. From the focus group discussions, it emerged that participants felt that self-concept and self-esteem had a direct influence on sexual decision-making. Participants expressed their sentiments as follows:

> *I think it's (*the decision to have sex*) got to do with self-esteem because this links up with popularity. Because they want to fit in and they do this* (have sex) *because it's the only way they'll be noticed.*

> *Young people do it to gain popularity. Guys don't want to know you if you don't indulge them in that way. I think it's got to do with self-esteem because this links up with popularity. Because they want to fit in and they do this because it's the only way they'll be noticed.*

> *I think abstinence is easy. It depends on the type of person you are. If you know, what you want and when you want it. Sex does not run away. You can have it later.*

> *...because of my rise in self-esteem, I decided for myself I don't have to please anybody. There are guys who want to do it with every girl, but many I spoke to said to me, the day I get married, I want to marry a virgin.*

> *If a man sees that you think so little of yourself, he's going to think nothing of you. I know I'm attractive and there are always guys hitting on me. They irritate me but they can see that I'm a woman that knows what I want and my self-esteem is not down there.* (Points to the floor).

The findings of studies dealing with the association between self-concept/self-esteem and sexual decision-making are inconsistent. Several studies indicate a positive association between self-concept and sexual-decision-making. Bayley (2003) highlights the importance of self-evaluation, self-acceptance and self-esteem in forming healthy behavioural adjustment and acquiring basic social skills for knowledge. Robinson, Holmbeck and Paikoff (2006) referred to the studies of Gulotta et al. (2000) and Gillmore,DeLamater and Wagstaff (1996) that indicate that young girls with higher self-esteem will most likely have the ability to resist outside pressures to engage in unsafe sexual behaviours than those with lower self-esteem who may lack the sense of control in sexual relationships. Conversely, Parsons et al. (2000: 380) found that young people must have the confidence or self-efficacy in their ability to practice safe sex, regardless of any rational decision-making. Similarly, Breakwell and Millward (l997) found that females with a greater assertiveness score were less likely to be virgins, had more sexual partners and were less likely to use condoms. This indirectly includes assertiveness as a related construct to self-esteem. Robinson et al. (2006: 461) found that men were more likely to endorse self-esteem enhancing reasons for having sex and those who did, have more sexual partners over their lifetime. These authors concluded that when self-esteem motivated sexual decision- making, young people were more likely to have a higher number of sexual partners and were less likely to use condoms consistently.

The need for acceptance by romantic partner (girlfriend / boyfriend) and peers
Participants agreed that young people engage in risky sexual intercourse because they wanted to feel accepted by others and experience a sense of belonging to someone special. This especially pertains to females. The following comments underscore females' need for acceptance by their romantic partner:

> *It's the sense of wanting to belong to the guy.* (Others agree).
> *...... in the case of females, they feel that if they have unprotected sex they feel loved, which is very stupid…..*

> *You just thinking of pleasing him when you have sex.* (Others agree).

...... Sometimes my boyfriend wants to sleep with me…aagh, you don't always lus for that (feel like having sex), *but then you ma give him what he wants … he is your boyfriend.*

The above suggests that female participants in this study are vulnerable to risky sexual practices because of their desire to have romantic relationships. This notion is underscored by literature that highlights the importance that romance, love and trust play during the adolescent developmental phase. These are such dominant needs and usually influence decision-making (Abott- Chapman & Denholm, 1997: 308). Gordon (1996) found that the strong desire of adolescents to develop intimate relationships with their peers at times takes precedence over all other factors. Orenstein in Robinson et al. (2006) also found that females expressed themselves vociferously concerning their need to feel desired by a man. Even though pregnancy may not be the desired outcome, adolescents may risk it for the sake of intimacy. Lanz and Tagliabue (2007) found that amongst emerging adults the presence of a romantic partner is a significant variable for females during this developmental phase, concerning planning for the future and the perception of the world. Benda and Corwyn (1998) posit that intimate sexual experiences can be an important depiction of interpersonal connection, reinforcing a need for emotional attachments or supplying a crucial connection of feeling loved and needed. They found that women of colour engaged in sexual relations for attachment and to feel loved.

Participants indicated that peer relationships are important to them and that they need to be accepted by the peer group. Because of participants' need for acceptance, the opinion of peers seemed to be highly valued and thus influenced participants' decisions concerning sexual relations. The following excerpts highlight perceptions and experiences concerning peer relations and peer dependence in sexual decision-making:

In schools and colleges most often they use sex as a sport because they tend to show off. For example, maybe your friend had sex, then you get to hear about this then you also have sex because otherwise you feel out of the group. So basically, they all go and have sex.

It's very difficult not to conform to societal pressure.. you have to adapt in the jungle to survive.

.... because they want to fit in and they do this (have sex) *because it's the only way they'll be noticed they want to belong.*

..... when I was at school there were groups like 'the fancy family group', (from wealthy families) *'the clever ones' and so on... For me to be in this group I have to do this or be like that. You have to know who and when to mix with. Sometimes people want to fall in classes for example the high class and you don't really accept yourself.*

It depends on the type of person you are. If perhaps you want to conform to what your friends want and wanting to be with them or like them or fitting in.
If you want to be with a group of friends they might tell you that you might have to do certain things to become part of the group. (Group agrees).

Participant views were consistent with the literature concerning the influence of peer relations on sexual practices. Peers have an influence on behaviour change among adolescents particularly in relation to initial sexual engagements, attitudes towards HIV/AIDS, condom use and safer sex behaviour (Bremridge, 2000; Lesch, 2000; Goodwin et al., 2004).

However, literature focusing specifically on friendships and peer relationships in the emerging adult developmental phase, indicates that friends and peers are not considered as important for emerging adults as in adolescence (Arnett, 2007). Emerging adults also spend more time alone than do adolescents and according to Larson (1990) they even spend more time alone than any other age group, except for the elderly. In general, emerging adults spend less time with friends than adolescents do and they make more decisions on their own concerning both the choice of their friends, and the friends' and peer group's influence on themselves (Arnett, 2007). Markiewicz, Lawford, Doyle and Haggart (2006) investigated the use of best friends as a "safe haven" (i.e. support, comfort, and reassurance) among adolescents and emerging adults. They found that emerging adults used their best friends less than adolescents in this regard.

Therefore, best friends were considered as a more important source of support for adolescents than for emerging adults.

Egocentricism and impulsiveness versus rational decision-making

Interestingly, participants in this study acknowledged the influence of egocentricism and impulsiveness on their sexual behaviour and seemed to find difficulty in explaining this kind of influence despite their awareness of the existence of risk associated with these influences. Student narratives indicated that often sexual intercourse was a spontaneous, unplanned, emotional action, an uncontrollable urge. The issue of invulnerability concerning these actions was also alluded to.

The following excerpts indicate impulsive sexual behaviour:

> *At that moment, you're not thinking of protection, you just thinking of pleasing him...* (Others agree) *and then the hormones, Miss, Then you think, Oh God I can't anymore, I must have it* (must have sex) (Female student).

> *You can control it. But you don't want to* (Others agree).

> *So in the moment they are not going to ask you. 'Do you have a condom'?*

> *I'm not trying to say it's a good thing, but it's like in the spur of the moment. You know. It's like just, I wanna get up there.* (Have sex) (Male student).

Participants referred to their feeling of invulnerability relating to sexual behaviour. This sentiment is highlighted in the following excerpt:

> *Lots of people are aware of AIDS but they engage in unprotected sex because they believe it won't happen to them. That's the problem with them having unprotected sex.* (The group agrees).

The association between egocentricism and impulsiveness versus rational decision-making during this phase may partially explain the findings of the study conducted by Arnett (1996). He investigated 4,000 college participants across 40 states in America, and found that sex without contraception and sex with a casual acquaintance were higher for college participants than any other age. Previous research indicates that adolescent egocentrism may influence their behaviours and relationships. Elkind (1978) refers to adolescent egocentrism as heightened self-consciousness. Elkind distinguishes two forms of egocentrism: the imaginary audience and the personal fable. Adolescents construct an imaginary audience in their minds and react to this audience according to what they perceive the audience is thinking of them. Elkind describes the personal fable as the adolescents' beliefs of their own uniqueness and feelings of invulnerability. It refers to the adolescents' overly dramatic fantasy that they create about their lives and the accompanying belief that they have a special destiny. If adolescents are unable to distinguish between their feelings and experiences from reality, they could indulge in high- risk sexual behaviour (Louw et al., 1998: 418-419).

Impulsivity implies that impulsive individuals act spontaneously, meaning that they act without considering consequences. Whilst rational decision makers use beliefs about the consequences of their actions, impulsive decision makers use non-cognitive cues, including affective and psychological cues (as opposed to merely ignoring consequences, to make decisions). (Donohew et al., 2000: 1079). Eysenck and Eysenck (1964) recognised two distinct features within impulsivity, which though correlated, are different and associated with different aspects of personality. These factors are: (a) impulsiveness, relating to those who do and say things without thinking and who act on the spur of the moment without being conscious of the risk involved, and (b) venturesomeness (also called sensation-seeking and risk-taking), relating to those who are aware of risks but are prepared to take those risks. Kahn, Kaplowitz, Goodman, & Emans (2002) concur; they conducted a study with adolescents and young adults aged between 12 and 24 years with a mean age of 18.3 years. They found that higher impulsiveness was significantly associated with early onset of first sexual intercourse, higher number of sexual partners, not using contraception and condoms. In fact, sensation seeking, defined as quest for new and extreme experiences, increases as

young people move from adolescents into emerging adults (Arnett, 2000). Keller (1993) investigated why young adults do not protect themselves against sexual transmission of HIV. Findings indicated that impulsiveness (60%) and naivety and perception ('just knew' the partner was safe) by some 50% of respondents influenced the decision-making for engaging in sexual risk of non-condom use. Parsons et al. (2000: 387) studied perceptions of the benefits and costs associated with condom use and unprotected sex among late adolescent college participants. They found that sexual risk behaviours were most related to situation temptation and perceptions of the immediate benefits associated with risky behaviours. Furthermore, college participants who engaged in sexual risk-taking reported "more frequent temptation for unprotected sex across varied situations and less self-efficacy in their ability to maintain safer sex practices" and could be described as "sensation seeking" with a high need for "optimal arousal and stimulation". The perceived pleasure of the moment takes priority as "benefit" of the situation compared to the perceived "cost" of the high-risk situation (sex without condom).
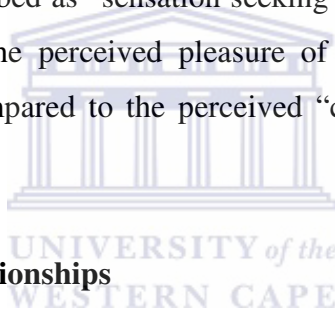
Romantic versus sexual relationships

Participants in this study distinguished between a primarily sexual relationship and a romantic relationship as factors in decision-making for safe sex. Participants considered a romantic relationship to be a relationship where emotions and feelings are involved while a sexual relationship is based on a physical attraction and sexual intercourse. Participants indicated that the latter is often associated with irresponsible decision-making and risky behaviours such as one-night- stands and flings. The following excerpts summarise the group's views:

> I *mean a sexual relationship is straightforward, going around a corner and doing it,* (have sex) *no place, no respect and just pull up your pants and move on. Whereas in a romance you don't really need the sex factor if you really love this chick* (girl) *or guy then you don't need to have sex. There's a conversation that you could have to take that place* (having sexual intercourse).

Participants agreed that, in a true romantic relationship, there is more love, respect, and communication about sex. This view is illustrated in the following excerpt:

In most sexual relationships there's not much emotion involved whereas in a romantic relationship its all about I love you and respect you, how I feel with you, I feel this and that. Whereas in a sexual relationship it's just sex. (Group agrees).

A female participant's candid response succinctly highlights the distinction:

I think that the emotion experienced (in a sexual relationship) *is lust it's not really about love and one can say it : You can have a fuck buddy* (purely for sex) *and you can have a boyfriend* (romantic relationship).

The rest of the group (including females) agreed with her. For these participants, this expression seems to be the normal use of derogatory colloquial language.

Arnett (2000) contends that many emerging adults expect to attempt numerous relationships and change several sexual partners. Emerging adults often believe that they should experiment in relationships and that such experimentation is necessary and healthy for finding the right partner. Emerging adults also benefit from unusual freedom in love and sexual relationships, compared to previous generations. Their search for a partner is likely to be based on sexual attraction and similarity between two partners (similarity in the areas of personality, intelligence, social class, ethnic background, etc.) while opposites rarely attract. Therefore, sexual experimentation and engaging in multiple sexual relationships typify the emerging adult developmental phase. Several studies indicate that young people who are in ongoing sexual relationships (romantic relationships) reported having sex with someone else during the relationship without using a condom (Keller, 1993). Moore and Rosenthal (1992) found that adolescents' worldviews on permissiveness, double standards, sexual control, and romance defined the contexts for their sexual decisions.

Communication and sexual negotiation

Participants, who supported abstinence until marriage and / or responsible sexual practices in romantic relationships, also emphasised the need for communication and sexual negotiation in a romantic relationship. Participants agreed that partners in a romantic relationship are expected to communicate and negotiate in a mutual respectful

manner about sex. Participants reported that there should be more communication concerning sexual issues between sexual partners. The following excerpts highlight participant views on this issue:

> *It's about communication in a relationship, without communication you would not know what to do.*

> *If a guy respects you and he really wants a serious relationship with you he's not going to force you into having sex with him.*

One female participant stated:

> *That's where respect in a relationship comes in. You have to respect your partner's decision and you'll just have to wait for it if your partner does want to have a sexual relationship.*

Related research has found that the perception of a partner's attitude towards communication, communication self-efficacy and communication outcome expectancies were associated with safer sex communication (Dilorio et al., 2000). DiClemente et al. (2001) found that those individuals who seldom communicate with their partner about sex have been associated with greater likelihood of engaging in sexual risk behaviour.

Family relationships and communication

Family communication is defined as the exchange of information within a family. (Epstein, Bishop, Ryan, Miller, & Keitner, 1993). According to Langley (1994: 5) communication includes the following factors: clarity and directness, listening skills, problem solving, negotiation, and decision-making. Stapelberg in van Heerden (1995: 38) states that the family system needs congruent, clear and direct communication in order for it to function at its best.

Participants participated enthusiastically but some of them expressed concern for not being able to discuss important issues concerning sexual decisions with their parents. Those participants who were able to communicate well with their parents concerning sexual issues suggested that they were able to make choices that are more responsible. Participants indicated that they found it easier to communicate with peers than with

their parents and family members. However, they stated that good communication between parents and young people is crucial for assisting in sexual decision-making and fostering the ability to negotiate sexual practices. The following excerpts expressed these sentiments:

> *The way we deal with things is mostly because of our family.... our parents.* (Group agrees).

> *If you have good communication, your parents will be able to tell you that you should carry a condom on you at all times.*

> *... I think you should have an open relationship with your parents. I look at my parents, we have an open relationship. They sat us down from a young age and spoke to us about the birds and the bees. They told us we must decide whether we want to have sex or not.*

> *My mom is different I have such a wonderful relationship with her I can speak to her. She knows the first time I had sex and with who. So that is what guided me through my teenage years. I feel sorry for you people* (referring to other participants in the group) *who can't communicate with your parents.*

> *I mean, you will be comfortable speaking about something this uncomfortable with people you trust and feel close to like your family, your best friend, cousins; not ma's and pa's* (grand mothers and grandfathers); *but I mean that family set up.*
> (good communication with parents) *And if that's not there, that support, I think you will have lots of problems.*

There were participants who experienced difficulty in communicating with parents. The following comments convey this:

> *Ja, whereas now parents are holding it back* (not communicating about sex) *but its actually wrong because now the children want to learn. And now they're* (children) *going out to learn* (outside of the home environment) *and they're learning the wrong thing* (becoming misinformed).

..If I ask my parents, a question regarding what I should do in a relationship. Then they come to me with what the bible says about sex. My parents don't talk about sex at all, or about anything. Its like I just live there, I sleep, eat and clean the house.

.. I do have an older sister and my sister in laws. I ask them questions. My mother can't take that, but she still won't approach me. My mother never had the guts to sit down and talk to me about these things because when she was young she couldn't sit down with her parents. (Others agree, they have the same problem).

There were those participants who stated that lack of communication led to negative behaviour such as resistance.

...... Now once you rebel you do a lot of things. Like when I was 15 I used to go clubbing. My parents didn't even know this. That was the best part and I used to come in 2, 3 (time) *in the morning with my brothers and they didn't know.*

However, all focus group participants agreed that there should be open communication and a spontaneous, honest relationship between themselves and their parents. Many participants felt that parents should start communicating with their children about sexual issues at a young age, indicated by the following excerpt:

Parents think they should start (communicating about sexual issues) *when their children are already 16 or 17. Children young, already here from 13, are already sexually active*.

Participants felt that good family relationships and communication are important for developing strong moral standards that guide the individual concerning sexual decision-making. These views are highlighted in the following excerpt:

....If you had a good upbringing with strong parents and if you've always been around people with strong values and self-esteem. ....if you're wise enough you'll use them as a mirror then you will not be drawn into having sex.

Literature highlights the need for general family communication as well as parent–child discussion about sex for responsible sexual-decision making (Fisher, 1987; Whitaker & Miller, 2000). Lack of communication about sex may cause adolescents to turn to peers for information and this may influence their sexual behaviour. However, literature is inconsistent concerning the effect of open communication between parents and their children on discussions of sexual behaviour. Some researchers found that open communication between parents and their children lead to positive behaviour change. Haupt et al.(2004) and Pettifor et al. (2004) found that open communication about sexual issues are seen as a means of challenging social norms and is therefore able to bring about positive behaviour change, such as delay in sexual debut and increasing safer sexual behaviour. Thus, young people who speak to their parents about sex and HIV/AIDS are more likely to engage in safer sexual behaviour. Rosenthal, Lewis, and Cohen (1996) found that female adolescents avoided having unwanted sex by ensuring that parents or peers were nearby in situations that could lead to intercourse. Other researchers have found a weak association between open parent-child communication and children's sexual behaviour, and in some instances, the converse was found. Diloria et al. (2000) found that the association between safer sex communication and condom use was weak while Somers and Paulson (2002) found that higher levels of parental closeness together with parental communication did not have any significant influence on adolescents' sexuality. They also found that greater parental communication (resulting in increased sexual knowledge) was related to increase in sexual behaviour among adolescent high school participants. Moreover, literature stresses that it is not just about parents' communicating with their children that is important, but rather the content of the conversations that impact on behaviour. Communication concerning sexual issues is a salient factor in conveying information, dispelling myths, establishing relationships of trust and thus bringing about positive sexual behaviour change in young people (Pettifor et al., 2004).

The above participant narratives highlighted the importance of communication and establishing good relationships in the family as key factors influencing the sexual behaviours of youth.

6.2.2 Gender and power relations.

In this study, participants were candid concerning the issue of gender and power relations and displayed enthusiasm during discussions. They suggested that relations between the genders have an influence on sexual behaviour. Participants reported that women are traditionally considered the weaker sex with females holding less power than males in society and in relationships, resulting in less negotiating skills in a sexual relationship. Participants highlighted the following issues concerning gender and power relations: The power or right of men to have sex in a relationship and to have multiple sexual partners, the power of age (older male sexual partners) and transactional sex (the use of gifts and money) in sexual manipulation, manipulation using the *love* word, and gender stereotyping and sexual behaviour. These issues are discussed below.

