THE INFLUENCE OF FAMILY DYNAMICS ON ADOLESCENTS' DEVIANT AND SEXUAL RISK BEHAVIOUR IN A MIGRATION AFFECTED COMMUNITY IN SOUTH AFRICA: AN EVIDENCE FOR PUBLIC HEALTH INTERVENTION.

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DECLARATION

I, F.C ANYANWU, hereby declare that this thesis submitted to the University of Venda for the degree of Doctor of Philosophy in Public Health has not been previously submitted for a degree at this University or any other institution. This is an original work, the materials used in the course of preparing this thesis have all been acknowledged by way of referencing.

Student …… Date……

ABSTRACT

The well-being of adolescents' population is a major concern to policy makers, educators and researchers all over the world. Research has shown that adolescents engage in deviant and risky sexual behaviour, and such behaviour may have consequences for their present or future health. Likewise, it has been shown that adolescents are also known to conform to societal norms if they are given proper guidance. In the light of this, the present study proposed to explore and explain the influence of family dynamics in the occurrence of adolescents deviant and sexual risk behaviour.

This study involved a sequential explorative, descriptive and analytic mixed method design, combining both qualitative and quantitative research approaches. The study was divided into three (3) phases. Phase 1 was purely qualitative in nature, where a total of 10 parents and 13 adolescents were engaged in an in-depth interview. Phase 2 was quantitative in nature, using a cross-sectional analytic design involving 388 adolescents, while Phase 3 was the development of a public health intervention to mitigate the influence of family dynamics on adolescent deviant and sexual risk behaviour. The qualitative data were analysed using thematic content analysis, while the quantitative data were analysed using the Statistical Package for Social Sciences (SPSS) version 22. The Chi-square test, Fisher's exact test, multinomial and binary logistic regression were used to compare differences between the dependent and independent variables. The level of statistical difference was set at $p<0.05$.

Couple conflicts was a common finding in the study. In addition, many families suffered severe financial constraints and some parents were disconnected from their children physically, emotionally and financially (particularly the fathers). Adolescents claim that the age difference between them and their parents remains a barrier to communication, in addition, some participants claimed that they received little or no sex education from their parents. The present study found a high level of recent physical violence (30%), alcohol (52.9%) and drug use (10%) among participants. The level of sexual activity in this study was high, with 60.1% of the participants being sexually active and 23.1% having been pregnant. In addition, only 35.6% using condoms regularly. There was gender difference among participants on the following variables: cigarette smoking, teenage pregnancy and having multiple sexual partners. Furthermore, participants differed significantly across age group on the following variables: cigarette smoking, sexual activity, having friends who are sexually active, reported pregnancy and currently having

a relationship. However, 'relationship with mother' was the family dynamic variable that recorded a wider effect on deviant and sexual risk behaviour. Furthermore, age, duration of stay in the community, living with siblings, relationship with mother, having enough money at home, being supported emotionally at home and parental love for each other, were predictors of deviant and sexual risk behaviour in the present study. There was also low level of risk perception and low level of skill for self-protection among the participants. As part of the objectives of the present study, the study findings were used to develop an evidence-based public health programme targeted at vulnerable adolescents and adolescents at high risk for deviant and sexual risk behaviour. It is hoped that this programme will be able to empower parents and caregivers to apply better parenting practices to forestall undue exposure of adolescents to factors that contribute to deviant and sexual risk behaviour.

The present study demonstrated that although adolescents have the propensity for deviant behaviours, many may transit to adulthood without much adverse sequelae even in the face of harsh family social and economic adversities. However, a proportion of the adolescent population in this community remains vulnerable due to the effects of family de-structuring, poverty and unemployment.

Keywords; Adolescents, deviant and sexual risk behaviour, family dynamics, migration affected community

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DEDICATION

I dedicate this work to my family and the almighty God

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List of abbreviations

AACAP	American Academy of Child and Adolescent Psychiatry
APA	American Psychology Association
ART	Antiretroviral Therapy
	Canadian Ministry of Health Promotion
CDC	Center for Disease Control
CHH	Child Headed Households
CINAHL	Cumulative index to nursing and allied health literature
CJCP	Centre for Justice and Crime Prevention
CSG	Child Support Grant
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
IOM	International Organization for Migration
MCT	Michigan Department of Education
NYP	National Youth Policy
NGOs	Non-Governmental Organizations
SCT	Social Cognitive Theory
SES	Socio-Economic Status
SPSS	Statistical Package for Social Sciences
Stat SA	Statatistics South Africa
STI	Sexually Transmitted Infection
SAASA	South African Social Security Agency
SAPS	South African Police Service
TPB	Theory of Planned Behaviour
USA	United States of America

UNSD	United Nation Statistics Division
UK	United Kingdom
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.5 Study background

Adolescents are often referred to as the leaders of tomorrow. Therefore, it suffices to say that the well-being of an adolescent population is vital for the progress of society. However, studies have shown that adolescents engage in deviant and risky sexual behaviour, and such behaviour may have consequences on their present or future health (WHO, 2014). Although adolescents are known to take risks, they are also known to conform to societal norms if they are given proper guidance (Estrada-Martınez, Padilla, Caldwell & Schulz, 2011), in the light of this, the family as a social unit is primarily charged with the responsibility to provide the needed guidance for these individuals. However, in the modern society, the traditional family structure is under economic and socio-cultural pressure and this has led to changes in family structure and composition. In some instances, the family is separated along geographical divides due to migration of breadwinners to more economically advanced cities in search of better paying jobs (Safta, Stan, Lurea & Suditu, 2014). The resulting family separation, its family de-structuring consequences and reversal of gender role, all result in lack of proper monitoring, guidance and supervision for the adolescents (Safta et al., 2014).

According to the World Health Organization (WHO, 2010), adolescence is a period when an individual transits from childhood to adulthood. By the WHO definition, it includes individuals between 10 and 19 years old. This period is characterized by rapid growth and development which is driven by biological processes, including the onset of puberty and the resulting sexual development (WHO, 2014). Changes relating to brain development and puberty ultimately result in new behaviours that define individuals in this age bracket, and these changes may come to bear on their outlook towards health and wellness (Viner et al., 2012). During this phase of development, young people acquire the necessary skills to lead a meaningful adult life and strive to gain social and economic independence and create their own identity. In their quest for achievements, they make lifestyle choices or engage in behaviours that affect their health. Some of the health and safety issues linked to adolescents include but are not limited to risky sexual behaviours, substance use, car accidents and violence (WHO, 2014). Although these health and safety issues are worth investigating, the present study focuses on adolescents' deviant and sexual risk behaviour because of its far reaching consequences on the society as a whole.

1.6 Understanding the concept of adolescence

The term adolescence literally means “to grow up” (Lerner & Steinberg, 2009). It is a period for growing up biologically, psychologically, socially and economically (Steinberg, 2013). The term “adolescence” was unpopular until the late 19th century. According to the Response Ability Initiative (RAI, 2015), before this era, only 2 (two) life stages were recognized, childhood and adulthood. Although, between the 16th and 17th century, researchers recognized a stage in life that is different from childhood and adulthood but they failed to properly characterize this developmental stage, this may be attributed to the simplistic nature of the social organization of the people at that time (Jaffe, 1998; RAI, 2015). However, in the late 19th century, organized and progressive efforts were made towards presenting adolescence as a crucial stage of life (Lerner & Steinberg, 2009; RAI, 2015).

It is noteworthy that some researchers argue that the concept of adolescence may have been invented by the dictates of the Western World, based on their level of technological development, which has inadvertently extended the period of dependence of young people on their parents vis-à-vis longer years in school. This is in contrast with practices in some parts of the developing world, where the culture recognizes only childhood and adulthood. In these cultures, children transform to adults after undergoing some rituals (what is known as rites of passage). During this stage, they can be betrothed or even married and assume adult responsibility (Kyalo, 2013). This practice presents a pitfall to the concept of adolescence. However, it can be argued that with increase globalization and the increased desire for technological advancement, as well as the increased need for higher education in the developing world, young people may be encouraged to delay the time of marriage and acquire more education in order to maximize their potential (Population Council, 2014).

Furthermore, there is no clear cut definition for the term adolescence. Some authors argue that the period of adolescence extends from 10 years up to 24 years of age in some societies because of the features of adolescence that persist in some individuals until early adulthood (Steinberg, 2013). This is against the backdrop of the WHO’s (2010) definition that group individuals aged 10 years to 19 years as adolescents, while those aged 20 years to 24 years are considered to be young adults. Furthermore, the term teenager is also loosely defined among researchers to refer to individuals aged 13-19 years old (UNICEF, 2008; Walrond, 2012) while the Center for Disease

Control (CDC, 2015) consider those aged 12-14 years as early teens and those aged 15-17 years as teenagers. Due to the differing arguments, the present study will adopt the WHO definition.

Towards late adolescence, certain privileges and rights are enjoyed by these young people. Some of these include change in political status, economic status, interpersonal status and legal status (Steinberg, 2013). However, with these privileges and rights, adolescents are expected to take responsibility and show accountability in exercising these rights and privileges, what Steinberg (2013) refers to as double shift in social status. In reality, most adolescents obey societal norms, rules and regulations but some are often caught up on the wrong side of the law. This has been attributed to adolescents' poor decision making when it comes to crime (Fagan, 2005). New science reliably show that adolescents think and behave differently from adults, and that the deficits in judgment and reasoning by teenagers are the result of biological immaturity in brain development. The adolescent's brain is immature in precisely the areas that regulate the behaviours that typify adolescents who break the law (Fagan, 2005).

1.6.1 Understanding adolescents' behaviour

1.2.1.1 Fundamental transitions associated with adolescence

According to Steinberg (2013), certain distinct transitions occur during adolescence. These changes can be found in all cultures and in every society. They include biological, cognitive and social transitions. These transitions provide an explanation of the peculiarity of adolescent behaviour.

1.2.1.2 Biological transition

The onset of puberty marks the beginning of adolescence, this process initiates the transformation of a child into an adult (Stang & Story, 2005). Interestingly, there seems to be no consensus on a marker for the end of adolescence. Some authors have suggested that the cessation of bone growth marks the end of puberty (Bahadur & Hindmarsh, 2000). However, this argument is flawed significantly because adolescence could be defined not only by the use of biological markers but by a mixture of physical, psychological, social, and mental measures and this may differ among individuals (Bahadur & Hindmarsh, 2000).

According to Shroff and Ricciardelli (2012), puberty is the complex sequence of biological and physiological changes that an individual undergoes in order to become a sexually mature adult, with the capability of reproducing and being able to perform physical activities required during adulthood. This sequence is consistent among adolescents. However, there are differences in the age of onset and duration between individuals (Stang & Story, 2005; Shroff & Ricciardelli, 2012). This is influenced by social and environmental factors (Steinberg, 2013). The resulting physical and sexual maturation influences adolescent self-perception and the way adolescents are viewed by others (Vartanian, 2000). Furthermore, pubertal maturation is a marker for initiation for the “rites of passage” that heralds the beginning of adulthood in some societies (Steinberg, 2013).

1.2.1.3 Cognitive Transition

Cognition is a word used to express how people think and their ability to critically analyse problems in other to find solutions (Steinberg, 2013). During adolescence, there is a remarkable development of cognitive function. According to WHO (2014), at the beginning of the second decade, adolescents begin to show more flexible reasoning and display problem-solving strategies away from the rigid way of thinking seen in younger children. Also, adolescents are able to give a deeper meaning to what they observe (Steinberg, 2013).

Social cognition is the term used to refer to thinking about social issues, including thinking about people and relationships. The part of the brain responsible for this is called the social brain. From this part of the brain, it is possible to recognize other people and their intentions, desires, beliefs, feelings and actions (Frith & Frith, 2007). Furthermore, studies have shown that the brain undergoes remodelling during adolescence and the structural development that occurs in the cortical regions of the brain may influence cognitive functioning during adolescence. It has also been shown that the development of cognitive skills that enables the control and coordination of thoughts and behaviour continues to mature during adolescence, while the environmental and biological changes occurring during adolescence lead to new social encounters and heightened awareness and interest in other people (Choudhury, Blakemore & Charman, 2006).

1.2.1.4 Social transition

Adolescents are not considered mature to handle adult responsibilities until they have attained social maturity. The society, family, friends and schools play an important role in socializing the adolescent, giving them a sense of belonging and arousing in them the desire to develop self-identity and assume new roles in their families and the society (Steinberg, 2013). As children transit towards adulthood, there is a gradual but consistent move towards independence from authority figures, resulting in increased involvement with their peers and increased interest in other people's opinions on them (Vartanian, 2000). As the need for independence increases, their primary social support may shift away from their families to their peers (Oswalt, 2015).

Adolescent social development involves a change in the quantity and quality of social relationships, expanding their network of friends and developing intimate relationships (Vartanian, 2000; Oswalt, 2015). Furthermore, adolescents may modify their lifestyle in order to fit in and gain acceptance among their peers. When they do this, they are responding to peer pressure which may result in negative or positive outcomes (Oswalt, 2015). It has been shown that allegiance to peers may have untoward health implications for adolescents who do not have the will to resist pressure to conform to the lifestyle of their friends (Steinberg, 2013).

Change in the social status and roles are common among adolescents across cultures. The way adolescents see themselves and the way the society sees them become important, their social relationship with their siblings, parents and peers also changes. The process of social transition is more pronounced in traditional cultures rather than contemporary societies, where there is no organized ceremony marking the passage from adolescence to adulthood (Steinberg, 2013). In traditional cultures, this is often marked by a ceremony with active participation of elders in the community. During this ceremony, adolescents are tutored on how to become responsible members of the society and how to go about their new roles as adult members of the society (Kyalo, 2013). This social change is less celebrated in some cultures. However, there are elements of social transition such as age of marriage, driving, drinking alcohol and age to own a property (Steinberg, 2013).

1.7 Adolescents and stereotypes

The social context within which adolescents live is constantly changing. As a result, young people constantly try to adjust, adapt and respond to these changes around them. They try to understand and interpret the world around them by testing boundaries (Clark, 2002). The challenges faced by each generation of adolescents is however different from that of the generation before them. The difference in behaviour that results from trying to adjust to the evolving social environment and the resulting lifestyle changes and values is often labelled bad behaviour (Clark, 2002). This is often generalized to include all adolescents. However, studies have shown that most adolescents undergo a smooth transition to adulthood, taking initiatives to live a healthy lifestyle (Clark, 2002). Some authors have argued that undue generalization (stereotyping) may actually have negative effects on the adolescents. According to a publication by the Wake Forest University (WFU, 2009), if such ideas are continuously reinforced either by the media or adults within the society, adolescents may begin to believe that they are expected to act in a similar manner (WFU, 2009). Some authors believe that the positive attributes of adolescents should be used to promote good behaviour. For example, some peers are involved in activities that promote health and the youth should be encouraged to affiliate with groups that have positive influence on their health as an alternative to the negative influence of bad association, which has been well documented to produce negative outcomes (Clark, 2002; WFU, 2009).

There is no doubt that some adolescents have a positive behaviour towards healthy lifestyle. However, there is overwhelming evidence that adolescents take risks that may affect their health (WHO, 2014). The American Academy of Child and Adolescent Psychiatry (AACAP, 2011) have provided biological explanation for adolescents' poor decision- making and risk behaviour. According to AACAP (2011a), the human brain continues to grow and mature into early adulthood. Specifically, the amygdala (a part of the brain) is said to be responsible for reactions such as fear and aggressive behaviour. This part of the brain develops early while the frontal lobe, a part of the brain responsible for control of reasoning and control of action, fully develops much later in early adulthood (AACAP, 2011a; de Guzman & Pohlmeier, 2014).

1.8 The family as an institution for adolescent socialization

The family as a social unit has a role to play in shaping adolescents' behaviour (Bearman & Brueckner, 2000). This is because adolescents depend on their families for norms, value system,

nurture and support (Sooryamoothy, 2012). Therefore, the parent may inhibit or facilitate health risk-behaviours by providing or restricting opportunities through direct supervision and monitoring of adolescents' behaviour (Sooryamoothy, 2012).

The family structure (mother, father and their children) as it used to be known, is fast changing under the influence of industrialization, modernization and globalization, which has also brought about an increase in migration. These forces have an influence on the family structure due to its effect on marriage, role expectations, the right of women and children and the sense of equity in family life (Giddens, 2006, cited in Sooryamoothy, 2012). Consequently, there has been a proliferation of new types of families (including single-mother, single-father, mother with a step-father, father with a step-mother, family of relatives and child-headed homes) which have implications for the upbringing of a child (Rani, 2006).

According to Aufseeser, Jekielek and Brown (2006), the family environment may promote quality adolescent health by modelling positive behaviour, providing close relationship and good communication. However, when this is not present, the adolescent often aligns with their friends and peers, and this may result in unhealthy relationships with untoward outcomes (Bearman & Brueckner, 2001).

1.5 The family and migration

According to the International Organization for Migration (IOM, 2011), migration is the movement of a person or a group of persons, either across an international border, or within a State. Migration is a major livelihood-seeking strategy for poor households within the Southern African sub-region, where migrants are able to contribute to the socio-economic development of their families from what they earn from working in foreign lands (Vearey, 2011).The result of the absence of one or more members of the family due to migration often puts a strain on the family and may even result in a change in traditional family structure and gender roles within them. This structural and gender role changes impact on the development of children (Safta et al., 2014).

Economic development in South Africa has attracted millions of migrants from all over the world, with the vast majority coming from neighbouring Southern African countries (Chirwa et al., 2007). It has also been reported that the level of internal migration within South Africa is far more than the migration occurring across the border into South Africa (Crush, 2011). This is not surprising

as migration has been dubbed a livelihood-seeking strategy among poor communities in Southern Africa; this implies that people in local communities migrate to industrialized areas to seek better opportunities (Vearey, 2011). However, this movement of people in search for job and better living condition comes with many consequences for the families in the communities who receive them (Vearey et al., 2011) and the families left behind by the migrants (Gao et al., 2010).

The direct impact of migration on family structure is that it results in separation of family members into two or more households geographically, with migrants living miles away from their spouses and children. It could also result in both parents leaving their children with grandparents in the village while they live and work in the city. This therefore de-structures the family and affects the functioning of the family as a unit (Wahyuni, 2000). The absence of a spouse creates a situation of single-parent-family, and this single parent status could even last for years due to the continued absence of the spouse. This phenomenon is not strange in South Africa, where the apartheid legislation played a major role in family de-structuring, especially among the blacks who were compelled to live away from their families in search of employment. Consequently, the women in these communities became de facto heads of households. Migratory labour pattern means that one or both parents would not always be present to tend to their children even when they are still considered current members of the family (Anderson, 2003).

1.9 Communities affected by migration in South Africa

Unemployment, poverty, poor housing, decaying infrastructure and prostitution are the common findings in mining communities in Southern African Countries (Cronjé, Reyneke & Van Wyk, 2013). In addition, there is a high prevalence of Sexually-Transmitted Infections (including HIV), unwanted pregnancies, malnutrition, substance use, and mental illness (Cronjé et al., 2013). These social and health consequences arise from several factors, including the direct environmental effect (damage to agro facility) of mining on the surrounding communities, the lack of proper housing for the miners and the gender inequality in the recruitment of mine workers (Desmond et al., 2005; Cronjé et al., 2013).

Some studies have reported that the high rates of unemployment among women and youth in these communities feed the HIV epidemic because of the sexual interactions between migrant mineworkers who live in close proximity to women and young people (Cronjé et al., 2013). On the contrary, the United Nations High Commissioner for Refugees (UNHCR) and the Southern African

Clinicians Society (2007) argue that some migrants are actually at risk of contracting HIV in the host community because they are coming from regions with lower HIV prevalence compared to the HIV prevalence in South Africa.

To further complicate this is the report that migrant workers are more likely than non-migrant workers to engage in risky sexual behaviours. This makes them more vulnerable to STIs, including HIV. Due to the low wages paid to some miners, they often live in shacks around the mining sites, while their families live in the sending communities. This results in the miners' dependence on commercial sex workers for sexual relief (Wolffers et al., 2002). According to Cronjé et al. (2013), this increases vulnerability to HIV infection among migrant miners. It has been suggested that this vulnerability makes migrant mineworkers an agent for STI transmission, both in the receiving and sending communities (Cronjé et al., 2013). Furthermore, the gender bias in employment opportunities within the mining industry favours males, creating an opportunity for males to seek intimacy and sexual satisfaction among women in the community (Lurie et al., 2000 as cited in Wolffers et al., 2002).

The selling and buying of sex is an old practice among mineworkers and commercial sex workers. However, evidence suggests that the exchange of sex for money also occurs among local residents who may engage in this practice to be able to provide for their families (Desmond et al., 2005). It has been reported that women are being forced by their poor social circumstances into relationships in order to get financial support for their families. In some cases they go as far as offering their children to men in order to get continuous financial support for the family. Furthermore, adolescent girls often become pregnant in order to qualify for child support in these communities (Cronje et al., 2013).

1.7 Family dynamics and adolescents' deviant and sexual risk behaviour

Magnani et al. (2001), cited in Vukovic and Bjegovic (2007) argue that there is a significant relationship between family structure and risky sexual behaviour among adolescents. This is a result of the structural dynamics of the family and its influence on social control, as well as the amount of social and economic resources accessible to an adolescent. Some authors have argued that family religiosity, through its influence on parental monitoring, parent-adolescent relationship quality and positive family routine provide a cohesive family environment, and set the stage for positive peer networks. This contributes to reduced levels of risky sexual behaviour

among adolescents (Manlove, Logan, Moore & Ikramullah, 2008; Simons, Burt & Peterson, 2009). However, parents who monitor their children's activities and peer environments, engage their families in regular activities and foster strong parent-child relationships which can help reduce risky sexual behaviour, regardless of family religiosity (Manlove et al., 2008).

This implies that families characterized by structural disruption have an increased likelihood of health risks among its adolescents. Magnani et al. (2001) also suggest that living in a two-parent family appears to be a protective factor against risky sexual behaviours. Similarly, Eitle (2005) reports that living with two natural parents serves as a protective factor against using tobacco, alcohol, or other illicit drugs. Furthermore, East, Jackson and O'Brien (2006) claim that one-parent families are less effective in supervising youth and grooming children. For instance, the absence of a father in the family reduces the opportunity for adolescents to acquire skills that come from the experience of the father and his social network. In the same vain, Eitle et al. (2013) agree that living in a single-parent family is a marker for unequal distribution of stress.

Studies conducted by Magnani et al. (2001) and Pergamit (2001) agree that living with a single parent is associated with early onset of adolescent sexual behaviour, vis-à-vis lower family incomes, less supervision and parental modelling. It has also been shown that adolescents who lost their mothers or who were raised by relatives or a single parent are more likely to engage earlier in sexual activities than those with intact families. Not having a father is associated with a higher rate of early sexual debut among males, while having a poor relationship with parents has been associated with higher rate of early sexual debut for both male and female adolescents (Mmbaga et al., 2012). In addition, King et al. (2004) found that adolescents who live with both biological parents are less likely to report sexual abuse than those who live with a single parent and those who reside with a biological parent and a step parent.

1.8 Programmes to reduce sexual risk behaviours among adolescents

Concerted efforts have been made to reduce sexual risk behaviour among adolescents, as well as to improve their health trajectories through programmes targeted at improving their knowledge, attitude and better decision making (Kirby, Coyle, Alton, Rolleri & Robin, 2011). Literature has shown a broad base of programmes developed in diverse settings that cover school-based health education programmes to individualized clinic-based programmes (Goesling, Colman, Trenholm, Terzian & Moore, 2013). Some of these interventions have targeted adolescents, while some

have focused on strengthening the family unit, in order to support the adolescent (Elkington et al., 2011; Kirby et al., 2011).

However, there has been many inconsistencies with regards to the impact of these programmes. For instance, among similar types of programmes, even among those that applied the same methodology, there is often significant variation in programme impacts (Chin et al., 2012). According to Goesling, Colman, Trenholm , Terzian and Moore (2013), diversity in programme approach and its implementation are necessary to meet the unique needs and interests of diverse communities because no single programme model is right for every population and setting (Goesling, Colman, Trenholm , Terzian & Moore, 2013).

Programmes developed to reduce sexual risk-taking do not have direct control on sexual risk behaviour. However, they influence risk and protective factors that ultimately affect adolescents' behaviour (Kirby et al., 2011). Some of these risk and protective factors include age, economic opportunities, parental monitoring and psychosocial factors such as knowledge, attitude, risk perception and self-efficacy (Kirby et al., 2011).

It has been shown that if a programme is developed to mitigate or enhance factors that have a strong impact on behaviour, and if the programme activities are implemented to change these factors, then the programme will have an impact on behaviour. Therefore, it is important to design and implement research/evidence-based programmes targeted at the factors that have a direct impact on behaviour (Kalmuss, Davidson, Cohall, Laraque & Cassell, 2003; Kirby et al., 2011). The present study is expected to provide evidence to support the programme which will be developed.