The power or right of men to have sex in a relationship and to have multiple sexual partners

The following excerpts summarise the sentiments of the majority of male participants concerning the power and control men expect in sexual relationships:

> *You can't just tell me, if you're going out with me 'No, I don't want to have sex'. That's not a reason. I can't accept that.* (Male student) (Others agree)

A female student responds to this statement as follows*:*

> *Yes miss, many guys are just like him* (points to the male student who had stated the above*) when you go out with them* (date them*) they expect that they will end up having sex with you… Some even want this on the first date.* The majority of the female participants agree with her.

Participants seemed to display acceptance of male promiscuity, with both male and female participants, acknowledging that sexual promiscuity (engaging in sexual relationships with multiple partners) was rife for both sexes.

The following excerpts highlight female participants' sentiments and acceptance of male promiscuity:

A female student comments on her finding condoms in her boyfriend's car as follows:

I trust him and love him and don't think he might be using these (condoms) *with other girls. If he is then as long as he uses protection with them and me, the same.*

A male participant comments on the actions and attitudes prevalent in his peer group concerning sexual relationships with multiple partners:

.... Say if a guy has 3 girls. Some guys say I sleep with 2 girls with a condom because then I don't break it up (the relationship). *Then my main girlfriend I sleep with her without a condom because she's the main one.*

A female participant states the following:

It was ok for men to have a string of girls because it was cool for a guy to do that and it wasn't cool for a girl to do that. Now girls have more than one guy. In general men are hornier than women......That is what stupid men or boys think (concerning having many sexual partners)*. In the area where I live, they say that horny girls carry condoms. They say 'fuck horny girls and make love to nice girls'. This is also stereotyping.* (Many agree).

However, a number of participants also indicated that there is an increasing number of female participants who also engage in sexual promiscuity. This tendency is highlighted in the following comment:

Nowadays girls are just like guys, they also have lots of guys they sleep around with. (Group agrees).

Literature suggests that societies (including females in some instances) are generally more tolerant towards male sexual promiscuity than they are of female promiscuity (Marshton & King, 2006). Power and control disparities in relationships create a context

for men to have multiple concurrent partners and fuel their reluctance to use condoms. Qualitative studies in South Africa consistently show that men believe they are more powerful than women are and expect to control women in their relationships (Jewkes, Vundule, Maforah & Jordaan, 2001; NSP 2007-2011, 2007: 32).

Adolescent males have an earlier sexual debut, a greater number of sexual partners, and are more likely to use substances before sex than females (Centers for Disease Control and Prevention (CDC), 2004). South African males also seem to have more sexual partners and earlier sexual debut than South African females (Anderson, Beutel & Maughan-Brown, 2007). According to the NSP 2007-2011 (2007: 41) 27.5% of South African males and 6.0% of females aged 15-24 had two or more partners in the year prior to the study. In a national survey in 2004, higher proportions of having multiple partners amongst youth aged 15-24 were also reported – 44% for males and 12% for females.

Strong feelings were also expressed about men's manipulation of females to engage in risky sexual intercourse. Participants were very candid concerning the issue of gender and power relations and displayed enthusiasm during discussions.

The power of age (older male sexual partners) and transactional sex (the use of gifts and money) in sexual manipulation
The following excerpts reflect participants' sentiments that older men who date young girls use the power of age to manipulate them into risky sexual behaviour.

> *They* (older men) *use manipulation to get what they want. When you fall for that they'll move on once they got what they want.*

> *Because, sometimes in a relationship you find that a girl of 16 she's involved with a guy of like 27, 28, she doesn't have much say, like he knows better than her. And if she says something he'll take her as a fool* (not having enough knowledge/ life experience, being ignorant)*. Sometimes the age gap is sometimes a problem.*

Ja, there is a chance of her being pressurized, she'll feel something like, I'm too small (too young) Their mindsets are not the same and he can overpower her by what he's saying. (Talk her out of it/ make her see things his way). If she's a virgin she'll end up having sex. (Female student).

Zanera and Miteka (2005: 219) suggest that in various societies young women engage in sexual relationships with men who are considerably older than they are. This practice can contribute to the spread of HIV/AIDS as it can introduce HIV to a younger, uninfected age cohort. Pettifor et al. (2004: 59) posit that older partners have been hypothesized to increase the risk for HIV infection both by being more inclined to be infected with HIV and through gender power differences, that increases the chances of unwanted and unsafe sexual practices.
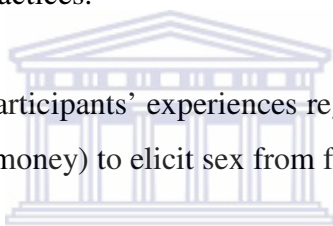
The following quotes reflect participants' experiences regarding the use of transactional manipulation (such as gifts or money) to elicit sex from females:

I don't want people to buy me stuff because I know that they'll want something in return and I'll feel obligated to give them what they want.

It's all about money, surely if the guy wants sex with no condom, she will give in because what she wants at the end of the day is money. This is something that is still happening and you find that most of the guys involved with much younger girls look at the girls as a challenge. They (guys) come here mainly to high schools to have sex, they pay their cash fare (payment) and the girls go out and have sex with them. They pay them even R280 and give them stuff (things) like that.

Sometimes, you just want to be treated well. Oh, my boyfriend bought me this and he's taking me to a posh place. It's all about status. (Group agrees).

Ma'm, I've gone out with a couple of married men. Its all about the CCC (Cars, cash and chequebooks). These guys start out by buying you gifts like cell phones , clothes and then it moves on to fetching you at school or college or wherever you want to go. You can just send them a 'Please call me' (SMS) and they're at your service. (Others agree).

> *Yes, the ladies they just want the money, all the time. They milk the guys for their money.* (Male student vigorously rubs thumb and forefingers together to suggest money).

Participants confirmed that these transactions took place in exchange for sex but were also aware that these relationships were temporary ones and never long standing. Manipulation into having sex and unprotected sex links with "transactional sex" offering money and gifts for sex. Pettifor et al. (2004: 50) define transactional sex as sex in exchange for gifts, money, luxuries, necessities, favours or other material or non-material items. They further assert that these relationships afford young women little opportunities for setting limits concerning sexual behaviour and they are thus unlikely to be able to negotiate safer sex. Giving or receiving gifts may thus be a more subtle form of coercion because it may affect the ability of young women and men to express their preferences about the type of sexual activity, its timing, or the use of safe practices when engaging in sex (Stavrou & Kaufman, 2000: 24). Because gift-giving is widely accepted as a strategy for achieving sexual goals among some youth in South Africa, youth may greatly under-report the practice to hide the fact that there is a transactional element in their relationships. (Stavrou & Kaufman, 2000: 24).

Manipulation using the "love" word

Participants indicated that men seemed to use the "love' word to manipulate women into having sex, because they assume this is what females want to hear. The excerpt below succinctly portrays this view.

> *If a guy wants to have sex with me I tell him to use a condom. Sometimes He'll say 'no, don't be boring, what's wrong with you? You know you're the only one …..and I love you'. Then sometimes you say its okay.* (To have sex with out a condom) *Sometimes guys can persuade you ….you have sex when they want it, how they want it.*

As previously stated, Benda and Corwyn (1998) posit that intimate sexual experiences could be a display of interpersonal connection, stressing a need for lost familiar attachments or providing an important connection of feeling loved and needed. They

found that women of colour in a rural Arkansas population had sex for attachment and to feel loved.

Gender stereotyping and sexual behaviour

Participants engaged in heated debate concerning gender stereotypes such as those held by males (and some females) has about females' way of dressing as an invitation for sex, society's negative attitude towards gay men and perceptions that gay men generally have unprotected sex, as well as perceptions of males versus females carrying condoms as a precautionary measure should an opportunity for sexual intercourse present itself.

The following two excerpts illustrate the conflicting views held by participants concerning revealing clothing worn by females and its association with sex:

> *I wear miniskirts but I definitely don't want sex when I wear it. I wear it because I feel comfortable wearing it and because I choose to wear it.* (Female view).

A male student's response to this:

> *That's the biggest load of bull. It's not about the mini skirt and the way you people* (females) *feel in it* (mini skirts); *it's about sex. The same thing… they* (females) *want to be noticed. Females want to be noticed when wearing mini skirts, they are asking for sex.* Some of the male participants agreed while others (mainly female) loudly protested.

Participants also felt that society still has a negative attitude towards homosexual individuals (gays) and sexual behaviour.

A student stated the following:

> *Society is not very accepting of us gay people and gays are viewed with suspicion as far as safe sex is concerned.*(Group agrees).

Participants suggested that there are still stereotypical views concerning females who carry condoms as a precaution to safe sex. However, it is acceptable for males to carry

condoms. When males carry condoms they are generally regarded as responsible and when females are in possession of condoms they are asking for sex:

Male participants commented on the issue as follows:

If she (a girl) *has a condom, she wants sex........* (Majority of male participants agreed).

A girl bringing a condom, man that tells you she wants to have sex with you.

While a female participant stated the following:

He will think the girl's a slut... there is a stigma when a girl carries a condom.

A female participant responded to the scenario of a male carrying a condom as follows:

I had a boyfriend and when I got into his car, there were always a lot of condoms. As long as he's coming to me and using a condom with me, I don't have a problem.
But the guys are taught that everywhere they go they must carry a condom. So he's going to be carrying a condom not because he wants to sleep with you.

On the issue of readiness to engage in sexual intercourse, male participants generally ignored the views of their female partners. These sentiments are reflected by the following excerpt:

No my girlfriend can't tell me she's not in the mood, (for sex) *she must please me too.* (Male student).

However, on the issue of taking responsibility for sexual health there was agreement that in spite of the stereotypical issue that females who carry condoms are "bad", both sexes should be responsible for safe sex. However, females are considered more responsible than males.

The imbalance in power relations between males and females has a broad influence on how they experience their lives, including sexual decision-making and the extent of the individual's assertiveness in negotiating sexual practices. Taffa (2002: 7) states that the

gendered/ sexual social positioning of young women in relation to their boyfriends/ sexual partners makes them obligated to be submissive, not to initiate sex and not to say no. Gilmore et al.(1996), identified beliefs about sexuality and sexual roles that influence decisions of Black inner-city male adolescents, such as distinguishing between "clean'' and "dirty" female partners, distinguishing love from sex, and contrasting the young men's power to engage in sex with their perceived powerlessness to become unwilling fathers.

Theoretical models ignore socio-cultural variables that influence behaviour, such as gender and racial/ ethnic culture (Auerbach in Melkote et al., 2000: 3). Gender roles and cultural values and norms have an impact on how men and women behave and the nature of the relationships where sexual activity occurs. Unsafe sexual practices are often not the result of a lack of knowledge, motivation or skill but have meaning within a specific personal and socio- cultural context. Since South Africa is generally a patriarchal, multi-cultural society, the issue of gender stereotyping on sexual decision-making is salient (Langen, 2005).
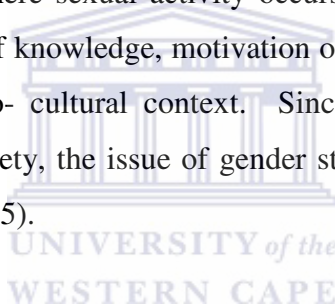
Various studies suggest that gender and the power relations associated with it, has the potential to confer upon men and women differential societal, family, peer and even personal norms and expectations concerning appropriate conduct. In this manner, gender norms and ideals govern attitudes and behaviour and are an important mediating factor in the sexual and reproductive experience. (Swart-Kruger & Richter, 1997; Swart, Seedat, Stevens & Ricardo, 2002; Varga, 2003: 160). Wood et al. (in Swart et al, 2002) contend that in South Africa, men use physical power to get what they want and forced sex may occur frequently for young women in the dating relationship. Eaton et al.(2003: 159) found that young men tend to claim ownership of their sexual partners. In terms of attitudes towards homosexuals and bisexuals, Herek, Chopp & Strohl, (2007) found that attitudes towards homosexual and bisexual individuals in the United States were very negative. Homosexual men and women experience severe prejudice, are stigmatised, marginalised and often denigrated.

Various studies in the South African context also highlight the association between gender and power imbalances in relation to sexual decision-making. The gender system fosters power imbalances that facilitate women's risks for sexual assault and sexually transmitted infections (STI's). South African men, like men in most societies, possess greater control and power in their sexual relationships. Women with the lesser power in their relationships are at the highest risk for both sexual assault and HIV/AIDS infection, stemming from the inability of women to control the actions of their sex partners. Men who have limited resources and lack the opportunity for social advancement often resort to exerting power and control over women. Men with a history of sexual violence hold sexist beliefs and negative attitudes toward women. These sexist beliefs and negative attitudes toward women also seem to be shared by men who do not have a history of sexual violence, a very alarming feature. In fact, negative attitudes toward women are so pervasive there is evidence that women themselves often hold them (NSP 2007-2011, 2007: 32). Unfortunately, men's attitudes toward women impede HIV preventative actions and can culminate in the acceptance of violence against women. Evidence reveals that men often hold attitudes that accept violence against women including beliefs that women should be held responsible for being raped. One in three men receiving STI clinic services endorsed the belief that women are raped because of things that they say and do and half of men believed that rape mainly happens when a woman sends a man sexual signals. (NSP 2007-2011, 2007: 32).

Thus, South Africa has one of the highest rates of violence against women. Sexual violence is linked with a culture of violence involving negative attitudes (e.g. deliberate intention to spread HIV) and reduced capacity to make positive decisions or to respond appropriately to HIV prevention campaigns. More significantly, the experience of sexual assault has also been linked to risks for HIV infection (NSP 2007-2011, 2007: 31).

It is therefore, not surprising that women endure most of the epidemic of HIV/AIDS. Women account for 55% of people living with HIV/AIDS in South Africa. (NSP 2007-2011, 2007: 28). Research has established that gender power inequities are believed to

be a salient factor in the HIV epidemic through their effects on women's power in sexual relationships. Pettifor et al. (2004) explored the effects of sexual power on both HIV serostatus and condom use consistency from a nationally representative sample of sexually experienced South African young women, 15–24 years of age. These researchers hypothesized that lack of sexual power and a woman's experience of forced sex with her most recent partner, would decrease the likelihood of consistent condom use and increase the risk for HIV infection among sexually experienced, 15- to 24-year-old women in South Africa. The results show that limited sexual power was not directly associated with HIV; it was associated with inconsistent condom use. Women with low relationship control were 2.10 times more likely to use condoms inconsistently and women experiencing forced sex were 5.77 times more likely to use condoms inconsistently. Inconsistent condom use was, in turn, significantly associated with HIV infection. Mordaunt (2003: 13) states that women are more vulnerable to HIV infection because of their status in society's patriarchal basis and therefore lack the power to negotiate in sexual relationships.

These narratives underscore the importance of taking into account the dictates of gender roles in understanding the conditions that predispose youth to sexual and reproductive complications.

6.2.3   Views on condom use

Views and experiences of condom use are interwoven into the above-mentioned findings for engaging in sexual risk behaviour. Findings related to some general views on condom use are presented in this section. It was clear that all participants were aware of the potential advantage of condom use and also have access to condoms. However, participants expressed mixed views on the utilization and perceived value of condom use. Participants expressed themselves without constraint concerning their use or lack of use of condoms. They acknowledged that sexual promiscuity and unsafe sex are very common amongst the young people they know. They seemed pessimistic concerning behaviour change. Participants noted throughout their discussions that condoms are an effective means of reducing exposure to STI's and HIV/AIDS as well as reducing the risk of pregnancy. They also acknowledged that as a group they are at

significant risk for negative health outcomes, and that their risk is increasing when not using condoms as more of their peers are becoming sexually active.

All participants acknowledged that the sexual experience differed with and without a condom. The majority indicated impulsively acting and primarily considered the feeling/ sensation during sexual intercourse without using a condom, rather than the consequences of their actions. There were however some participants that indicated the use of rational decision-making when engaging in sex by using a condom. They indicated that they were prepared to forgo experiencing 'heightened' pleasure, rather than risking exposure to STI's and HIV/AIDS. Self-protection was thus a priority to them. The following excerpts highlight participant views.

> *It is not a belief that has become a truth it is a choice you make. It is a truth that there is a big difference in having sex with a condom and having sex without one. Without a condom, it is so much nicer, way nicer. But just because you know that I might get sick and there is HIV and this STD's, you've taught your mind to the fact that I have to use a condom and you've taught yourself to accept that this one* (sex with a condom) *is much nicer than the one without a condom. Whereas the one without the condom is way much nicer.*

> *Some people are told what condom use is like, or they are told that if they actually have sex without a condom they won't even know the difference but in the long run sex is about using mostly your imagination, I think.* (Group agrees). *So if you don't have enough imagination you won't enjoy it.* (Sex).

> *With the skin to skin issue there's a slight difference. You know, to pleasure yourself* (having sex without a condom is more pleasurable) *is like, what? an hour if you're lucky. But in the long run getting AIDS is a lifetime consequence. So what would you consider? Your life, or an hour of pleasure?* (Others agree).

A female student commented as follows:

> (By wearing a condom) *It's actually cancelling the risks. He* (boyfriend) *actually cares about you that much as well that is why he is showing you he is prepared to protect himself and he's protecting you by using a condom.*

Other participants indicated that they felt disrespected if requested to have unprotected sex (having sex without the use of a condom). One female student became extremely agitated and stated:

> *I feel disrespected if a guy has the intention of having sex with me the whole time and then when it comes to the time* (to have sex) *he doesn't have a condom. What the hell does he think of me? Pussy out for him.* (No sex for him) (Shouts).

Participants indicated that condoms are not 100% safe. They commented on this as follows:

> *Condoms are not 100% safe and that, but it's quite a las* (effort, nuisance)*, if you're going to try to do it skelmpies* (hide from) *your parents, and that, I mean you can't walk around with a whole box of condoms especially if you know you're quite eager to do it* (have sex). *I mean sex is normal. Like me, personally if I've got a condom on it's not the best thing on earth but it's the safest. It's safe for when I'm using it so that's why I don't naturally know the difference…*

> *Using a condom is sometimes fooling yourself, because what if the condom bursts and you don't know. Then you think you're having safe sex because the pill or injection is preventing you from falling pregnant and it is not so you can still get HIV or a STI.*

Participants also expressed some views on why using condoms are not popular they stated the following:

> *People like to experiment, you want to find out what's it like without a condom …to have it skin –to- skin. There's also the myth that skin to skin is better.* (Group agrees).

If you are not having sex, it won't worry you. If you are not used to wearing a condom it won't be easy to put one on.

Guys always say if I go to a party I can't handle (control) *myself. Its both* (partners) *who should be responsible because a female is supposed to be able to* (handle) *control herself? So don't tell me guys that you are the weaker sex.*

Females want you to treat them as equal, so if a guy can take the responsibility (for condom use) *I think the girl should also take the responsibility.*

I think it's a 50/50 decision both are responsible.

If you're mature enough to have sex you should be mature enough to take responsibility. Make sure you protect yourself.