1.9 Scope of study

Although studies have shown that adolescents' behaviour can be influenced by their family system, the environment, and their personal factors, it is believed that the family system has more influence on the adolescent than extra-familial factors. Adolescents who live within a secure family system where the parents are united, morally and financially stable are more likely to show good behaviour in the face of changing environmental, social and personal factors. Therefore, the present study was delimited to

1. Understanding the dynamics within the family and how these dynamics affect deviant and sexual risk behaviour among adolescents.
2. Developing a public health programme to mitigate the negative influence of the family on adolescent behaviour.

1.10 Problem Statement

Thabazimbi is a mining community in the Waterberg district in Limpopo, South Africa. It is home to both local and migrant dwellers, and research has shown that there is a high rate of unemployment, illiteracy, teenage pregnancy and HIV infection in the community (Thabazimbi Municipal Annual Report, 2013). The high level of youth unemployment, coupled with high number of employed mine workers, may present an opportunity for a complex interaction that may increase vulnerability to deviant and sexual risk behaviour. The family environment of these adolescents may also fail to provide adequate social, financial and moral support because it has been shown that about a quarter of the households are headed by single mothers and about 114 households are headed by individuals younger than 18 years of age (Stat SA, 2011). Furthermore, public health programmes instituted in the community to reduce sexual risk behaviour have not been specifically targeted at adolescents and therefore have not addressed the dynamics of the family and the relationship it has on adolescents' behaviour.

1.11 Rationale for the study

Although South Africa is a migration hot spot in the Sub-Saharan region, not much is known about the deviant and sexual risk behaviour of adolescents in the communities that receive migrants in South Africa. The effect of migration on family has been widely studied, just like the relationship between the family and adolescents' deviant and sexual risk behaviour. However, there appears to be no study that has examined adolescents' deviant and sexual risk behaviour in relation to family dynamics in a community affected by migration in South Africa. This presents a gap which the present study hopes to fill.

1.12 Significance of the study

There has been a tremendous generational transformation in family values. This may have led to the liberalization of morals, as expressed by young people in today's society. The present study aims to assess this problem with the view of developing a programme to limit the effect of family

dynamics on adolescents' deviant and sexual risk behaviour in a community affected by migration. It is hoped that the programme developed from the findings of this study will become a tool to capacitate the families residing within the mining towns on how to better support their children in order to limit untoward health outcomes. The findings may also inform strategic school health programmes focused on mitigating negative modelling behaviour but rather encourage positive health behaviour among adolescents.

1.13 Purpose of the study

The purpose of this study is to explore and explain the influence of family dynamics on the occurrence of adolescents' deviant and sexual risk behaviour in a migration affected community in South Africa. Secondly, it seeks to develop a programme (public health intervention) to improve health behavioural outcomes for the adolescents living in these communities.

1.13.1 Objectives

The objectives of the study will be divided into three phases

Phase 1

To explore the family dynamics in Thabazimbi and its influence on the behaviour of adolescents living in the community.

Specific objectives

1. To explore the social support system available to adolescents in the community.

2. To explore the level of financial support available to adolescents within the family.

3. To explore parenting processes adopted by families in the community.

4. To describe the experiences of families regarding deviant and sexual risk behaviour among adolescents living within the community.

Phase 2

Assessment of deviant and sexual risk behaviour among adolescents in the Thabazimbi community.

Specific objectives

1. To determine the nature and pattern of deviant and sexual risk practices among adolescents in the study setting (Behaviour capabilities).

2. To determine the adolescents' perceived benefits and risks of engaging in deviant and sexual risk behaviour in the community (Outcome expectations).

3. To assess the adolescents' perceived level of skills for self-protection against deviant and sexual risk in the community (Self-efficacy).

4. To assess the perceived influence of parents on adolescents' deviant and sexual risk behaviour in the community (modelling behaviour).

Phase 3

To develop a public health programme to mitigate the influence of family dynamics on adolescent deviant and sexual risk behaviour.

1.14 Definition of terms

1.14.1 Sexual risk behaviour

Sexual risk behaviours are those behaviours or activities that expose an individual to the risk of pregnancy or infection with HIV and other sexually transmitted infections (STIs). It includes unprotected sex, early sexual debut, using alcohol or drugs before sexual intercourse, multiple sexual partners, forced or coerced sexual intercourse and sexual intercourse for reward (Avert, 2009). In the present study, sexual risk behaviour will include early sexual initiation, unprotected oral, anal and vaginal sex, multiple sexual partnerships and exchange of sex for gift or money.

1.14.2 Programme

According to the Centre for Disease Control (CDC, 2012), a programme is any set of organized activities supported by a set of resources to achieve a specific and intended result. In the present study, a programme means a Public Health intervention designed in line with the findings of this study to mitigate the effect of family dynamics on adolescent sexual risk behaviour in a migration receiving community.

1.14.3 Family structure

Family structure refers to the combination of relatives that comprise a family. In the present study, family structure refers to the composition of the family and the spousal partnership that heads the family.

1.14.4 Adolescent

According to the World Health Organization (WHO, 2010), an adolescent is an individual aged 10 to 19 years. In the present study, an adolescent is an individual aged 15 to 19 years living under the care of an adult or living in a household where he/she may be the head of a household.

1.14.5 Deviant behaviour

This is any human behaviour that violates existing and generally accepted social norms (Nalah & Ishaya, 2013). In the present study, deviant behaviour will include violence, school absenteeism, disobedience and substance abuse.

1.14.6 Migration

The International Organization for Migration (IOM) defines migration as the movement of a person or a group of persons, either across an international border, or within a State (IOM, 2011). In the present study, migration is the movement of people from one place to the other, within a country or from across the border.

1.14.7 Community affected by Migration

These are communities that receive or send migrants. In the present study, a community affected by migration is a place with an influx of migrants. This will include migrants from within the country and those from other countries.

1.14.8 Family dynamics

A family is said to be dynamic because it is a system of interconnected and interdependent interactions of individuals. The factors that affect the family system are: behavioural factors, biological factors, extended family, social welfare, health care and services, recreation, employment, school, church, and friends (Canadian Ministry of Health Promotion, 2010). In the present study, the family dynamics variables to be measured will include family structure, partner relationship, parent-child relationship, socio-economic support and employment status.

1.14.9 Parenting processes

In the present study, parenting processes will include parental-adolescent communication, parental monitoring and parenting style, as highlighted by Huebner and Howell (2003).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature relevant to the study and it is divided into two sections. Section A discusses the theoretical based literature while section B discusses the data based literature. This study was guided by the Social Cognitive Theory (SCT) and the key variables examined in this review include deviant and sexual risk behaviour, the family system, modelling behaviour, outcome expectancies, and self-efficacy for healthy sexual behaviour. Others include, sexual behavioural capabilities of adolescents and parenting processes.

Relevant articles were accessed from data bases that include: Academic search complete, CINAHL, Health sources, Masterfile premier, MEDLINE, Science Direct and Google. The key words include adolescents, family, sexual risk behaviour, modelling, self-efficacy, outcome expectancy, behavioural capability.

It is noteworthy that in order to provide a historical perspective on the development of the Social Cognitive Theory and its further evolution, some old publications were cited.

2.2 Theoretical framework for the study

Models are symbolic representations of complex issues, thereby providing a framework for understanding and interpretation of these issues (Funnell, Koutoukidis & Lawrence, 2005). They may also provide links to understanding the complex aetiology of health problems and serve as a framework to develop different approaches to solving these problems (Coreil, 2008).

In explaining the pathways to adolescent behaviour, Coreil (2008) explains that several theories have been put forward to explain why young people may engage in risky behaviour. Top among these theories include the Theory of Planned Behaviour (TPB) and the Health Belief Model (HBM). These two models are commonly used in the field of health promotion to investigate risk behaviour among adolescents. However, they are intrapersonal (psychological) models that basically explore an individual's beliefs and perception regarding a particular behaviour and its outcome (Coreil, 2008). Although these beliefs and perceptions are modified by some social factors, these psychological models do not explain the intricate relationship between an individual, the environment and human behaviour. On the other hand, the Social Cognitive Theory (SCT)

which is founded on the principle of triadic causal determinism (Bandura, 1989), is a psychosocial (interpersonal) model that describes how social relationships influence cognition and behaviour (Coreil, 2008).

According to Bandura (1989), psychological theories have traditionally emphasized learning through the effects of one's actions. They often explain human behaviour as being shaped and controlled by the individual's internal ability, what Bandura (1989) termed one-sided determinism. However, the SCT favours a triadic reciprocal determinism (illustrated in Figure 2.1). This shows that behaviour, cognition, personal and environmental factors all interact in a bidirectional manner to influence each other. However, this does not imply that these factors influence each other equally. Some may have overriding influence on the others (Bandura, 1989). Therefore, the SCT is considered the more suitable model to guide the present study. It should however be emphasized that the present study is not attempting to validate the SCT but rather using it as a guide to investigate adolescents risk behaviour.

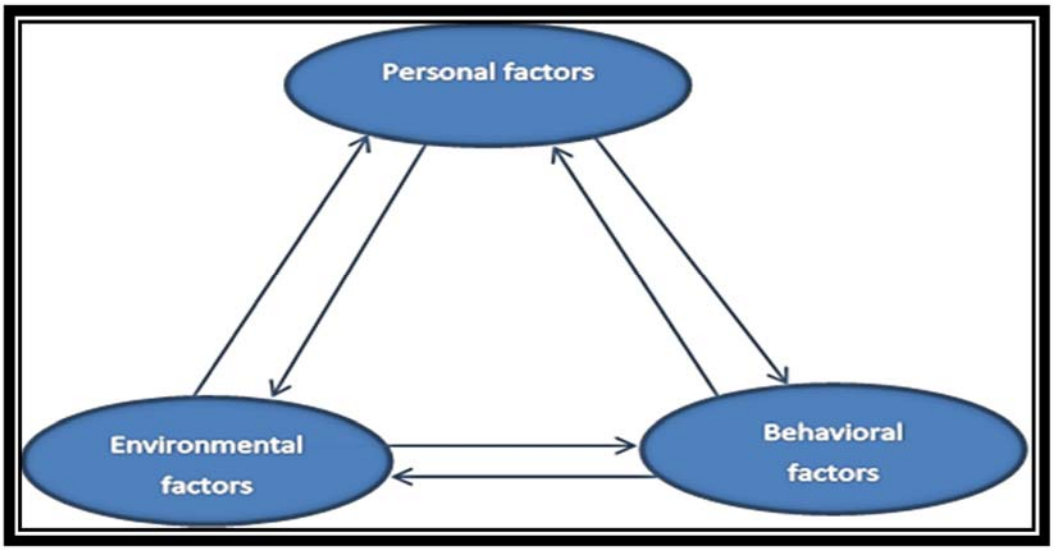

Figure 2.1: Schematization of triadic reciprocal causation in the causal model of social cognitive theory. Adapted from Bandura (2001).

2.2.1 Social Cognitive Theory

The SCT was proposed by Albert Bandura in 1986. This theory states that learning is achieved in a social context, emphasizing the importance of internal and external social reinforcement in learning. The SCT is relevant in health communication and provides a framework for designing, implementing and evaluating programmes (Twente, 2014). The key constructs within the theory include modelling (effect of environment), outcome expectations, self-efficacy, and behavioural capability (Figure 2.2).

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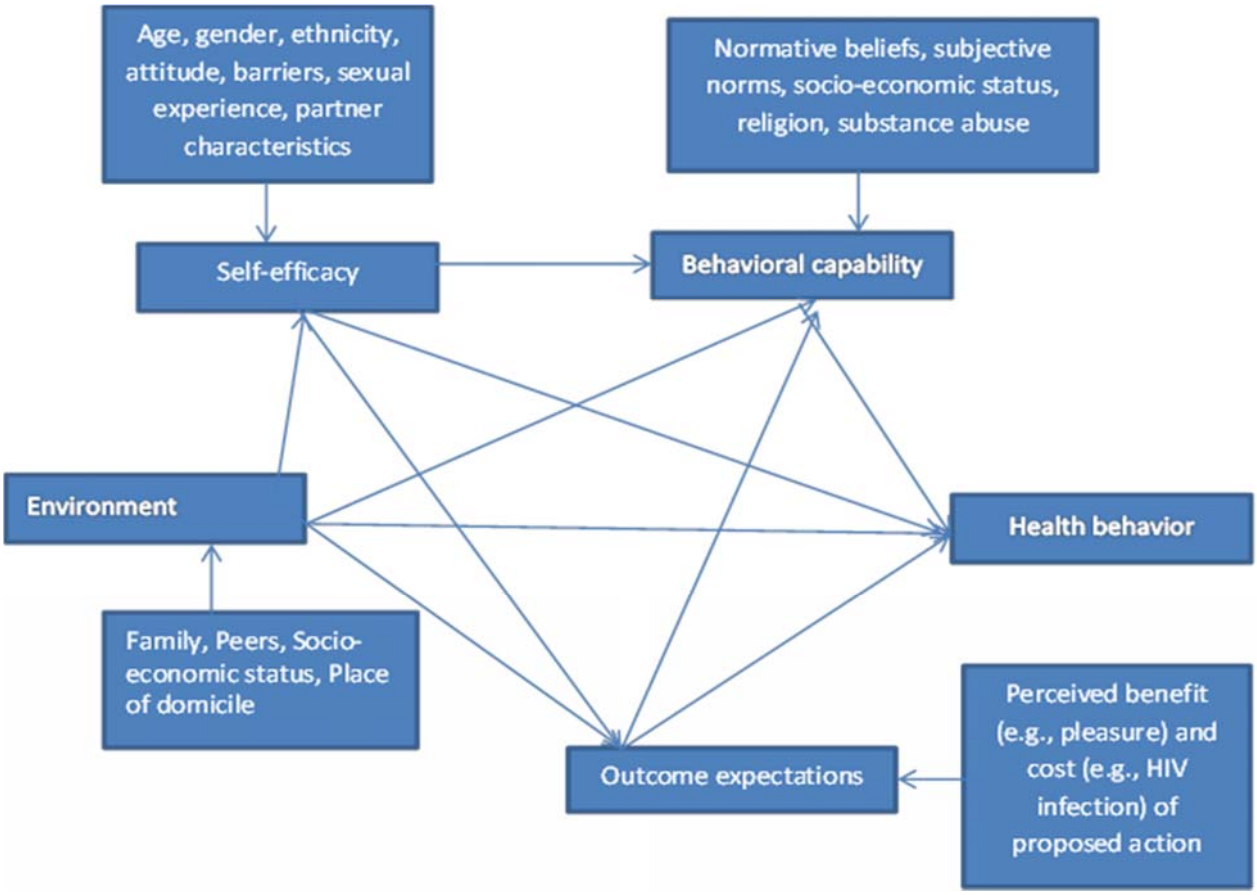


Figure 2.2: The Social cognitive model of health behaviour; modified from Anderson-Bill, Winett and Wojcik (2011)

2.2.2 Explaining the SCT

Learning is usually done through observation. This is referred to as modelling or vicarious learning (Coreil, 2008; Denler, Wolters & Benzon, 2014). In the SCT, this forms one of the most important constructs because young people learn or adopt new behaviour by observing people they admire, people very close to them or people they look up to. It therefore implies that the behaviour of an adolescent may be influenced by an adult in the family (perhaps a father, a mother or a combination of both parents). Adolescents may also be influenced by older siblings, peers, other adults from within or outside their family. If these adults are able to influence the child positively, the child would be less likely to adopt risky life-styles that may affect his/her health. In situations where the parents are absent or not available, adolescents may look for extra-familial models to emulate, and this may provide an untoward opportunity to follow the dictates of their peers, which may result in unhealthy practices. In addition, unending family disputes or the eventual dissolution of a marriage may lead to single parenting. Furthermore, the introduction of a new partner, may create a socially imbalanced environment that may result in lack of trust between the adolescent and parents, and force the adolescent to seek other sources of love and trust and eventually engage in behaviour that may affect his/her health.

The beliefs regarding the expected outcomes of a particular behaviour will also drive participation in that behaviour. This construct of the SCT holds that an individual will engage in an act if there is a perceived benefit associated with the act or if the outcome is favourable. The awareness of the protective value of using a condom, such as preventing unwanted pregnancy and sexually-transmitted diseases will drive an individual to use it. This construct may be based on the level of knowledge and understanding of the consequences associated with the behaviour. This knowledge may come from the interaction with the members of the family. On the contrary, adolescents who believe that the use of alcohol before sex increases sexual pleasure and performance may engage in this practice because of the perceived gain. However, Bandura (1989) highlights that, although the perceived expected outcome of an action may independently motivate a behaviour, in most cases, the decision to engage in a behaviour is influenced by an individual's perceived ability to perform the action correctly. According to Bandura (1989), activities in which the level of competence dictates the outcomes, the outcomes people anticipate will depend largely on their beliefs of how well they will be able to perform such activities. For example, the thought of pregnancy as a negative outcome of having premarital sex is diminished if an individual has strong self- efficacy in negotiating condom or contraception use.

Self-efficacy describes an individual's appraisal of a behaviour and their perceived ability to perform the task. If they feel confident in performing the task, then it is more likely that they will engage in such acts. Bandura (1989) argues that because humans have the capacity to control their own thoughts, judgment and actions, they are in a position to change their situation through their own efforts. Furthermore, an individual's beliefs on their ability to control events that affect their lives are considered important determinants of good behaviour. This implies that the self-efficacy construct of the SCT is a proximal determinant of human motivation, affect and action (Bandura, 1989). For instance, a young woman who believes that she has the ability to resist advances by her partner to engage in unprotected sex is more motivated to have condom protected sexual intercourse than someone who does not believe in such ability.

However, the perceived ability may not translate to actual ability when faced with the real life situation; this is explained by the behavioural capability construct in the SCT. An individual may perceive him/herself as being capable of avoiding certain risk behaviour; such as resisting unprotected sex, but may succumb to this practice when under pressure. Bandura posits that the ability to resist bad behaviour hinges on an individual's internal standards, capability for self-direction, self-demands and self-sanctions. In the absence of these, an individual will conform to whatever situation or pressure they are faced with.

Finally, this model is summarized using an example of a young woman who enjoys all the love and care at home and has an exemplary role model in her parents, siblings, family member and friends. If she believes that the outcomes of unprotected sex (such as unwanted pregnancy and sexually transmitted infections) are undesirable and she also perceives herself as having the ability to resist unprotected sex, then she is likely to resist pressure to have unprotected sex and make better choices regarding her sexual practices.

2.3 Data-based Literature

2.3.1 Overview of deviant and sexual risk behaviour

Nalah and Ishaya (2013) defines deviant behaviour as any human behaviour that violates existing and generally accepted social norms. Commonly identified deviant behaviour among adolescents include alcohol use, cigarette smoking and the use of other illicit substances (Ajao et al), it also includes behaviours like violence and school absenteeism (Hughes, 2017). In a study conducted among adolescents attending public schools in Brazil, it was documented that over 80% of the

adolescents between 14 and 17 years old had used alcohol and cigarettes. In the same study, it was found that adolescents who used marijuana or cocaine were more likely to engage in antisocial behaviour (Nardl, Cunha, Bizarro, & Dell'aglio, 2012). Furthermore, a relationship between illicit substance use and sexual risk behaviour has long been established (Anyanwu et al., 2013c; CDC, 2017).

Sexual risk behaviours are those behaviours or activities that expose an individual to the risk of pregnancy or infection with HIV and other sexually-transmitted infections (STIs). They include unprotected sex, early sexual debut, using alcohol or drugs before sexual intercourse, multiple sexual partners, forced or coerced sexual intercourse and transactional sex (Avert, 2009).

Although sexual risk behaviour is common among adolescents, the social environment in some societies encourages these behaviours. This assertion is corroborated by Malhotra (2008) who argues that the sexual revolution in the United States of America (USA) has led to increased sexual risk behaviour. The impact of increased risk taking is particularly worse for young people because studies have shown that engaging in early sexual practices is associated with multiple sexual partnerships, increased rates of teenage pregnancy and STIs (Michigan Department of Education, 2007; Malhotra, 2008), it has also been shown that early sexual practices increase the likelihood of engaging in other sexual risk behaviours (Sandfort, Orr, Hirsch & Santelli, 2008; IOM & NRC, 2011) like inconsistent condom which is an important determinant for STIs, including HIV infection (Schantz, 2012).

High levels of sexual practices have been credited to adolescents in the USA, about half of persons aged 15 to 19 years have tried vaginal sex, more than half have tried oral sex, and about 11% have tried anal sex (Malhotra, 2008). Similarly, the Youth Risk Behaviour Surveillance System in the USA shows that almost 50% of all participants reported ever having sex, 17.1% reported having four or more partners in their lifetime and 7.1% had had sex before their 13th birthday, with more males likely to engage in sexual activities before they are 13 years old (Newby & Snyder, 2009).

Mutinta (2012) posits that sexual risk behaviour is influenced by personal beliefs about long-term relationships, attitudes towards sex for variety, a drive for material wealth, a lack of satisfaction in relationships, levels of trust and attention, pursuit of the long-term goal of marriage, and HIV denialism. This assertion is consistent with literature, where gender and ethnic differences in

sexual behaviour have been documented (Michigan Department of Education, 2007), females were more likely than males to have sex with older people and black adolescents were more likely to have ever had sex before they were 13 years old. Also, Black adolescents were more likely than white adolescents to report that they had been pregnant or made someone pregnant. Furthermore, it has also been reported that people who engage in sexual-risk behaviours were more likely to indulge in other health-risk behaviours. For instance, those who use alcohol and other substances where more likely to have multiple sexual partners, low intention to use protection, and having unprotected sex with casual partners (Rew et al., 2011).

Available data have shown that the rate of sexual risk behaviour is higher in the USA compared with other developed countries, for instance, the rate of teenage pregnancy in the USA is about one and half times more than the United Kingdom (UK), which happens to be in second place behind the USA (UNSD, 2006). However, research suggests that there is a downward trend in sexual risk behaviour in the USA, as shown by data from the Michigan Department of Education (2007). However, there appears to be a reduction in the number of high school students who have ever had sexual intercourse, decreasing from 54% in 1991 to 47% in 2003, while condom use among sexually active students increased significantly from 46% in 1991 to 63% in 2003 (Michigan Department of Education, 2007).

Similarly, Puente, Zabaleta, Rodríguez-Blanco, Cabanas, Monteagudo, Pueyo, Jané, Mestre, Mercader and Bolíbar (2011) report high rates of sexual risk behaviour in Catalonia. In their study, 38.7% of adolescents had had sex at least once and 82.3% of boys and 63.0% of girls were engaged in sexual risk behaviours. Boys were shown to have more sexual partners and used condoms less often than girls (Puente et al., 2011). In Serbia, Stanković, Miljković, Grbeša and Višnjić (2009) attributes the lower rate of risk behaviour seen in their study to the traditional attitude towards gender roles and environmental control of female sexuality in Serbia. According to Stanković et al. (2009), American adolescents practice oral sex considerably more frequently than vaginal intercourse because of their belief that it lowers the risk of unwanted pregnancy and STIs. Only 9.4% of adolescents in the Serbian study practiced oral sex, compared to 32% in the USA (Malhotra, 2008). Interestingly, it has been shown that the Human immunodeficiency virus (HIV) and many other STIs such as herpes, chlamydia, gonorrhoea, and syphilis are easily transmitted during oral, vaginal, or anal sex (Malhotra, 2008).

Studies conducted in Taiwan have shown that there has been an increase in sexual activities among adolescents, the number of adolescents who had been sexually active increased from 12% in 1998 to about 57% in 2008 (Tung, Farmer, Ding, Tung & Hsu, 2009). According to Tung et al. (2009), only 11.9% of the sexually active adolescents used condoms consistently. It is however noteworthy that more recent studies have shown a decline in the number of sexually active adolescents (27.8%) and the rate of condom use has also increased to 31.4% (Tung et al., 2011).

In Cambodia, a study conducted among adolescents showed that 12.7% had had sex within three months prior to the study. Out of these sexually-active adolescents, 34.6% reported having two or more sex partners over the same period, and 52.6% did not use a condom during their last sexual intercourse. It was also reported that substance use, high levels of peer delinquency, high family income were associated with sexual risk behaviour among male adolescents while among females, a higher likelihood of risky sexual behaviour remained significantly associated with higher levels of substance use, higher levels of community-violence witnessing, and lower levels of family support (Yi, Poudel, Yasuoka, Palmer, Yi & Jimba, 2010).

In Africa, studies have also shown high levels of sexual risk behaviour. This was shown in a study that analysed national data from 24 countries in Africa from 2000 to 2010. This study found that about 25% of 15-19 year olds reported having sex before their 15th birthday. However, this figure decreased across many of these countries over time. It was further reported that about 5% of female adolescents reported being married in most of the countries, while about 20% had started bearing children (Doyle, Mavedzenge, Plummer & Ross, 2012). These practices (early sexual debut and childbearing) were common among those with low educational goals and those living in the rural areas, while multiple partnerships were more common among males. Males and females who reside in urban areas and females with higher level of education were more likely to report multiple partnerships and urban youths and those with higher education also reported more condom use (Doyle et al., 2012). In the same vein, another study accessed the relationship between poverty and sexual risk behaviour using a nationally representative data from Burkina Faso, Ghana, Malawi, and Uganda. It was found that rich girls in Burkina Faso, Ghana, and Malawi deferred sexual debut, compared with poorer girls. However, this association was not statistically significant for girls in Uganda. Among boys, wealth status was weaker and was only significant in Malawi. Furthermore, wealthier adolescents were most likely to use condoms at their last sexual act (Madise, Zulu & Ciera, 2007).