Taylor et al. (2003) found that despite increases in knowledge of the risks of unprotected sex, South African youth often do not use condoms when having sexual intercourse. Their survey showed that only 50% of rural sexually active adolescent participants reported using condoms in the 30 days prior to their study. Parsons et al. (2000) explored the perceived benefits and cost associated with condom use by late adolescent college participants. There findings supported some core findings of this study. They found that the perceived benefits of not using a condom were linked to: feeling more connected to a partner, experiencing the pleasure of the moment as well as feeling better when depressed or intoxicated, outweighed the perceived cost of wearing a condom. However, reported levels of male condom use at last sex are high in South Africa, mostly amongst youth at 72.8% for males and 55.7% for females aged 15-24, (NSP 2002-2011, 2007: 41).

6.2.4   Social and cultural issues in sexual decision-making

Eaton et al. (2003: 149-150) postulate that vast evidence exists concerning the complexity of sexual behaviour. This is influenced by factors at three levels: cultural factors within the person, within the proximal context (interpersonal relationships and physical and organisational environment) and within the distal context (culture and structural factors).   They further state that AIDS researchers and designers of

intervention models, in Africa, have acknowledged a need to consider objective social, economic, environmental and political factors. Studies they have consulted reveal a recurring pattern of conditions that leads to risky sexual behaviour. Gillies (1999) posits that health related behaviours (such as condom use) are influenced not only by individual choice but also by the extent to which social conditions permit such behaviours. MacPhail & Campbell (2001: 1616) assert that it is imperative to note that variations in the social and cultural environments of young people make for heterogeneous behaviours and beliefs that are evident both between populations, such as between South Africa and developed countries and also within populations, such as youth in this particular study.

The influence of culture on safe sexual practices

As previously stated, Mordaunt (2003:50) and Van Dyk (2001: 90) highlight the influence of culture on locus of control; a comprehensive definition of culture is also given. However, this will be briefly restated to clarify the concept in the thematic analysis. Culture defines what is acceptable or non-acceptable in a specific community or society. It influences behaviour and is closely associated with traditions, customs and beliefs. Culture is not an individual construct but occurs in a social context (Lesejane, 2004: 24).

Participants regarded culture as having an influence on safe sexual practices. They refer to culture within the context of language and race. The nature of this influence was dependent on the individual's culture as some cultures were seen to promote discussion of sexual practices while others do not. Participants pointed out that communication concerning sexual issues and sexual health was taboo in some cultures. This was expressed with intensity and frustration, yet candidly. In some instances, participants were so intense they seemed unable to express themselves fluently and seemed to grapple for words.

The following quotes are examples of their sentiments:

> *I think that somewhat it depends on your culture. Aah um how can I say ………*
> (Student struggles to express himself) *It's not easy to speak about big things like that…*
> (long pause) (sex)*…I think it does affect a teenager somehow. Because it's terrible if*

you can't talk about these things. Like the Whites (western culture)*, they talk about these things naturally. They communicate then they know these things.*

There are facilities but parents are not okay with it. There are parents who feel that their children should not be using contraception and condoms because they are then having sex and not showing respect. They are very traditional these parents.

Participants' responses suggested that cultural influences are more significant in rural areas. However this perception might relate more to the factor of ethnicity (with black adults being more reluctant to discuss issues related to sex with their children) rather than urban versus rural settings. The following sentiments illustrate this point:

It's difficult in the rural areas...... In the rural areas we don't go out, we don't have (night clubs) *clubs there's no way we can express our views and that.* (Particpant gesticulates with hands in frustration). *We don't talk about drugs and sex and stuff like that, its private we don't talk about that. If you talk about sex its like you're interested in it.* (Participant displays emotion by raising voice, becomes more intense).

Definitely it's a cultural thing... It's very embarrasing to discuss. If you ask the question of how a baby came out (is born) *they tell you it was brought by a crane or something. Because they scared* (parents/ elders*) if they tell us, we will try it* (have sex)*. So they're trying to protect us in their way.*

He's trying to make a point that they (parents/ elders*) think it's an encouragement. They* (parents/elders) *think. 'If you give your child the knowledge about sex, he'll know what to do and what not to do. So in other words he'll go and experiment. You're opening him'* (exposing him to sex) (Participant's view based on his experiences of parents in a rural setting).

Facilitator: *Do you think this aspect of culture applies to rural families only*?

It applies to everybody not just in the rural areas. (Group agrees).

For us blacks its (influence of culture) *all over the place* (everywhere). (Gesticulates).

Sinha, Curtis, Jayakody,Viner and Roberts (2006) report interesting findings of a study on culture, identity, religion and sexual behaviour among black and minority ethnic teenagers in East London "A strong connection with parents' traditional culture (speaking a language other than English with parents) was associated with lower risk of starting sex in both young men and women. Traditional cultural identification (as indicated by friendship choices) was protective against starting sex in young men but not in women. However, once the men started sex, they were at increased risk for having unprotected sex.

The role of religion/ values in sexual practices

Pargament (1997: 4) defines religion generally, as a multidimensional construct that includes both institutional religious expressions, such as dogma and ritual, and personal religious expressions, such as feelings of spirituality, beliefs about the sacred and religious practices.

Participants in this study did not view religion as having any effect on their sexual practices. Religion was seen as lacking allure and credibility. Participants regarded religion as being critical, judgemental and outdated. Religious institutions view young people as immoral and wayward; yet they do not offer youth solutions or support. Participants proposed that religious institutions adapt their principles to changing times, as there are current issues such as AIDS that religious leaders are apprehensive to address. Participants indicated that if religious institutions did not embrace change, then they could no longer be considered as moral agents of change. They expressed their sentiments as follows:

> *I think religion has lost the plot in trying to tell people what to do, because they* (religious institutions) *haven't changed with the times. They're still stuck in the old times and they're falling behind. If they don't change then what is their purpose anyway? That is why so many churches are closing their doors* (losing members and having to close down).. *people, especially young people, don't want to go to church anymore.*

The "old times" was explained as:

> Get *married, and then have sex, no abortions. If this happens* (having premarital sex or abortions) *you should not be allowed in the church anymore.*

Some participants felt that church leaders should be more liberal in their approach.

> *They should at least have that AIDS people* (people who are trained in the field of HIV/AIDS) *come in once in a while to speak to us. These church leaders shouldn't preach to us 'you people mustn't do It'* (have sex) *because young people will just do that, young people are doing it* (having sex). *They must leave it up to the individual to decide if they want to do* (have sex) *it or not.*

> *In church their focus is only on changing the person. So now, I think that they must start making their sermons more interesting. Changing their sermons with the times…. It's boring in church.* (Student shrugs shoulders and throws the hands up in disillusionment).
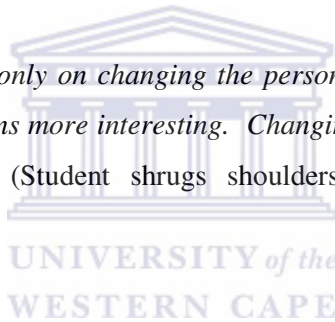
Participants responded to the significance of religion and its role in the lives of young people as follows:

> *It used to be important not anymore....People ignore religion. People nowadays don't take religion seriously. There's no religion that will keep you from having sex, you feel nothing.* (No sense of morality)… *they've given up.* (Religious institutions have given up). (Group agrees).

However, participants expressed concern for the decay in the moral fibre of society as religious institutions should take an active stand in assisting youth with youth specific challenges. Participants agreed that the change in society and rapid global change as well as advancement in technology is the cause for disappearing traditional morals and values. They feel that there is a decline in morals and values as society seems to tolerate moral decay more readily. Participant sentiments concerning the decline of societal morals and values are expressed in the following excerpt.

I think it's become more okay for them to do this type of thing, have unprotected sex, do drugs. Before, (previous generations) if someone was seen pregnant it was a shame. Nowadays they're girls walking around flashing their stomachs and they're about 16 or 15 years old. It's become more acceptable to have sex and to show it off to everyone. There's no more shame.

Participants felt that religious institutions should utilise and train youth leaders more effectively in order to deal with issues concerning young people.

The following excerpt indicates this:

I think that they should have discussions like this with their youth as well but not with somebody that's older. More like somebody their own age that they can talk with.

Yes, we have youth leaders but they don't communicate with us regarding sex. These people are staunch in their faith and they won't preach things that are different from what the church preaches. Their message is just abstain it's a sin. So maybe the church or religious institution has to change to say maybe, use condoms and wait, maybe if the right person at the right time comes along. If they do this then maybe young people will listen.

Participants' scepticism concerning the role of religion as an influence on their sexual practices, may be characteristic of a broader scepticism of social structures during this developmental phase. According to McNamara-Barry and Nelson (2005: 246) emerging adulthood is best characterized as a period during which young people question the beliefs in which they were raised, place greater emphasis on individual spirituality than association with a religious institution and select the aspects of religion and spirituality that best suit them. Arnett and Jensen (2002) found that individuals placed great emphasis on critical thoughts about spiritual issues rather than accepting an existing belief completely.

However, numerous studies have found religion to be an important influence on moderating risky behaviour amongst youth. For example, one study found that participants who were sexually abstinent (mostly defined as never having engaged in

vaginal intercourse) had more conservative values and sexual attitudes, few sexual experiences of any kind, and greater religious involvement (Byers, Henderson & Hobson, 2007). In a review of research conducted by Regnerus (2003) concerning adolescent risk behaviours, including the use of alcohol and drugs, and engaging in sexual intercourse, religion seemed to have a protective influence and also distinguished (to a greater or lesser extent) between those adolescents that participated in such behaviours and those that did not (Regnerus, 2003). Sinha, Cnaan and Gelles (2007) found that the perceived importance of religion was significantly associated with eight of ten youth risk behaviour variables, including sexual activity. Fehring, Cheever, German and Philpot (1998) conducted studies on the effects of religion among older adolescents (aged 17-22 years) and found that a high rating of significance of faith (coupled with orthodox beliefs, and involvement in organized religious activities) predicted less permissive sexual attitudes.

Sinha et al. (2006) concluded on findings of a quantitative study about the role of religion in sexual behaviour that Muslim or Hindu women were less likely to have had sex compared to those who reported no religious affiliation. They found that for young men religion was not significantly associated with having had sex and for both sexes; religion per se did not seem to influence contraception use. However, regular attendance of religious ceremonies was associated with a lower risk of having had sex and having unprotected sex amongst young men but not young women.

Sub-Saharan African studies on the effects of religion have focused on contraceptive use intentions to protect oneself against out-of-wedlock pregnancies. However, a recent study in Zambia suggests that the effect of religious affiliation on the risk of HIV infection may be minimal. If the risk reducing effect of affiliation to conservative groups is only temporary (i.e., affiliation delays sexual initiation but reduces the likelihood of condom use when sexual initiation takes place) the overall protective effect of belonging to conservative religious groups on the risk of HIV infection may be minimal (Agha, Hutchinson & Kusanthan, 2006: 554).

Use of drugs and alcohol

Participants indicated that both drugs and alcohol are commonly used amongst the population of this study. They also state that both these factors play a major role in some individuals engaging in unprotected and unplanned sex. Participants were enthusiastic and expressed themselves freely, thus slang and colloquial language was widely used. In addition, the emotions generated were integrated into the analysis. The following excerpts indicate this:

The guys I used to know used to come to me with the stuff (drugs) *on them, with the bankies and the lollies* (local slang for drugs*). But because I told them from the start don't even go there, when it comes to me. Because they think they can get you drugged so they can get sex from you.*

Miss, girls sell themselves for drugs…Yes, I was on drugs and it increases your sex drive…They (young people) *don't act with a clear mind if they're drugged or drunk. Yes, it* (having drugs alcohol and unprotected sex) *actually is common, especially at parties.* (Group agrees).

I think that people use drugs and alcohol as an excuse for their actions. Because if I were to get tipsy or whatever. I can still make my own decisions. I can still say 'No, I must go home'. They're just using it as an excuse 'I was drunk.' So no one can think bad of them.

Participants felt that it was common to have unprotected sex when using drugs or alcohol, resulting in unsafe sex and promiscuity. The following comments indicated this:

They're both the same (drugs and alcohol). *I could move with one group and their preference could be drugs and then some of my other friends prefer alcohol, some cigarettes. As she said* (refers to student in the group)*, everything depends on what group you hang out with.* (All group members agree).

Drugs in your alcohol that's what they do first alcohol was a big thing. Now drugs combined with alcohol is the thing. You can't get going on alcohol only. Now everyone

brings a straw (drugs), when they want to enjoy themselves…you know, what I mean (have sex). *That's what it's about, not just alcohol.*

Literature underscores the above. Research in the United States suggests that the use of alcohol and other substances among adolescents is linked to risky sexual behaviour such as unplanned sexual intercourse, multiple sexual partners, inconsistent condom use, and STIs. Stoner, George, Peters and Norris (2006) found that alcohol intoxication was a main effect on self-reported likelihood of proceeding with sexual activity despite the unavailability of a condom. They found that highly intoxicated participants reported that they were more likely to engage in unprotected sexual activities in the vignette than sober participants did. Gullette and Lyons (2006:28) report similar findings; participants who drank alcohol were more likely to engage in unplanned sexual activity with casual partners and did not use condoms after consuming alcohol.

South African research also highlights the association between substance use and risky sexual behaviour. For example, Mpofu, Flisher, Bility, Onya, and Lombard (2006) found that young people with early sexual experience and a history of substance-use tended to have multiple sexual partners, highlighting the need for targeted HIV prevention interventions for young people in South Africa. They also found that substance use nearly doubled the chances of involvement with risky sexual behaviour, supporting the findings of other studies with urban or college participants in South Africa (Pettifor et al., 2004; Reddy et al., 2003). Substance use is a precursor to many health-risk behaviours in teenagers and adolescents, including involvement with multiple sexual partners (NSP 2007-2011, 2007: 42).

Further discussion revealed that environmental circumstances such as poverty were considered as contributing to unsafe sexual behaviour.

The impact of environmental/external social and community factors: poverty
According to Satcher (2001:14) *Community can be defined in several ways: through its geographic boundaries; the predominant racial or ethnic makeup of its members; or through the shared values and practices of its members. Most persons are part of several communities, including neighborhood, school or work, religious affiliation,*

social groups, or athletic teams. Whatever the definition, community influence on the sexual health of those who comprise it is considerable, as is its role in determining what responsible sexual behaviour is, how it is practiced and how it is enforced.

Participants (some of whom live in poor communities), agreed that poverty/lower socio economic standing is a major issue in most communities and also contributes to youth engaging in sexual activity. They expressed their sentiments as follows:

Poverty can cause you to act irresponsibly when it comes to sex.......

......most people know about this (HIV/AIDS) *but they don't want to change their behaviour. Why should they, there's nothing to do but have sex as a recreation, they don't have jobs and so on, there's no future.*

People want to feel appreciated because they have nothing so they turn to prostitution.

Participants acknowledged that trading sex for money or gifts is commonplace in some impoverished communities.

I don't have money….. He wants sex. He gives me money or sometimes buys me stuff... Then I think okay, we have sex…. I need the money he needs the sex…we both happy.

Research also suggests the association between social/environmental factors and sexual behaviour. Fore example, Kelly and Parker (2000) posit that in South Africa, socio-economic background is considered the most important factor in the prediction of sustained adoption of risk prevention measures. According to them, South African research indicates that low levels of education, poverty, unemployment and overcrowding seem to be associated with higher levels of adolescent sexual activity and less knowledge of HIV/AIDS. Given the history of apartheid in South Africa and its resultant racial and social stratification, problems linked to poverty mostly affect black youth. O'Leary et al. (2002: 161) stated that key environmental factors related to HIV transmission are: poor living conditions, lack of social services and unemployment.

Poverty is linked to the likelihood of young people experiencing sexual coercion and physical abuse in relationships. It is also the reason why young women in desperate economic positions, agree to sexual relationships with men in exchange for financial support or gifts (MacPhail & Campbell, 2001: 1616). Adolescents from lower socio-economic groups experience eight times as much physical abuse and four times as much attempted rape and actual rape in relationships than did adolescents from higher socio-economic standing (Whitefield, Woods, & Jewkes, 1999). Research conducted by Phillips (2006: 64) and Mordaunt (2003) concur with other research findings indicating that individuals from lower socio-economic groups are predisposed to health risk behaviours compared with their counterparts from higher socio-economic groups.

South Africa is experiencing rapid urbanisation. However, distinctions also exist between urban and rural youth sexual behaviour. Urban South African youth seem to have more information about HIV/AIDS while youth in poorer rural communities are less inclined to have access to the media and thus have less knowledge than their privileged counterparts in urban areas (Kelly & Parker, 2000). Mordaunt (2003: 46) concurs that poor people are not only economically deprived but are severely restricted concerning access to information. This results in an unequal distribution of knowledge in the population resulting in "knowledge gaps" between people of low and high socio-economic status. Whitefield et al. (1999: 145) posit that in the South African context poverty as a structural factor is influential in young people's sexual behaviour and HIV risk.

With reference to FET college participants, Ferreira (2002: iii) found that FET college participants are mostly African language speaking, unmarried with home and socio-economic conditions of a very low level.

It is clear from the above extracts that the elements/sub-themes as identified by the researcher, are all interrelated and that the decision to engage in sexual risk behaviour will adversely affect sexual health.

6.2.5 Summary of findings relating to perceptions and experiences of decision-making in relation to engagement in safe or unsafe sexual practices.

The focus group discussions highlighted a number of factors that influenced sexual behaviour and decision-making. These factors included personal factors, gender and power relations, views on condom use as well as social and cultural factors influencing sexual decision-making.

In conclusion, the study of Marston and King (2006) seems to support some core findings related to the perceptions and experiences of participants in this study on reasons for engaging or not engaging in sexual risk behaviour. They highlight seven themes that emerged from their study on social factors that influence young people's sexual behaviour. These themes are; young people assess potential sexual partners as "clean" or "unclean" when deciding to use a condom or not; sexual partners have an important influence on behaviour in general; condoms are stigmatising and associated with lack of trust; gender stereotypes are crucial in determining social expectations and behaviour ; there are penalties and rewards for sex from wider society; reputations and social displays of sexual activity or inactivity are important and social expectations hamper communication about sex. They also found that these themes are not exclusive to any particular country or cultural background and that all themes were present, in varying degrees, universally. This therefore, has an influence on information campaigns and condom distribution programmes that alone are not enough to bring about behaviour change.

6.3   Views on and experiences of sexual health promotion in terms of HIV/AIDS

The researcher approached the data-collection and data-analysis on safe sex promotion by government and institutions/organizations, without any theoretical assumptions. The researcher explicitly conducted the research having an open mind and paid heed to the views of the participants. The findings that emerged were categorized according to some core principles and elements of social marketing theory and are listed in the Table

6.2. Social marketing theory will be discussed briefly followed by a discussion of the findings related to sexual health promotion in terms of Social marketing theory.

6.3.1 Social marketing theory

At the core of social marketing is the concept of exchange, which implies that target audiences weigh the cost and benefits of changing behaviour/ accepting a social idea. Furthermore, social marketing is the *design, implementation and control of programs seeking to increase the acceptability of a social idea, cause or practice among a target audience and involves decisions concerning product planning, place, pricing, promotion, communication and marketing research. When improving the quality of life of individuals is at the core of an organization, rather than the manufacturing of products, the type of marketing activity that organization engages in is called social marketing* (Kotler & Armstrong, 1991: 619).