In South-western Nigeria, the number of adolescents who reported having sexual intercourse was 22.9% of the sexually active participants, 22.2% had paid for or demanded for payment for sex, while only 26.7% used condom during their last sex and 16.3% had reported having an STI (Adeomi, Adeoye, Adewole, Israel & Temitayo-Oboh, 2014). In Ghana, Asante, Meyer-Weitz and Petersen (2014) examined the association between substance use and risky sexual behaviours among homeless youth and found that 12% and 16.2% used alcohol and marijuana daily respectively. Youths that used alcohol, smoked marijuana and cigarettes were more likely to have been sexually active, less likely to use a condom, engage in multiple sexual partnerships and survival sex (Asante, Meyer-Weitz & Petersen, 2014).

In South Africa, the 2nd South African National Youth Risk Behaviour Survey (2008) shows that 38% of learners reported ever having sex. Thirteen percent of the sexually-active learners reported initiating sexual intercourse at the age of 14 years. Among the learners that had ever had sex, 41% had more than one past sexual partner, 52% had sex in the past three months, 16% had sex after consuming alcohol, 14% had sex after taking drugs, 31% practiced consistent condom use, 19% had been pregnant or made someone pregnant (The 2nd South African National Youth Risk Behaviour Survey, 2008). Similarly, Awotidebe, Phillips and Lens (2014) reported a slightly lower number of adolescents in the Western Cape who reported being sexually active. Of the 27.2% who were sexually active, about 48% reported having had sex before the age of 15 years while 42.2% reported penetrative sex with more than one partner in their lifetime. Furthermore, only 44.8% of them reported consistent and regular use of condoms for every sexual encounter. Peer influence, gender difference and lack of HIV information were said to influence the sexual risk behaviours of these adolescents (Awotidebe et al., 2014).

In the Vhembe District of Limpopo South Africa, Maluleke (2010) reports that a high number of adolescents engage in sexual practices early, resulting in high rates of teenage pregnancy and early marriages. It was also reported that adolescents engaged in unprotected sexual intercourse, and that they are likely to have sexual intercourse without a condom in return for a reward, and to have sexual intercourse with a famous person. Furthermore, about 20% of the sexually active participants had used alcohol or marijuana before sexual intercourse (Maluleke, 2010).

It has been shown that risk behaviour is common among adolescents, irrespective of their location or place of domicile. However, the proportion of adolescents engaging in risk behaviour may differ

from one society to another. The reason for these differences may also differ, depending on the accepted societal norms, culture and traditions. The sexual revolution is spreading across the world from wealthy and industrialized nations to the poorer developing nations. The impact of this is an increase in sexual risk behaviour that may result in untoward health consequences for young people (Malhotra, 2008). Stanković et al. (2009) suggested that traditional family values may still have protective impact on the adolescents. These values should therefore be enforced.

2.3.2 The family system and generational changes

Several authors have proffered different definitions for the term 'family'. However, there has not been a universally accepted definition and this may result from the various dynamics of the family across cultures (Koerner & Fitzpatrick, 2004; Bigombe & Khadiagala, 2004; Yankuzo, 2014). However, Koerner and Fitzpatrick (2004) have grouped the various definitions into three general perspectives. The first perspective includes structural definitions, which is based on the presence or absence of certain family members such as parents, children, and extended family members (Koerner & Fitzpatrick, 2004). The second perspective includes definitions within the functional capacity of the family. This perspective lays emphases on maintaining a household, socializing children, providing emotional and material support, and fulfilling roles (Koerner & Fitzpatrick, 2004). The third perspective, identified by Koerner and Fitzpatrick (2004), emphasizes exchanges among people and how their behaviour generates a sense of family identity with emotional ties and an experience of a history and a future.

The family is the backbone and the basic unit of every society (Yankuzo, 2014). Every human society has one form of family unit or the other. These units may however differ in the form, process, and rules governing them across different societies (Yankuzo, 2014). Bigombe and Khadiagala (2004) define the family as a unit of production, consumption, reproduction, and accumulation that may be affected by the economic environments within which the family functions. However, the family structure in recent times has evolved to include a diverse combination of spousal partnerships, some of these include single parent families, stepfamilies, cohabiting couples and same sex couples. It has also been reported that some of these formations are dynamic and may change over time (The Social Issues Research Centre, 2008).

Although the key social trends support continued change in family structure in some societies, marriage and the traditional nuclear family structures remain the norm for most people in some

societies (The Social Issues Research Centre, 2008). According to Smith (2007), the basic structure of the family as well as the value system has been reshaped. Families today are smaller and less stable, the emphasis on marriage is less pronounced and cohabitation is discernible, the value of children and values for children have also changed (Smith, 2007). There has also been a departure in gender roles from the traditional system (which puts men in charge) to a more egalitarian system. These changes have transformed the traditional family type and family values to an emerging, modern family types and a new set of family values (Smith, 2007).

According to Brooks and Bolzendahl (2004), childbearing is increasingly becoming disconnected from marriage. This can be seen in the rise in the percentage of births to unmarried mothers that rose from 5.3 percent in 1960 to 36 percent in 2005. Smith (2007) posits that the rise in divorce and the decline in fertility and marital births have in turn had a major impact on the type of household in which children are raised. Smith (2007) also reports that women have greatly increased in number as far as employment goes and this has influenced the gender role within the family, especially the division of responsibility between the husband and wife. In the USA, the percentage of working women grew from 42 percent in 1960 to 72 percent in 2005. The traditional home with an employed husband and a stay-home-wife declined from 53 percent in 1972 to 21 percent in 1998-2002, while the modern pattern of both spouses being employed grew from 32% to 58-59% in 1996-2002 (Smith, 2007).

Smith (2007) argues that family values regarding marriage, divorce, childbearing and childrearing and the duties and responsibilities of husbands and wives have also changed. Furthermore, attitude relating to sexual behaviour has changed over the last generation (Smith, 2007). According to the Social Issues Research Centre (2008), children within these networks may begin to negotiate complicated exchanges with other children and adults in relationships that might not normally occur in the traditional nuclear family structure. These varied forms of families is fast gaining acceptance in the UK but the traditional nuclear family structure still remains the basis for family organization in the large proportion of households (The Social Issues Research Centre, 2008).

A study conducted in the USA shows that the traditional family (in which the husband is the breadwinner and the wife is a full-time homemaker) has declined from 60 percent of all families in the USA in 1972 to 29 percent in 2007. Furthermore, it has also been documented that about

19 million American singles between the ages of 30 to 44 have never been married and this is about 31 percent of all people in that age group. The median age at first marriage is higher now than it was in the past. The percentage of children under 18 years living with two married parents also fell from 77 percent in 1980 to 67 percent in 2008, while the single-parent American households increased from 11 percent of all households in 1970 to 29 percent in 2007 (The U.S. Census Bureau, 2008). The number of children growing up without their fathers is increasing as a result of increasing dissolution of two parent families and the increasing prevalence of single motherhood (Jensen, 2000). Although an increasing number of fathers have less contact and support for their children, it must be said that majority of children still enjoy quality fathering in intact two parent families (Jensen, 2000).

Cole (2006) argues that single-parent families and step-families were also common in the past. However, the conditions that created these kinds of families were mainly due to death from diseases and wars, which is quite different from the causes of today's single families and step-families, which are caused by divorce and non-marital childbearing (Cole, 2006). This is supported by evidence from a study conducted in the UK, which shows that the rise in single parenthood in the UK is attributed to the increase in divorce among married couples with children and separations between cohabiting couples with children. The number of households headed by single parents in 2007 was three times more than the figures in 1971 and the majority of single parent households are headed by women and about 87% of children in such households live with their biological mothers (The Social Issues Research Centre, 2008). Furthermore, it has been suggested that adolescents from households headed by a single parent and those in stepfamilies have been shown to experience higher rates of victimization compared with those from intact families (living with two biological parents). Those from stepfamilies showed a higher risk, and this elevated risk is seen in the persistent high levels of family problems they encounter. On the other hand, those from single families face victimization risk as a result of their lower socioeconomic status and residing in more violence-prone neighbourhoods and schools (Turner, Finkelhor & Ormrod, 2007).

In the UK, marriage still remains the most common form of partnership in family life, with the married couple making up 67% of families in 2006. Haven said that, the rate of marriage in the UK is on the decline. This can be seen in the marriage figures that dropped from 480,285 in 1972 to 275, 140 in 2006 (The Social Issues Research Centre, 2008). According to the Social Issues Research Centre (2008), it appears that the proportion of single parent fathers has increased by

2 percent over the last 35 years. This is contrary to the proportion of single parent mothers, which has increased from 6 percent to 22 percent during the same period (The Social Issues Research Centre, 2008).

In the traditional African society, polygamy was the preferred form of marriage. This type of marriage benefited from the large number of people within it and their contribution towards the success of the family (Waruta, 2005). According to Waruta (2005), the spread of Christianity in Africa has also brought about changes in the African family structure because it condemned polygamy and promoted monogamy as the only morally accepted type of marriage. This is not to say that monogamy was not practiced in the traditional African family system, rather, it was not as widely spread as polygamy (Waruta, 2005).

Tembo (2013) argues that the traditional African family has been significantly influenced by colonialism, Western money economy, industrialization, migration, and urbanization. This has brought about social change that has led to a transformation of the traditional African family system from what it was 5 to 10 decades ago. In the African family setting, the polygynous family provided support for their young ones through the several adult members of the family. The wives, uncles, aunts and other adult members of the family were involved with the care of the children. There was never a distinction between the biological and non-biological kin as far as primary parental obligations were concerned (Tembo, 2013). In a more general sense, the traditional African family was well-organized, well-fed and well-to-do, based on their customs and traditions. There was a sense of belonging in every member of the family and the interest of the family as a unit was prioritized over individual aspirations (Obidi, 2005; Waruta, 2005).

Afisi (2010) concurs that the family structure of the contemporary African society is undergoing drastic re-structuring due to the academic and economic empowerment of the African women. To this end, the traditional role of women in home-making and nurturing of children is gradually being abandoned as women become more involved in other professional activities different from home making (Bigombe & Khadiagala, 2004; Afisi, 2010).

Educational attainment, demand for and availability of health care, employment and migration have been shown to drive socioeconomic changes, which has transformed the traditional African family structure (Bigombe & Khadiagala, 2004). Furthermore, African families are in the web of

political and socioeconomic circumstances which result from fragile domestic economic status, poor governance and civil conflicts. In addition, the African family has faced tremendous pressure from the impact of the HIV/AIDS pandemic which is currently ravaging and threatening the existence of the African families and households (Bigombe & Khadiagala, 2004).

In South Africa, the family structure has been affected by a long history of oppression under the apartheid government vis-a-vis the migrant labour law in apartheid South Africa, which ultimately separate the bread winners from their spouses and children. The typical child in South Africa is raised by a woman in a single-parent household, and most children live in poor households, where adult members of the family are often unemployed (Holborn & Eddy, 2011). In some instances, the impact of HIV and AIDS on family income have contributed immensely to the poor living conditions of children and their trajectories to health (Holborn & Eddy, 2011).

According to Holborn and Eddy (2011), the effect of the HIV/AIDS pandemic in South Africa has led to more children growing up with absent fathers, and in single-parent households. Children growing up with one parent, or without their fathers, are at a significant disadvantage as a result of possible decline in family income. This has been shown to exacerbate the impact of family breakdown on children.

2.3.3 Parenting processes

The family remains the primary source of a child's socialization. This is because it is within the family framework that parents and children treat each other with kindness, love and care. Their relations are pure and honest and it is through this process that the child becomes gradually prepared for life in the given environment and society (Jose-Maria, Aviles, Skakova & Tukenova, 2015). According to Coley, Votruba-Drzal and Schindler (2009), youth who engaged more regularly in activities with their families and who had fathers who were more knowledgeable about their friends and activities thereafter reported lower average levels of risk behaviours in comparison to their peers with less engaging parents.

Although the structural composition of an adolescent family may have implications for his/her health trajectories, it has been suggested that the family structure also impacts on the parenting processes (Gayles, Coatsworth, Pantin & Szapocznik, 2009). A single-parent-led family may be

constrained with taking decisions and implementing roles to discipline or support a child's behaviour compared to dyadic families (Gayles et al., 2009). To support this argument, Wang, Hsu, Lin, Cheng and Lee (2009) found that adolescents who did not come from two-parent families had worse risk behaviours than others.

The socio-economic status of a family may influence parent–child relationship. Socio-economic changes such as level of education, changes in value system, provision of essential needs have been shown to impact parent-child relationships. Parents are less able to exercise control over the behaviour of their young ones when they receive financial support from them or when the children begin to provide the economic needs of the family (Wamoyi, Fenwick, Urassa, Zaba & Stones, 2011). According to Wamoyi et al. (2011), as young people receive more education and contribute more to their families' economic well-being, they emerge as decision-makers in their own right and parental influence begins to wane.

Parents who give positive parental care to their children provide an opportunity for positive sexual behaviour in their children. According to Abu and Akerele (2006), an incremental effort in parental care brings about an almost proportionate increase in positive adolescents sexual behaviour. Furthermore, parental care, deed, supervision and monitoring of children's relationships influence the sexual behaviour of adolescent children. According to Kim (2008), there is strong evidence that positive parental influence improves adolescents' sexual behaviour. Some of the Parental factors that offer strong protection against the onset of early sexual activity among adolescents include an intact family structure, parents' disapproval of adolescent sex, parental monitoring; and, to a lesser extent, parent-child communication about sex and its consequences.

Researchers have shown that when parents engage in positive parenting practices, they encourage their daughters to develop better behaviour and make better choices regarding their health. However, when parents underestimate their daughter risk, it influences their ability to effectively monitor and control their children. Adolescents who felt that their parents underestimated their risk reported that their parents had fewer rules to be obeyed, less parental oversight, less parent-child communication, and less disapproval of risk (O'Donnell, Stueve, Duran, Myint-U, Agronick, Doval & Wilson-Simmons, 2008). It has been shown that through proper parent-child connections and relationships, the child is able to develop social experiences

and absorb socially acceptable behavioural, spiritual and material roles that are passed from generation to generation (Jose-Maria et al., 2015).

2.3.4 Family economy, social support and adolescent risk behaviour

According to Hallman (2004), economically disadvantaged youths have an increased risk for unsafe sexual behaviours and experiences. Female adolescents from low socio-economic status (SES) are more likely to exchange sex for money or gifts and are also more likely to have experienced forced sex as well as having multiple sexual partners (Hallman, 2004). Low SES has also been shown to lower adolescents' chance of secondary abstinence and the age at sexual debut in both males and females. Family SES has also been associated with reduced condom use at last sex, and communication of sensitive sexual matters with the most recent partner (Hallman, 2004). However, research has shown that the negative effect of low SES on sexual behaviour has a significant female preponderance (Hallman, 2004; Ahimbisibwe, 2014). In a related study, McLaughlin and Kaplan (2008) sought to examine the relationship between total household income and risky sexual behaviours, including the use of birth control, number of sexual partners, age at first intercourse and the contraction of STIs. It was reported that the level of income is negatively correlated with unprotected sexual intercourse among females. It was also found that the level of income plays a role in an adolescent's decision and choice of contraceptive.

Similarly, Kipping, Smith, Heron, Hickman and Campbell (2015) found that for a one-category reduction in social class, maternal education or income, the odds of having a greater number of multiple risk behaviours increased by 22, 15 and 12%, respectively. Furthermore, there was evidence of a strong relationship with decreasing SES and criminality, car passenger risk, TV viewing, scooter risk, early sexual behaviour and weekly tobacco use.

Interestingly, Isiugo-Abanihe and Oyediran (2004) found an inverse relationship between household socio-economic status and sexual experience, although it was shown that those from low SES homes started sexual activity earlier than those from medium or high SES. It was also reported that sexual experience increased as SES declines. However, Isiugo-Abanihe and Oyediran (2004) argue that the level of sexual activity may also increase with increases in SES. This may be attributed to inadequate parental care and monitoring by well-to-do parents who are often pre-occupied with pursuit of professional careers and wealth. Furthermore, Miller, Benson and Galbraith (2001) argue that adolescents may also be influenced by their environment, for

instance, adolescents who have older siblings or pregnant teenage sisters have an increased risk of becoming teenage mothers.

According to Lenciauskiene and Zaborskis (2008), living in an intact family is significantly associated with decreased involvement in early sexual risk behaviour. However, easy communication with parents, especially with the mother, was more significant for females than for males' early sexual behaviour. Furthermore, a low level of maternal monitoring had a higher impact on males early sexual behaviour, while a low level of paternal monitoring had a higher impact on females (Lenciauskiene & Zaborskis, 2008). It has also been said that parent-teen connectedness, parental support and monitoring of children's activities decrease the risk of adolescent pregnancy (Miller, Benson & Galbraith, 2001)

In a study conducted by Kalina, Madarasova Geckova, Klein, Jarcuska, Orosova, van Dijk and Reijneveld (2013), it was reported that parental monitoring was more strongly associated with sexual risk behaviour than parental social support. Paternal monitoring was associated with early sexual debut among females and non-condom use among males. They however concluded that parental monitoring and parental support may effectively delay the age of first sexual intercourse and increase the frequency of condom use among adolescents (Kalina et al., 2013).

According to DeVore and Ginsburg (2005), intervention studies with a parenting component demonstrated immediate and long-term protective effects on adolescent risk behaviour. Parent-child connectedness and authoritative parenting style are protective for teens. Parental monitoring has a protective effect on many adolescent risk behaviours in both middle-class populations and poor urban environments and has been shown both to moderate the effect of peer influence and to persist into late adolescence. On the other hand, unsupervised time, exposure to sexual possibility situations, and out-of-home care increase sexual behaviour, improved parent-child communication reduces sexual risk behaviours (DeVore & Ginsburg, 2005).

2.3.5 Parental Monitoring

Parental monitoring is an important force in the development of an adolescent. However, the degree, type and frequency of monitoring that is effective in reducing sexual risk taking among adolescents still needs to be determined (Huebner & Howell, 2003). Proper parental monitoring

of adolescent behaviour is said to reduce early sexual initiation, smoking and marijuana use, and unsafe sexual behaviour (Coley et al., 2009). Conversely, low levels of parental monitoring have been associated with increased levels of delinquent behaviour, smoking, alcohol and drug use, and unsafe sexual practices (Caldwell, Beutler, Ross & Silver, 2006).

It has been shown that some adolescents may participate in activities that their parents are not aware of. It has been suggested that parents may otherwise be more interested in knowing about some activities that their children are engaged in rather than others. It may also be that they hide such activities that they think their parents may not approve of (O'Donnell et al., 2008). According to Peltzer (2010), the onset of coitache is predicted by living with someone other than the two biological parents, being less monitored by parents, having more advanced physical maturity, involvement in dating behaviour, having more permissive attitudes towards sex, alcohol use, delinquency, school problems and depressive symptoms.

Adolescent girls who report that their parents oversee their activities, set rules for them and communicate disapproval of risky behaviour are less likely to engage in disapproved conduct, alcohol use and sexual behaviours related to early sexual initiation. Therefore, by enhancing positive parental monitoring, adolescent risk taking behaviour may be controlled (O'Donnell et al., 2008).

It has been shown that maternal stress condition may affect parenting skills, and parenting skill have been shown to be negatively associated with child problem behaviours (Murphy, Marelich, Armistead, Herbeck & Payne, 2010). For instance, a sample of HIV infected mothers was assessed for stress of having to cope with their health condition and their ability to engage their children. Mothers who were more worried about their own health, are more likely to engage children less frequently in family routines. In addition, they are also shown to have poorer parent-child communication, and poorer and less consistent parenting discipline. It should be noted that the stress of HIV is not the only stress faced by these mothers as they are also faced with HIV associated poverty and stigma in their communities (Murphy et al., 2010).

2.3.6 Parent-child Communication

The quality of relationship shared between parent and adolescent reduces the odds for sexual initiation and intention to have sex among adolescents, and frequent sexual communication with

parents significantly reduced the effects of sexually-active friends and experienced peer pressure on adolescents' intention to have sex (van Bongardt, Graaf, Reitz & Dekovic, 2014).

According to Whitaker and Miller (2000), the effects of peer influence on adolescents' sexual behaviour could be controlled by parent adolescent communication about sex. It is presumed that parents are more knowledgeable than peers and are therefore expected to provide accurate information about sex to their wards, and if adolescents receive accurate information from parents they may act on the basis of that information rather than on the potentially inaccurate information provided by peers (Whitaker & Miller, 2000). Parent-adolescent communication yields better result when there is associated parental closeness and monitoring. According to Whitaker and Miller (2000), it is possible that parents who talk to their children about sex or condoms have closer relationships with them. By extension, it is believed that children who spend more time talking to their parents about sex and condoms would most likely spend less time with their peers, thereby reducing opportunity for peer influence (Whitaker & Miller, 2000).

On the one hand, parental disapproval and lack of parental attention are factors that limit disclosure of personal and intimate activities among adolescents, while on the other hand, greater closeness to parent is associated with more disclosure of adolescent activities (Yau, Tasopoulos-Chan & Smetana, 2009). Young people may increase their sexual disclosure to their parents if they believe that their family will be receptive, warm and supportive (Somers & Vollmar, 2006). Furthermore, Bangpan and Operario (2012) identify anxiety and fear as the factors limiting young women from discussing sex with parents, they are often afraid to violate family and community norms about sexuality. Therefore, young women from conservative cultures may abstain from sex to conform to parental expectations and avoid family conflicts. This is exemplified by adolescents in Swaziland where parental norms was the most influential factor towards young people's intentions to abstain from sex. This may be related to the Swazi tradition where girls are expected to retain premarital virginity, which promotes sexual abstinence (Sacolo, Chung, Chu, Liao, Chen, Ou, Chang & Chou, 2013). Traditionally, parents are expected to instil values and prepare their girls to participate in an annual reed dance to encourage maidens to retain pre-marital virginity (Sacolo et al., 2013).

2.3.7 Parenting style

Based on the level of disciplinary control or demandingness, warmth or responsiveness and autonomy granting, Karavasilis, Doyle and Markiewicz (2003) describes four types of parenting styles. An authoritarian parenting style is characterized by low responsiveness, high demandingness, and low levels of autonomy granting. On the other hand, an authoritative parenting style is characterized by high responsiveness, high demandingness, and autonomy granting. A permissive parent shows high levels of responsiveness and autonomy granting and low levels of demandingness. A neglectful parent is disengaged, showing low levels of both responsiveness and demandingness and autonomy granting.

It has been suggested that the quality of parent-adolescent relationship has a significant effect on the development of risk behaviours among adolescents (Newman, Harrison, Dashiff & Davies, 2008) and parental permissiveness and having friends who support risk behaviour enhance opportunities for substance use and sexual risk behaviour (Donenberg, Emerson, Bryant & King, 2006). Adolescents whose parents or caregivers practiced authoritative parenting style showed higher protective and fewer risk behaviour than those from non-authoritative families. Evidence also shows that parenting styles and behaviours related to warmth, communication and disciplinary practices improves academic achievement and psychosocial adjustment (Newman et al., 2008; Abar, Carter & Winsler, 2009). Furthermore, a review of literature on the relationship of parenting style and risk-taking behaviour of adolescents found that the authoritative parenting is the most protective against substance use, whilst the neglectful style was shown to increase risk among adolescents (Becona, Martınez, Calafat, Juan, Fernandez-Hermida & Secades-Villa, 2012).

Authoritative parenting style has also been associated with positive child outcomes such as social and cognitive functioning, academic achievement, self-esteem, social adjustment, and social competence (Domenech Rodriłguez, Donovick & Crowley, 2009). In addition, Piko and Balazs (2012) provides evidence in support of the protective role of authoritative parenting style in relation to adolescent mood problems, particularly among girls. Parenting style has also been show to predict different behaviour in boys and girls. Mothers' responsiveness has been shown to be the only predictor of male child behaviour, while among girls, fathers' responsiveness and strictness predicted girl child behaviour. However, mother's strictness was associated with high depressive score among girls (Piko & Balazs, 2012).

Although authoritative parenting style is associated with low rates of child psychopathology compared with authoritarian and permissive parenting styles (Domenech Rodrilguez et al., 2009), Huebner and Howell (2003) found no relationship between authoritative parenting style and the level of sexual risk taking. However this was disappointing because this type of parenting style creates an environment that encourages communication. However, Huebner and Howell (2003) attribute this lack of association to sociocultural and environmental influences that may affect parenting processes. Strikingly, there was no gender bias in parenting process interaction in their study but Piko and Balazs (2012) reports that mothers are more involved in their girl child, they exercise more control and demand more from them but they also show more response to their needs and care. Fathers are said to show no gender bias in responsiveness and demandingness.

A study that assessed mothers' parenting processes, youth disclosure and problem behaviour found that authoritative parenting was positively associated with youth disclosure and was negatively related to problem behaviour, and coercive parenting was negatively associated with youth disclosure and was positively related to problem behaviour (Low, Snyder & Shortt, 2011). The level of warmth and hostility expressed by caregivers has been shown to be associated with early coitache and multiple sexual partnerships (Gardner, Martin & Brooks-Gunn, 2011). It has also been suggested that caregivers' effect on the behaviour of adolescents is influenced by the neighbourhood of residence. Furthermore, caregiver hostility increased the likelihood of early sex and multiple sexual partnerships and this was aggravated by neighbourhood disadvantage (Gardner et al., 2011; Black et al., 2009).

2.3.8 Modelling behaviour and its influence on deviant and sexual risk-taking

Young people learn attitude and behaviour by observing other people around them. This type of learning is called vicarious learning. It involves watching, listening and mimicking people who are admirable. These influential people often become role models to these young individuals (Kaur, 2014). According to Kaur (2014), a role model is the person that an individual admires or looks up to, and such a person may come from the individual's family or just someone they read about or see on TV. Furthermore, The American Academy of Child and Adolescent Psychiatry (2011) defines a role model as someone who serves as an example by influencing others and further argues that for many children, the most important role models are their parents and care givers who support them (AACAP, 2011b).

Adolescents often shape their lives to conform to that of their role model. By not only observing but also putting into practice what they see and what they hear, they are said to be modelling the behaviour of the role model. This has been described as one of the most powerful learning mechanisms (Taylor, Peplau & Sears, 2011). It has been shown that modelling behaviour may have both positive and negative effects on the health of adolescents (Yancey, Grant, Kurosky, Kravitz-Wirtz & Mistry, 2011). It therefore follows that adolescent behaviour may be influenced by their social relationships and this could serve as a tool to promote protective behaviour among adolescents (Yancey et al., 2011).

As children grow older, they acquire skills to help shape their behaviour, build an identity for themselves and imbibe a value system. They are able to do this by learning from their role model, people close to them or people they admire. The choice of who to emulate may be based on certain attributes which may include but not limited to parents' personality, talents and character (Anderson & Cavallaro, 2002). The sequel of these attributes may bring ill-health or improve the health trajectories for the individual concerned because it has been shown that parents and other family members are important role models for children (Anderson & Cavallaro, 2002). For instance, the presence of the father in the family contributes to the upbringing of the child. The father contributes to the child's financial wellbeing, while the child sees him as a role model and his presence also enforces discipline and supervision for the child (Flouri & Buchanan, 2003).

Researchers have demonstrated that children generally would grow up to be like their parents (Stephens, 2007). Therefore, children from homes where parents indulge in substance abuse are more likely to do so than those whose parents do not smoke or abuse substances. Furthermore, Elkington, Bauermeister and Zimmerman (2011) highlight that adolescents who are raised in unstable families, such as those characterized by unending family conflicts, parental substance abuse and neglect and lack of support for young ones are prone to replicate what they see in their families as they grow older. These family risk factors are said to be associated with increasing substance use with age (Elkington et al., 2011).

Adolescents have also been shown to model siblings' behaviour. Whiteman, Zeiders, Killoren, Rodriguez and Updegraff (2014) postulate that younger siblings' deviant and sexual risk behaviour may be acquired from modelling such behaviours from older siblings. This shows an association between older siblings' earlier and younger siblings' later risk behaviours. This social

learning mechanism through modelling is a salient process through which older siblings transmit norms and expectations regarding participation in health risk behaviours (Whiteman et al., 2014).

Parents remain key players in moulding adolescent behaviour. However, the impact of changing economic landscape has brought about changes in family structure and employment patterns and this has put a strain on the ability of parents to effectively monitor and control their children (O'Donnell, Wilson-Simmons, Dash, Jeanbaptiste, Myint-U, Moss & Stueve, 2007).

Identifying a positive role model has been associated with low risk behaviour and most young people are likely to identify their parents as their role models (Yancey, Siegel & McDaniel, 2002; Kim, 2008) while some adolescents also identify non-parental figures as their role models (Yancey, Siegel & McDaniel, 2002). The influence of adult behaviour on the adolescent may be positive or negative. A negative adult influence has been shown to increase adolescents risk for negative outcomes such as externalizing, internalizing, substance abuse and negative school attitudes. According to Yancey, Grant, Kurosky, Kravitz-Wirtz and Mistry (2011), there appears to be a strong relationship between different role models and adolescent health behaviour. Adolescents who identified teachers as their role models are more likely to engage in health promoting behaviour, compared with those without a role model. However, other types of role models like family members and athletes also have strong positive predictive value. Conversely, it has been shown that adolescents who reported an entertainer as a role model were less likely to engage in health-promoting behaviour. This group of adolescents have higher odds of substance use and physical violence compared with those who had no role model (Yancey et al., 2011).

As children grow older, peer associations become an alternative to child-parent relationship. This is more pronounced during adolescence, when friends can be a source of support and wellbeing but may also become models of deviant and risky health behaviour (Rubin, Bukowsky & Parker, 2006). According to Sieving, Eisenberg, Pettingell and Skay (2006), the sexual behaviour of adolescents is influenced by the attitude and behaviour of their friends (Cherie & Berhane, 2012). The higher the number of friends who are sexually experienced, the greater the likelihood of sexual involvement by an adolescent. This may be related to a perception among youths whose friends are sexually active that they will gain respect among their friends if they also have sex (Sieving et al., 2006).

Rew et al. (2011) suggest that even when adolescents are not engaging in sexual risk behaviour but engaging in other health risk behaviour or associate with peers who engage in risk behaviour, their propensity for sexual risk behaviour increases. To support this assertion, Ali and Dwyer (2011) argue that peer effects are important determinants of sexual behaviour. Their research suggests that a 10 percent increase in the quantity of close friends initiating sex will increase the likelihood of sexual behaviour by approximately four percent for an adolescent.

Although it has been shown that delinquent peers are likely to engage in risky sexual behaviour, youths who associate with such peers may be influenced into behaving in a similar way (Le & Kato, 2006; Elkington et al., 2011). However, the influence of peers may also have positive impact on health behaviour, for instance, adolescents modelling their friends positive attitude and behaviour about health can mitigate the influence of deviant friends on adolescent risk behaviour (Cattelino, Glowacz , Born, Testa , Bina & Calandri, 2014).

2.3.9 Perceived benefit and risk associated with sexual risk behaviour

Newby, Brown, French and Wallace (2013) posit that young adults' risky sexual behaviour is driven by their positive outcome expectancies for unprotected sex. Similarly, Ott, Millstein, Ofner and Halpern- Felsher (2006) explain that sexual behaviour is influenced by a positive motivation for sex, which may be physical (the desire for feelings of excitement or pleasure), relationship-oriented (the desire for intimacy), social (the desire for peer approval or respect) or individual (the desire to gain a sense of competence and learn more about oneself). Furthermore, adolescents believe that having sex would bring about intimacy, provide sexual pleasure and improve their social status. However, these expectations differ by gender and level of sexual experience (Ott et al., 2006).

The negative outcomes of having unprotected sex are enormous. In light of this, some researchers have investigated the intention to use condoms among adolescents. It was reported that attitude towards condom use, the perceived social norm regarding condom use and self-efficacy to use a condom were important predictors of the intention to use a condom among adolescents who had no previous sexual experience, while perceived social norm predicts intention to use condom among those with previous sexual experience (Rijsdijk, Bos, Lie, Ruiter, Leerlooijer & Kok, 2012). It has also been reported that adolescents who have not been sexually

exposed are more likely to report greater costs and fewer benefits over engaging in sexual activities than adolescents who were sexually active. Therefore, some adolescents continue to engage in risky sexual activities even when their assessment of the cost of their actions outweighs the benefits of the same. This suggests that other factors such as peer pressure and pressure from partner may play a role in adolescents' decision to have sex (Deptula, Henry, Shoeny & Slavick, 2006).

Furthermore, an intention to have a baby has been shown to be a significant predictor of unprotected sexual intercourse. Foster, Higgins, Biggs, McCain, Holtby and Brindis (2011) report that participants who desired to have a baby were 41% more likely to report being willing to have unprotected sex than those not interested in having any more children. However, it has been shown that young people are aware of the negative outcomes associated with unprotected sex. This was demonstrated by a study conducted among university students in South Africa, which found that most (90.9%) of the participants understood the magnitude and problems posed by STIs, including HIV. It also showed that 94.6% believe that anyone could become infected with HIV or fall pregnant when exposed to unprotected sex. In addition, 87.3% believed that alcohol consumption while engaging in sexual activities increases the chances of being infected with HIV, other STI or falling pregnant, while 92.40% believed that having multiple sexual partnerships increases the risk of being infected with HIV and other sexually transmitted infections. Finally, the study found that 68.5% believed HIV could be contracted through oral sex (Anyanwu, Goon, Tugli, Olukoga, Amusa, Netshikweta & Ajao, 2013).

Sexual pleasure has been shown to be a strong motivation for unprotected sex among adolescents. Among college students in California, it was found that both male and female participants reported that unprotected vaginal intercourse was more pleasurable than protected vaginal intercourse, with males reporting higher pleasure ratings for unprotected vaginal intercourse than women. However, men who perceived a larger decrease in pleasure between unprotected and protected intercourse were less likely to have used condoms than those who perceived a smaller decrease in pleasure (Randolph, Pinkerton, Bogart, Cecil & Abramson, 2007). Furthermore, research suggests that people may abandon condoms in an effort to facilitate both physical and emotional closeness (Randolph et al., 2007). In the same vein, O'Sullivan, Udell, Montrose, Antoniello and Hoffman (2010) posit that the decision to engage in unprotected sex

may be influenced by perceived sexual pleasure and the desire to remain intimately connected with a partner (O'Sullivan et al., 2010).

Widdice, Cornell, Liang and Halpern-Felsher (2006) explain that some adolescents believe that sex would improve or enhance a relationship vis-a-vis improved positive feeling, fun and pleasure. In their study, they found that female participants were more likely to mention that sex improves a relationship, while males were more likely to mention that sex improves social standing. Although one in three participants believed that there is no risk of using a condom, 46% mentioned condom malfunction as a risk of using condom during sex. Similarly, a longitudinal study evaluated the relationship between risk and benefits perception regarding oral and vaginal sex. It was reported that adolescents believed that they were safer having oral sex than vaginal sex. They believed that oral sex is less risky than vaginal sex on health, social, and emotional outcomes. Some adolescents also believed that oral sex is more acceptable than vaginal sex for adolescents their own age because it does not cause a great shift to their values and beliefs (Halpern-Felsher, Cornell, Kropp & Tschann, 2005).

Cherie and Berhane (2012) posit that oral and anal sexual activity is a common practice among high school learners in Addis Ababa, and the majority of them intend to continue having oral and anal sex. Cherie and Berhane (2012) suggest that the reason for this may be associated with the practice of exchanging sex for gifts. As shown by Cherie and Berhane (2012) nearly half of the participants in their study agreed to have exchanged oral and anal sex for gifts. Those whose best friends engage in oral and anal sex are more likely to also engage in oral and anal sex. This is supported by a study conducted among homeless youths in Accra, where 54% reported having exchanged sex for food, money and accommodation, with females more likely to engage in such behaviour than males (Asante, Meyer-Weitz & Petersen, 2014). Furthermore, young women who have experienced hardship growing up and who have little or no social support or those from dysfunctional families may seek early parenthood as a way of creating love for themselves (Hanna, 2001). Similarly, Unger, Molina and Teran (2000) argue that young women with low educational goals may decide to become pregnant because they consider early childbearing as a way of achieving adult status and becoming relevant in the society.

The risks associated with unprotected sex are enormous and some of the negative outcomes to the young mother include but are not limited to infertility as a result of complications of abortion,

school drop-out and forced marriages, while the baby may suffer birth injuries, low birth weight, neglect abuse and abandonment (Olaitan, 2010). Among university students in Nigeria, unwanted pregnancy is perceived as a cause of maternal poverty (95.8%), termination of educational career (62%), child neglect and abandonment (38.5%) (Olaitan, 2010). Similarly, Olaitan (2011) reports that unwanted pregnancy is a significant cause of termination of educational career and a significant cause of medical complications such as vesico-vaginal fistula and recto-vaginal fistula. However, the most commonly reported unfavourable outcome of unprotected sex is unintended pregnancy (Wasie, Belyhun, Moges & Amare, 2012).Evidence suggests that adolescents who report unintended pregnancy are also likely to report multiple sexual partnerships. However, adolescents who are favourably disposed to using emergency oral contraception and believe in its effectiveness are less likely to use condom. This may make adolescents less-prepared to practice STI protective behaviours (Wasie, Belyhun, Moges & Amare, 2012).

In another university-based study conducted in the Venda area of Limpopo, South Africa, the majority of the participants perceive unwanted pregnancy as leading to serious negative consequences, including impaired mental health (87.7%), maternal health conditions (86.3%), shame and withdrawal from the society (86.6%) child neglect and abandonment (84.8%). Many (60.30%) participants perceived unwanted pregnancy as leading to termination of educational career, maternal poverty (74.50%). Female students were more likely to agree that unwanted pregnancy may lead to shame and withdrawal from the society compared to their male counterparts (Anyanwu, Goon & Tugli, 2013).

Among adolescents in Northern California, pregnancy was considered a more serious health related risk of having unprotected sex than having a sexually transmitted infection, including HIV. The most commonly-mentioned psychosocial risk was that having sex may lead to a negative impact on a relationship such as falling out of love with a partner (Widdice et al., 2006). Although the majority of the participants identified at least one benefit of having sex, about a quarter reported that there was no benefit of having sex (Widdice et al., 2006).

Adolescents who defer having sex, report that their reason for delaying intercourse is because they are not ready for it. However, among older adolescents (aged 17-19 years) the most common reason for abstinence was fear and this may be attributed to their understanding of the impending consequences associated with risky sexual behaviour (Long-Middleton, Burke, Lawrence,

Blanchard, Amudala & Rankin, 2013). According to Long-Middleton et al. (2013), most of the participants cited the risk of sexually transmitted infections and pregnancy as their main reasons for being fearful. However, the intention to delay sexual intercourse has been shown to decrease with age. A study conducted by Rijsdijk, Bos, Lie, Ruiter, Leerlooijer and Kok (2012) show that among sexually inexperienced adolescents, the intention to remain sexually inactive is negatively related to age, while the belief that they could get pregnant was positively related with the intention to delay sexual intercourse.

Unger, Molina and Teran (2000) report that the perceived positive outcomes of teenage pregnancy were associated with increased risk of unprotected sexual intercourse. This perception was particularly high among Latinos, non-natives of the USA and girls with low educational goals and low parental monitoring. According to Unger et al. (2000), positive perception towards pregnancy/childbearing may be a motivating factor for unprotected sex among adolescents. In-other-words, adolescents who consciously want to become pregnant may not take measures to prevent pregnancy from occurring even if they have been taught how to obtain contraceptives or negotiate contraceptive use with their partners (Unger et al., 2000).

2.3.10 Self-Efficacy and its influence on deviant and sexual risk behaviour

Self-efficacy has been identified as one of the key predictors of risky sexual behaviour. It is believed that sexual risk behaviours such as condom use during intercourse and refusing unsafe sexual practices may be prevented by improving adolescents' self-efficacy towards those behaviours (Dilorio et al., 2001; Farmer & Meston, 2006). In addition to self-efficacy, self-concept is also an important predictor of safe sexual behaviour (Houlihan, Gibbons, Gerrard, Yeh, Reimer & Murry, 2008), it is a combination of sexual attitudes, behaviours and beliefs about one's attractiveness and self-worth (Murry et al., 2005). Adolescents with a positive self-concept are likely to have a positive influence on sexual risk cognition. In other words, because they appreciate who they are and what they stand for, they are less likely to engage in risky sexual behaviour (Lou, Chen, Li & Yu, 2010). However, the self-efficacy to delay or refuse sex can be influenced by the type of partner, for instance, an individual may feel confident that he/she can delay sex when he/she is with a non-abusive partner but this level of confidence may wean when he/she is with an abusive partner in which case he/she may be forced to have sex (Boafo, Dagbanu & Asante, 2014).

Although social and cultural barriers may impede protected sexual intercourse among females, those that are able to overcome these barriers and are able to discuss their needs with their partners are more likely to protect themselves during sexual intercourse (Guiella & Madise, 2007). Furthermore, it has been shown that adolescents who had never engaged in sexual intercourse have a higher self-efficacy than those who are sexually engaged (Lalbahadur, 2008).

Kalichman et al. (2002) posit that condom use self-efficacy is a better predictor of safe sex practices than condom use skills and knowledge. This is because condom use self-efficacy has a direct effect on the frequency of unprotected sex, while condom application skills do not. Although Schwarzer and Luszczynska (2005) also agree that self-efficacy is a good predictor of safe sexual practices, they also suggest that the expected outcomes of condom use among adolescents should also be considered. This is because adolescents with high self-efficacy and low negative outcome expectations regarding condom use are more likely to use condoms regularly. In their study, the self-efficacy for condom use (91%), self-efficacy to negotiate condom use with a partner (97%) self-efficacy to discuss condom use with a new partner (94%), were high among the vast majority of the participants but only 22% reported regular condom use. This brings to the fore that condom use self-efficacy is influenced by many factors, some of which are age, gender, ethnicity, condom use attitudes and barriers, sexual experience, and partner characteristics (Farmer & Meston, 2006). This finding was corroborated by Redmond and Lewis (2014) who found gender based differences in sexual self-efficacy among African-American adolescents, where females reported higher perceived sexual self-efficacy than males.

According to Redmond and Lewis (2014), the lower self-efficacy reported among males does not necessarily mean that they are less confident in their ability to protect themselves but may result from their unwillingness to practice these behaviours because they do not consider themselves susceptible to HIV infection. However, Guiella and Madise (2007) report that males who feel confident in their ability to use condoms correctly are more likely to use condoms. Furthermore, Crosby, Diclemente, Wingood, Sionean, Cobb, Harrington, Davies, Hook and Oh (2001) argue that the ability or knowledge on how to apply condoms correctly does not translate to a safer sexual practices among adolescents. They therefore suggest that building rational and sexual negotiation skills among these young individuals may increase the consistency and correct use of condoms among adolescents.

A study conducted among South African youth to determine factors associated with high self-efficacy for sexual negotiation and condom use, found several factors to be predictors of self-efficacy, with some gender differences in the predictors of self-efficacy. Among the female participants, knowing how to avoid HIV, having spoken with someone other than a parent or guardian about HIV/AIDS and having life goals were positive predictors of self-efficacy, while not using condoms during their first sexual encounter, having a history of unwanted sex, and believing that condom use implies distrust in one's partner were factors associated with low self-efficacy. Among the male participants, believing they are at risk for HIV, reporting that getting condoms is easy, and having life goals, were positive predictors while not using condoms during their first sexual experience, a history of having unwanted sex, believing condom use is a sign of not trusting one's partner, and refusing to be friends with HIV-infected persons, were factors associated with low self-efficacy among male participants (Sayles, Pettifor, Wong, MacPhail, Lee, Hendriksen, Rees & Coates, 2006).

When intoxicated, young people may report lower self-efficacy to use condoms and this has been associated with poor condom use behaviour during sexual intercourse when intoxicated (Abbey, Parkhill, Buck & Saenz, 2007). This is supported by a study that shows that alcohol intoxication reduces women's intentions to use condoms. In the study, intoxicated women reported lower future condom use than those who were sober. In other words, intoxication influenced condom use self-efficacy and condom negotiation intentions (Davis, Masters, Eakins, Danube, George, Norris & Heiman, 2014). Therefore in women with low self-efficacy in condom use, it is believed that alcohol intoxication may be focused on situational cues that remind them that they cannot use condom effectively. This may reduce the woman's intention to negotiation and use condom (Davis, Masters, Eakins, Danube, George, Norris & Heiman, 2014).

Adolescents' body image and body appearance have been associated with sexual refusal self-efficacy. Studies have shown that young women who are not pleased with their general body appearance or specific parts of their body are less likely to refuse sexual advances (Yamamiya, Cash & Thompson, 2006). Studies have also shown that a positive sense of Afrocentric appearance significantly increases sexual refusal self-efficacy but no relationship was found with body image (Plybon, Holmer, Hunter, Sheffield, Stephens & Cavolo, 2009). Other studies have reported a significant relationship with body image and sexual refusal self-efficacy (Yamamiya, Cash & Thompson 2006; Wingood et al., 2002). In the same light, Lee, Salman and Fitzpatrick

(2009) posits that depression may reduce self-efficacy for HIV preventive measures. According to their study, participants who had high HIV preventive self-efficacy engaged less in risky sexual behaviour but those who reported having symptoms of depression were more likely to report increased sexual risk behaviour.

In a study to determine the knowledge of correct use of condom among adolescents in Burkina Faso, Ghana, Malawi and Uganda, the strongest predictor of knowledge of correct condom use among both male and female adolescents was exposure to a condom use demonstration. Adolescents who have observed a condom demonstration are 2 to 5 times more likely to have good knowledge of correct condom use than those who have not. The age of participants, having ever received sex education in school, ever attended school and exposure to the radio were also significant predictors of knowledge of correct use (Bankole, Ahmed, Neema, Ouedraogo & Konyani, 2007).

2.3.11. The nature and pattern of deviant and sexual risk taking

In a study among never married youths in Côte d'Ivoire, the rate of primary abstinence was 33% and 6.7% observed secondary abstinence. Educated females were 11 (eleven) times more likely than those without education to practice either primary or secondary abstinence. Males who had no religion, or were practicing religions other than Christianity or Islam were significantly less likely than other male youths to practice sexual abstinence. Living in the north-west region of the country significantly decreased the odds of sexual abstinence among female youths. Similarly, female youths living in rural areas were 0.42 times as likely as those in the urban areas to practice sexual abstinence (Koffi & Kawahara, 2008).

Increased sexual experience is associated with greater sexual risk behaviours. It is possible that as girls become sexually experienced, they begin to perceive themselves as less assertive (Auslander, Perfect, Succop & Rosenthal, 2007). Furthermore, only 15% of girls in their study perceived themselves as communicating their sexual desires to their partner about 25% of the time. This implies that sexual assertiveness is related to prior sexual experiences. Those girls who had been sexually active longer and had more partners felt more able to initiate sex, but less able to refuse sex and insist on pregnancy-STD preventive methods (Auslander et al., 2007).

A study conducted among college students in Nigeria found that a quarter of the student population engaged in multiple sexual partnerships, while about 44% reported that they did not like using condoms. Those who had multiple sexual partners were less likely to appropriate decisions regarding STI control. Interestingly, about 44% of those who had multiple sexual partners agreed that multiple partnerships is a sexual risk behaviour and just over half of those who had information about HIV and AIDS were willing to use condoms (Ojikutu, Adeleke, Yusuf & Ajijola, 2010). According to the CDC (2010), condoms are highly effective in preventing pregnancy and STIs and more so when used correctly, but many youth lack the knowledge and experience needed for effective use. Among respondents to the 2011 YRBS, 34% of students were currently sexually active, and 40% of these sexually active students did not use a condom at last intercourse (CDC, 2012). A measure of the consistency of condom use was shown to be 38% in Burkina Faso, 47% in Ghana, 20% in Malawi and 36% in Uganda. It was also found that age difference between partners is a major determinant of consistent use of condoms. Young men who were 0-4 years older than their partners were about two and a half times more likely to use condoms consistently than those who were between 5-9 years older than their partners. Other important predictors of consistent condom use were place of residence, level of education, living arrangements and exposure to mass media (Bankole, Ahmed, Neema, Ouedraogo & Konyani, 2007).

Condom use within steady and casual sexual relationships was examined among mid-adolescents. It was anticipated that with casual partners, condom use was not likely to be planned ahead of time but it was expected for that to be the case with steady relationships. Therefore, buying and carrying condoms and communicating about condom use with partner (preparatory behaviours) were expected in the steady relationship but not the casual relationship. Results however confirmed that condom use with steady sex partners was explained by preparatory behaviours, habits, and to some extent, behavioural willingness. On the other hand, condom use with casual sex partners was predicted by willingness to take risks. This implies that with a casual partner, no preparations are made for unexpected sexual activities and this may expose the adolescents to undue sexual risk (van Empelen & Kok, 2006). In a related study, Nelson, Morrison-Beedy, Kearney and Dozier (2011) accessed black adolescent mothers' decisions regarding condom use with various partner types. The study found that adolescent mothers always used condoms with their perceived casual partners (those with no emotional intimacy) but never used condoms during sexual intercourse with males with whom they were emotionally intimate (for example, the biological fathers of their children).