The implication of the above definition is that an integrated marketing strategy should be used when sexual health promotion is planned and implemented and the strategy should be based on knowledge of the target audience. The four *P's* of marketing – product, place, price and promotion, form the core elements of the marketing strategy.

Table 6.2   Promotion of safer -sexual practices findings in terms of social marketing theory

Theme	Sub-theme
Target audience segmentation	Target audience segmentation
Product/message: Safe sex promotion	• Confusing messages by public figures/ politicians and the influence of the media on sexual health promotion programmes. • Negative views of current promotional programmes by government.
Place considerations (Where individuals will access the programme products and services).	• Accessibility and confidentiality. • Attitudes of staff at health care clinics/centres and confidentiality.
Promotion campaigns (advertising) (The communication strategy used with your audience to spread the message)	• Access to information. • Message approach: shock tactics. • Message content/theme: research-based themes/ adapting with time. • Conflicting views on promoting abstinence/ condom use. • Promoting HIV/AIDS counselling and testing. • Promotion by means of leisure activities and the use of the media. • Use of media in promoting safer sexual practices

The marketing product refers to the desired behaviour the audience is requested to perform and includes the associated benefits, tangible objects and/or services that support behaviour change. The place is where they will access the program products and services or where they are thinking about the issue. The price in social marketing refers to the costs for the target audience to access the products or programmes or to change the behaviour. Promotion is the communication strategy with your audience to spread the message.

There are also other key social marketing concepts which will be briefly explained. Evaluation refers to evaluation of the process using a regular feedback from audiences by evaluating the process, impact and outcomes of a programme and to change the 4 *P's* when the data shows that a change would improve results. The behaviour goal describes the target behaviour that needs to be promoted. Exchange operates on the principles of the costs and benefits for the audience and for the programme (Kotler & Andreasen, 2003). Kotler and Andreasen (2003: 5) further postulate that programmes intending to bring about behaviour change that benefit the individual and the community, have to adhere to criteria that are acceptable by the consumer (target audience). Thus, programme developers should be well informed concerning social marketing principles. Social marketing theory has the following strengths: it provides practical advice for media campaigns, is gaining recognition among media campaign planners and researchers, builds on attitude change and diffusion theories (Baran & Davis 2003: 307).
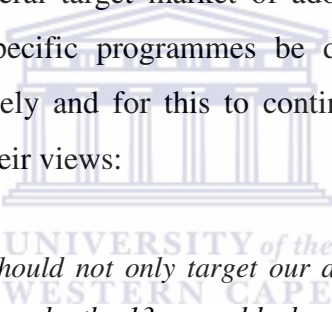
The weaknesses of social marketing theory include the following: it is source-dominated, does not consider ends of campaigns, undervalues intelligence of average people, and has difficulty addressing cultural barriers to influence, can be expensive to implement (Baran & Davis 2003: 307).

One of the key criticisms of social marketing theory is that sources use feedback from their target audiences to modify their campaigns. However, this change is mainly limited to a change in the message rather than the goal of the information. If an audience is opposed to adopting the message, strategies are adopted to break this resistance. Little thought is given to whether the audience may be justified in their resistance. Often the audience is blamed for being too ignorant or apathetic. Social marketing theory is often criticized for being customized to situations where elite sources are able to dominate elements of a larger social system. (Baran & Davis 2003: 306-307).

6.3.2   Target audience segmentation

Market segmentation is the process of dividing the target market into groups to better understand their current behaviours, evaluating each segment and selecting target segment(s) and then developing an appropriate marketing mix for those segments which include developing messages and tailoring programmes to meet their specific needs. Segmenting target markets helps us to group those with commonalities as well as gain a better understanding of their specific wants, needs, barriers and behaviours (Kotler, Roberto & Lee, 2002: 5).

Participants in this study had strong views on segmenting the market for the promotion of safe sex. Besides the general target market of adolescents and emerging adults, participants suggested that specific programmes be developed to include younger children and parents respectively and for this to continue across the life span. The following quotes summarize their views:

> *Maybe the government should not only target our age group but maybe they should target the younger ones, maybe the 13 year olds, because that's where it starts. If you make them aware from a young age where they are curious and want to find out about sex and AIDS then it won't maybe bother them. They* (parents and government) *do not seem to know that kids of all ages are having sex. .... Government should make sure that they give information to everyone of all ages.*

Strong views and consensus were expressed about the role of parents and targeting parents in promotional campaigns. Parents should be taught to communicate with their children about sex and provide structure and an environment that promotes security and self-esteem. The following excerpts highlight this:

> "*Maybe the government and the media should target parents... Some parents send out messages in the wrong way...*

> *Parents should know the whereabouts of their kids and must be able to communicate with their kids.*

The importance of targeting the appropriate audience is emphasised by social marketing theorists (Kotler & Andreasen, 2003) who stress the importance of knowing your audience and putting them in the centre of decisions you make regarding promotional strategies. It is crucial to target those who have a reason to care or change and it is equally crucial to understand that you are not the target audience and really do not have the best answer.

McNeal (2000) proposes the segmentation of target markets when designing programmes for youth, and advises that the age and cognitive level of development appropriate for a particular age group must be considered. Furthermore, for messages to be effective, they must be simple, consistent, straightforward, use visual information, stem from a variety of sources and be repeated frequently over a long period. Early commencement of prevention messages is advised as children begin to mimic behaviours early in life. Messages can be targeted at youth as early as 8 to 10 years, prior to the onset of sexual activity and when their cognitive skills are developed enough to grasp messages. Messages should accommodate and adapt to the heterogeneous nature of young populations, consider cultural and environmental distinctions and include young people in programming.

In order for programmes to be successful they cannot be applied uniformly and should be flexible. The factors to consider concerning the flexibility of these programmes are diversity of the youth population in terms of stages of development, disabled youth, culture, language, socioeconomic status and religion and sexual preference (gay and lesbian youth) (Schutt-Aine & Maddaleno, 2003).

6.3.3   Product/ message: Safe sex promotion

Confusing messages by public figures/politicians and the influence of the media on sexual health promotion programmes.

The plan of action for health and development of adolescents and youth in the Americas, 1998 – 2001 according to the Pan American Health Organization (PAHO, 1998) stipulates that giving young people access to accurate information allows them to make informed choices, from issues on sexuality to decisions concerning education and work. The manner through which these messages are sent, reaching wide target audiences, is through the media of broadcasting and print. Therefore, media has the ability to convey messages to young people that could influence their sexual practices. (Schutt-Aine & Maddaleno, 2003). However, media programming hardly ever portrays sexual behaviour in the terms of long-term relationships, use of contraceptives, or the negative consequences of sexual behaviour (Satcher, 2001: 8).

Similar sentiments were expressed by participants in this study. They stated that media is a major source of information and influences sexual attitudes and behaviours. Media is also seen as portraying materialism and conflicting messages regarding body image, religion, morals and values, and unsafe sex. Media is seen as damaging the effectiveness of the Anti- AIDS campaign with the type of programmes screened on television and the comments made by prominent politicians concerning HIV/AIDS. Media is also seen as conveying conflicting messages that in turn affect the effectiveness of the Anti- Aids campaign. Participants displayed intense opinions concerning the manner in which the South African government is marketing the message to young people. In some instances, participant responses were loaded with anger. Participants felt that the media is actually conflicting what government awareness campaigns are trying to achieve. The following statement confirms this:

> *They* (the media) *confuse us* (youth). *The one day they talk about sex as if it's dirty we mustn't do it, use the condom and so on…. the next day they show things that's almost a porn show on TV.* (Group agrees).

Participants felt that sex is overused in media as they were constantly bombarded with images of sexual explicitness either in advertising or in movies and in this manner sex is promoted and emphasised. Participants also felt that the media endorses sex and promiscuity because of the accessibility of pornographic material to the public. The following excerpts highlight these sentiments:

> .... *But I blame the media, like TV and so on because they send messages about sex that make it seem okay.*
> *There are porn sites on the internet and soft porn movies on eTV, in time slots early enough for young children to watch* (view) *so what are they* (media) *saying?*
> *… They advertise everything hinting at sex, everything is brought across in a sexual manner. Everything is made sexual.* (Group agrees).
> *Even in the advertisement for the AIDS campaign with the girl who goes out with the guy with the nice car (possessions) and then he gives her AIDS and the next week he's with another chick* (popularity gives him the opportunity to have many girlfriends) (reference to HIV/AIDS advertisement on television). *It's all about materialism.*

Literature indicates that political commitment at the highest levels, coupled with resources sustained over time is crucial for the success of programmes addressing adolescent sexuality. It was established that those countries most successful in reducing HIV/AIDS rates are those whose political leaders took the epidemic seriously more than a decade ago. (UNFPA, 2003a: 51-52).

In this study, participants also commented on political will negatively influencing the promotion of sexual health. They were also outspoken concerning the publicity surrounding conflicting comments of politicians regarding HIV/AIDS. Politicians should not make comments that confuse the public especially the youth. The following comment takes a jab at famous remarks made by South African politicians:

> *I think after sex you must have a shower* (sarcastic comment in response to a public statement made by then Deputy President Zuma at his rape trial). (Group members all laugh).

*Yes… and Mantu can come with her garlic (*referring to a diet of garlic and fresh fruit and vegetables, proposed by then Minister of Health, Mantu Tshlabala- Mtsimang for AIDS sufferers). (Everyone laughs).

Negative views of current promotional programmes by government

Strydom (2003) posits that the target audience should not only be involved in the planning of the product, but they also need to identify with the total image of the promotion product in order to enhance the probability of accepting the idea that is promoted.

Participants indicated that the South African government should change its marketing strategy for the anti-AIDS or sexual behavioural change campaign so that the message becomes more effective. They were of the opinion that the current marketing strategy is ineffective as young people find the messages repetitive and dull.   The consensus among participants was that the Abstinence, Be faithful, and Use a condom (ABC) campaign is ineffective and for government to get the message across effectively a new strategy needs to be implemented. Participants responded to the ABC campaign and its effectiveness concerning sexual practices and behaviour change as follows:

In my opinion I don't think that it has made any changes because you still find many people who are scared of testing. And they don't seem to be abstaining that's another problem. So I don't think this AIDS thing is being really taken into consideration properly because all they (government) *tell you to use is condoms.*

They are just talking (South African government)*…. to everybody, but nobody's doing that, nobody's listening. Maybe there is a minority that do abstain and haven't been in a sexual relationship yet, but it's the way the media and everything around us is* (Media influences sexual behaviour).

6.3.4 Place considerations (Where individuals will access the programme products and services)

Accessibility and confidentiality

Murray (2003: 7) found that issues concerning the accessing of services and physical environment, such as waiting areas, confidentiality and experiences at reception - were main themes in young people's evaluation of sexual health services.

Participants also expressed the need that health care clinics /centres for young people should be on some 'neutral'' ground where they can be at ease and not unexpectedly bump into relatives. They felt that it was an embarrassing and stressful experience to use community clinics as it was not a very private experience and the community would become aware of their (participants') sexual activities. Thus, the concerns regarding the aspect of confidentiality at such centres were raised. The following extracts indicate why participants fear the use of community health care clinics/ centres.

> *Yes everyone wants to know why you're coming to fetch it.* (Condoms).

> *Yes, but if you go to fetch the condoms everybody looks at you, you feel so embarrassed.*

> *And what if you bump into a family member? Ooooh God! (*Gesticulation, raises hands and covers face, indicating panic and embarrassment) (Group agrees, very vocally).

> *It's not easy in the rural areas. Like in the city it's big, not everybody knows you. In the rural area its embarrassing to go to the clinic, everybody knows you. They'll know you're having sex.*

Participants also stressed the importance of providing young people with information concerning the services provided by health care centres and their locality so that young people could access them easily and know what purpose they serve. The following excerpt indicates this:

> *I think that government should make more of these places that provide info. on AIDS and counselling and so forth* (health care clinics)*, available to young people. They*

should also provide the directions to these places so that it's not so difficult to find because it's not always clear where the place is and what its function is.

Attitudes of staff at health care clinics/centres (places) and confidentiality

At the Department of Reproductive Health and Research, World Health Organization forum on Building a Better Future for Youth: Learning from Experience and Evidence (WHO, 2006), various speakers mentioned the expectations youth have of youth friendly reproductive services. These included respect, privacy, confidentiality, short waiting time, affordable fees and access to as many services as possible in one visit. Participants found that community health care workers have no empathy or rapport with youth. They also expressed an urgent need for transformation concerning the attitudes and behaviour of community health care workers towards the youth who make use of their services. Participants expressed themselves with disappointment and intense disapproval of the current status quo as the negative attitudes of health care workers towards young people, adversely affect the decisions of young people to use their services. Their perceptions of the attitudes of community health care workers are illustrated in the following comments:

> *But the clinics and the testing and counselling in the community is not being effective for sure. If you need to change, you need to change your mindset both the people in the communities at the clinics, those* nurses (health care workers) *who judge us and we ourselves*. (Change our attitudes).

> *Many of the nurses at these community clinics are so rude even if girls come there for pregnancy testing then they ask them Why did you open your legs?. They're supposed to be there to help you not ridicule or judge you. I worked for a youth or peer education programme called SPADES and as participants, we had to visit 14 health care clinics and find out about the attitudes of nurses and health care workers and so on. We went to interview people that were sitting there* (in the health clinics) *and we spoke to nurses and looked at the facilities they had. Only half of the places we visited were properly equipped and were treating people in a proper way. Not being judgemental, rude and so on…. That is why many of us don't want to go to these clinics..*

> *If you go to the clinic or pharmacy for a test or contraceptives and people see that you're young or aren't married they immediately look at you funny* (judgemental).

Participants felt that community workers should be:

> *...people who don't judge, and that's what I would like about them* (health care workers, nurses).

> *….People who are kind and who care about us.* (Care for the youth). (Group agrees).

6.3.5 Promotion campaigns (The communication strategy used with your audience to spread the message)

Access to information

Participants indicated that if the promotion of safe sexual health is to be successful then all individuals should have access to information, especially via the media. Participants indicated that in some instances some communities (poor rural communities) do not have access to relevant media, referring to media that understands the particular community and who could recognise their (community's) particular needs. They were of the opinion that government should ensure that all communities are able to receive media messages via radio, as this is accessible to most communities. These views are supported by research. The Kaiser Family Foundation and the South African Broadcasting Corporation (2007) conducted a Young South Africans, Broadcast Media, & HIV/AIDS Awareness National Survey. Approximately 4 000 South Africans aged 15-24 years were surveyed to better understand the attitudes of young South Africans concerning the media's role in HIV prevention and education. The survey found that young South Africans living in rural areas are more likely to trust radio disc jockeys or talk show hosts, fictional television and radio characters, political leaders, and popular sports and music stars as sources of information about HIV/AIDS, than those living in urban areas. The following extract reflects participant opinions concerning access to information on HIV/AIDS and safer sexual practices via radio for young people living in rural areas:

If you can present (information) *to 7 to 12 year olds concerning what AIDS is all about and how to protect yourself and all that. But you find in some areas those people they don't have Metro* (a radio station)*; they have other radio stations so* they *are disadvantaged. They also have someone struggling with it from the outside* (outside the community*) and not part of the youth of the community* (so community needs are not known and issues concerning the youth are not known). *If the government can make it a fact* (take a decision) *and say okay, fine all the radio stations be involved in broadcasting the message* (sexual health messages)*, then everyone should receive the message.*

Message approach: shock tactics

Shock tactics were regarded as the use of distressing or frightening images in health promotion campaigns. Participants were overwhelmingly in favour that the messages should scare youth with the realities of AIDS. Research on the use of shock tactics (fear) has mixed findings. Witte, Berkowitz, Cameron and McKeon (1998) conducted and evaluated a fear appeal campaign used to decrease the spread of genital warts. They found that fear appeals can be powerful persuasive devices if they bring about strong perceptions of threat and fear (which motivate action) and if they induce strong perceptions of efficacy with regard to a recommended response (which channels the action in a health protective direction). Conversely, Ruiter, Abraham and Kok (2001) suggested that threatening information should not be used to persuade people to adopt health-promoting behaviours as it may have hidden psychological side effects and de-sensitize target audiences.

Participants strongly encouraged the use of shock tactics. Participant sentiments concerning the use of shock tactics in health promotion campaigns follows:

The way they are advertising the AIDS thing is wrong. They tell you get it then you die in a few years, no, tell people AIDS kills you, period. Let them have that advert of the girl (referring to current advert on TV) *let them show her dead or dying. Scare them.. Such an advert is effective.* (The whole group agrees).

Show the thing for what it is. Show them what AIDS really is. … The sores, the puss, the holes, the rotting, everything! (Student uses gesticulation, hand gestures to bring across message more dramatically). (The whole group agrees).

Researched based content of message - adapting with time

The salience of understanding transitions to adulthood and the association between social structures supporting youth (example national institutions, communities, families, religious institutions, civil society, and media) should be an area of priority for researchers. Researchers should also make the results of analysis and synthesis on youth issues more readily available and clearer to stakeholders. Similarly, policymakers should be more aware of best practices and open to applying evidence-based results in decision-making. The lack of documentation of findings or unsuccessful youth programmes restricts the understanding of how to improve them. A "safe" forum should be created to allow programme directors, researchers, and youth to share experiences of unsuccessful programmes (Department of Reproductive Health and Research, World Health Organization: Frontiers in Reproductive Health, Population Council, Youth Net, Family Health International, 2006). To produce soundly researched programmes, joint projects should be undertaken with universities and collaboration should take place with national policy makers. Expert groups should also be consulted and youth should do research. (PAHO, 1998: 20).

Participants also highlighted the issue of relevancy of messages and research-based messages. They regarded current marketing messages as not being relevant and that these messages should be progressive and evolve with time. They expressed their sentiments as follows:

Government has been saying for a long time as long as you use a condom its okay. But now for the next 20 years they are going to tell us abstain. Don't you think that the young people of tomorrow are different? The message for the last 10 years was use condoms. People are using more condoms than in the past. But the message needs to change maybe it will have its effects eventually. But the abstinence message I'm not so sure that this message will work. (Group agrees).

Participants also felt that in order for government campaigns to be effective they need to do thorough research on the sexual behaviour issues. The following excerpts illustrate this:

> *....If government can educate young children about HIV and AIDS the situation can be much better. They need to investigate this thing thoroughly.*

> *We need to know why this country is the way it is* (regarding the HIV pandemic) *because if you go to countries like China with a bigger population AIDS is not so bad there. They must research this thing.*

Conflicting views on promoting abstinence and condom use

Participants indicated that there was a need for abstinence and risk reduction messages geared toward all young people, regardless of their sexual experience, but there was no consensus about the viability of such a message. Some participants indicated that sexual health messages should first emphasize abstinence, and then condom use. However, all participants acknowledged that to abstain from sexual intercourse was difficult. The following excerpt illustrates this.

> *It's not easy to stop something that you are already doing* (having sex). *Yes a condom yes, but abstaining is difficult.* (Group agrees).

Some felt that the message should be changed to promoting abstinence (marketing the concept of virginity):

> *Change it around,* (message) *say for example I might be a virgin but I'm not getting AIDS like you might get if you continue* (to have unprotected sex). *Make it sound good, that being a virgin is kwaai* (is good) (Sell the concept of virginity).