The female condom is a proven effective female controlled HIV prevention device but only about 8% of sampled population of adolescents in Cameroun reported ever using it (Tarkang & Bain, 2014). Participants who disagreed on the effectiveness of the female condom in preventing STIs, including HIV, and who believed that youths are susceptible to HIV, are not likely to use it. Conversely, participants who disagreed that the female condom makes sexual intercourse less enjoyable, that due to religious beliefs they would feel guilty using the female condom, that they lack knowledge on the correct use of the female condom, and that distance to the nearest female condom supply point is far, were more likely to use it (Tarkang & Bain, 2014). Sociocultural and biological factors predispose women to a heavier burden of HIV/AIDS than men (Tarkang & Bain, 2014).

Normative beliefs and subjective norms have been shown to adversely affect lifetime condom use current condom use and self-efficacy in condom use. Consequently, these believes and norms stand as a barrier to the prevention of STIs (Sarkar, 2008). In some cultures, women are raised to submit to cultural norms and practices that expose them to unsafe sexual practices. The inability to express their desire to practice safe sexual practices often place them at a disadvantage in decision making regarding contractive use (Sarkar, 2008). Sociocultural practices in Swaziland may support the high rate of risky sexual behaviour. For example, males are expected to have multiple sexual partners and this shows power, masculinity and sexual dominance over females who are raised culturally to submit to men's leadership and polygamy (Tobias, 2001).

Some of the socioeconomic factors associated with unprotected sexual intercourse include cost of condoms, moral values, ethnicity, religion, gender inequality, inability to negotiate condom use and the stigma attached to the use of condoms while aversion for condom, consumption of alcohol or use of drugs prior to sexual intercourse, and anxiety and depression are personal factors that are negatively associated with unprotected sexual intercourse (Sarkar, 2008; Asante, Meyer-Weitz & Petersen, 2014).

It has been shown that church based populations are not immune to risky sexual behaviour, Hawes and Berkley-Patton (2014) examined the sexual risk behaviour of an African American church based population. It was shown that among highly religious (as determined by descriptive analyses), 12.5% had more than 10 lifetime sexual partners participants and 17 % of participants

had a history of STIs. In addition, about a quarter had sex while high on drugs or alcohol, 11 % had sex against their will, and 7 % had been in a correctional facility (Hawes & Berkley-Patton, 2014).

Cherie and Berhane (2012) posit that understanding adolescents' sexual behaviour is important in instituting interventions to prevent and control sexually transmitted infections including HIV among this category of individuals. The reasons given by adolescents for indulging in oral and anal sex include prevention of pregnancy, preserving virginity, and reduction of HIV and STIs transmission. In their study, 5.4% and 4.3% reported having oral and anal sex respectively. Furthermore, multiple partnerships were reported by 61.2% of the respondents who had oral sex and 51.1% of students practicing anal sex (Cherie & Berhane, 2012).

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodology that was used in this study. It covers the following, the study design, study setting, population and sampling, method of data collection and analysis and ethical consideration. This study was divided into three phases, with the first two phases having different methodologies, while the third Phase describes the development of a public health programme. The reason for this division is to better explore the variables in this study and also because the study involves two different target populations with different objectives.

3.2 Research setting

The study was conducted in Thabazimbi, a mining community in the Limpopo Province. The term Thabazimbi means 'mountain of ore' in the Tswana language. It is situated in the Waterberg District (Figure 3.1), covering an area of 11,190km^2 in the South-western part of Limpopo, South Africa. It shares borders with Botswana, and is located about two hour's driving distance from Pretoria. The major economic activities include mining (iron ore and andalusite) and agricultural practices. The area has one of the largest ore mining shafts in Africa with more than two million tons of ore mined each year (Thabazimbi Municipal Records, 2013). There are 25,080 households with average household size of 2.80 and female headed households of 24.70%. The population of Thabazimbi is put at 85,234, with the majority aged 15-64 years. The population is growing at 2.63% per annum with about 141 males for every 100 females while the level of youth unemployment is put at 26.90% (Thabazimbi Municipal Records, 2013). There are formal and informal settlements in the community as shown in Figures 3.2-3.4 in the appendix.

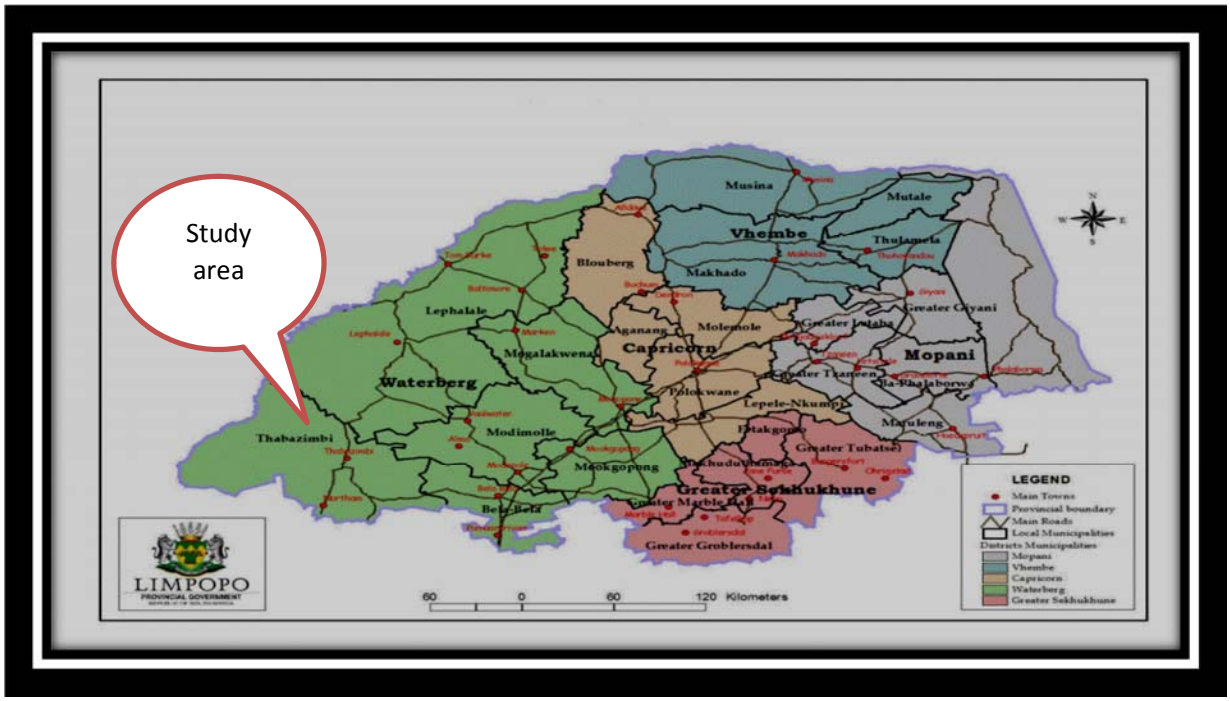


Figure 3.1: A Map of Limpopo, showing the study area. Source: Wikipedia (2015).

3.3 Research methodology

This study involved a sequential explorative, descriptive and analytic mixed method design combining both qualitative and quantitative research approaches. The decision to apply this method was based on the assumption that the true picture of the dynamics of the family will only be adequately uncovered after exploring the problem using a qualitative study and then using the themes generated to develop the family dynamics variables that were measured against adolescents' behaviour in the quantitative phase of the study.

3.4 Phase 1: Qualitative study (Exploration of the family dynamics in Thabazimbi and its influence on the behaviour of adolescents).

The Phase 1 of this study was approached from a purely qualitative angle. This decision is based on the objectives of this phase of the study, which focused on the intricate issues around family dynamics and how it affects the adolescent. The researcher assumed that these issues would be better explored using a qualitative approach, which can dig deeper and answer the questions 'why' and 'how,' as highlighted by Babbie (2007).

The qualitative approach explored in detail the variables of interest and themes that arose from this phase of the study. It was used to extract the family dynamics variable that formed the foundation on which the instrument for the quantitative study was based. According to Green and Thorogood (2009), in a mixed method research, qualitative interviews are often beneficial in the initial stages of the study to explore the subject matter and to use the findings to develop questionnaires using the vocabulary of the participants.

3.4.1 Study design

An exploratory design was used in this phase of the study. This design has been found useful in exploring and describing a phenomenon within its context (Green & Thorogood, 2009). This design was used to inquire how family members within Thabazimbi community relate with one another and how the level and quality of relationship and support within the family rubs off on the adolescents.

3.4.2 Study population and sampling

Thabazimbi is richly populated by a mixture of indigenous and migrant families from across Southern Africa and beyond. This study targeted local and migrant households living in close proximity to the mining facilities in Thabazimbi. The households of interest were those families with adolescents aged 15 years to 19 years, including child/adolescents headed households. The Purposive sampling method was used to identify suitable households for in-depth interviews. The participating households were selected based on their structural characteristics and closeness of household to the mines. The interviewees included consenting parents/caregiver and their adolescents who were aged 15 to 19 years. The interviews continued until data saturation was

researched, and at this point, a total of 23 interviews had been conducted. Among the interviewees were 10 parents and 13 adolescents (two of whom were heads of household).

3.4.3 Inclusion criteria

The following were taken into consideration during sampling:

- Age of adolescents: only households with adolescents aged 15-19 years were included in the study.
- Status of household: households headed by parent, siblings, grandparent, relatives and child headed households were all eligible to participate
- Distance from an active mine: only households within 20 km radius of an active mine were considered.

3.4.4 Exclusion criteria

- Families and adolescents who had not lived in the community for more than six (6) months were excluded from the study, this is to ensure that participants are familiar with the environment.

3.4.5 Instrument for data collection

An interview guide (Appendix 1) designed in line with the specific objectives for this phase of the study was used to direct question during the interview. The development of this instrument was done in consultation with experts at the School of Health Sciences, University of Venda. This instrument was only a guiding tool used to keep the participants in focus of the aim of the study, in order words, the participants were allowed to express themselves while the researcher used probing questions to dig deep for more information.

3.4.6 Pre-test

Pre-testing of the instrument was done to adjust and modify the questions where necessary. The instrument was pre-tested among one adult and one adolescents from two households in the community who were also part of the study. Data collected from them were analysed and this helped to improve on the subsequent interviews.

3.4.7 Recruitment and training of research assistants

The research participants were diverse in their ethnicity, with over eleven different languages spoken in the community, so it was imperative to select research assistants who were multi-lingual in order to make data collection less difficult, on the other hand, the researcher had to select individuals who were experienced in conducting qualitative interviews. Therefore, the researcher selected two assistants with a master's degree in a relevant field who had been involved in field work related to the present study. These assistants served as moderators to the home-based caregivers who were also involved in the study because of their language prowess and their level of experience working within the community.

A total of five research assistants were recruited to serve in this phase of the study, and two days were set aside for training purpose (to train and familiarize them with the objectives of the study and the plan for data collection). They were taught how to make objective and keen observation, take down notes and operate the voice recorder which was used during data collection. For the purpose of quality assurance, the home based caregivers were supervised by the moderators, while the researcher served as the general supervisor.

3.4.8 Data collection

Data collection commenced in late June, 2016 and was completed by the end of August, 2016. This process took place at the homes of selected families and each interview lasted for 45-60 minutes. The researcher explained the purpose of the study to the participants before seeking their consent to participate in the study. Those who gave their consent were taken to a secure and comfortable part of the house for the interview. A voice recorder was used to record the conversation with the participants while other methods of data collection were also employed, for instance, research assistants took notes while the researcher also took notes and made observations during the interviews. The questions were asked in English language for those participants who spoke English while those who were not literate in English had the questions asked in their mother tongue. In order to build trust among the adolescent, and encourage them to speak freely, the researchers conducted the interviews in a sequence, the parents were interviewed first and their children were interviewed later.

Participants were engaged in a one-on one interview with the aim of uncovering their everyday activities as a family, some members of the family felt embarrassed about the question that they had to answer while it was obvious that some tried to cover up and not tell the truth about what happens in their family. This was common among parents. On the other hand, adolescents were open and talked freely about the dynamics within their family, in some cases giving a completely different account of what their parents had said. This process continued until there was no new information coming from the participants and it was at this point that the researcher stopped interviewing participants.

3.4.9 Data Analysis

Data were analysed using thematic content analysis. This method is widely used because it aims to present the key elements of participants' account (Braun & Clarke, 2006; Green & Thorogood, 2009). The following steps were followed during data analysis:

1. The data was reviewed thoroughly by listening to the recordings over and over again and also going through the field notes in other to make sense of the message. The researcher then began to transcribe the recordings beginning with the most interesting interviews

2. Interesting features in the transcripts and field notes were identified and coded systematically and the codes were later organized.

3. The identified codes were grouped and from these groups the researcher identified themes and similar themes were put together.

4. The themes were reviewed against available data, those that did not have sufficient data base to support them were collapsed to feed into another theme or excluded. Each theme was described to capture its true essence.
5. The themes were organized to present a narrative that represents the data across themes.

3.4.10 Measures of Trustworthiness

Research findings must be evaluated in relation to the procedures used to generate the findings so as to ensure trustworthiness or soundness (Graneheim & Lundman, 2004). Lincoln and Guba proposed the concepts of credibility, dependability, transferability and confirmability as

appropriate constructs in validating qualitative research. These constructs were applied to this study to ensure trustworthiness.

Credibility

This construct is the alternative to internal validity. The goal here is to ensure confidence in the truth of the findings. To ensure credibility, the researcher identified respondents who met the eligibility requirements, they were interviewed in a secure and comfortable place in their home away from ear shots of people so as to create an environment conducive for disclosure. Furthermore, they were engaged for a prolonged time. During this time, the researcher observed the participants as they talked and made additional notes and further clarified questions to find out more about what is being said. The researcher also invited comments and opinions from colleagues on the processes undertaken during data collection, where necessary, amends were made to ensure credible outcomes.

Transferability

This is the alternative to external validity or generalizability. Although it is difficult to make a general statement within the context of a qualitative research, the researcher ensured proper and in-depth description of the context within which the research was approached. For instance, by stating the scope and delimitation of the study and by properly defining concepts that were applied during the study, this will serve as a guide for comparing the findings in this study in a different context or situations.

Dependability

This is an alternative to reliability; it refers to the consistency of the inquiry. This is not easily achievable in qualitative research due to the changing social context within which this type of research is conducted (Lincoln & Guba, 1985). The researcher ensured dependability by allowing cross-checking of codes by colleagues who were not part of the study to review the entire process that were applied during the study and matching these processes with the findings or outcome.

Confirmability

This captures the concept of objectivity. Confirmability in this study was ensured by proper documentation of the procedures for checking and rechecking of data, and the attestation of the

results by colleagues who were also part of the study, and the results were also compared with findings by other authors.

3.5 Phase 2: Quantitative study (Assessment of the deviant and sexual risk behaviour of adolescents in Thabazimbi community)

This phase was approached from a quantitative perspective and it was structured in line with the SCT.

3.5.1 Research design

A quantitative cross sectional analytic design was used in this part of the study. This design provided a snapshot on the issues relating to adolescent deviant and sexual risk behaviour and their family dynamics and also to examine relationships between and among variables. For example, it allowed for comparison to be made across gender and parenting processes. This is in cognizance that adolescent behaviour as well as family dynamics are constantly changing with time, varying with culture/traditions and influenced by industrialization and globalization.

3.5.2 Target population

Based on the operational definition provided in this study, the target population were adolescents aged 15-19 years. The reason for choosing older adolescents was that the researcher assumed that adolescents at this age must have attained the necessary maturity to adjust to the sensitive nature of the subject matter addressed in this study. They are therefore not likely to be emotionally and mentally traumatized. Although studies have shown that a good number of adolescents report having engaged in sex before their 15th birthday, individuals aged 15 years and above are more likely to be sexually exposed than those that are younger (Michigan Department of Education, 2007: Newby & Snyder, 2009; Anyanwu et al., 2013a).

3.5.3 Sample size and Sampling

There are about 4,799 adolescents aged 15-19 years in the community (Census, 2011). The sample size was calculated using slovin's formula (Cochran, 1963).

$$n= N / (1+N e^2)$$

Where 'N' is the total number of adolescents, 'n' is the sampled adolescents and 'e' is the accepted level of error set at 0.05.

n= 4799/(1+ 4799 x 0.0025)

Therefore, the number of adolescents sampled was 369

There are four main settlements in the research area that met the selection criteria outlined in section 3.4.3 (page 56). These include Thabazimbi, Smash Block, Jabulani and Northem, these settlements have about 1661, 1688, 12 and 1438 adolescents aged 15-19 years respectively. The settlements formed clusters from which samples were selected and the percentage composition of each cluster and the number of adolescents selected are shown in Tables 3.1 and 3.2 respectively.

Table 3.1 Population frame according to residence clusters

Residence cluster	**Number of adolescents aged 15-19 years**	**Percentage**
Thabazimbi	1661	34.6
Smash Block	1688	35.2
Jabulani	12	0.2
Northem	1438	30.0
Total	4799	100

(Source: Thabazimbi Municipal Records, 2013).

Simple random sampling technique was used to select the participating households from where adolescents were sampled to participate in the study. Twenty households were selected randomly from each zone, and in selected households, every adolescent within the 15- 19 years old was eligible to participate in the study.

Table 3.2 Sampling frame

Residence cluster	Number of adolescents aged 15-19 years	Percentage	Number of Adolescents sampled
Thabazimbi	1661	34.6	128
Smash Block	1688	35.2	129
Jabulani	12	0.2	1
Northem	1438	30.0	111
Total	4799	100%	369

3.5.4 Instrument

Findings from the qualitative study were used to create the family dynamics variable that were measured against adolescent deviant and sexual risk behaviour. A questionnaire (Appendix 2) was used for data collection. This instrument was formulated based on the constructs of the SCT. It was divided into five sections; section A covered socio-demography and family dynamics. Section B provided information on the nature and pattern of deviant and sexual risk practices among adolescents (Behaviour capabilities). Section C focused on adolescents' perceived benefits and risks of engaging in deviant and sexual risk behaviour (Outcome expectations) while section D provided information on the perceived level of skills for self-protection against deviant and sexual risk in the community (Self-efficacy) and finally, section E shed light on influence of parents and other adults on adolescents' deviant and sexual risk behaviour in the community (modelling behaviour).

3.5.5 Pre-test

The instrument was pre-tested among 30 adolescents in a location that was not marked for sampling. These adolescents were given 30 minutes to complete the questionnaire. During the exercise, it was realised that the time allocated for filling out the questionnaire was inadequate and that some participants could not interpret some of the questions and therefore were unable able to answer the questions correctly. Their comments were therefore used to revise the questionnaire and additional time was allocated for completing it.

3.5.6 Validity

To ensure validity of the instrument, the researcher avoided the use of ambiguous words and lengthy sentences, making sure that the questions were asked in simple English language. Furthermore, the researcher ensured that the research topic was thoroughly researched and the objectives of the study were compared with findings of relevant studies in order to draw questions that were relevant to the research topic. The researcher also discussed the questions with his supervisors and other experts in the School of Health Sciences, who also offered their opinions.

The instrument was based on the constructs of the SCT and the questions were therefore developed in line with the constructs of the theory. This helped to focus the questions on the issues that needs to be covered in this study based on the specific objectives.

3.5.7 Reliability of the instrument

The reliability of the questionnaire was determined using test-retest methods. Thirty seven adolescents were asked to complete the questionnaire on day 1, and the same set of participants was given the same questionnaire two days later and the two responses were compared using Cronbach Alpha correlation technique. A result of 0.86 was achieved and this was found to be within the accepted limits as expressed by Nunnaly (1978).

3.5.8 Data collection

Prior to data collection, the researcher met with the ward counsellors on the modalities involved in the process. This enabled the counsellors to facilitate entry into the community. With the help of the research assistants, eligible participants were identified and were given a copy of the questionnaire to complete after the aim and objectives of the study had been explained to them. Data collection proceeded from one zone to the other, participants were given 45-60 minutes to complete the questionnaire and assistants were around to support those participants who needed help. The questionnaire was collected by the research assistants immediately after completion

3.5.9 Data Analysis

The completed questionnaires were scrutinized after data collection. Those that were not properly completed were excluded, and all completed questionnaires were collated and coded starting

from 001 to 388. Data were then captured into the Statistical Package for Social Sciences (SPSS) software version 22. After cleaning the data, descriptive and inferential statistics were applied to the data. Fisher's exact test and Chi square test were used to find relationship between categorical variables while multinomial logistic regression was used to predict the outcomes of family dynamic profiles. The level of statistical significance was set at $p<0.05$.

3.5.10 Ethical considerations

3.5.10.1 Ethical clearance

The proposal was approved by the Higher Degrees Committee of the School of Health Science, after which it was sent to the University Higher Degrees Committee and subsequently to the Health, Safety and Research Ethics Committee where the final approval was given with project number SHS/16/PH/06/2305. The researcher also secured approval from the community leaders and ward counsellors in Thabazimbi community.

3.5.10.2 Informed consent

The participants in this phase of the study were considered as minors because of their age. Therefore their parents or guardian gave written consent on their behalf before they were allowed to participate in the study. However, oral consent was given by adolescents before the questionnaires were handed to them. The purpose of the study was explained to the participants and their parent/parents, the sensitive nature of the content of the questionnaire was also explained to them. They were informed of their right to withdraw from the study should they feel uncomfortable with the process. For adolescents who were heads of household, the researcher got consent from ward counsellors to allow them participate.

3.5.10.3 Confidentiality and Anonymity

The participants were assured that the information provided by them and all forms of documentation received from them will be secured from the public domain. In addition, the participants were not asked to provide any form of identification by way of name and address.

3.6 Phase 3: A programme to mitigate the influence of family dynamics on adolescents deviant and sexual risk behaviour in a community affected by migration.

The Phase 3 involved the development of a programme that is expected to be useful to stakeholders in instituting control measures to curb deviant and sexual risk behaviour among adolescents. To achieve this, the researcher integrated the findings of Phase 1 and 2 studies (Figures 6.1 and 6.2).

3.6.1 Programme development

The programme was based on the findings of the phase 1 and phase 2 studies. It was also hinged on the elements of the practice theory which was made popular by Dickoff, James and Wiedenbach (1968). The elements in this theory include:

1. The Goal: This is to develop a programme to mitigate the influence of family dynamics on adolescent deviant and sexual risk behaviour.

2. The Directive: This is the prescribed plan of action through which the goal will be achieved.

3. The survey list: This includes specific activities involved in achieving the goal. They include, context, Agent, Recipient, Procedure, Dynamics and Purpose.

Context: This describes the framework within which the programme activity will take place. In the present study, the activities took place at the homes of adolescents. This activities are supported by the National Youth Policy framework 2009-2014. This framework guaranties adolescents' rights to care, accommodation, education, etc.

Agent: These are the individuals or group of people that will be involved in the implementation of the programme. They will include policy makers (National, Provincial and Municipal level), NGOs, social workers and caregivers.

Recipients: These are the individuals that will benefit from this programme. In this programme, the recipients were entire households (Parents, adolescents and siblings).

Procedure: This emphasizes the principles, routine, path, steps and rubrics to follow in-order to accomplish the set goal (Dickoff et al., 1968). This element talks about the methodology for the programme development.

Dynamics: These are the factors that may influence the uptake of the activities. They include Political will, lack of social amenities, motivation on the part of the Agent or the lack thereof, poverty, effect of living in a high risk environment and family background/dynamics.

Purpose: This describes the anticipated outcome of the programme. In this study, the programme capacitated the family by encouraging improved communication, care and support within the family. It also empowered adolescents to take appropriate initiative for their own health.

3.6.2 Plans to validate the Programme

At the end of the programme development, the researcher engaged the community in a dialogue in a bid to validate the findings of the study and also give the community and other stakeholders a chance to critique the programme.

CHAPTER FOUR

RESULTS AND DISCUSSION OF PHASE 1 OF THE STUDY: QUALITATIVE STUDY

4.1 Introduction

This chapter presents the themes and sub-themes as well as the literature control on relevant findings of this phase of the study.

The specific objectives of this phase were as follows:

1. Explore the social support system available to adolescents.

2. Explore the level of financial support available to adolescents within the family.

3. Explore Parenting processes adopted by families in the community.

4. Describe the experiences of families regarding deviant and sexual risk behaviour among adolescents living within the community.

The process of data collection and the procedure for analysis was explained in chapter three. At the end of data collection, the researcher developed a transcript for each interview after listening to the audio recordings several times. Just before commencing analysis, the researcher re-read the transcripts and listened to the audio recording to ensure that no vital information was lost in transit. While reading, important topics were coded and similar codes were merged to generate themes. In discussing the themes, the quotations from participants were presented to support the argument while literature served as control. The alphabets ‘P’ and ‘A’ were used to differentiate between the comments made by the parents and those made by the adolescents respectively.

4.2 Profile of the participants

The adult participants in this phase of the study were mostly females who had little or no formal education and were unemployed. Among the adolescent participants, most were learners who were not married (Table 4.1).

Table 4.1 Demographic profile of participants in the Phase 1 study.

	Adolescent		Parents	
Gender	Male	3	Male	1
	Female	10	Female	9
Age	15-19	13	<50	6
			>50	4
Level of education	Student	8	<Grade 12	8
	Not attending	3	Grade 12 and above	2
	Completed grade 12	2		
Employment status	Employed	1	Employed	1
	Unemployed	3	Unemployed	7
	Self employed	-	Self employed	2
Relationship status	Single	13	Single	6
	Cohabiting	-	Cohabiting	2
	Married	-	Married	2
Religion	All Christians		All Christians	

4.3 Themes and the central story

The themes that emerged include 1) Challenges faced by families in the community 2) The level of social support available to adolescents 3) Behaviours endangering the lives of adolescents and 4) Effectiveness of parent-child communication. Under these themes are sub-themes as shown in Table 4.2. The families in the community are faced with numerous challenges, ranging from poverty, unemployment, households headed by adolescents and a volatile environment which remains a source of negative influence to adolescents. These challenges weaken the social support system that otherwise would provide needed support and guidance to the adolescents in the community. It might be on this premise that the adolescents are lured into deviant and sexual risk behaviour. Furthermore, communication between the parents and the adolescents was found to be weak. It was therefore impossible for the parents to advise their adolescent children on the implication of their misconduct.

Table 4.2. The themes and sub-themes

Theme 1. Unstable social network that diminishes adolescents' opportunity for good behaviour
Sub-themes
1.1. Spousal closeness and family unity
1.2. Unstable families and their ability to provide positive parenting for their children
1.3 Conditions that limit parents' ability to provide discipline and support'
1.4 Lack of support from social workers.
Theme 2. Challenges faced by families in the community
Sub-themes
2.1. High levels of unemployment and its impact on the family
2.2. Financial constraint within the family
2.3. Meeting the needs of vulnerable adolescents within the community
Themes 3. Effectiveness of parent-child communication
Sub-themes
3.1. Generational gap as a hindrance to effective communication
3.2. Insufficient sex education by parents
3.3. Parent-adolescent closeness and its impact on behaviour change
3.4. Effectiveness of rules and regulations and the level of control enforced by the parents'.
Theme 4. Behaviours endangering the lives of adolescents
Sub-themes
4.1. The influence of the environment on adolescent behaviour
4.2. Headiness and unruly behaviour
4.3. Sexual risk behaviour among adolescents
4.4. Alcohol and drug abuse among adolescents

4.4 First objective: Exploring the social support system available to adolescents.

During the interview, the theme that emerged was 'Unstable social network that diminishes adolescents' opportunity for good behaviour. The following sub-themes also emerged; 'Spousal closeness and family unity', 'Unstable families and their ability to provide positive parenting for

their children', 'Conditions that limit parents' ability to provide discipline and support' and 'Lack of support from social workers'.

4.4.1 Spousal closeness and family unity

During the interview, the issue of conflict between parents was recurrent, this was particularly so among single mothers. This is not to say that married couples did not experience conflicts in their marriage but the phenomenon was more prevalent among single and cohabiting couples. Some of the comments made by participants include:

> *"My boyfriend cheats on me and we are always fighting" (P005)*
>
> *"We fight because he has other women around" (P010)*
>
> *"My parents are always fighting and I don't like it" (A003)*

It has been shown that conflicts between parents affects their ability to effectively care for their children. If recurrent, such conflicts also puts a strain on parent-child relationship. Such parents are likely to be aggressive and hostile to their children or become lax or uninterested in the activities of the child and both of these spectrum of parenting pattern supports untoward outcomes for the child. Furthermore, family conflicts have been said to be generational and could be transmitted from one generation to the next. This may arise from either genetic predisposition or by the recurrent family environment where the children experience such conflicts (Reynolds, Houlston, Coleman & Harold, 2014). However, couples who de-escalate their conflicts and find a way to make amends are less likely to experience emotional and behavioural difficulties among their adolescents (Driver, Tabares, Shapiro, Nahm & Gottman, 2003). A parent had this to say:

> *".....some of them (adolescent), their parents have failed them, some parents are drinking and fighting in front of their children and this may affect their upbringing" (P008)*

During the interview, it was observed that many households experience couple conflicts. However, this was down played as some participants felt uncomfortable to discuss the issue. Whilst the parents denied any form of conflict with their partners, the adolescents revealed that their parents or their mother and her partner/s where constantly fighting. An adolescent had this to say:

"My older sisters' (the one I live with) boyfriend drinks a lot and he is always fighting with her". (A007)

Although the present study found deviant behaviour among adolescents in single parents households where the head of household experienced conflicts with her partner, it also found deviant behaviour in two-parent families. Furthermore, deviant behaviour was also reported in families that had minimal or no conflicts among the parents. The reason for conflicts differed from one household to the other, for some it was because one partner was cheating on the other, while for some it was because a partner neglects his responsibility to his children. However, it must be said that children who are exposed to persistent conflicts within their homes are more likely to exhibit behavioural problems. For instance, couple conflicts have been associated with internalizing and externalizing behaviour among children (Reynolds et al., 2014; Driver et al., 2003).

4.4.2 Unstable families and their ability to provide positive parenting for their children

Many authors have shown that the reason for adolescent deviant behaviour is multi-faceted (Abar et al., 2009; Ahimbisibwe, 2014). This assertion is supported by the findings of the present study, which show that there are many reasons why some adolescents behave the way they do; many parents and adolescents within the study community have proffered reasons to explain adolescents' deviant behaviour. The reasons given by participants can be grouped into the following, familial separation which may be as a result of father's job, parents who are not exemplary to their children and parents who do not take care of the needs of their children. The following are some of the comments by the participants.

"Lack of home training because the parents are badly behaved, badly-behaved parents breed badly -behaved children" (P002)

"In many households, parents even drink with their kids, this place is not a good place". (A010)

Modelling is an important way adolescent learn behaviour. Parents are role models to their children, therefore children learn a lot from their parents through observation or by direct teaching of cultural norms and traditions. Therefore, children are often misguided when the family is unstable or the parents are absent, emotionally distant or the parents themselves are immoral (Popenoe, 1998). During the interview, a participant had this to say:

> *"The parents in this community are not taking good care of their children, some children are pregnant while they are still young, some children are abandoned when they get pregnant and some commit suicide when they discover they are sick (HIV positive)" (A008)*

It has been shown that adequate parental monitoring of adolescent will reduce the likelihood of an adolescent engaging in early sexual risk behavior (Coley, Votruba-Drzal & Schindler, 2009). However, low levels of parental support and monitoring have been associated with increased levels of smoking, alcohol and drug use, and unsafe sexual practices (Caldwell, Beutler, Ross & Silver, 2006).

4.4.3 Conditions that limit parents' ability to provide discipline and support

The circumstances surrounding families in this community makes it difficult for parent/s to meet their obligations to their children. Those who are gainfully employed in the mines are torn between keeping their social responsibility to their families and keeping up with their job demands. Some of these mine workers live in hostels in the mines which are designed to accommodate only staff members but not their families. Therefore, most of the time they are away at work, leaving the responsibility of raising the children to their spouses or relatives. On the other hand, those who are unemployed grapple with finding some means to provide for their families. This situation makes it difficult for such parents to monitor and exercise control over the activities of the children, especially the adolescents.

It has been shown that adolescents who live with both their parents who are in a stable relationship are more likely to show academic success (Holborn & Eddy, 2011). It is only reasonable to expect that children who live with parents who support them emotionally and provide assistance with their school work, would generally do better than those who do not have such support (Holborn & Eddy, 2011). Conversely, adolescents whose parents have low levels of education and those who live in single parent families are more likely to engage in risk behaviour and substance abuse (Lunga, 2009).

Furthermore, families where the father is either dead or absent have been shown to struggle with maintaining discipline and monitoring of adolescents (Kimani, Kisilu & Kombo, 2010). The absence of the father creates a vacuum, a lack of role model especially for the male adolescent. These families are also likely to struggle with providing food, clothing and paying of school fees (Kimani, Kisilu & Kombo, 2010). Interestingly, it has been speculated that the de-facto female

head of household may engage in risky sexual behaviour as means to survive but this behaviour may increase the risk of HIV infection (Kimani, Kisilu & Kombo, 2010).

This follows an argument that most single mothers endure emotional and financial problems; they are likely to struggle with maintaining discipline; they face loneliness and depression and they often lack ability to care for their children and establish a routine for them (Kotwal & Prabhakar, 2009). This could be heightened by low levels of financial and emotional support provided by their partner and the continued demand on their time and resources by their children (Pillay, 2010). This is however different in two-parent families where the contribution of each parent serves as a reinforcement of family values (Anderson, 2003).

By extension, single parenthood would include grandmothers raising their grandchildren. This is a common phenomenon in South Africa, perhaps secondary to the HIV and AIDS pandemic which has left many children orphaned. Taking on this responsibility comes with many constraints on the grandmothers (Lunga, 2009). In Australia, a study showed that grandparents experienced physical health, finance, social isolation and children's physical and emotional problems as challenges they faced while caring for their grandchildren (Backhouse, 2009). Similarly, a study in South Africa reported physical, emotional, social and financial problems as well as the stress of coping with badly behaved grandchildren as the challenges they faced (Lunga, 2009). Many grandmothers are frail, some even suffered from medical conditions that restricted their ability to effectively monitor and control their adolescent children. Some did not have sufficient education to support their children with their academic activities. In addition, frail grandmothers were unable to support and monitor adolescents. A grandmother had this to say:

> *"…I do not attend to my grandchild's school activities, I am too old and not strong enough to do so but I send my elder grandchild to attend meetings and also to help the younger ones with their school work" (P001)*

Another grandmother lamented*…." I cannot see properly. So, my grandson is often at home to assist me". (P004)*

4.4.4 Lack of support from social workers

During the interview, vulnerable households maintained that social workers in the community had not been responsive to their calls for help. They complained that government employees working

in the community had been anything but efficient. Their particular emphases were on social workers. A household complained that they had asked the social workers to assist them with their 16-year old son who was using drugs and taking alcohol, the social workers promised to come and take him for rehabilitation since 2015 but till now they have not seen the social workers. This is not the only complains against the social workers. This is what a grandmother had to say:

> *"My grandson does not receive a grant, but I don't know why. I have complained to the social worker, they said they will attend to it but till now, I have not seen them". (P004)*

> *"There is no other support from any other place, not even from SAASA. They used to come once in a while to distribute food parcels but they are no longer doing that". (A011)*

This finding is not peculiar to the present study; a study conducted in the Eastern Cape also reported that social workers in the community were not responsive to the complaints of the members of the community (Shambulu, 2014). This is concerning because social workers are key partners in the drive to improve quality of life among vulnerable populations in South Africa. Significantly, the present study documents evidence to support the recruitment and training of more social workers and other agents of change in the community. For instance, in the absence of the parents or an adult family member who can speak and represent the vulnerable children, some of these children become underserved and miss out on the events going on in the community. This is shown by the following comments made by a grandmother:

> *"My grandchildren are not given food parcels, like other children in the community and I don't know why" (P005)*

Findings from similar studies corroborate the findings of the present study. For instance, Karimi (2015) found that young people experience financial, social and emotional neglect, especially young mothers. Similarly, the present study found that pregnant teenagers are often denied support during their pregnancy. A teenager had this to say:

> *"My parents became angry with me when I told them I was pregnant. They did not support me during the pregnancy". (A005)*

A further challenge that emerged during the interview was violence or threat of violence. Many participants agreed that the community was not safe, especially at night. There were stories of

people having been attacked and killed in the community and those that visited the taverns were at an increased risk. It has been documented that about 40% of young people aged 12-22 years in South Africa have been exposed to crime or violence (CJCP, 2006; cited in Steyn, Badenhorst & Kamper, 2010). Some adolescents had this to say:

> *"There is a lot of fighting and killing in this place. Sometimes people get killed in this community, especially at the taverns" (A003)*

> *"Truancy, violence, drug use and alcohol abuse are the order of the day in this community" (A002)*

These comments show that there is a need for community social workers and agents of change to assist vulnerable adolescents in the community through dialogue and advocacy with the concerned parties to enable adolescents to live long enough to attain their maximum potential.

4.5 Second objective: Exploring the level of financial support available to adolescents within the family.

The theme generated under this objective was 'Challenges faced by families in the community'. The sub-themes included 'High levels of unemployment and its impact on the family', 'financial constraint within the family' and 'Meeting the needs of vulnerable adolescents'.

4.5.1 High levels of unemployment and its impact on the family

It is common knowledge that unemployment is a significant problem in South Africa (Klasen & Woolard, 2001; de Witte, Rothmann & Jackson, 2012). It has also contributed tremendously to household poverty in this country (Klasen & Woolard, 2009). The problem of unemployment is lopsided in favour of men (Amoteng & Makiwane 2003). This was evident in the present study, where most of the adult female participants reported being unemployed. Unemployment, particularly among black communities in South Africa, have increased the burden of poverty among households who are graciously taking the responsibility of accommodating and taking care of their unemployed relatives (Klasen & Woolard, 2009).

Unemployment is also a driver for human migration as shown in the present study. Some parents particularly the fathers have moved to other locations in search of jobs, leaving behind their wives or adolescent children to care for themselves. This finding is corroborated by Amoteng and

Makiwane (2003) who argue that economic migration of bread winners often results in reversal of gender roles, single parenthood and poverty. This is what one of the participants had to say:

> *'I miss my parents, I wish they were here, now I do things they should be doing. I don't have money, when my parents don't send money to me on time, I go to my cousin for help and sometimes I go to the church, but my younger ones don't like this, they feel ashamed about it". (A005)*

de Witte, Rothmann and Jackson (2012) argue that unemployment result to negative affective experiences which include but not limited to worthlessness, conflicts, boredom and loneliness, this inhibits youth empowerment and rather creates a void which may be filled with self-destructive behaviors like risky sexual practices, drug abuse and violent behaviours (McNamara, 2003). This assertion was supported by the following statement:

> *"Children here are not well behaved and there is poverty and no jobs, they don't have something to keep them busy that's why they engage in bad behavior" (P007)*

Unemployment has been shown to increase risk behaviour, some young people may engage in unprotected sex in an attempt to survive, though they are aware of the high risk behaviour of their partners but do it anyways because of the financial gain they will receive from such a person (Graham, 2016). This is supported by the following quote:

> *"Girls follow older men because of what they can get from them" …..some of the children stay with old men only because of the money because their parents are not buying food at home". (P005)*

4.5.2 Financial constraints within the family

Families in this community suffer severe financial constraints. This includes those who are employed. The interviewed adults and adolescent members of households said they are often unable to meet their financial obligations to provide for their children and siblings, even when they pooled all their resources together. The worst affected are the child-headed households and homes where the grandmother is the bread winner. The following are some of the comments made by some of the participants:

"I struggle to meet the obligations of feeding of my grandchildren because my grant money is not enough, even when I included the children's grant, it is still not enough. My son (47 year old) is also living with me and the children" (P007)

Poverty has a grave influence on parenting in South Africa. According to Kotchick and Forehand (2002), it limits the intent of parents to raise their children within an environment, where harshness and emotional abandonment is not common-place. In view of this predicament, the South African government has moved to support disadvantaged families with fund transfers in the form of old-age pension and child-support grant (Cluver, Boyes, Orkin, Pantelic, Molwena & Sherr, 2013). Furthermore, it has been speculated that the provision of this grants, especially the child support grant, have reduced the likelihood of adolescent girls engaging in transactional sex and sexual relationships with older men (Cluver et al., 2013).

However, it appears that the provision of grants to deserving families have not sufficiently improved the plight of adolescents in this community, by its nature, being a mining community, there is an influx of people coming to live and search for jobs, the increase in population has also increased the number of unemployed family members who have come from distant locations to seek jobs. This addition to the family puts a strain on the available family resources and the capacity of the host family to provide for their children (Klasen & Woolard, 2009). A participant made the following comment:

"My uncle does not behave well. He eats all our food but we don't see him when he has some money. When he does not have money he comes to live with us and eat our food" (A002)

Economically disadvantaged youths are more likely to engage in deviant sexual practices such as having sex in exchange for money or gifts and engaging in multiple sexual partnership. In addition, having a poor family background has also been associated with early sexual debut and reduced condom use among the youths (Hallman, 2004; McLaughlin & Kaplan, 2008).

"I have many boyfriends so I can get money to support myself" (A008)

However, it has been suggested that the level of sexual activity may also increase with an increase in the level of family income, especially in the absence of adequate parental care and monitoring particularly among parents who are high career pursuit professionals (Isiugo-Abanihe & Oyediran, 2004).

4.5.3 Meeting the needs of vulnerable adolescents.

Although the problem of inequality and poverty is wide-spread in the study community, its impact is worse felt among adolescents who live by themselves or those who live in households where the parents or caregivers are unemployed. This assertion is documented in literature, where it has been shown that young people in resource scarce communities face a great deal of challenges (UNFPA, 2012). As shown in the present study, the challenges faced by vulnerable adolescents are multi-faceted. These include poverty, loss of parents to HIV and AIDS pandemic, parental separation, absent fathers and absent mothers, lack of social and emotional support and high level of school dropout. The issue that resonated most among the participants was that the majority lacked financial support, when such support was available, it was often not sufficient. Some of these young people work to be able to support themselves when they are supposed to be in school studying. Some adolescents had this to say:

> *"I don't go to school, I stopped attending when my mother died. I do casual jobs to support myself and my grandmother but I also get support from my grandmother when I don't have money" (A006)*

> *"My aunt supports me with money sometimes and I also survive on my younger brothers' grant money. I also work on farms to make some money". (A008)*

> *"My parents are dead and I am now living alone with my younger ones" (A011)*

Parental support has been judged to have the greatest influence on adolescent behaviour (Carlson, 2012). This support is seen to influence adolescent behaviour in two ways. The first is through the parenting style adopted by the parent and the family structure within which the adolescent is raised. Secondly, through the control of extra familial factors such as peer pressure (Carlson, 2012). The amount of financial resources available to the adolescent can influence their health outcomes on many fronts, some of which include nutritional status, place of domicile and whether they engage in deviant behaviour or not (Mayer, 2002).

It has been shown that economically disadvantaged youths are more likely to engage in unsafe sexual behaviour; they are also more likely to engage in multiple sexual partnership and the females are at a greater risk of being raped (Hallman, 2004). The effect of low SES is however biased against females (Ahimbisibwe, 2014). During the interview, some adolescents reported

that they had no one to support them financially, socially and emotionally. This is evident in some of the comments as follows:

> *"My adolescent granddaughter has no one to support her. Her mother is always sick and her father does not care. She is suffering, she does not get well taken care of, like other children". (P007)*

> *"I don't have support from anyone since my mother died, I don't get any support from my elder brother with whom I live" (A008)*

> *"My sister supports me, but she does not give me all that I want, I get money from my boyfriend". (A007)*

Furthermore, some adolescents expressed no faith in their family (especially their father) to support them and provide for their needs. This is what some participants had to say:

> *……"to get money from him to support the children we have to fight over it until he gives it to me. He does not contribute to the moral upbringing of the children because he is always absent and he does not take care of his 17 year old daughter who lives with me (she is not even my daughter)" (P010)*

> *"I assist her when possible but she is grown up now and can take care of her own things" (P006)*

The commonly-encountered problems in child headed-households (CHH) include insufficient funds, lack of support with academic work, experience of deep emotions like sadness and anger (van der Mark, 2015). It has been reported that the average income available to CHH is around R1, 221.00, but this could range from no income to about R 3,000.00 per month (Shambulu, 2014). The findings of the present study are in line with literature, which revealed that CHHs live in poverty and may also lack social support. The following comment was made by one adolescent participant:

> *"We live on the rent of our shop (R800 a month) and when I do casual jobs. It is from this money that I take care of myself and my little sister". My aunt used to support us but now she has relocated". (A011)*

It is common to learn that most CHH survive on fund transfer from the government. However, some of the CHHs are completely on their own, without any form of support from the government. A particular head of household says that he and his younger sister have not been attending school and they do not receive grant from the government. When probed further on this, it was revealed that they do not have birth certificates and therefore do not have identity documents, even though both their late parents were South Africans.

> *"There is no one to help us, we don't receive the grant and we have been chased away from school because we don't have birth certificate, I complained to social workers and they promised to help us but they don't ". (A011)*

The communities where these children live may take advantage of them because they have nobody to defend their rights. This was buttressed by Shambulu (2014). Furthermore, Shambulu reports that some siblings in the CHH, may misuse their funds (CSG), while the head of household continues to toil to provide for everyone in the family. In the present study, the reverse seems to be the case: in one household where the adolescent head of household reported that her mother collects her CSG because she (the mother) is responsible for raising her daughter. This leaves the adolescent scrambling for other means to survive. One adolescent had this to say:

> *"My mother collects my grant money because my baby lives with her in the Eastern Cape, I don't feel bad about it because she is using it to take care of my baby" (A005)*

Another striking challenge are the difficulties experienced by the head of a CHH in maintaining law and order in the home. This may be the case when the age difference between the head of household and the sibling is marginal. One head of household said it is difficult to get her younger sister to run errands for her. She would have to plead and sometimes offer financial incentives before she can get her sister to assist with chores at home, and sometimes she would have to fight with her younger brother to do chores at home. One adolescent had this to say:

> *"My sister behaves badly sometimes, she would ask me and other people to pay her money to run errands for them, my brother is always absent. I quarrel with him before he can perform household chores" (A005)*

This kind of dispute is common in these kind of households but not peculiar to it. This is corroborated by Mthethwa (2009). Furthermore, the heads of households are at liberty to do

whatever they like, after all, they set the rules at home and no one can tell them what to do. The behavioral outcome in the family would therefore depend on the conduct of the head of household, therefore, if he/she is wayward or nonchalant, the siblings may copy his/her behaviour. It is important to note however that the conduct of children in CHH are not always destructive, contrary to general expectation (Shambulu, 2014). It is often expected that in the absence of parents or an adult, children in this kind of settings would become wayward and destructive but this is not always the case; for example, some of them have lost both their parents to the HIV and AIDS pandemic (Germann, 2005) and are aware of the consequences of engaging in risky behavior. Such adolescents are careful and vigilant. The current study illustrates this with the comments of one participant:

> *"I am in charge of the house, I do what I like. I have friends, some have good behaviour while some drink, smoke and go to taverns all the time, but they have not been able to change me to behave badly" (A011)*

It has been documented that households where adolescents contribute to the economic needs of the family or where parents receive financial support from adolescents, such families, are likely to struggle with exercising control over such children (Wamoyi, Fenwick, Urassa, Zaba & Stones, 2011).

4.6 Third objective: Exploring parenting processes adopted by families in the community.

The theme generated under this objective was 'Effectiveness of parent-child communication' and the sub-themes derived include: 'Generational gap as a hindrance to effective communication', 'Insufficient sex education by parents', 'Parent –Adolescent closeness and its impact on behaviour change' and 'Effectiveness of rules and regulations and the level of control enforced by the parents'.

4.6.1 Generational gap as a hindrance to effective communication

In the present study, both groups of participants (parents and adolescents) identified age and cultural differences as hindrances to effective communication between parents and their children. This was particularly common among households headed by grandmothers. Many participants expressed the view that the cultural values of the society is being eroded by modernization and the older generation is overwhelmed by the behaviour of young people. Similarly, many young

people do not comprehend why older people do not share their sentiments regarding certain behavioral decisions that they take. Adolescents in the present study expressed discomfort sharing their personal problems with their parents, some say they are afraid of what their parents might say while some worry that their parents would forbid them from having a relationship. This is what some adolescents had to say:

> *"As an African child, we don't often discuss with our parents certain topics but I do discuss my personal issues with my friends and not my grandmother. I don't discuss my sexual life with her because she might not understand". I don't discuss such things with my grandmother because of the age difference between us" (A009)*

Similar sentiments where expressed among grandmothers, a particular grandmother said the following:

> *"I don't encourage my grandson to discuss his personal things with me, I don't want to encourage him to start thinking about those things. Besides, he is still too young for those kind of things" (P004)*

It has been postulated that adolescence is a stage for self-discovery, a time when young people begin to form bonds with peers (Vartanian, 2000) and gradually shifting their source of primary social support away from their parents to their peers (Oswalt, 2015). Parents who remain distant from their children may create an opportunity for such a child to bond strongly with a peer who may influence him/her negatively (O'Donnell et al., 2008).

Adolescents are more likely to disclose their personal and intimate activities to their parents only when they believe their parents will give them the attention they desire and when such intended activities will not be disapproved by their parents (Yau, Tasopoulos-Chan and Smetana, 2009). They are also more likely to disclose when they perceived that there is warmth, support and understanding from their families (Somers & Vollmar, 2006).

4.6.2 Insufficient sex education by parents

Adolescents who were interviewed during this study complained that there was little or no sex education from their parents or caregiver. Some say the only time their parents talk about HIV or pregnancy to them is when they were being scolded for bad behaviour at home. However, it is

important to note that this complaint was common among adolescents in grandmother headed household. This is what one participant had to say:

> *"Sex education is not enough at my home, my grandmother is so strict but she only advise me about sex when I offend her". (A001)*

The environment within which young people live today is different, adolescents feel uncomfortable discussing sex with their parents, and parents on the other hand are either not willing or uncomfortable to initiate such discussions (Rosenthal & Feldman, 1999). Although many parents agree that children need to be educated about sex, some believe that adolescents have already been exposed to sex through different platforms ranging from the television viewing, magazines, billboards and social media. They believe adolescents already know more than they are supposed to know (Dyson, 2010).