Participants acknowledged that condom use is avidly promoted but seemed disillusioned that it had no impact on behaviour change. However, they felt that when marketing health promotion messages, consistent condom use should be stressed and

that good quality condoms be provided. The following excerpt highlights this viewpoint:

Yes, we are told to use condoms and we see it on all the posters and bill boards and in magazines .We are even given condoms for free and this is good,… but the government specials are not so good. (Quality of the government issued condoms is poor). (Everyone laughs but agree).

Participants suggested that wanting sex was natural and that some individuals seemed to be addicted to sex. This is indicated in the following excerpts:

There are people who are not willing to take responsibility for their actions and who don't condomise. There are also those people who are addicted to sex and don't want to have sex with condoms. Nymphomaniacs who go crazy and still don't protect themselves. So government can try and tell them to change but it won't happen. (Health promotion messages will not be heeded).

Personally I think that changing the way they advertise these things (sexual health) *is not going to do anything because people want to have sex. They've been trying to reach out to us in many ways but teenagers just wanna have sex and whenever there's a different way of doing it* (advertising) *teenagers are saying 'Aagh its HIV again' and condomise…*(same marketing messages are used) *They're just doing* it (having unprotected sex) anyway. *They* (those doing the marketing) *need to bring in a strong message to use the condom …..everytime you have sex.*

The issue of promoting voluntary counselling and testing arose during the discussions.

Promoting voluntary counselling and testing for HIV/AIDS

Participants stressed that voluntary counselling and HIV/AIDS testing should occur regularly. The following extract conveys this*:*

Yes, but if you know you are a sexually active person and you are using contraceptives then what about getting yourself tested regularly? Then if there's doubt in your mind then you'll know if you have yourself tested.

Participants felt that the promotion of HIV/AIDS testing should be a government initiative. The following excerpt indicates this:

I think that maybe the government should use the message…the message should be turned around like for ABC. First Abstinence, but if for example you feel you want to do it (have sex)*, first get tested, then be faithful and be in a relationship, then use a condom.*

Participants felt that HIV/AIDS testing was important even if one is not sexually active. The following extract forms a synopsis of participants' sentiments:

Yes, like the time we got tested here on campus. There were a lot of guys standing around, asking you: 'Why you're being tested? What have you been doing'? So I told them 'No, I want to be tested' and say 'I'm negative with proof. What can you tell me'? And he was speechless; there was nothing he could say. So the thing is, it's not about getting tested because you're sexually active, but you could stop at an accident and help somebody and perhaps cut yourself and then get into contact with the blood and become infected. Or through needles.

An issue of real concern was that some participants did not want to know their HIV status. This sentiment is highlighted in the following excerpt:

It is sometimes good not to know your status.... there are people when they have HIV or AIDS , they become sick and you eat but you become sick again (recurring illness) *and you battle* (suffer) *alone* (no assistance during illness). *Others don't want to have that stage. They want that when they're sick, they want to die. That is why they prefer not to go there* (get tested). *They just want to become sick, one go* (student clicks fingers) *then die.*

Promotion by means of leisure activities and the use of media.

Literature underscores the importance of marketing health promotion messages to young people effectively. Mass media, such as radio, television and print media, can be used to raise awareness in the policy area and encourage responsible sexual practices as well as publicise available services as well as sporting and recreation events in the community (UNFPA, 2003b). Participants stressed that attention should be given to the

needs of young people for leisure activities, especially in poorer communities as a way of promoting healthy living.

Participant sentiments concerning the promotion of leisure activities to promote healthy life styles follow:

> *Where I live in Langa they encourage kids to take part in sports activities, things that will keep them busy. Because peers hold more influence over you when you are not busy, or occupied with positive things. They say the devil finds work for idle hands and minds. When they busy with good activities they won't do bad things. So this could keep them from having sex.*

The above narratives underscore participants' concerns about the current situation concerning the marketing of health promoting messages. They indicate that if these messages are marketed effectively it could result in promoting safer sexual practices (condom use, reduce the number of sexual partners) among young people and so fight the AIDS pandemic.

Use of media in promoting safer sexual practices

As previously highlighted by participants, the media can play a significant role in sexual health promotion. In this study, participants generally perceived the media as having a negative influence on the promotion of safe sex messages. However, literature does indicate that the media can play an important role in promoting safe sex messages. For example, media and entertainment are often effective ways of reaching young people. James et al.(2005: 158) highlight the importance of print media in the context of health promotion. They found that print media could be used to influence and reduce behaviours that place young people at risk for disability and disease. Print media that considers the characteristics and factors that lead to a problem and that is developed in conjunction with relevant stakeholders, including the target group, have been found to be more effective.

The Kaiser Family Foundation and the South African Broadcasting Corporation(2007), Young South Africans, Broadcast Media, and HIV/AIDS Awareness National Survey, 2007) found that media in general, and radio and television in particular, play an

important role in the lives of most young South Africans. Large majorities live in homes with a radio (87%) and a television (74%). Two-thirds indicated they watch television (66%) and listen to the radio (68%) every day or almost every day, and most say they do more of both on the weekends. Broadcast media has a significant role to play in HIV prevention in South Africa, and much investment has been made in HIV awareness and education through the media in recent years.

As previously mentioned, young South Africans living in rural areas are more likely than those in urban formal areas to place lots of trust in radio disc jockeys or talk show hosts, fictional television and radio characters, political leaders, and popular sports and music stars as sources of information about HIV/AIDS. Regarding messaging, young South Africans are significantly in favour of more HIV/AIDS messaging in the media; eight in ten agree there should be more HIV/AIDS messaging and programming on radio and television. They also strongly support messaging that is hopeful and culturally relevant, focussed on young people's aspirations, and offers straightforward information about how to prevent HIV/AIDS (The Kaiser Family Foundation, & the South African Broadcasting Corporation, 2007).

Siphepho and Gmeiner (2000: 29) found that the most important media influence on the youth was from movies and television. Thus, to communicate the importance of the fight against the spread of HIV/AIDS it could be beneficial to use television stars as popular role models to convey this message.

Further questions posed to focus group participants allowed for the exploration of additional information relating to their views about health facilities in the college sector in relation to sexual health promotion.

6.3.6 Views and suggestions on health facilities in the college sector

Participants' views and suggestions on health facilities in the college sector revealed that there was a need for the availability and access to condoms and sexual health care on campus, youth friendly services on campus and in the community, as well as confidentiality and flexibility of these health care facilities. Although this was the last

issue at the end of a lengthy discussion, participants needed no encouragement and proceeded in an enthusiastic manner. These suggestions are categorised in terms of themes listed in Table 6.3 below.

Table 6.3 **Summary of themes concerning participants' views about the kind of health services they would like provided on FET campuses**

Themes concerning the provision of health services at FET campuses
• Availability and access to condoms and sexual health care on campus.
• The incorporation of life skills programmes into the curriculum.
• Voluntary counselling and testing facilities on campus.
• Youth friendly services on campus and in the community, confidentiality and flexibility of these health care facilities.
• Young people want to be involved in decision–making concerning health promotion facilities, services and issues that affect youth.

As discussed in Chapter 1, the baseline survey and needs assessment of FET colleges, by Planned Parenthood Association of South Africa (PPASA, 2004), found similar requests from participants and staff relating to the provision of health care facilities and services. PPASA established that the principal needs of participants and staff at FET colleges are: continuous counselling for those affected and infected by HIV/AIDS, attending to the pregnancy and drug problems on the campuses, the provision of voluntary counselling and testing (VCT) services and the provision of condoms to participants. Participants' suggestions as to what should be done in colleges to promote safer sexual health will be discussed.

Health promotion is considered an essential tool for achieving the health and development of adolescents through social change. The PHO, in their plan of action for health and development of adolescents and youth in the Americas (for the period 1998 – 2001), defined health promotion as *a process by which individuals and their communities exercise control over the determinants of health, thus improving their state of well-being. The strategies for health promotion include formulating healthy public*

policy, reorienting health services, tapping the potential of communities to work towards their health and wellbeing, creating healthy environments, strengthening personal health-related skills and forming special alliances with the mass media. Health promotion activities require that the effort and responsibility necessary be shared between individuals, families, communities, organizations, health systems and governments. The health programmes with the most impact promote simultaneous changes at different levels of influence, within a wide variety of actors (PAHO, 1998: 19).

Availability and access to condoms and sexual health care on campus.

Participants highlighted the need for the availability and access to condoms and sexual health care on campus. They stated that access to condoms is a priority on each campus. The following excerpts highlight participants' sentiments:

> *There's no condoms available to us here on campus. Then you don't have to go to a special place* (Clinic) *to go and get the condom it's available on campus.*

> *It's not about having sex on the college grounds. It's about having the condom on you when you go home or whenever you're gonna have sex.*

The incorporation of life skills programmes into the curriculum

Participants also emphasised the importance of incorporating life-skills programmes relevant to their needs into the college curriculum so that issues affecting them could be discussed. Life-skills include a number of skills that lead to the holistic development of the individual. They include social and interpersonal skills together with communication, negotiation skills, assertiveness and empathy. Life-skills also involves developing cognitive skills as well as decision making, critical thinking, self-evaluation and emotional coping skills that include stress management and increasing an internal locus of control. (Mangrulkar, Whitman, & Posner, 2001).

Researchers concur that adolescents who receive HIV/AIDS and STI sex education and life-skills education, appear to be less likely to engage in sexual activity and if they have

sexual intercourse, to engage in safe sexual practices (Jemmott, Jemmott, & Fong, 1992; Magnani et al., 2005).

The following extract forms a synopsis of participant sentiments concerning life- skills programmes:

> *Life skill programmes must be brought in with topics that affect us… and stuff that is important for us so that we can talk about it… We need a forum for participants to engage, because we come from different religious, cultural, social backgrounds, so to bridge the gap we need to understand certain things….. We need to debate, come together.* (All agree).

Voluntary counselling and testing facilities on campus

Participants commented on the issue of voluntary counselling and testing facilities on campus as follows:

> *They should have a clinic available for us here,* (on campus) *where we could make appointments for voluntary counselling and testing not just to get treatment for infections and get free condoms or do pregnancy testing. If we had clinics at college. I would feel more comfortable because I would think that there are others who think like me. I will have myself tested if its here. I think it should be encouraged* (voluntary testing). (All participants agree).

> *Everyone should get tested and it should be done here at the college.*

Youth friendly services on campus and in the community, confidentiality and flexibility of these health care facilities

Youth friendly services are defined as those that respond positively to young people's needs for proper and the latest information, they provide a complete range of accessible and affordable services as well as quality care in the most appropriate way for young people. This includes an environment that guarantees privacy and confidentiality for the young person and services provided by non-judgmental professional staff (trained in adolescent health and development and youth friendly approaches), so that young people can make free and informed choices about their health and sexuality. For these

services to be accessible and affordable to young people, it may be necessary to have convenient hours, outreach services and affordable fees (United Nations Interagency Group on Young People's Health Development and Protection in Europe and Central Asia, 2002). Researchers concur that youth-friendly reproductive health services should increase young peoples' access to STI treatment, condom use, HIV prevention methods and protection against unwanted pregnancies (Laga, Schwärtlander, Pisani, Sow & Caraël, 2001). At the Department of Reproductive Health and Research, WHO forum on Building a Better Future for Youth: Learning from Experience and Evidence; various speakers commented on the expectations youth have of youth friendly reproductive services: Dastile, from *Participants Partnership Worldwide/South Africa*, suggested that youth are mainly concerned with a welcoming atmosphere that offers privacy and confidentiality. Matara, from I *Choose Life/Kenya,* reported that youth are frequently unaware of programmes and are ignorant of where services are available.

Meyrick and Swann (2001) found that the availability of youth-based contraceptive services in a specific locality is associated with lower conception rates. Many young people have a poor understanding of their own sexual health needs, know little about available services or are deterred by shame or embarrassment and often feel unwelcome at traditional reproductive health clinics. It is therefore important to provide youth friendly services (UNFPA, 2003a: 41). The WHO (2004) advises that people such as parents, teachers, health workers, counsellors, etc, who are perceived as credible, trustworthy, have a high status and are positive role models and who are successful and competent should teach the curriculum. Educational institutions can also implement strategies to reduce HIV infections (UNFPA, 2003a: 31).

A recent study of adolescent preferences found respect, privacy, confidentiality, short waiting time, and affordable fees were most important to young people. Youth prefer "one-stop shopping"—that is, access to as many services as possible in one visit (Department of Reproductive Health and Research, World Health Organization forum on Building a Better Future for Youth: Learning from Experience and Evidence, 2006).

The following extracts reflect participants' opinions concerning the need for youth friendly services:

> *This health care clinic on campus should have nurses that are cool, not judgemental. They should be able to talk to us, the way we speak, not with all that jargon of sexual stuff. I should be able to tell her I'm feeling so horny right now and she mustn't come with technical sexual explanations. We must be able to speak comfortably to her, like one on one.*

The following excerpts comment on the convenience of locality of these centres:

> *Those girls that go for pregnancy tests have to leave campus and they can't attend their classes because they have to go to clinics. If it's on campus you don't have to miss out on classes that much.* (Female student displays irritation).

> *We should have like a big health centre where everything we need for our health is available..*

> *Many of the clinics are not close to your home, if its at the college it will be better, its easier access for us and because many of the nurses are so rude even if girls come there for pregnancy testing then they ask them Why did you open your legs?. They're supposed to be there to help you not ridicule or judge you.*

Concerning the issue of confidentiality and flexibility, participants commented as follows:

> *Going to a public clinic is very public. So some people would prefer a more confidential setting like here* (At college). *And it must be open after college hours and on weekends.* (Group agrees).

> *You can't go to a private doctor or clinic because your parents will see if you have to use their medical aid, so a college clinic will be perfect.*

> *We would want a clinic here at college so that people can't stigmatise, ogle and be judgemental.*

We need people to come in who have HIV or sexual diseases. They should speak to us about what they're experiencing.

Young people want to be involved in decision–making concerning health promotion facilities, services and issues that affect youth

The following comment indicates that young people want to be involved in decision–making concerning health promotion facilities, services and issues that affect youth.

They (adults, government authorities) *don't have a clue about these things* (issues that affect youth)…. *They don't always know what's best for us. We know what works and what doesn't. They must ask us about the things that affect us.*

The PAHO (Schutt-Aine, Maddaleno, 2003) advises that youth should be involved directly in the planning and delivery of health services and interventions. They further state that youth involvement is crucial for recognizing needs, goal setting and proposing services and activities that will be pleasing and accessible to youth. Through youth participation young people could develop experience as peer educators improve skills, self-esteem and leadership potential among participating youth. Youth could also attain better results than adult professionals.

The above narratives indicate the importance of providing young people with youth friendly, empathetic, convenient and relevant health promoting services on FET campuses.

In general the literature suggests that successful programmes for youth concerning safer sexual practices involve multifaceted approaches that acknowledge the complexity of young people's lives and the main role players in their lives such as parents, religious leaders, educators and peers as well as the influence of the media. Messages concerning safer sexual practices must be clear, unambiguous and offer youth options. The content of these programmes should not reprimand and be critical of the target market. Services that are effective in appealing to youth are those that are friendly, pleasing, tolerant and offer more than one service. (Scales & Lefferts, 1999; Kirby, Laris & Rolleri, 2007).

6.4   Summary

The content analysis highlighted factors/themes considered by focus group participants to be important influences on sexual behaviour and decision-making. These themes included personal/individual factors (intra-personal and interpersonal), gender and power relations, views on condom use, and social and cultural issues in sexual decision-making.

From the themes emerged a number of sub-themes or factors that influenced sexual behaviour and decision-making amongst emerging adults. These sub-themes included: self-concept and self-efficacy, the need for acceptance by the romantic partner or peers, egocentricism and impulsiveness versus rational decision-making, romantic versus sexual relationships, family relationships and communication, gender power imbalances and dynamics in relation to sexual negotiation, age difference dynamics in sexual relationships, manipulation via the use of "love" word and gender stereotyping. Other important sub-themes were the influence of culture, religion, drugs and alcohol, and the impact of poverty on sexual behaviour and sexual decision-making amongst emerging adults.

Focus group participants also revealed their perception of personal risk and their attitudes towards risky sexual practices (having multiple sexual partners and lack of condom use when having sexual intercourse). Moreover, they expressed their personal views on what should be done to effect positive behaviour change in terms of sexual practices. They also expressed their concerns regarding the promotion of sexual health in the media as well as their needs for sexual health services at FET institutions and in the community.

The findings outlined in this chapter and the findings of the previous chapter are used to recommend guidelines for sexual health promotion. These guidelines are discussed in the next chapter.

CHAPTER 7

SEXUAL HEALTH PROMOTION GUIDELINES

7.1 Introduction

This chapter presents guidelines for sexual health promotion based on the findings of this study. It should therefore be noted that, that within the context of this study, the guidelines flow directly from the quantitative-qualitative exploration and are not presented as the result of an applied/developmental research process. The discussion is structured, based on the proposed political and community structures/ institutions involved, but because of the interrelatedness of these issues, some overlap is inevitable. As indicated in the preferred definition of "guidelines" (see Chapter 1.) the purpose of the following guidelines is to influence/direct the course of action for promoting responsible sexual practices by means of offering comprehensive recommendations, based on the clear voices of the youth who participated in this study and previous, relevant literature. The guidelines are intended for implementation in the FET sector. Since the State presides over this sector; the guidelines could be considered by the various stakeholders associated with the FET sector. Thus, public departments such as the departments of health, education and social development, as well as policy makers and service providers, may find the guidelines useful.