Some parents are of the view that the school system would be in a better position to give more evidence-based teaching about sex (Dyson, 2010). This is supported by arguments that parents might be limited in depth and scope because some parents do not have the requisite knowledge on contemporary issue about sex (Rosenthal & Feldman, 1999). However, Shtarkshall, Santelli and Hirsch (2007) argue that promoting healthy adolescent sexuality is not to be strictly a responsibility for parents or school teachers but rather a collective responsibility of both.

During the interview, it was evident that parents were really uncomfortable talking about sex, especially among older parents (those above 45 years of age), as most of them could not respond to the researcher's questions directly. This is what a parent had to say:

> *"I do not talk about sex that much with my child. I believe the teacher is doing that at school" (P002)*

However, it has been shown that frequent sexual communication with parents significantly reduced the effects of sexually active friends and experienced peer pressure on adolescents' intention to have sex (Bongardt, Graaf, Reitz & Dekovic, 2014). Furthermore, Whitaker and Miller (2000) found that the negative influence that peers have on adolescent sexual behaviour is diminished when there is effective parent-child communication about sex. This is premised on the fact that parents will provide accurate information about sex than peers. In addition, children who

spend more time talking to their parents about sex and condoms would most likely spend less time with their peers, thereby reducing opportunity for peer influence (Whitaker & Miller, 2000).

4.6.3 Parent –adolescent closeness and its impact on behaviour change

During the interview, participants expressed similar views on their closeness with their parents or children, as the case may be. Several adolescents agreed that they were close to their parents but they also claimed that being close with their parents did not influence their behaviour. Some parents claimed that they had a good relationship with their children but during the interview, these claims were refuted by their children. It appeared that the bonding involved in these relationships were not strong, because as much as they claimed that they were close to each other. Adolescents were quick to say that being close to their parents had no influence on their behaviour. This is what some participants had to say:

> *"My closeness to my mother does not change my behaviour, my behaviour depends on me". (A003)*

> *"Although am close to my elder sister, I don't discuss my personal life with her because she might not be happy that I am dating". (A007)*

> *"I am close with her and I advise her on the way to live right. I give her opportunity to come to me with her problems but she does not discuss her problems with me". (P005)*

Parent-child closeness is an important factor in fostering healthy adolescent development. However, it has been shown that the relationship between parents and their children begins to wane as the children begin to attain adulthood (Oswalt, 2015). The effect of this has been argued back and forth; some say that even as the child grows older, the relationship with parents remain an import source of social and emotional support (Collin & Steinberg, 2006) while others argue that the protective effect of this relationship on adolescent behaviour may also diminish as the child grows older (O'Donnell et al., 2008). However, some authors posit that the effectiveness of the parent-child relationship on adolescent risk behaviour depends on the quality of such relationships (Newman et al., 2008).

The present study support claims that the effect of parent-child relationship on positive adolescent behaviour may dwindle as adolescents get older because adolescents reported having a close

relationship with their parents. They also reported engaging in risky sexual behaviour, such as multiple sexual partnership, drinking alcohol and even teenage pregnancy. However, this was a common occurrence among older adolescents. On the other hand, some adolescents reported that they did not enjoy a good relationship with their family. This was common among adolescents in a sibling headed household. This is what one adolescent had to say:

> *"I don't enjoy a good relationship with my elder brother, we are not close and he does not support me that's why I prefer to live with my aunt". (A008)*

4.6.4 The effectiveness of rules and regulations and the level of control enforced by the parents

In a community fraught with different vices which present obstacles to healthy childhood development. It becomes extremely difficult to supervise and monitor children and keep them safe. Many parents complained about bad behaviour among children living in this community. For some, the complaint was that the children were disrespectful, while for others it was that the children engaged in drinking alcohol, smoking marijuana and using other harmful substances. The ability of some of the households to maintain discipline is diminished due to several reasons. For example, some households are headed by elderly grandmothers who are not able to monitor or control their grandchildren because of their own medical conditions, while in some households, there are no adults to monitor adolescents and these young people automatically become decision makers in their households. In some households, there is a single mother who is limited in her ability to maintain law and order in the home. During the interview, participants were on a varying scale on their style of parenting, this is what some participants had to say:

> *"I am not harsh to my siblings because I believe that when you are harsh, they will end up doing things that are not good and so far they obey me" (P005)*

> *"She is not strict and allows me to make my own decision. She allows me to do what I want as long as I don't get into trouble" (A006)*

> *"I don't allow them to do as they please but I allow them to express their opinions on issues that concern them" (P003)*

There is evidence to support authoritative parenting style as the most protective with regards to adolescent risk behaviour compared with authoritarian and permissive parenting styles

(Domenech Rodriłguez et al., 2009; Becon et al., 2012). The present study found that this is not always the case. Some participants expressed support for authoritarian parenting style where the parent is seen as being overtly strict. For instance, one participant expressed that her parents are authoritarian and she believes she has turned out to be better because of that. These are some comments to support that:

> *"I can describe them as strict parents, they even punish me when I disobey, I believe my behaviour is good because of it". (A013)*

> *"I believe a parent should be strict, otherwise children will get into trouble especially the girls" (P010)*

Broadly speaking, the assertion that authoritative parenting supports healthy adolescent behaviour may have been made because this type of parenting style creates an environment that encourages communication. However, Huebner and Howell (2003) found no relationship between authoritative parenting style and the level of sexual risk-taking. Parental permissiveness enhances opportunities for substance use and sexual risk behaviour (Donenberg, Emerson, Bryant & King, 2006). On the one hand, parents who set rules and monitor them are likely to reduce early sexual initiation, smoking and marijuana use, and unsafe sexual behaviour (O'Donnell et al., 2008; Coley et al., 2009). On the other hand, adolescents who are not properly monitored are at increased risk of delinquent behaviour, smoking, alcohol and drug use, and unsafe sexual practices (Caldwell, Beutler, Ross & Silver, 2006). Furthermore, when parents are harsh and inconsistent with their punishment, they reinforce bad behaviour (Laghi, Baiocco, D'Alessio & Gurrieri, 2009; Tafa` & Baiocco, 2009).

4.7 Fourth objective: Describing the experiences of families regarding deviant and sexual risk behaviour among adolescents living within the community

The theme under this objective was 'The behaviours endangering the lives of adolescents' and the sub-themes include 'The influence of the environment on adolescent behaviour', 'Headiness and unruly behaviour', 'Sexual risk behavior among adolescents' and 'Alcohol and drug abuse among adolescents'

4.7.1 Influence of the environment on adolescent behaviour

It has been noted that the environment within which adolescents are raised is important in shaping his/her behaviour, family environment, peer group, school environment and the media have all been shown to influence adolescent behaviour (Rebellow, 2015). In the present study, many parents expressed concern that the environment where their children are being raised is hostile and dangerous. Some say that parents are not in harmony with each other, others say that the proliferation of drinking spots within the community is a negative attraction to young people, and some say that delinquent children in the community are a source of negative influence on some children in the community. These are some of the comments made by participants:

> *"This environment can change people for the worse. It has changed my brother, now his behaviour is bad: he drinks, smokes and comes home whenever he likes" (A010)*

> *"Life is hard in this community, am afraid that my siblings may end up like the children in this community. They are shooting and robbing people in this community, I feel I may become like them if I continue to live here" (A005)*

> *"The behaviour of young people in this community is very bad; they drink, smoke and move around at night, even those that are 12 years old" (P005)*

A similar study conducted in South Africa supports the assertion made by participants in the present study that the environment within a migration affected community such as this is hostile and dangerous (Cronje et al., 2013). According to Cronje et al. (2013), mining communities in South Africa are characterized by unemployment, poverty, poor housing, decaying infrastructure and prostitution, and these conditions lead to high prevalence of STIs (including HIV), unwanted pregnancies, malnutrition, substance use, and mental illness. Furthermore, it has been reported that some women within these communities may engage in illicit sexual activities in order to make ends meet. In some cases, women have been said to offer their children to men in order to get financial support for their families (Cronje et al., 2013). This is what a parent had to say:

> *"Some young girls sell themselves to older men because their parents are not taking care of them" (P005)*

Although these challenges that adolescents face are real, the family environment has been shown to inhibit deviant behaviour among adolescents by modelling positive behaviour (Aufseeser,

Jekielek & Brown, 2006; Malhotra, 2008) but when this is not done, adolescents often align with their friends and peers, and this may result in unhealthy relationships (Bearman & Brueckner, 2001). This is what one parent had to say:

> *"Association with bad friends leads to bad behaviour". (P001)*

In addition, high risk communities are shown to increase the risk of antisocial and delinquent behaviour among adolescents from an early age (Farina, Arce & Novo, 2008). Moreover, it has been shown that peer delinquency is a predictor of sexual risk behaviour, this implies that those who have delinquent friends are more likely to become delinquent themselves (Le & Kato, 2006).

4.7.1 Headiness and unruly behaviour

Many children will grow up to abide by the norms of their society but some will not. Many reasons have been put forward as to why young people may be disobedient to authority figures. The level of brain development has been shown to play a key role in adolescent risk-taking. However, these risk are being moderated by social and environmental factors (Fagan, 2005; Steinberg, 2013). The family environment has been documented as the most crucial to adolescent development, others include peer pressure and living in an unsafe environment. During the interview, participants reported that the level of moral decadence in the community is alarming. These are some of the comments made by participants:

> *"Children here are disrespectful and disobedient to their parents. They do not obey rules and regulation" (P003)*

Immature thought processes on the part of adolescents may be misconstrued by parents or adult family members to be unruly behaviour. Research has shown that adolescents act on impulse and this has been attributed to low cognitive development, which is normal in this age group (Choudhury et al., 2006). However, it is important to note that some adolescents are aware of the consequences of their intended action but decide to continue to do it anyways.

> *"Children in the community are badly behaved, they don't listen to their parents, walking at night, taking alcohol and drugs and staying on the street at night" (P008)*

This could be as a result of failure of the family to adequately monitor adolescent behaviour and reinforce family values through positive parenting, on the other hand, failure of the family system would activate and reinforce peer relationship and this may result in untoward outcomes for the adolescent (Cuyper, 2008). An adolescent had this to say:

> *"There are rules at home but I don't obey them always because I have to spend time with my friends". (A002)*

According to Cuyper (2008), adolescents who have delinquent friends are more likely to become delinquent. Indeed, to some of these adolescents, they are only trying to understand and interpret the world around them by testing boundaries (Clark, 2002).

4.7.2 Sexual risk behaviour

Sexual risk taking is rife among young people in this community, multiple sexual partnership, and exchange of sex for money and having sexual relationship with older men, were some of the sexual risk behaviours credited to adolescents in this community. During the interview, one participant asked, "how can a child bring home groceries when she is not working". Some of them follow older men because of what they can get from them. Below are some of the comments by some participants:

> *"I don't think that children in this community are alright. Some of them are already having sex and they teach even the toddlers about sex, my 4 year old child is talking about sex because of what he hears them saying". (P010)*

> *"Young people in this community indulge in many nasty things like teenage pregnancy, they don't take care of their bodies". (A010)*

> *"I have many boyfriends so I can get money to support myself" (A008)*

It is true that sexual risk taking is common in the community under study but it is also not uncommon in other communities in South Africa and the world over. It is however of a particular concern in this case because of the diverse and dynamic nature of the area under study. In this community, many families are fractured, some children have lost their parents and are therefore raised by family members or distant relatives, and some are raised by single parents while some

were living by themselves. In these kind of settings, adolescent monitoring and control is often hampered.

4.7.3 Alcohol and drug abuse

Many participants were quick to point out that alcohol and drug abuse was a common problem in the community, they lamented that it is particularly concerning because adolescents are also partaking in the act. Many participants were worried that children as young as those in primary school were also involved in the use of alcohol and drugs, and it was also noted that some children spend their grant money on purchasing alcohol. Many participants were concerned that this might contribute to school absenteeism and deviant behaviour among young people in the community. These are some of the comments by participants:

> *"The behaviour of young people in this community is bad; some of them are heavy drinkers and some are smokers. They do casual job and drink the money away". (P005)*

> *"My second child behaves badly. He roams the streets and spends his school transport money on alcohol and dagga". (P008)*

Alcohol abuse has a tremendous impact on the psycho-socio-development of an individual, making harmful use of alcohol a global health problem (WHO, 2011). Furthermore, some of the social problems attributed to alcohol and drug abuse include but are not limited to poor school attendance, early school leaving, violence and unemployment (EMCDDA, 2010). Studies have shown that there is a rise in the number of young people in South Africa who are engaged in substance abuse (Parry et al., 2004). In addition, the level of knowledge of these young individuals on the implication of such usage on their health is low while their engagement in illicit substance use continues to rise (Ajao et al., 2013).

According to Rew et al. (2011), the use of alcohol and other illicit substances have been associated with multiple sexual partnership, low intention to use protection, and having unprotected sex with casual partners. Furthermore, substance abuse in males have been associated with peer delinquency, and it has also been documented that females who engage in illicit substance use are more likely to indulge in risky sexual behaviour (Yi et al., 2010). In a similar study, it was found that among youths, substance use is strongly associated with risky

sexual behaviour, and youths that used alcohol, smoked marijuana and cigarettes were more likely to have been sexually active, less likely to use a condom, engage in multiple sexual partnerships and practice survival sex (Asante et al., 2014).

CHAPTER FIVE (A)

RESULTS OF PHASE 2 OF THE STUDY: QUANTITATIVE STUDY

5.1 Introduction

This phase of the study was designed in line with the social cognitive theory, the questionnaire was designed to elicit outcomes related to the four constructs of the theory which are as follows

- Behaviour capabilities
- Outcome expectations
- Self-efficacy
- Modelling behaviour

However, these constructs were measured against family dynamic variables derived from Phase 1 of the study. The family variables measured include relationship with father, mother, and siblings. Others were level of peace and love in the home, level of financial and emotional support available to the adolescent. The process of data collection and the procedure for analysis has been explained in chapter three.

5.2. Socio-demographic profile of participants

Three hundred and eighty eight adolescents participated in this phase of the study with an almost equal gender distribution, 199 male (51.3%) and 189 female (48.7%). They were aged between 15 and 19 years. The mean age was 16.8 years and the modal age was 16 years (Table 5.1).

Table 5.1: Age and Sex distribution

Gender	**Age**					**Total**
	15	16	17	18	19	**N=388**
Female	47	45	40	26	31	189
Male	43	51	37	32	36	199
Total	90	96	77	58	67	388

As shown in Table 5.2, the majority (89.7%) of the participants were in secondary school, 6.5 % were at primary school level while 39 (10.1%) were not attending school. Furthermore, 348 (89.7%) were Christians, 4 (1.0%) were Muslims, 30 (7.7%) had other religious beliefs while 2

(0.5%) did not have any religious affiliation. The majority (57.0%) lived in a two-parent household, 88 (23.0%) lived with either their mother or father, 28 (7.3%) lived with their grandparents. The vast majority (99.9%) were black, and the remaining 0.5% were Indian. The vast majority (98.9%) were single, with only one (0.3%) participant reporting being married.

Table 5.2: Demographic profile of participants

		Number	Percentage
What is your race	Black	386	99.5
	Indian	2	0.5
Relationship status	Cohabiting	3	0.8
	Married	1	0.3
	Single	384	98.9
What is your religion	Christianity	348	89.7
	Islam	4	1.0
	None	2	0.5
	others	30	7.7
Level of educational	Not attending school	39	10.1
	Primary	25	6.5
	secondary	324	83.4
Who do you live with	Friends	1	0.3
	cousin	2	0.6
	Aunty	7	1.8
	uncle	5	1.3
	Grandparent	28	7.3
	siblings	24	6.3
	Alone	2	0.6
	Partner	4	1.0
	Husband	1	0.3
	Mother or father	88	23.0
	Parents	220	57.0

As shown in Table 5.3, the majority (68.8%) of the participants reported that their fathers were employed; 8 (2.1%) were self-employed; 77 (19.8%) were unemployed and 36 (9.3%) reported that their fathers were either dead or absent. About a third (36.9%) reported that their mothers were employed; 12 (3.1%) were self-employed; 195 (50.3%) were unemployed and 38 (9.8%) reported that their mothers were either dead or not known to them.

Table 5.3: Employment status of parents

	Status	Number	Percentage
Father's occupation	Employed	267	68.8
	Self employed	8	2.1
	Unemployed	77	19.8
	Dead and absent fathers	36	9.3
Mother's occupation	Employed	143	36.9
	Self employed	12	3.1
	Unemployed	195	50.3
	Dead and absent mothers	38	9.8

Migration history of participants

As shown in Table 5.4, the majority of the participants were born in the Limpopo Province of South Africa. This is followed closely by the Northwest Province. This may be because of the close proximity of the two provinces. However, a good number of participants were from other provinces of South Africa, while some where born outside of South Africa but had come to settle in this community to live with their parents, family members or to search for job.

The majority (39.2%) of the families here migrated from the Northwest Province, while 31.9% are from different districts in Limpopo Province in South Africa, others have also come from other southern African countries (11.3%). The majority (66.5%) have lived in the community for longer than 5 years, while 31.0% have lived there between 2 to 5 years and 2.6% have just lived there for less than two years. Furthermore, 32% of the participants were born and raised in the community and have no other place to call home, while 59.5% reported that they visit their place of birth yearly, quarterly or always. However, 8.5% reported that they had never visited their place of birth since they moved to this community (Table 5.4).

Table 5.4: Migration History of the participants

	Place	Number	Percentage
Place of birth of adolescent	Limpopo	201	51.8
	Northwest	116	29.9
	Eastern cape	21	5.4
	Free state	6	1.5
	Gauteng	9	2.3
	Kwazulu-Natal	3	0.8
	Western cape	1	0.3
	Mpumalanga	9	2.3
	Cross border	22	5.7
Place of birth of parents	Limpopo	124	31.9
	Northwest	152	39.2
	Eastern cape	34	8.8
	Free state	6	1.5
	Gauteng	13	3.4
	Kwazulu-Natal	2	0.5
	Western cape	3	0.8
	Mpumalanga	16	4.1
	Cross border	44	11.3
Duration of stay in the community	>5 years	258	66.5
	2 to 5 years	120	31.0
	<2 years	10	2.6
Frequency of visit to place of birth	Never	33	8.5
	Yearly	95	24.5
	Quarterly	42	10.8
	Always	94	24.2
	Born in Thabazimbi	124	32.0

Family dynamics

As depicted in Table 5.5, 268 (71.7%) participants reported being in a good relationship with their father, while (241) 91.4% reported the same for their mother. Among those living with people other their parents, 241 (91.6%) are in good relationship with the person they live with. Three hundred and twenty five (89.8%) are in a good relationship with their siblings, while 332 (85.8%) say there is peace in their homes, while 355 (91.5%) say they felt loved by their family. Three hundred and ten (79.9%) say they are supported financially by their parents or the person they live with. However, only 189 (48.7%) reported always having enough money at home to take care of their needs. Furthermore, 293 (76.7%) are supported emotionally by their parents or the person they live with, while 290 (77.1%) said their parents are in love with each other (Table 5.5).

Table 5.5: Family dynamics

Questions	Yes		No	
	n	%	n	%
Are you in a good relationship with your father?	268	71.7	106	28.3
Are you in a good relationship with your mother?	342	91.4	32	8.6
If you live with someone else, are you in a good relationship?	241	91.6	22	8.4
Are you in a good relationship with your siblings?	325	89.8	37	10.2
Is there peace in your home?	332	85.8	55	14.2
Do you feel loved by your family?	355	91.5	33	8.5
Do your get financial support from the person you live with?	310	79.9	78	20.1
Is there always enough money to take care of your needs?	189	48.7	199	51.3
Does the person you live with support you emotionally?	293	76.7	89	23.3
Do your parents love each other?	290	77.1	86	22.9

5.3 The nature and pattern of deviant and sexual risk practices among participants.

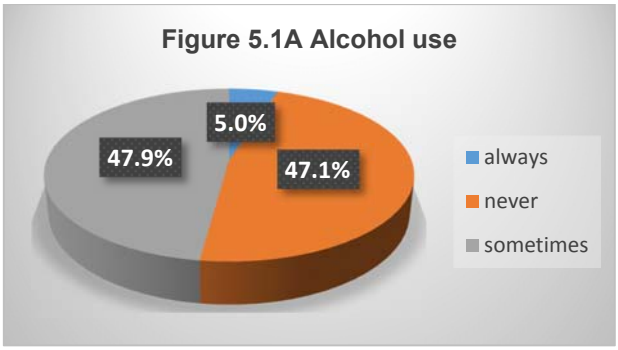
Table 5.6 shows that one hundred and fifteen (29.8%) have recently engaged in a fight, 38 (9.8%) have used drugs, 82 (21.5%) have changed school because they are having problems at school. 125 (32.9%) are not always obedient to their parents or the person they live with. Ninety three (25%) often have problems with their siblings.

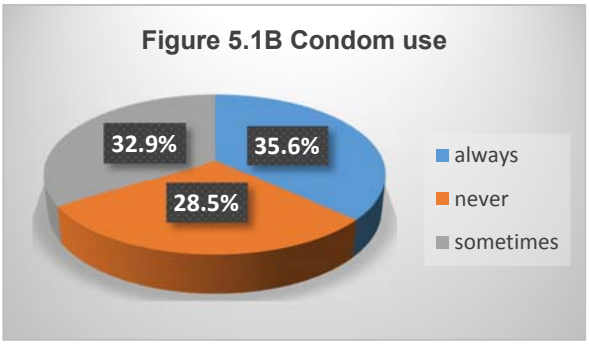
Almost half (49%) of the participants reported coming home very late at night. More than half (60.1%) of the participants have been sexually active. Eighty seven (23.1%) have been pregnant or made someone pregnant while 244 (63.7%) have friends who are sexually active, 68 (17.5%) are either mothers or fathers (Table 5.6).

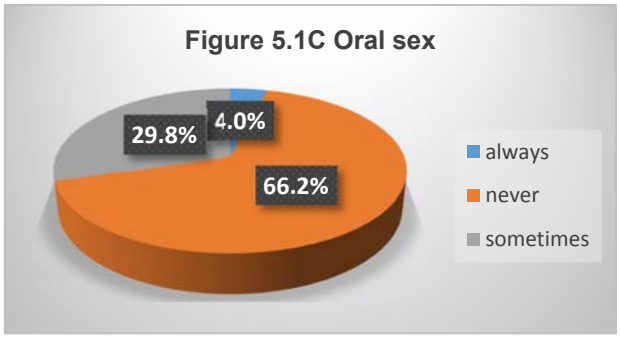
Table 5.6 Deviant and sexual risk behaviour among participants

Questions	Yes		No	
	n	%	n	%
Have you been involved in a fight recently?	115	29.8	271	70.2
Do you smoke cigarettes?	51	13.1	337	86.9
Have you ever used drugs?	38	9.8	349	90.2
Have you changed school because of problems at school?	82	21.5	300	78.5
Are you always obedient to the person you live with?	255	67.1	125	32.9
Do you attend school regularly?	302	79.5	78	20.5
Do you often have problems with your siblings?	93	25.0	279	75.0
Do you sometimes come back home late at night?	190	49.0	198	51.0
Do you often have problems with your friends?	113	29.3	273	70.7
Do you often have problems with your neighbours?	75	19.4	311	80.6
Have you ever had sex?	232	60.1	154	39.9
Have you been pregnant or made someone pregnant?	87	23.1	290	76.9
Do you have friends who have sex with their boy/girlfriend?	244	63.7	139	36.3
Do you currently have a boy/girlfriend?	226	58.7	159	41.3
Do you have more than one boy/girlfriend?	107	28.2	273	71.8
Do you have a baby?	68	17.5	320	82.5

As shown in Figure 5.1, one hundred and seventy seven (47.1%) participants have never taken alcohol while 180 (47.9%) take alcohol sometimes and 19 (5.0%) take alcohol regularly. Amongst the sexually active participants, 85 (28.5%) have never used condom while 98 (32.9%) do not use condoms regularly and 106 (35.6%) use condoms regularly. The majority (66.2%) have never practised oral sex, while 13 (4.0%) engage in oral sex regularly. The vast majority (76.6%) have never engaged in anal sex while 7 (2.2%) practise anal sex regularly.







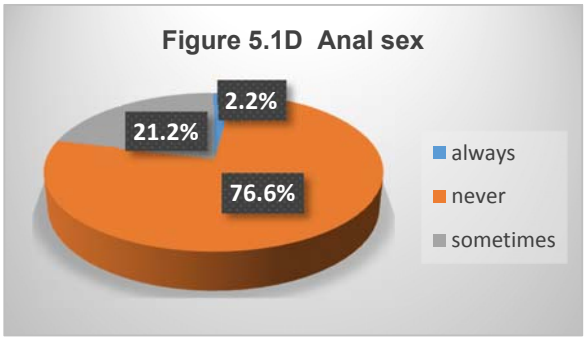


Figure 5.1 Sexual risk practices among participants

As shown in Table 5.7, 60 (15.8%) have had a boy/girlfriend who works in the mines. Among those that have a boy/girlfriend working in the mine, 55 (91.7%) have sex with the mine workers and out of these, 33 (55.0%) have used condoms regularly. Furthermore, 26 (43.0%) reported exchanging sex for money.