7.2 A framework depicting core findings and indicating implications for policies and programmes for sexual health promotion

The framework of the PAHO, see figure 7.1 as presented by Schutt-Aine & Maddaleno (2003: 20) has been adopted and adapted to summarize the findings of the current study and it also indicates the implications for the development of policies and programmes for promoting safer sexual practices (See Figure 7.2). The researcher has selected this framework because it supports basic theoretical guidelines and findings of the study as explained in the discussion below. It is also in line with basic assumptions of Bronfenbrenner's ecological systems theory (see Chapter 2 and figure 2.1) that defines

complex layers of the environment, each having an impact on a child's (and eventually on the young adult's) development. The framework of the PAHO indicates the factors that should influence programmes and policies for adolescent sexual health (see figure 7.1) and enhances the direct findings of this study. The framework has a development-centered approach within the context of the family, culture and the environment. It is centered on healthy development, with sexual health and development as an essential element of general health. The framework highlights the various factors that influence sexual health and development outcomes. These include biological, psychosocial, and cognitive development at the individual level. At the social and environmental level, factors such as family, peers, schools and educational level, society, culture, socioeconomics, equity rights and empowerment influence an adolescent's sexual development. All are interwoven and interdependent as indicated in the figure 7.1 (Schutt-Aine & Maddaleno, 2003:19). The researcher has named the adapted version of the PAHO framework for the purposes of this study as The Ecosystemic Framework for the Understanding of Youth Sexual Practices (EFUYSP), which is depicted in Figure 2. Furthermore, the EFUYSP illustrates this study's core findings and indicates implications for policies and programmes relating to sexual health promotion particularly in the FET sector, where there seems to be a paucity in terms of the provision of effective sexual health promotion services.
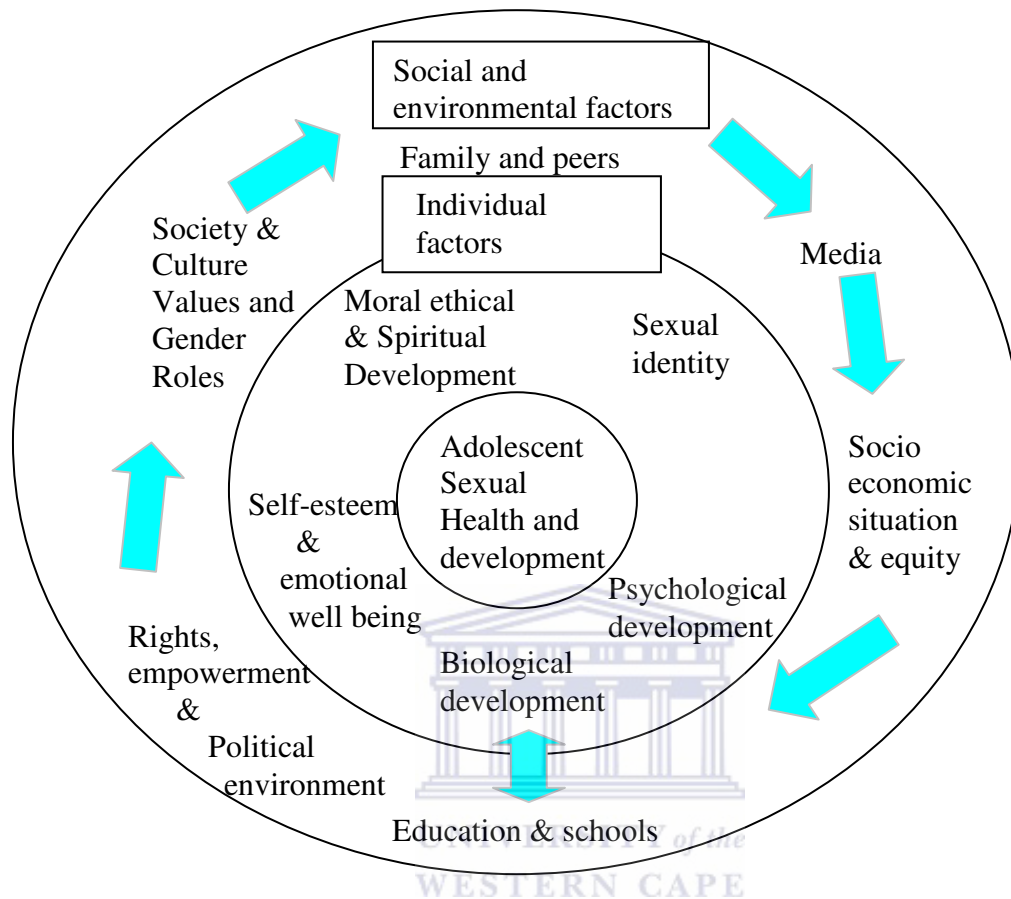
Figure 7.1 PAHO Sexual Health and Development of Adolescents and Youth in the Americas: Programme and Policy Implications Framework (Schutt-Aine & Maddaleno, 2003: 20).

Social and environmental factors

Individual factors

Peers

Family

Media marketing messages

Culture and Gender

Self- esteem

Self- efficacy

Sexual practices amongst youth

Socio economic situation/ poverty

Religion

Political environment

Community

Educational institution/ college

UNIVERSITY *of the*
WESTERN CAPE
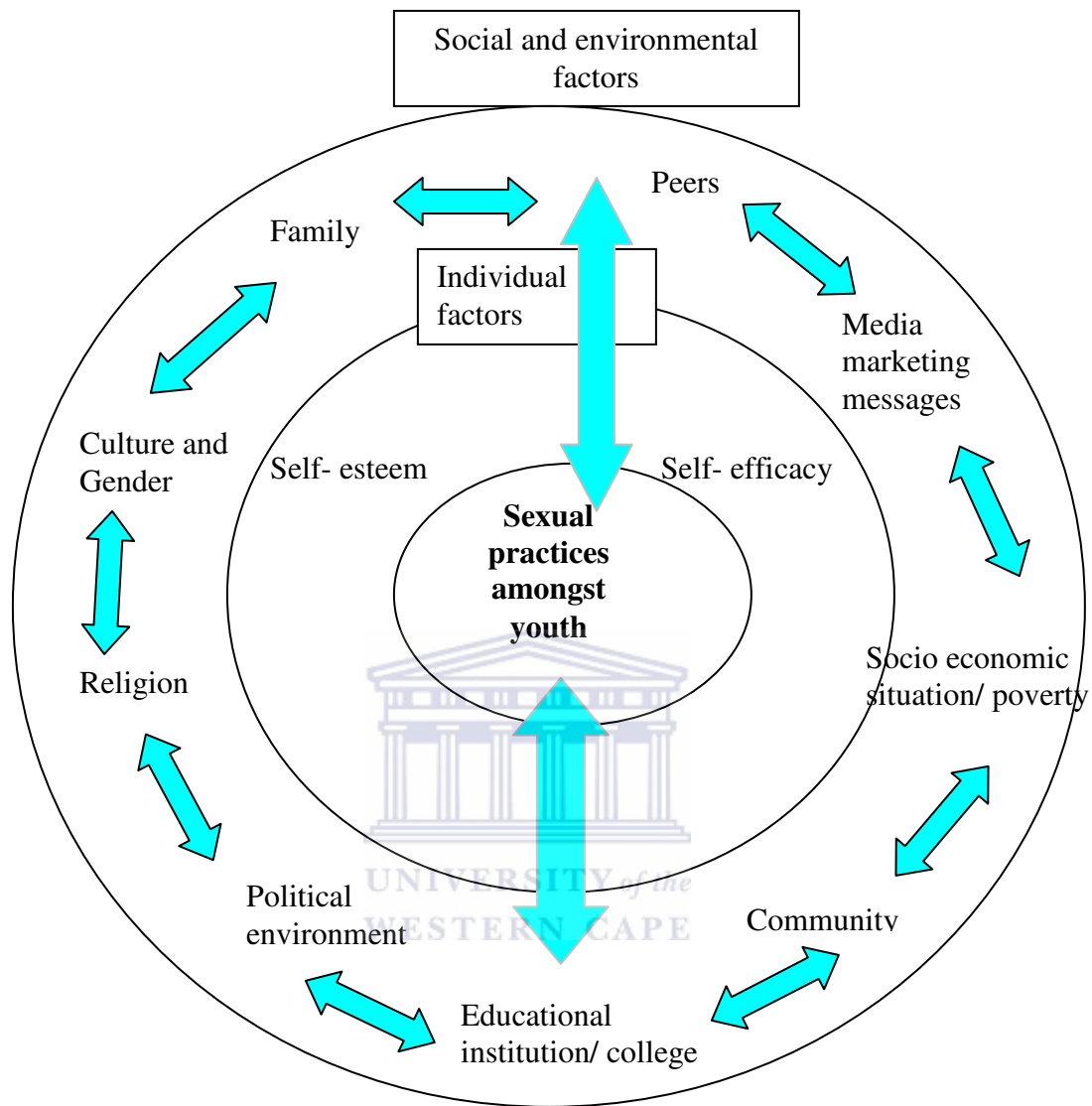
Figure 7.2 The Ecosystemic Framework for the Understanding of Youth Sexual Practices (EFUYSP) is an adapted version of The Framework of the Pan American Health Organisation's (PAHO) Sexual Health and Development of Adolescents and Youth in the Americas: Programme and Policy Implications Framework (Schutt-Aine & Maddaleno, 2003).

The diagram illustrates the interrelatedness of the environmental, social and personal factors that are perceived to impact on college students' sexual practices and that should be considered in sexual health promotion. The individual's sexual behaviour is influenced by self-esteem and self-efficacy which in turn relates to family relations, and

peer influences. On the macro level the political environment is directly and indirectly instrumental in sexual health promotion in that it formulates policies for health and well-being for schools, colleges and the work place and is also expected to directly lead and support promotional campaigns. The current government has the responsibility for promoting gender equity and human rights and to actively address poverty. Community level issues such as poverty, religion, and the multi-cultural nature of our society influence sexual practices, gender roles and stereotyping. Community structures and institutions as well as the mass media have vital roles particularly in the spreading of information that influences attitudes, social behaviour and cultural norms.

7.3 Guidelines emerging from study findings

The discussion of the guidelines/ comprehensive recommendations for practice that follow will be enriched by integrating theory and recommendations pertaining to the findings of this study. Therefore, the following guidelines are posited based on the study's findings.
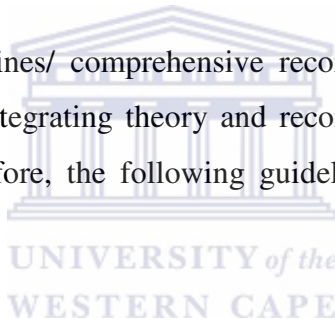
7.3.1 Political Environment

The political environment refers to government on all levels that effect and implements policies. The policy environment on the macro level is linked to the sexual development of youth through programmes preventing health problems and the provision of services. The following guidelines/ comprehensive recommendations pertaining to the political environment are discussed below.

(a) Youth involvement in planning policies and programmes

This study found that youth expressed a need to participate in decision-making concerning health promotion facilities and services and on issues that affect youth. Research supports these findings and indicates that youth should be involved in issues that affect them at all levels especially policy making levels. Youth participation produces policies and laws that have a direct influence on sexual health promotion, provision of adequate resources like youth friendly centres, distributing suitable information on sexual health and supporting gender equity. Youth involvement also

produces networks that actively support the needs of youth at the local level. Incorporating youth into the development of youth sexual health promotion programmes would promote youth empowerment as proposed by the PAHO (Schutt-Aine & Maddaleno, 2003). Within the context of the HIV/AIDS pandemic in South Africa, the current government should play a leading role in sexual health promotion in terms of policies and collaborative programmes with community based organisations and non-government-organisations. The following clear guideline is extracted from this discussion:

> **The youth should be involved in the formulation of policy and programme planning as well as the implementation of programmes regarding sexual health issues. This includes representation in governmental structures on all levels, especially in the fields of health, education, and social development and in collaboration with relevant organisations.**

(b) Culture and gender inequality.

Participants viewed cultural values and gender roles as factors that impact on youths' sexual practices. This study highlighted imbalances in gender power relations in favour of males, which influence sexual decision-making and in turn sexual practices. Young women are seen as lacking the power to negotiate safer sexual practices while young men report having sex with multiple sexual partners without using condoms. Gender stereotyping is also a reflection of the imbalance in power relations between males and females regarding sexual practices. For example, when males are in possession of condoms, they are considered responsible while females in possession of condoms are perceived to be inviting sexual intercourse. Research supports the findings of this study in terms of the influence of cultural values and gender roles as key factors on the decision-making process of young peoples' sexual practices (Van Dyk, 2001; Mordaunt, 2003; Lesejane, 2004).

The implications of these results are that promotion of sexual health is not just messages about "safe sex" but messages that continuously reaffirm equality of women in sexual decision-making.

Gender mainstreaming, a process of consistently instilling a sensitivity of gender differences in policy, planning, budgeting, and implementation of programmes and projects with the intention of overcoming inequalities between males and females, should be a priority for government structures. Gender mainstreaming in health has the promise of revolutionizing any existing policies and health delivery services so that no one is denied their right to sexual health on the basis of gender (ECOSOC, 2004). Government should be involved in implementing gender mainstreaming in all spheres of society as the following guidelines propose.

The following guidelines are crucial to consider:

On a programme level, a multi-sectoral approach should be followed to implement gender equity programmes, raise awareness of gender stereotyping and cultural diversity. Governmental departments such as the Department of Social services, Health, Education and Social Development as well as NGO's, religious organisations and community-based organisations should collaborate to provide programmes, workshops, presentations and the use of the media (radio , television and print media, pamphlets and posters) that address gender issues in sexual health. These social programmes should pay particular attention to:

- **Improve relationship dynamics that foster equal rights for all regardless of gender and sexual orientation (as the stereotyping of**
  Promoting programmes that raise awareness of sexual manipulation
  and exploitation, including using the media such as the radio, television,
  print media and posters.

Policy should be implemented to create a sympathetic media and business environment that promotes young peoples' health by transforming business practices that are considered detrimental to the health of young people through regulating and monitoring programme content and reducing the frequency of advertising detrimental products or programmes in the media. This would prevent the circulation of harmful advertising or programming of products such as tobacco, alcohol and other harmful substances. This would also prevent confusing sexually explicit programmes from being broadcasted.

(c) Poverty

Participants (some of whom live in poor communities), suggested that social conditions such as poverty influenced their decision-making and were related to individuals engaging in transactional sex, sex with older men (in the case of females). These actions also predisposed them to health risks such as STI's and HIV/AIDS (Kelly & Parker, 2000; & O'Leary, 2002). Research supports the findings of this study in terms of the influence of poverty on sexual practices. The conditions of poverty contribute to the likelihood of young people experiencing sexual coercion and physical abuse in intimate relationships. (Whitefield et al., 1999; MacPhail & Campbell, 2001; Mordaunt, 2003; & Phillips, 2006). The following guidelines have emerged from this study's findings.

Policy-makers should recognize and promote the social and economic conditions of families by acknowledging the relationship between poverty, educational opportunities, and human development. The social and economic condition of a family influences the extent to which the environment promotes the positive development of youth.

Concerted efforts by government organisations such as the Department of Social services, Social development, Education and Labour should collaborate with community organisations and actively involve communities concerning poverty alleviation. Poor communities should be targeted with social upliftment programmes through integration with educational institutions such as FET colleges, NGO's, religious organisations and local government organisations where workshops could be conducted and courses offered to raise educational levels and to improve skills. Small business ventures in the community should be encouraged. Government, NGO's and private investments should be involved in setting up these ventures.

Community driven programmes should be a priority. These integrated programmes should include the following:

- **promoting healthy sexual practices (information on safer sexual practices) ,**
- **effects of alcohol and drug use on sexual practices and other social factors,**
- **gender equality and accepting diversity.**

- **self-development (self-efficacy and self-concept) through community forums, workshops, community drives, seminars training programmes and government initiatives.**

- **Educational institutions like schools and colleges should attempt to link with the community and organisations within the community to provide career, employment and sporting opportunities for youth while they are still at these institutions through multi-sectoral collaboration.** This would improve their chances as adults for participation in the labour force and end the cycle of poverty.

- **Vocational skills training and internship opportunities should be provided to youth to gain essential work experience and investigate career prospects.** This would offer youth a sense of self-worth (boost self-concept) and purpose which in turn would encourage responsible sexual practices (UNFPA, 2003a: 31).

Specific anti-discrimination policies should be implemented to ensure that marginalized populations have equal access to opportunities and services. **Policies and legislation should work to reduce exposure to unhealthy conditions, racial and ethnic discrimination, gender inequities and risk behaviours** (PAHO, Schutt-Aine & Maddaleno, 2003).

(d) *Collaboration of government, non-government organisations, (NGO's) and community based organisations in research on sexual health promotion*

Participants in this study highlighted the need for researched-based sexual promotion programmes. Previous studies support this finding and acknowledge the need for research to be conducted into understanding transitions to adulthood and the association between social structures supporting youth (such as national institutions, communities, families, religious institutions, civil society and the media). It is considered important that researchers inform youth and other stakeholders of results on youth issues. Similarly, policymakers should be more aware of best practices and apply evidence-based results when implementing policies that affect youth. A "safe" forum should be created to allow programme directors, researchers, and youth to share experiences of unsuccessful programmes (Department of Reproductive Health and Research, World

Health Organization:Frontiers in Reproductive Health, Population Council, YouthNet, Family Health International, 2006).   To produce thoroughly researched programmes, joint projects should be started with universities and collaboration should take place with national policy makers. Expert groups should also be consulted and youth should do research (PAHO, 1998:20). The following guidelines emerged from the discussion.

> **It is recommended that the previously mentioned government structures should initiate collaborative forums for doing research and sharing information about lessons learnt. The co-ordination and collaboration between government, NGO's, communities, and religious organisations should be improved and sustained. Researchers should engage in participative-action research with the youth on issues related to sexual health promotion. Policymakers should be informed of best practices and apply evidence-based results when implementing policies that affect the youth.**

(e) Planning of programmes according to sound marketing principles

Participants in this study also highlighted the importance that the planning of programmes initiated by the government and collaborative forums should be based on sound social marketing principles. This aspect will be further discussed when the role of the media is presented later in this chapter. Programmes should be planned according to the needs and lifestyle of the different target groups. The following guidelines are crucial to consider.

> **The policy environment on the macro level should ensure that the South African government organisations such as the Departments of Health, Education and Social Development as well as organizations such as churches, schools and higher educational institutions implement policy that ensures the implementation of intervention programmes at an early age and are segmented across the lifespan. Messages should also accommodate and adapt to the heterogeneous nature of young populations, consider cultural and environmental differences and include young people in sexual health.**

Therefore, the various government departments should ensure that they appoint specially assigned experts in the field of sexual health promotion who are able to identify with the needs of the target market when promoting sexual health programmes.

7.3.2   Communities

Communities are generally defined based on geographical boundaries or functional boundaries like shared values, practices or predominant racial or ethnic make-up (Satcher, 2001:14). The young person is ideally nested in a family/household where there is a supportive relationship that fosters personal development of children and the youth. Families in turn should be supported by local political, educational, social-developmental, economic, religious, cultural, health and recreational structures and institutions. Participants in this study highlighted the role of communities in sexual behaviour, especially in communities where poverty, unemployment, drug abuse, and violence are rife. The influence of family, peers, cultural norms, gender inequality, poverty, religion, recreation and media messages on community level, were also highlighted. Guidelines are offered pertaining to specific community structures and issues as highlighted by participants in this research, acknowledging the interrelatedness of the community and political environment.

(a)   Collaboration of organisations, facilities and structures in the community.

In the previous discussion the issue of multi-sectoral collaboration was highlighted and it is vital to elaborate on this in the following guidelines pertaining to communities.

Active youth participation should be encouraged by involving youth groups in sexual health programme development and implementation. Young people are often detached from the neighbourhood institutions that surround them and special promotion strategies should be implemented to include them in community-based organisations and summits or municipal meetings where they are able to highlight their concerns and ideas to community leaders. In this manner, youth could affect positive change on issues that directly affect them in their communities. Educational institutions should initiate youth connectedness to organisations in the community. An example would be to initiate a college programme of "Big Brother, Big Sister" where students are trained to go out to

school and engage with school children in discussions on sexual and other self development issues that will promote sexual health.

Collaboration in forums, action, and task groups. Formal and informal political, social –developmental, health and religious leaders (including youth leaders) in the community should collaborate and cooperate for:

- **research based sexual health promotion programmes with social marketing experts and the media.**
- **monitoring media messages that influence sexual risk behaviours.**
- **monitoring social development programmes of the government and initiate community based development programmes with the private sector.**

(b) Educational development programmes for the youth in the community

Participants in this study clearly indicated that sexual health promotion/sexual decision-making is not merely sending messages to the youth through the media and personal communication. It is related to self-development, self-concept, and respect for self and others. Therefore, sexual educational programmes should be part of self-development throughout the life stages of the individual. The following guidelines are thus recommended:

Pre-schools, schools, colleges/universities, NGO's and other relevant role players should introduce age appropriate educational-developmental programmes for their learners/students. These programmes should inter alia include self-development, communication skills, gender equity and general life skills related to sexual development and health.

Community organisations should take the lead in providing training for practitioners who work with youth to enable them to deal with youths' sexual health. Training should include sensitisation training for health professionals to encourage them to be non-judgmental and empathetic to the sexual health needs of young people.

(c) *Health care services for the youth in the community*

Health care practitioners in the community should consider young people's experiences concerning the lack of confidentiality, customer-orientation, and friendliness in clinics where sexual health issues are promoted. The following guidelines should be implemented:

Youth-friendly, health care services including sexual health promotion should be a basic service to communities with the following aims

- **Provide basic, accurate information concerning the risks of unsafe sexual practices**
  (such as multiple sexual partners, lack of condom use during sexual intercourse).
- **Promotion programmes should increase the knowledge of the target audience by providing basic information that could assist youth in evaluating risk. These programmes should focus on emphasizing required skills for decision-making**.

(d) *Parents/caregivers in the community as target audience for educational/support programmes*

Participants suggested that the family (particularly the communication in families concerning sexual issues) influences youths' lives and in turn their sexual practices. Participants indicated that there is a need for open communication about sexual issues as it assists in sexual decision-making. Good family relationships and communication are considered important for developing strong moral standards that guide the individual concerning sexual decision-making. Participants felt that parents/caregivers should take a more active role in discussing sexual issues with their children at an early age and offer age-appropriate information. Open communication with parents equips children with sexual negotiation skills, challenges social norms and brings about positive behaviour change, such as delay in sexual debut and safer sexual practices. Parents and family communication with youth on sexual issues are seen as a means of producing positive behaviour change, such as delay in sexual debut and increasing safer sexual behaviour. (Fisher, 1987; Whitaker & Miller, 2000; Haupt et al., 2004; Pettifor et al., 2004). The implications

are that the home environment could be a setting for promoting positive/non-risky sexual practices. This implies that the following guidelines should be adhered to.

Parents/Caregivers should be involved in the development of and targeted by social development organisations, religious leaders, staff of community health facilities, pre-schools and others, with programmes that builds parenting skill capacities. These programmes should include:
- **parent child communication on sexual issues**
- **nurturing self-efficacy and self-concept of children**
- **Substance abuse and its effect on sexual behaviour.**
- **Ensure that programmes geared at parents assist in developing a home environment that is nurturing, empathetic, monitors and allows for open discussion of sexual issues.**

Collaborative efforts between the relevant government departments and the abovementioned structures should raise awareness of negative influences such as family violence and substance abuse of parents/caregivers on the behaviour of the developing child and eventually the young adult.

(e) Religion, values and sexual behaviour of adolescents and young adults in the community

The decline of societal morals and values and the view that religion seemed to have no effect on youths' sexual practices were highlighted in the study. Religion was perceived as lacking credibility, was judgemental and archaic. Religious institutions were seen as inflexible and could not be considered moral agents. These findings are consistent with research about religious views of emerging adults. However, research indicates mixed findings on the influence of religion on sexual practices. Empirical studies indicate that emerging adults question the beliefs in which they were raised, emphasise individual spirituality more than association with a religious institution and select aspects of religion and spirituality that best suit them (Arnett & Jensen, 2002; McNamara-Barry & Nelson, 2005). Religious leaders (including youth leaders) in action groups and within religious institutions should take cognisance of these findings. The following guidelines emerged from the discussion:

Religious training institutions should provide programmes for and by religious leaders emphasizing their role in promoting safer sexual practices through workshops, religious conferences, religious services, seminars and multi-media channels. These programmes should foster the idea that speaking openly about sexual issues using a religious platform is no longer a taboo.

Prominent religious leaders (such as Archbishop Desmond Tutu) should be used to encourage open debate on the role of the church in promoting sexual health.

Youth leaders should be involved in programmes of religious organisations and institutions to plan programmes for positive change in terms of sexual practices.

7.3.3 The media

Participants in this study highlighted concerns for the current manner in which sexual health is promoted through the media. The concerns were on two levels. Firstly, though media is considered a key source of information and influences sexual attitudes and behaviours, the entertainment programmes (lyrics of songs) on television and other mass media are seen as portraying conflicting messages regarding body image, religion, morals and values, and unsafe sexual practices. These messages often contradict the promotional messages for sexual responsible behaviour and negatively affect the effectiveness of the anti-Aids campaign. In this regard, the following recommendations are presented within the context of this guideline:

Multi-sectoral committees for sexual health promotion of the youth in the community (As previously mentioned) should act as "watch-dogs" to

- **Alert the Film and Publications board as well as the South African Broadcasting Co-operation (SABC) complaints committee about programmes that negatively influence the sexual behaviour of children and adolescents and contradict the sexual health promotion messages.**
- **Voice concerns of the community when business advertisements promote issues like promiscuous behaviour and inequality regarding gender issues.**

Another major concern highlighted in this study was the manner in which promotional messages are planned and implemented. Participants' concerns and suggestions relate to basic principles of the social marketing strategy. Therefore, these findings are presented as guidelines based on some core marketing concepts and principles.

Collaborative/multi-sectoral community task/action groups, involving the youth and experts in the field of social marketing should consider the following social marketing guidelines for sexual health promotion of the youth:

- **All planning and implementation should be "customer orientated", meaning that the planners should have research based information on the lifestyle and decision-making of the market they want to reach.**

- **Segment the market and choose a target market. The planners should plan and develop age appropriate strategies, considering lifestyle and decision-making, especially the "costs"/"price" involved for the target market to change behaviour.**

- **Plan the promotion strategy (product) for this target market, considering what message must be spread to whom, where, when and by what media.** Examples proposed are: information about the extent and severity of HIV/AIDS and STI's, persuasion messages to promote consistent condom use, messages to reinforce gender equality in relationships, assertiveness, sexual negotiation skills and self-confidence.

- **Plan and implement different elements of marketing communication in an integrated way to send and reinforce messages consistently**. The following examples are recommendations by participants:

  Publicity in papers, magazines on television and radio programmes of research findings on sexual behaviour and the incidences and tragedies of HIV/AIDS as well as relevant information pertaining to youth issues.

 **Publicity of positive sexual lifestyle of role models.**

Awareness and persuasion messages should be used in media like television, radio, outdoor and indoor posters that address:

- safer sex practices like condom use,
- equality and rights of women in relationships;
- substance abuse and sexual decision-making
- the effect of parents' life style and communication on the youth's behaviour
- the use of leisure activities to promote healthy lifestyles

Using one-to-one and peer group interactions in radio talks and in peer education to explore sexual life-style consequences and relationship issues.

Regarding the approach in the writing of the messages on condom use, participants were adamant that soft approaches do not work, and that emotional, scaring (shock tactics) realities for not using condoms, should be consistent and candidly conveyed.

Planners should also think of creative ways to break the image of condoms that reduce sexual pleasure.
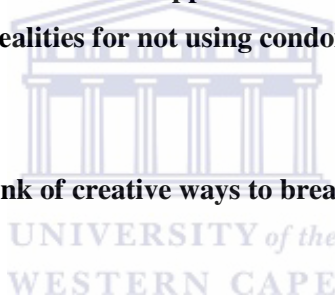
Determine well-structured decisions concerning place and times where the messages will be spread and services will be available.

Regarding services at clinics, a strong recommendation was that only people who are youth-friendly, supportive and respectful should be available in a confidential setting.

Evaluate when the life cycle of a message has run out and develop and plan new strategies.

Develop models of media advocacy and test them in diverse settings.
Test the effectiveness of broadcast (television, radio), print media (magazines, brochures, posters, newspapers) and the internet in their various settings such as churches, communities (rural and urban), educational institutions, local, regional and national government organisations. Relevant and consistent training on mass media strategies such as social marketing strategies for those individuals involved

with youths' sexual health programmes should be provided. These media representatives should be sensitised to issues concerning youth health and should incorporate gender, self-development, community, and a cultural perspective as proposed by PAHO (1998).

Sexual health promotion of the youth is not a haphazard way of spreading your own ideas of what should and what should not occur (Kotler et al., 2002). A basic requirement is that the youth should be involved in collaborative political and community action groups and that a marketing communications plan should be developed with expertise from this field.

7.3.4 The college/educational setting

This study's findings suggest that sexual decision-making in the life-stage of youth is preceded and continuously influenced by a developmental process in which social issues, structures and events on various levels interact with each other and influence the student's sexual decision-making. The previous guidelines and recommendations can be regarded as "external" but complementary to the internal promotional policies and strategies of the college setting. The educational institution should promote itself as a setting that endorses health and wellness of students on all levels (in terms of the NCV life skills programme that commenced in FET colleges in January, 2007). The college domain provides a setting for the interaction between the student, peers, parents, community, NGO's and religious organisations and educators.

The interrelatedness of the factors affecting safe/unsafe sexual practices on the various levels has direct implications for the college setting. Guidelines emerging from this study's findings are posited as follows:

The educational institution should ensure that they have policies in place that guarantee an ethos of positive living (as promoted in NCV life skills programme). Policies on HIV/AIDS and STI's, as prescribed by The National Policy on HIV and AIDS for learners and educators in public educational institutions and students and educators in Further and Higher Education and Training institutions, should be in place (1999).

The Department of Education should ensure that the curriculum content develops knowledge of HIV/AIDS and STI's and focuses on developing positive self-concept and self-efficacy. Although the colleges have a comprehensive programme for strengthening life skills, the **curriculum content should be enhanced to include a stronger emphasis on assisting students to develop a positive self-concept and introducing a strong focus on self-efficacy and sexual decision-making.**

The curriculum should also focus on the influence of drug and alcohol use on sexual behaviour. The education department should ensure that a variety of participatory teaching methods are used when teaching health promotion programmes such as small group discussions, games, simulations, role-playing, theatre, dramatizations and rehearsals (Schutt-Aine & Maddaleno, 2003).

Efficient, professional and youth friendly sexual health promotion services on campus should be implemented:

- **Sexual health promotion programmes should be integrated both formally and informally in and outside the educational institution to achieve maximum effect.**
- **Formal integration could take place through programmes being presented across the curriculum, across various subject areas through role-play, problem-solving techniques, group work, and peer education.**
- **Programmes could be integrated in an informal setting outside the educational institution through rallies, awareness marches, sports and recreation events, as well as music shows, plays and theatre.**

Social marketing principles should be implemented by using various communication media to target the audience through (promotion) plays, games, creative writing, songs, dance music concerts, the use of posters, pamphlets in and outside the college setting, local radio stations and considering the introduction of a college radio station that promotes safer sex.

Sexual health promotion messages aimed at college students should include:

- **Clear, catchy, concise and simple messages.**

- **Demonstrations and presentations by staff and guest speakers as well as talks by community and religious leaders or well-known celebrities should be a regular occurrence.**

- **Individuals who are affected or infected by AIDS should present their stories to students as guest speakers.**

- **The use of technologies such as the internet and e-learning could be implemented in educational institutions to further spread messages (on safer sexual practices, self-development, and dangers of drug and alcohol use, peer pressure, gender stereotyping and cultural diversity) in the college sector.**

Provide an all-inclusive package of services that includes counselling and student support services. Sexual and reproductive health services should include pregnancy testing, family planning, voluntary counselling, and testing for HIV/AIDS and STI's. Either these services could be college-based or college linked to **allow the amalgamation of education, health and social services systems and the community.** It is therefore essential to provide youth-friendly services in the educational setting as it is linked to safer sexual practices (Meyrick & Swann, 2001; UNFPA ,2003a: 41).

Programmes and services should be complemented and reinforced by peer education programmes. College students' ideas on sexual behaviour are influenced by peers (Bremridge, 2000; Lesch, 2000; & Goodwin et al., 2004). Peer education strategies train and use youth to educate and mentor other youth and is highly recommended on college level (Ferreira 2002).

Peer education, mentoring and peer counselling programmes should include:

- **Teaching students to feel positive about themselves and the choices that they make**

- **Encourage assertiveness** in countering negative peer influence especially concerning sexual negotiations and drug and alcohol use.

- **Skills in exercising options concerning sexual practices, sexual abstinence**, the consistent use of condoms, the reduction in the number of sexual partners

and being faithful as well as the influence of drug and alcohol use on risky sexual practices.

- **Strongly promote gender equity and gender sensitivity**.
- Should **include use of presentations, drama, skits, music and dance (productions), concerts** focusing on issues highlighted in this study such as safer sexual practices, drug and alcohol use, developing self-efficacy and self-concept.

The college council (or institutional heads) should ensure:

- **That competent individuals are appointed who are committed, empathetic and approachable when dealing with sexual issues.**
- **That the above individuals are properly trained to do life skills training.**

Long-term strategies should be developed **to support those involved in presenting programmes** (such as lecturers/teachers, peers, community members, religious leaders) through workshops, training, and networks to assist individuals in providing quality programmes.

Programmes should involve long-term commitment instead of sporadic involvement (Schutt-Aine & Maddaleno, 2003).

A team approach should be developed when planning and implementing programmes to promote youths' safer sexual practices.

- **College staff (in addition to lecturers, peers and student support personnel) should be involved in staff development programmes** that keep staff abreast with information on issues affecting the student population such as safer sexual practices, drug and alcohol abuse and voluntary counselling and testing.
- **Workshops involving all college staff and students should be implemented regularly** to encourage safer sexual practices.
- This **multi-disciplinary team should** also **interact with religious and community leaders as well as government, NGO's and local organisations**. Thus, links should be developed.

Forums should be established to encourage open debate.

- **These forums should comprise of staff, students, and the Department of Education.**
- **The following issues that affect sexual practices should be discussed at these forums: the provision of services, planning of sexual health promotion programmes for safer sexual practices and other programmes dealing with self-concept and self-efficacy, gender equity and drug- and- alcohol use in the college environment and the community.**

7.4   Summary

This study set out to explore the sexual behaviour of emerging adult college students in order to make recommendations for promoting sexual health. The findings clearly indicated that promoting sexual health of late adolescents and emerging adults is a developmental process that cannot be seen in isolation of the political, social, educational, structures and family influences. Therefore, guidelines emerging from the findings of this study were presented that implied that the promotion and reinforcing of responsible sexual practices for youth is dependent on these inter-related factors.

CHAPTER 8
LIMITATIONS AND CONCLUSION

8.1   Introduction

The key findings of the study were highlighted, summarised and used to formulate guidelines/recommendations in the previous chapter.   In this final chapter the limitations of the study are highlighted.

8.2   Limitations of this research

This study has certain limitations.   These limitations will be discussed in terms of the factors below.

8.2.1   Use of colleagues

Given the logistics in the administration of the study's questionnaire, the researcher had to make use of colleagues in the administration of the questionnaires at the various campuses.   This situation could have contributed to the large number of non-response (invalid) questionnaires received.   However, this outcome is not unique to this study. Research indicates that in large scale sexuality surveys it is frequently found that between 30% and 40% of individuals selected for the sample are not successfully recruited and published studies reporting participation rates of less than 50% are not uncommon (Wiederman & Whitley, 2002:105).

8.2.2   Self-report measures

Self-report measures were used in this study. Both the reliability and validity of self-report measures in the study of health-related behaviour and particularly sexual behaviour studies are questionable.   However, self-report measures remain the most popular measuring instrument in behavioural studies (Catania, Gibson, Chitwood & Coates, 1990b).   Since sexual behaviour is private and cannot be easily measured or verified, social scientists are dependent upon individuals' self reports of their sexual behaviour.   These respondents are inclined to under-or-over-estimate how often they engage in sexual activity because the survey items are not adequately understood.

Individuals' interpretation of survey terms can thus influence responses. Therefore, sex research generally, is in need of a solid validity index of self-reported sexual behaviour (Bogart, Cecil, Wagstaff, Pinkerton & Abrahamson, 2000:108). Currently there is insufficient data to establish which techniques minimise measurement error for a given sub-population. Thus, as with other sex research, the extent of over or under reporting in this study, cannot be established without an accurate validity index (Lesch, 2000: 69).

Though survey research and self-report measures, such as the questionnaire used in this research, are exposed to questions concerning measurement error and participation bias, the general result is that both the validity and reliability of self-report questionnaires can be considered acceptable, if the questionnaire is carefully designed and administered (Kraft et al, 1999). As previously discussed (Chapter 3), the researcher implemented steps in both the design phase and during the administration of the questionnaire to address these issues. The instruments used were also found to be reliable/ valid. However, results should still be interpreted with due consideration of the methodological issues.
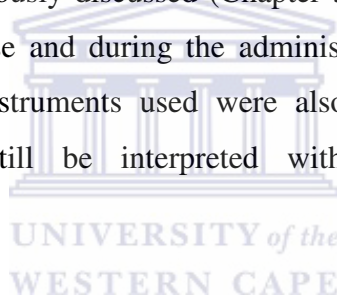
8.2.3   Memory / Recall error

The researcher concedes that memory /recall error could have influenced the results of this study. With reference to vividness and personal salience, a great deal of an individual's sexual experience may become hazy with time. The personal salience of a sexual encounter could have a profound influence on the recall of sexual experiences and the salience of any specific encounter may diminish significantly when the intricacy of those encounters increases. This means that an individual may have more difficulty in the recall of specific acts if the individual has many sexual partners and varied sexual behaviour repertoire. (Catania et al.,1990b; & Dockrel & Joffe, in Lesch, 2000: 71-72).

In this study, the questionnaire focused on issues such as knowledge of HIV/AIDS as well as information regarding sexual behaviour that participants had experienced. This information was requested and therefore the possibility of recall error due to time- lapse factors was possible. The researcher, however, continuously reassured the participants that the questionnaire was confidential. This was done to address issues of

embarrassment, self-presentation bias and fear of exposure. This therefore ensured the anonymity of participant responses and hopefully, increased the accuracy of responses.

8.2.4   Research questionnaire (instrument) used in the South African context

The researcher acknowledges that the use of South African developed instruments in this study would have been the ideal. However, given the parameters of this study, the researcher found no appropriate South African instruments that would adequately cover the issues being researched in this study.   Kaaya et al. (2002), underscore the need to develop standardised core instruments for South African use that would allow for some flexibility for the cultural variations and context.   Developing standardised measures on HIV-related issues (e.g. knowledge, attitudes and behaviours) within the South African context will allow for comparison that is more scientific across different research areas.

8.2.5 Participation bias

 The researcher acknowledges that participation bias could have influenced the results of this study. Participation bias refers to   the various motivations for participating in a study. Participation bias may pose a problem in the study of sexual behaviour, as participants are always recruited on a volunteer basis because of ethical reasons. Thus, their real intentions are not always known. Participants may volunteer for help-seeking reasons because they may be experiencing sexual or emotional difficulties. Alternatively, those who are experiencing problems may deliberately avoid participation as the questionnaire may be considered a threat (Catania et al, 1990b). In this study, participation may have been influenced by a degree of curiosity, given the nature of the topic. Students may have also volunteered participation as a means of getting away from the routine of attending regular classes. However, at all the campuses where the questionnaire was administered, students expressed an interest in and appreciation for the nature, purpose and relevance of the research.

8.2.6   Self- presentation bias

Self-presentation bias is the display of underlying values that a culture or specific sub-cultures place on disclosing sexual experiences to others. Therefore, individuals may

have had a desire to present themselves to others in a positive manner. Self-presentation bias may lead to over or under reporting of a particular sexual behaviour, depending on whether that behaviour has a positive or negative social value. There is no clarity on the influence of self-presentation concerning self-reports of specific sexual activities across sex, age, sexual orientation and cultural sub-groups at risk for AIDS. It has not been established which behaviour is most sensitive to presentation bias. However, it has been found that heterosexual women had no problem reporting participation in vaginal intercourse but were hesitant to admit to anal intercourse in personal interviews. Heterosexual participants were also more inclined to refuse to answer questions concerning masturbation than those items concerning coitus. It also seems that ethnic differences and sexual orientation may influence sexual disclosure. However, the exact nature of this influence has not yet been established (Catania et al. 1990b; Dockrel & Joffe in Lesch, 2000).

8.2.7 Motivation

As indicated in the onset of this chapter, the researcher acknowledges that a large number of non-response (invalid) questionnaires were received. Catania et al. (1990b) assert that an individual's degree of motivation to perform the role of participant may be an important source of measurement of error. Highly motivated respondents may attempt to understand and answer questions whereas less motivated participants may skip items or give fewer and less thorough answers. It is not known if the relevant motives can be modified to obtain the most favourable conditions for collecting sexual information. No clarity exists if factors such as financial compensation for study participation, length of questionnaire completion, and order of questions, reduce or increase error measurement. These have not been explored in an area of research that is inclined to elicit the extremes of respondent motivation (Catania et al., 1990b). In this study, the researcher attempted to improve respondents' motivation by clearly explaining the objectives of the research and informing participants of the significance of their contribution in affecting change in future generations' sexual practices.

With regard to the motivation to participate in this study, cognisance has to be taken that participation was voluntary. All participants were informed of the significance of

the research. They were also informed that their contribution would assist researchers in attempting to understand adolescent/youth sexual behaviour and that their contribution would be invaluable, as it would assist in the formulation of future interventions. This served as possible motivation for participants to provide accurate responses and to adopt a sincere approach to the questionnaire.

Thus, the role that the above participant variables have played in the current study has not been established. For this reason, the research also contained a qualitative component.

8.3 Conclusion

The combined method of quantitative and qualitative research was found to be most effective, and the qualitative exploration provided depth to this study which would not have been possible by doing a comprehensive quantitative study only. Any limitations that might have presented regarding the quantitative survey were counteracted by the overwhelming responses and in-depth sharing of experiences in the focus groups.

This study contributed to the body of knowledge pertaining to sexual health practices amongst youth particularly emerging adults in the college setting. It is anticipated that the findings of this study could influence those individuals involved in health promotion amongst young people in various settings to use ethical, creative and persuasive methods that have a holistic focus. In this manner, promotion campaigns could incorporate as many factors and role-players when appropriate, so that sexual health promotion is placed within the larger context of general health promotion. Furthermore, the study could influence the evaluation and planning of health care policy which in turn would develop health care decision-making that influences the provision of services for improving the quality of life of youth and communities in South Africa.

In conclusion, it is recommended that in the era of the HIV/AIDS pandemic, that comprehensive team-based research be undertaken to investigate the complexity of sexual decision-making amongst young people.

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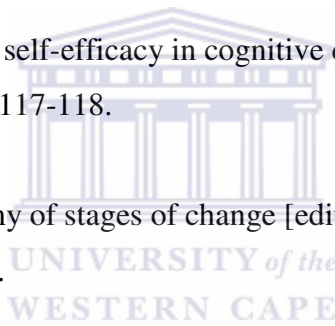
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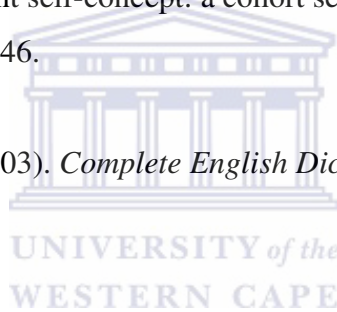
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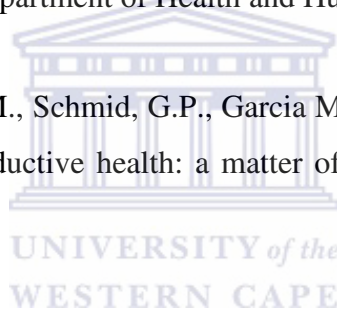
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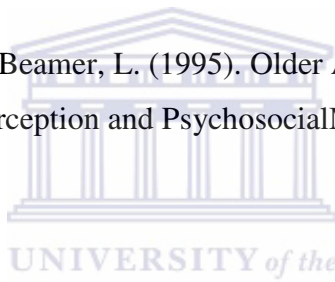
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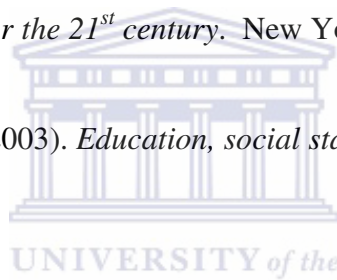
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FURTHER EDUCATION AND TRAINING (FET):
INFORMED CONSENT FORM: FOCUS GROUP

Title of the research project: **HIV/AIDS-related knowledge, attitudes and behaviour of FET college students: implications for sexual health promotion**.

Principal Researcher: **Colleen Gail Moodley**

Contact telephone no: **0823472700**

As an adult learner, I, the undersigned hereby acknowledge the following:

1. The researcher/research assistant has explained to me that the purpose of this focus group discussion/ questionnaire is to generate ideas on how sexual health promotion should be implemented within the FET sector. Assurance was therefore given that confidential matters pertaining to me would not be on the agenda for discussion, unless I choose to do so.

2. I understand the possible benefits of this research.

3. I may use a nick-name in the focus groups if I do not wish to be identified, but I accept that confidentiality cannot be assured within focus group discussions.

4. I understand that the goal of the focus group/questionnaire is to explore the group's views on the topic and individuals in the group will not be named in the report.

5. I understand that the information will only be used for research purposes.

6. I agree to voluntary participate in this research and can at any time withdraw from the discussion should I wish to.

I hereby consent voluntarily to participate in this research

Signed……………………………………………………….on………………………
……………..at…………………
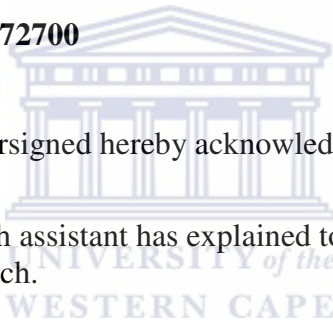
ADDENDUM B

FURTHER EDUCATION AND TRAINING (FET):
INFORMED CONSENT FORM: QUESTIONNAIRE

Title of the research project: **HIV/AIDS-related knowledge, attitudes and behaviour of FET college students: implications for sexual health promotion**.

Principal Researcher: Colleen Gail Moodley

Contact telephone no: 0823472700

As an adult learner, I, the undersigned hereby acknowledge the following:

1. The researcher /research assistant has explained to me the purpose and procedure of this research.

2. I understand the possible benefits of this research.

3. The instructions are clear to me.

4. I understand that the information will only be used for research purposes.

5 Anonymity is ensured in that I will complete the questionnaire without furnishing my name and that the questionnaire is posted in a sealed "post-box".

6 I agree to voluntary participate in this research, by completing the form.

7 I can withdraw from the research at any time should I wish to, and will then return the partially completed form.

I hereby consent voluntarily to participate in this research

Signed………………………
…………………………………….on……………………………………..at……………
………………………………….

ADDENDUM C

FURTHER EDUCATION AND TRAINING (FET):
FOCUS GROUP INTERVIEW SCHEDULE

AIM OF THE STUDY

THE PURPOSE OF THIS FOCUS GROUP INTERVIEW IS TO GAIN A BETTER UNDERSTANDING OF THE FACTORS THAT PLAY A ROLE IN THE SEXUAL KNOWLEDGE, ATTITUDES AND BEHAVIOURS OF YOUTH BY EXPLORING:

- PARTICIPANTS' PERCEPTIONS AND/OR EXPERIENCES OF DECISION-MAKING IN RELATION TO THEIR ENGAGEMENT IN SAFE OR UNSAFE SEXUAL PRACTICES AND TO

- EXPLORE PARTICIPANTS' VIEWS ON AND THEIR EXPERIENCES OF SEXUAL HEALTH PROMOTION.

IT IS HOPED THAT THIS INFORMATION WOULD BETTER INFORM POLICY MAKERS AND RELEVANT INSTITUTIONS ON HOW TO PROMOTE HEALTHIER LIFESTYLES AMONGST YOUNG PEOPLE AND TO PROVIDE THE RELEVANT SUPPORT SERVICES.

INSTRUCTIONS TO RESEARCH PARTICIPANTS

➤ Thank you for consenting to participate in this research.

➤ Please be assured that the information you share will be treated with the strictest **CONFIDENTIALITY.** This information will be used for research purposes only.

➤ TO ENSURE ANONYMITY NO NAMES WILL BE FURNISHED.

➤ Please give an **honest** account of the information that is needed for the purposes of the research.

The following core open-ended questions will be verbally posed to all groups to facilitate free flowing responses:

Question 1

What are your views on factors that influence youths' decisions to engage or not engage in sexual risk behaviour that is detrimental to sexual health?

(Sexual risk will be explained as engaging in sex without a condom and having multiple partners.) Probing questions will be asked to explore decisions to use or not use condoms.

Question 2

What are your experiences concerning the promotion of safe sex and sexual health to South African youth?
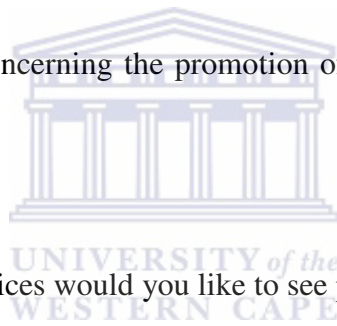
Question 3

What health facilities and services would you like to see provided to students on FET campuses?

ADDENDUM D

FURTHER EDUCATION AND TRAINING (FET):
GUIDELINES FOR CONDUCTING RESEARCH

Dear Colleague

Thank you for your willingness to assist me with this research. Please emphasise the following points when administering the questionnaire:

- **ONLY** students who are aged **18-24 years** may complete the questionnaire

- The questionnaire **must be completed under examination conditions**. Participants may not discuss or view one another's responses.

- **Please read the instructions to participants on page 1** and emphasise that participants must read the instruction to each question carefully.

- As administrators, **you may clarify any questions raised by the participants** at any time during the completion of the questionnaire.

- Please **return all questionnaires promptly in a sealed container including the unused ones.**

Thanking you once more for your willingness to assist

C.G.MOODLEY

ADDENDUM E

<div style="border:1px solid black; text-align:center;">

FURTHER EDUCATION AND TRAINING (FET) SEXUAL HEALTH QUESTIONNAIRE

</div>

AIM OF THE STUDY

THE PURPOSE OF THIS SURVEY IS TO GAIN A BETTER UNDERSTANDING OF THE FACTORS THAT PLAY A ROLE IN THE SEXUAL KNOWEDGE, ATTITUDES AND BEHAVIOURS OF YOUTH. IT IS HOPED THAT THIS INFORMATION WOULD BETTER INFORM POLICY MAKERS AND RELEVANT INSTITUTIONS ON HOW TO PROMOTE HEALTHIER LIFESTYLES AMONGST YOUNG PEOPLE AND TO PROVIDE THE RELEVANT SUPPORT SERVICES.

INSTRUCTIONS TO RESEARCH PARTICIPANTS

➢ **Thank you for consenting to participate in this research.**

➢ **Please be assured that the information you share will be treated with the strictest CONFIDENTIALITY. This information will be used for research purposes only.**

➢ **TO ENSURE ANONYMITY YOU MUST NOT FURNISH YOUR NAME.**

➢ **Please give a honest account of the information that is needed for the purposes of the research.**

COMPLETION OF THE QUESTIONNAIRE

➢ **PLEASE ANSWER THE QUESTIONS BELOW BY CIRCLING OR TICKING OR CROSSING THE ANSWER OF YOUR CHOICE IN THE RELEVANT SPACE.**
➢ **IN SOME QUESTIONS YOU NEED TO TICK MORE THAN ONE SPACE PER QUESTION.**
➢ **IT IS THEREFORE IMPORTANT THAT YOU READ THE INSTRUCTION TO EACH QUESTION VERY CAREFULLY.**
➢ **DOTTED LINES MEAN THAT YOU NEED TO WRITE YOUR OWN RESPONSE.**

SECTION 1: GENERAL INFORMATION

1.1   What is your gender/ sex?

Male	1
Female	2

1.2 What is your age in years?

1.3 Which population group do you belong to? (FOR STATISTICAL PURPOSES ONLY)

South African Asian	1
South African Black	2
South African Coloured	3
South African Indian	4
South African White	5
Foreigner - Asian	6
Foreigner – Black	7
Other	8

1.4   What is your marital status **at present**?

Unmarried/ single in no relationship	1
Unmarried but in a relationship with 1 partner	2
Unmarried but in a relationship with more than 1 partner	3
Married with one partner viz. husband or wife	4
Married with more than one partner viz. husband or wife	5
Divorced/separated	6
Widowed	7

1.5
SECTION 2: SEXUAL PRACTICES

2.1.(a) Do you make use of any contraceptive/ safe sex/ family planning methods?

Yes	1
No	2

(b) If YES/, what methods do you use?

…………………………………………………………………………………………

…………………………………………………………………………………………

…………………………………………………………………………………………

………………………………………………………………………..

2. 2   How many sexual partners have you had in the past 12 months?

None	1
One	2
Two	3
Three	4
Four	5
Five or more	6

SECTION 3: AIDS AND HIV KNOWLEDGE

PLEASE TICK <u>ONE</u> OPTION ONLY <u>FOR EACH</u> OF THE FOLLOWING STATEMENTS.

		DEFINITE LY TRUE	TRUE	FALSE	DEFINITE LY FALSE
3.1	Coughing and sneezing DO NOT spread HIV.				
3.2	Using Vaseline or baby oil with condoms lowers the chance of getting HIV				
3.3	You can get HIV/AIDS by sharing a glass of water with someone who has AIDS.				
3.4	Pulling out the penis before the man ejaculates (cums) prevents a woman from getting HIV during sex.				
3.5	A woman can get HIV if she has anal sex with a man.				
3.6	All pregnant women infected with HIV will have babies born with AIDS.				
3.7	Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.				
3.8	People who have been infected with HIV quickly show serious signs of being infected.				

3.9	A healthy looking person can be infected with HIV, the virus that causes AIDS.				
3.10	There is a vaccine that can stop adults from getting HIV.				
3.11	People are likely to get HIV by deep kissing, putting their tongue in their partner's mouth, if their partner has HIV/AIDS.				
3.12	There is a female condom that can help decrease a woman's chance of getting HIV.				
3.13	A person will not get HIV if she or he is taking antibiotics.				
3.14	Taking a test for HIV a week after having sex will tell if a person has HIV.				
3.15	A person can get HIV by sitting in a hot tub or swimming pool with a person who has HIV.				
3.16	One can get HIV through witchcraft.				
3.17	Having sex with a virgin can cure HIV/AIDS.				
3.18	One could get HIV from oral sex (kissing the male or female genitals).				

SECTION 4: SELF -EFFICACY

Imagine that these situations were to happen to you**. Indicate how you would react,**

USING THE 4 POINT SCALE BELOW. CHOOSE ONLY <u>ONE</u> answer in <u>each</u> of

the tables below.

4.1 Imagine that you met someone at a party. He/She wants to have sex with you. Even though you are very attracted to each other, you're not ready to have sex. How sure are you that you could keep from having sex?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.2 Imagine that you are in a romantic relationship, but you have not had sex yet. Your boyfriend/girlfriend really wants to have sex. Still, you don't feel ready**. How sure are you** that you could keep from having sex <u>until you feel ready</u>?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.3 Imagine that you and your boyfriend/girlfriend decide to have sex, <u>but he/she does not want to use a condom</u>. <u>You do not want to have sex without a condom</u>. **How sure are** you that you could keep from having sex, until your partner agrees to use a condom?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.4   Imagine that you and your boyfriend/girlfriend have been having sex without condoms previously. Now you decide that you want to start using condoms when you have sex. **How sure are you <u>that you could tell your partner about your decision</u>?**

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.5 Imagine that you are having sex with someone you have just met. You feel it is important to use condoms. **How sure are you** that you could tell the person that you want to use condoms?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.6 Imagine that you use birth control pills to prevent pregnancy. You want to use condoms to keep from getting a STD/STI or HIV. **How sure are you** that you could convince your partner that you also need to use condoms?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.7 How sure are you that you could use a condom correctly or explain to your partner how to use a condom correctly?

| Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.8   If you need to use a condom, and none are freely available, how sure are you that you have the courage to go to the pharmacy/shop to buy one?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

4.9   If you decide to have sex, how sure are you that you would have a condom available?

Absolutely/totally Sure	1
Sure	2
Unsure	3
Absolutely/totally Unsure	4

SECTION 5: SELF-CONCEPT
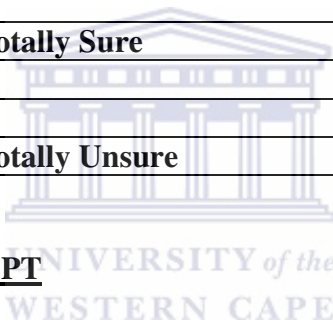
The next questions ask about **how you see yourself and your feelings or thoughts about how others see you. (Self–concept).** Please indicate whether you agree or disagree with each of the following statements?

		ALWAYS	MOST OF THE TIME	SELDOM	NEVER
5.1	In general, people like and value what you do.				
5.2	You are well accepted and regarded by your relatives.				
5.3	You are inclined to feel that you are a failure.				
5.4	Your family respects you and values your advice.				
5.5	Your friends are aware of your past accomplishments and appreciate you for them.				
5.6	Your friends value you as a person.				
5.7	You have failed in your family's goals and expectations of you.				
5.8	You take a positive attitude toward yourself.				

THANK YOU!

ADDENDUM F   **WESTERN CAPE EDUCATION DEPARTMENT LETTER OF CONSENT TO CONDUCT RESEARCH AT THE FET COLLEGE**

Dear Mrs C. Moodley

RESEARCH PROPOSAL: HIV/AIDS-RELATED KNOWLEDGE, ATTITUDES AND BEHAVIOUR OF FET COLLEGE STUDENTS: IMPLICATIONS FOR SEXUAL HEALTH   PROMOTION.

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **19ᵗʰ July 2005 to 24ᵗʰ March 2006.**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December 2005).
7. Should you wish to extend the period of your survey, please contact Dr R. Cornelissen at the contact numbers above quoting the reference number.
8. A photocopy of this letter is submitted to the Principal where the intended research is to be conducted.
9. Your research will be limited to the following College: **College of Cape Town**.
10. A brief summary of the content, findings and recommendations is provided to the Director: Education Research.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:
    > **The Director: Education Research**
    > **Western Cape Education Department**
    > **Private Bag X9114**
    > **CAPE TOWN**
    > **8000**

We wish you success in your research.

Kind regards.

Signed: Ronald S. Cornelissen
for: **HEAD: EDUCATION**
DATE: 19ᵗʰ July 2005