Table 5.7 Adolescents engaging in sex with mine workers

Questions	**Yes**		**No**	
	n	%	n	%
Have you had a boy/girlfriend that works in the mine?	60	15.8	320	84.2
Have you had sex with him or her?	55	91.7	5	8.3
Do you have oral sex with this person?	32	53.3	28	46.7
Do you have anal sex with this person?	20	33.3	40	66.7
Do you use alcohol before having sex?	26	43.3	34	56.7
Do you use condom regularly with this person?	33	55.0	27	45.0
Does he or she give you money for sex?	26	43.0	44	56.7

As shown in Table 5.8, there was a statistically significant gender bias on the following questions 'Do you smoke cigarette?' (p=0.000), 'Have you been pregnant or made someone pregnant?' (p=0.002) and 'Do you have more than one boy/girlfriend? (p=0.028).There appears to be slightly more male smokers than female and more males were likely to engage in multiple sexual partnership than females. However, more females were likely to have been pregnant than males reporting to have made someone pregnant. The other variables that tested for deviant and sexual risk behaviour showed no significant difference in the way the participants responded along gender lines.

Table 5.8 Gender differences in deviant and sexual risk behaviour

Question	Yes	No	X^2	p-value
	n	n		
Have you been involved in a fight recently?				
Female	59	130	2.269	0.322
Male	56	141		
Do you smoke cigarettes?				
Female	12	177	14.90	**0.000*** **
male	39	160	4	
Have you ever used drugs?				
Female	17	172	1.236	0.539
Male	21	177		
Have you changed school because of problems at school?				
Female	36	152	3.684	0.158
Male	46	148		
Are you always obedient to the person you live with?				
Female	116	69	3.171	0.205
Male	139	56		
Do you sometimes come back home very late at night?				
Female	87	102	1.272	0.259
Male	103	96		
Have you ever had sex?				
Female	114	74	0.045	0.978
Male	118	80		
Have you been pregnant or made someone pregnant?				
Female	57	127	12.69	**0.002** **
Male	30	163	0	
Do you currently have a boy/girlfriend?				
Female	112	77	2.919	0.232
Male	114	82		
Do you have more than one boy/girlfriend?				
Female	41	145	7.147	**0.028***
Male	66	128		

*** Significant**

On some questions, the responses of participants differed significantly according to their age. Some of the questions that showed statistical significance include 'Do you smoke cigarettes?

(p=0.000), 'Have you had sex?' (p=0.000), 'Have you been pregnant or made someone pregnant?' (p=0.002), 'Do you have friends who have sex with their boy/girlfriend?' (p=0.000), 'Do you currently have a boy/girlfriend?' (p=0.001). As shown, all other questions did not show significant difference in response across the age of participants (Table 5.9).

Table 5.9 Age differences in deviant and sexual-risk behaviour

Questions	Yes	No	FET	p-value
Do you smoke cigarettes?				
15	2	88	20.098	**0.000*** **
16	12	84		
17	9	68		
18	15	43		
19	13	54		
Do you often have problems with your neighbours?				
15	17	73	6.822	0.556
16	18	78		
17	18	58		
18	7	51		
19	15	51		
Have you ever had sex?				
15	26	64	68.493	**0.000*** **
16	52	44		
17	53	23		
18	49	9		
19	52	14		
Have you been pregnant or made someone pregnant?				
15	9	76	24.184	**0.002** **
16	15	79		
17	20	56		
18	20	37		
19	23	42		
Do you have friends who have sex with their boy/girlfriend?				
15	42	47	33.034	**0.000*** **
16	54	42		
17	52	24		
18	47	11		
19	49	15		
Do you currently have a boy/girlfriend?				
15	39	50	26.017	**0.001** **
16	51	45		
17	43	33		
18	46	12		
19	47	19		

***Significant** FET= Fishers Exact Test

The relationship status of the adolescents with their fathers was tested against some deviant behaviours, as shown in Table 5.10. The response the following questions were shown to be significant, 'Have you been involved in a fight lately?' (p=0.002), 'Are you always obedient to your

parents or the person you live with?' (p=0.049), 'Do you attend school regularly?' and 'Do you sometimes come back home very late at night?' (p=0.025). The other questions showed no significant difference between those who were in a good relationship with their father or not.

Table 5.10 Participants' risk behaviour and relationship with their fathers

Are you in a good relationship with your father	Yes	No	X^2	p-value
	involved in a fight lately			
No	46	59	16.435	**0.002****
Yes	63	204		
	Do you smoke cigarette			
No	15	91	0.159	0.923
Yes	34	234		
	Have you used drugs			
No	13	93	1.488	0.829
Yes	24	243		
	Problems at school			
No	29	73	8.803	0.066
Yes	50	216		
	Are you always obedient			
No	61	44	9.534	**0.049***
Yes	187	75		
	Attend school regularly			
No	64	37	29.299	**0.000*****
Yes	227	39		
	Problems with your siblings			
No	28	75	1.931	0.748
Yes	61	194		
	come back home very late at night			
No	62	44	7.396	**0.025***
Yes	119	149		
	Have problems with your friends			
No	33	73	4.427	0.351
Yes	73	193		

***Significant**

Most of the questions on deviant behaviour that were measured against adolescent-maternal relationship showed a statistically significant difference. As seen in Table 5.11, 'Have you ever been involved in a fight recently?' (p=0.014), 'Do you smoke cigarette?' (p=0.021), 'Have you used drugs?' (p=0.000), 'Have you changed school because of problems at school?' (p=0.000), 'Are you always obedient to your parents or the person you live with?' (p=0.000), 'Do you attend school regularly?' (p=0.049), 'Do you often have problems with your siblings?' (p=0.016) and 'Do you sometimes come back home very late at night?' (p=0.017).

Table 5.11 Participants' risk behaviour and relationship with their mothers

Are you in a good relationship with your mother	Yes	No	X^2	p-value
	involved in a fight lately			
No	16	15	12.435	**0.014***
Yes	96	245		
	Do you smoke cigarette			
No	8	24	7.766	**0.021***
Yes	39	303		
	Have you used drugs			
No	10	22	25.327	**0.000*****
Yes	24	317		
	Problems at school			
No	17	13	28.964	**0.000*****
Yes	61	277		
	Are you always obedient			
No	10	22	22.085	**0.000*****
Yes	236	98		
	Attend school regularly			
No	19	11	9.551	**0.049***
Yes	270	66		
	Problems with your siblings			
No	15	17	12.149	**0.016***
Yes	76	250		
	come back home very late at night			
No	20	12	8.094	**0.017***
Yes	159	183		
	Have problems with your friends			
No	7	25	1.710	0.789
Yes	103	237		

***Significant**

On whether there is peace at home, the following found significant relationship as shown in Table 5.12, 'Have you been involved in a fight lately?' (p=0.000), 'Have you used drugs?' (p=0.000), 'Have you changed school because of problems at school?' (p=0.000), 'Do you attend school regularly?' (p=0.004), and 'Do you often have problems with your siblings?' (p=0.000). Other questions showed no significant difference.

Table 5.12 Peace in the home of participants and its relationship with risk behaviour

Is there peace in your home	Yes	No	X^2	p-value
	involved in a fight recently?			
No	32	22	28.201	**0.000*** **
Yes	83	248		
	Do you smoke cigarettes?			
No	11	44	2.765	0.251
Yes	40	292		
	Have you ever used drugs?			
No	15	39	28.682	**0.000*** **
Yes	23	309		
	Problems at school?			
No	23	29	24.514	**0.000*** **
Yes	59	270		
	Are you always obedient?			
No	28	26	7.118	0.130
Yes	226	99		
	Attend school regularly?			
No	32	20	15.395	**0.004** **
Yes	269	58		
	Problems with your siblings?			
No	22	31	32.346	**0.000*** **
Yes	71	248		
	come back home late at night?			
No	34	21	5.115	0.078
Yes	156	176		
	Have problems with your friends?			
No	20	35	4.420	0.352
Yes	92	238		

***Significant**

Furthermore, on whether they feel loved by their family, the following questions showed significant difference (Table 5.13), 'Have you been involved in a fight lately?' (p=0.002), 'Have you used drugs?' (p=0.000), 'Have you changed school because of problems at school?' (p=0.000), 'Are you always obedient to your parents or the person you live with?' (p=0.038), 'Do you attend school regularly?' (p=0.000) and 'Do you often have problems with your siblings?' (p=0.034).

Table 5.13: Family love and its relationship with adolescents' deviant behaviour

Do you feel loved by your family	Yes	No	X^2	p-value
	Involved in a fight recently?			
No	46	59	16.435	**0.002****
Yes	63	204		
	Do you smoke cigarettes?			
No	7	26	2.056	0.152
Yes	44	311		
	Have you ever used drugs?			
No	10	22	28.421	**0.000*****
Yes	28	327		
	Problems at school?			
No	16	15	22.256	**0.000*****
Yes	66	285		
	Are you always obedient?			
No	16	17	6.544	**0.038***
Yes	239	108		
	Attend school regularly?			
No	16	15	18.320	**0.000*****
Yes	286	63		
	Problems with your siblings?			
No	14	18	6.742	**0.034***
Yes	79	261		
	Come back home late at night?			
No	18	15	0.449	0.503
Yes	172	183		
	Have problems with your friends?			
No	10	23	0.205	0.902
Yes	103	250		

***Significant**

On the question of whether adolescents are supported financially (Table 5.14), the following found significant difference 'Have you ever used drugs?' (p=0.001), 'Have you ever changed school because of problems at school?' (p=0.001), 'Are you always obedient to your parents or the person you live with?' (p=0.002), 'Do you attend school regularly?' (p=0.000). The other questions did not find significant difference.

Table 5.14 Financial support and its influence on deviant behaviour

Does the person you live with support you financially	Yes	No	X^2	p-value
	Involved in a fight recently?			
No	28	39	3.093	0.213
Yes	87	222		
No	Do you smoke cigarettes?			
Yes	15	63	3.168	0.075
	36	274		
No	Have you ever used drugs?			
Yes	15	62	14.039	**0.001****
	23	287		
No	Problems at school?			
Yes	23	51	13.121	**0.001****
	59	249		
	Are you always obedient?			
No	38	38	12.666	**0.002****
Yes	217	87		
	Attend school regularly?			
No	48	26	16.283	**0.000****
Yes	254	52		
	Problems with your siblings?			
No	21	55	0.958	0.620
Yes	72	224		
	Come back home late at night?			
No	44	34	2.163	0.141
Yes	146	164		
	Have problems with your friends?			
No	21	57	0.768	0.681
Yes	92	216		

***Significant**

The level of emotional support provided by parents or guardian were tested against deviant behaviour and some of the questions asked showed statistical significance in the response provided by the participants. ‘Have you ever used drugs?’ (p=0.013), ‘Have you changed school because of problems at school?’ (p=0.000), ‘Are you always obedient to your parents or the person you live with?’ (p=0.008), ‘Do you attend school regularly?’ (p=0.012), and ‘Do you often have problems with your siblings?’ (p=0.000). Other questions asked in this category did not show statistical significance (Table 5.15).

Table 5.15 Emotional support and deviant behaviour

Does the person you live with support you emotionally	Yes	No	X^2	p-value
	Involved in a fight recently?			
No	37	52	8.500	0.075
Yes	76	215		
	Do you smoke cigarettes?			
No	11	78	1.022	0.600
Yes	40	253		
	Have you ever used drugs?			
No	16	72	12.684	**0.013***
Yes	22	271		
	Problems at school?			
No	31	54	31.859	**0.000*****
Yes	51	241		
	Are you always obedient?			
No	49	39	13.786	**0.008****
Yes	203	84		
	Attend school regularly?			
No	58	27	12.917	**0.012***
Yes	238	51		
	Problems with your siblings?			
No	36	50	30.705	**0.000*****
Yes	57	225		
	Come back home late at night?			
No	48	41	1.154	0.562
Yes	139	154		
	Have problems with your friends?			
No	32	57	3.263	0.515
Yes	79	212		

***Significant**

Most of the questions on deviant behaviour that were test against parent-parent love for each other showed a statistically significant difference. As seen in Table 5.16, ‘Have you been involved in a fight lately?’ (p=0.000), ‘Have you ever used drugs?’ (p=0.002), ‘Have you changed school because of problems at school?’ (p=0.000), ‘Do you attend school regularly?’ (p=0.000), ‘Do you often have problems with your siblings?’ (p=0.011) and ‘Do you sometimes come back home late at night?’ (p=0.000).

Table 5.16 Parents love for each other and its influence on deviant behaviour

Do your parents love each other	Yes	No	X^2	p-value
	Involved in a fight recently?			
No	44	41	26.539	**0.000*** **
Yes	67	222		
	Do you smoke cigarettes?			
No	15	71	3.660	0.160
Yes	33	257		
	Have you ever used drugs?			
No	17	68	17.522	**0.002** **
Yes	19	271		
	Problems at school?			
No	30	52	21.480	**0.000*** **
Yes	51	237		
	Are you always obedient?			
No	49	34	8.062	0.089
Yes	200	86		
	Attend school regularly?			
No	51	30	28.048	**0.000*** **
Yes	241	47		
	Problems with your siblings?			
No	31	53	13.163	**0.011***
Yes	62	214		
	Come back home late at night?			
No	58	28	16.158	**0.000*** **
Yes	125	165		
	Have problems with your friends?			
No	27	59	1.053	0.902
Yes	82	206		

***Significant**

Multinomial and binary logistic regression models were applied to the data set as shown in Tables 5.17A, 5.17B, 5.23 and Tables 5.18-5.22 respectively. In Table 5.17A, the dependent variable being “Do you take alcohol” had three categories; those who take alcohol ‘always’, those who take alcohol ‘sometimes’ and those who ‘never’ take alcohol (those who take alcohol sometimes formed the reference category). This variable was tested against demographic variables like age, duration of stay in the community and who the adolescent live with. The analysis shows that alcohol consumption increased with age. Compared to the reference category (19 years), those who were between 15 years (p=0.001) and 16 years (p=0.041) were 3.7 times and 2 times more likely to report that they have never consumed alcohol respectively. Concerning the duration of stay in the community, living in the community for less than 2 years and greater than 5 years

showed a positive relationship with alcohol consumption compared to the reference category. However, these variables were not significant predictors of alcohol consumption the community.

Table 5.17A: Multinomial logistic regression model for alcohol use among participants

		Never			Always		
Independent variable		B	Sig	Exp (B)	B	Sig	Exp (B)
Intercept		-1.273			-0.188		
Age of participants	**15**	1.309	**0.001***	3.701	-0.695	0.333	0.499
	16	0.759	**0.041***	2.137	-1.203	0.099	0.300
	17	0.081	0.835	1.084	-0.997	0.126	0.369
	18	-0.252	0.555	0.777	-1.064	0.131	0.345
	19	Reference category					
Duration of stay	**<2years**	0.601	0.419	1.825	0.212	0.926	1.236
	>5years	0.048	0.849	1.050	1.155	0.073	3.173
	2 to 5years	Reference category					
Who do you live with	**Aunty**	0.247	0.902	1.280	-3.616	0.188	0.027
	Father	0.778	0.683	2.178	-1.932	0.193	0.145
	Grandparents	2.205	0.319	9.068	-3.235	0.467	0.039
	Mother	1.156	0.524	3.177	-1.928	0.093	0.145
	Parents	1.279	0.477	3.594	-2.085	0.050	0.124
	Siblings	0.753	0.684	2.123	-3.395	0.050	0.34
	Uncle	Reference category					

***Significant,** The reference category is sometimes

Alcohol consumption was also measured against family factors as shown in Table 5.17B, similarly, “Do you take alcohol” had three categories; those who take alcohol ‘always’, those who take alcohol ‘sometimes’ and those who ‘never’ take alcohol (those who take alcohol sometimes was used as the reference category). The variables that predicted whether adolescents were less likely to take alcohol include ‘not having enough money at home’ and families were parents do not love each other (couple conflicts).

Table 5.17B: Multinomial logistic regression model for alcohol use among participants

		Never			Always		
Independent variable		B	Sig	Exp (B)	B	Sig	Exp (B)
Intercept		0.027					
Good relationship with father	**No**	0.466	0.121	1.594	-0.603	0.345	0.547
	Yes	Reference category					
Good relationship with mother	**No**	0.117	0.818	1.124	0.506	0.545	1.659
	Yes	Reference category					
Relationship with siblings	**No**	-0.424	0.331	0.655	-0.497	0.562	0.608
	Yes	Reference category					
Peace at home	**No**	-0.300	0.522	0.740	-0.304	0.739	0.738
	Yes	Reference category					
Feel loved	**No**	0.161	0.783	1.175	0.006	0.995	1.006
	Yes	Reference category					
Supported financially	**No**	0.011	0.975	1.011	-0.624	0.355	0.536
	Yes	Reference category					
Money always at home	**No**	-0.161	0.544	0.851	1.926	**0.020***	6.863
	Yes	Reference category					
Supported emotionally	**No**	-0.029	0.927	0.971	0.934	0.114	2.546
	Yes	Reference category					
Parents in love with each other	**No**	-0.157	0.645	0.855	1.372	**0.031***	3.943
	Yes	Reference category					

***Significant,** The reference category is sometimes

All the family dynamics variables tested were not predictors of drug use among adolescents in the community (Table 5.18). However, not having a good relationship with father as well as not having a good relationship with siblings showed a negative relationship with drug use among adolescents in the community.

Table 5.18: Binary logistic regression model for drug use

Independent variables		Estimates (B)	Significance	Expected (B)
Good relationship with father?	**No**	-777	0.095	0.460
	Yes	Reference category		
Good relationship with mother?	**No**	0.943	0.093	2.569
	Yes	Reference category		
Relationship with siblings?	**No**	-0.388	0.527	0.679
	Yes	Reference category		
Is there Peace in your home?	**No**	0.657	0.273	1.928
	Yes	Reference category		
Do you feel loved by your family?	**No**	0.227	0.741	1.255
	Yes	Reference category		
Are you supported financially?	**No**	0.270	0.583	1.310
	Yes	Reference category		
Is there always money at home?	**No**	0.186	0.682	1.205
	Yes	Reference category		
Are you supported emotionally?	**No**	0.283	0.524	1.327
	Yes	Reference category		
Do your parents love each other?	**No**	0.848	0.069	2.336
	Yes	Reference category		

The reference category was 'Yes'

Having a baby was predicted by whether the adolescent was supported emotionally by their parents or who they live with. Those who lack emotional support at home were more likely to experience teenage pregnancy than those who were supported emotionally (Table 5.19).

Table 5.19: Binary logistic regression model for teenage pregnancy among the participants

Independent variables		Estimates (B)	Significance	Expected (B)
Good relationship with father?	**No**	0.031	0.931	1.031
	Yes	Reference category		
Good relationship with mother?	**No**	0.470	0.380	1.600
	Yes	Reference category		
Relationship with siblings?	**No**	-0.424	0.457	0.654
	Yes	Reference category		
Is there Peace in your home?	**No**	0.483	0.397	1.620
	Yes	Reference category		
Do you feel loved by your family?	**No**	0.686	0.313	1.986
	Yes	Reference category		
Are you supported financially?	**No**	-0.189	0.663	0.827
	Yes	Reference category		
Is there always money at home?	**No**	0.025	0.939	1.025
	Yes	Reference category		
Are you supported emotionally?	**No**	-1.112	**0.012***	0.329
	Yes	Reference category		
Do your parents love each other?	**No**	0.555	0.164	1.742
	Yes	Reference category		

***Significant,** The reference category was 'Yes'

As shown in Table 5.20, sexual experience among the participants was negatively associated with financial and emotional support available to the adolescent while being positively associated with availability of money at home (poverty) and the amount of love that exist between their parents. Those that were not supported financially and emotionally were more likely to have had sex, interestingly, those whose parents were not in love with each and those who expressed poverty at their homes were less likely to have had sex.

Table 5.20: Binary logistic regression model for sexual engagement among participants

Independent variables		Estimates (B)	Significance	Expected (B)
Good relationship with father?	**No**	0.091	0.757	1.095
	Yes	Reference category		
Good relationship with mother?	**No**	0.280	0.569	1.323
	Yes	Reference category		
Relationship with siblings?	**No**	0.153	0.727	1.166
	Yes	Reference category		
Is there Peace in your home?	**No**	-0.040	0.933	0.961
	Yes	Reference category		
Do you feel loved by your family?	**No**	0.057	0.924	1.059
	Yes	Reference category		
Are you supported financially?	**No**	-0.717	**0.043***	0.488
	Yes	Reference category		
Is there always money at home?	**No**	0.967	**0.000*****	2.630
	Yes	Reference category		
Are you supported emotionally?	**No**	-0.826	**0.010***	0.438
	Yes	Reference category		
Do your parents love each other?	**No**	0.926	**0.007****	2.525
	Yes	Reference category		

***Significant,** The reference category was 'Yes'

Having sexually-active friends was predicted by the availability of financial and emotional support to the adolescent. Those who have no financial and emotional support at home were more likely to engage with friends who are sexually-exposed (Table 5.21).

Table 5.21: Binary logistic regression model for association with sexually exposed friends

Independent variables		Estimates (B)	Significance	Expected (B)
Good relationship with father?	**No**	0.468	0.123	1.597
	Yes	Reference category		
Good relationship with mother?	**No**	0.132	0.792	1.141
	Yes	Reference category		
Relationship with siblings?	**No**	-0.453	0.303	0.636
	Yes	Reference category		
Is there Peace in your home?	**No**	0.729	0.144	2.074
	Yes	Reference category		
Do you feel loved by your family?	**No**	0.044	0.944	1.045
	Yes	Reference category		
Are you supported financially?	**No**	-1.116	**0.002****	0.328
	Yes	Reference category		
Is there always money at home?	**No**	0.413	0.113	1.512
	Yes	Reference category		
Are you supported emotionally?	**No**	-679	**0.031***	0.507
	Yes	Reference category		
Do your parents love each other?	**No**	0.606	0.077	1.833
	Yes	Reference category		

***Significant,** The reference category was 'Yes'

Having multiple sexual partners was positively associated with the level of closeness to siblings (p=0.000). Those who are not in a good relationship with their siblings are 5.7 time less likely to have multiple sexual partners than those who enjoy a good relationship with their siblings (Table 5.22).

Table 5.22 Binary logistic regression model for multiple sexual partnerships among participants

Independent variables		Estimates (B)	Significance	Expected (B)
Good relationship with father?	**No**	0.199	0.515	1.220
	Yes	Reference category		
Good relationship with mother?	**No**	0.667	0.160	1.949
	Yes	Reference category		
Relationship with siblings?	**No**	1.740	**0.000***	5.696
	Yes	Reference category		
Is there Peace in your home?	**No**	-0.638	0.209	0.528
	Yes	Reference category		
Do you feel loved by your family?	**No**	-0.460	0.467	0.632
	Yes	Reference category		
Are you supported financially?	**No**	0.594	0.089	1.811
	Yes	Reference category		
Is there always money at home?	**No**	0.223	0.438	1.250
	Yes	Reference category		
Are you supported emotionally?	**No**	0.247	0.447	1.280
	Yes	Reference category		
Do your parents love each other?	**No**	-0.011	0.973	0.989
	Yes	Reference category		

***Significant,** The reference category was 'Yes'

As shown in Table 5.23, the frequency of condom use was positively associated with maternal closeness (p=0.029). In addition, those who had never used condoms were more likely to report that they were not in a good relationship with their mothers. The other family dynamic variables were not significant (p>0.05).

Table 5.23: Multinomial logistic regression model for condom use among participants

		Never			Always		
Independent variable		B	Sig	Exp (B)	**B**	Sig	Exp (B)
Intercept		0.303			0.204		
Good relationship with father	**No**	-.616	0.145	0.540	-0.273	0.486	0.761
	Yes	Reference category			Reference category		
Good relationship with mother	**No**	1.563	**0.029***	4.774	1.303	0.065	3.681
	Yes	Reference category			Reference category		
Relationship with siblings	**No**	-.122	0.818	0.885	-1.059	0.080	0.347
	Yes	Reference category			Reference category		
Peace at home	**No**	.766	0.215	2.151	-0.840	0.260	0.432
	Yes	Reference category			Reference category		
Feel loved	**No**	-1.286	0.119	0.276	0.676	0.437	1.966
	Yes	Reference category	.		Reference category		
Supported financially	**No**	-.159	0.733	0.853	-0.591	0.190	0.554
	Yes	Reference category			Reference category		
Money always at home	**No**	-.615	0.098	0.541	-0.018	0.958	0.982
	Yes	Reference category			Reference category		
Supported emotionally	**No**	-.254	0.566	0.776	-0.534	0.228	0.586
	Yes	Reference category			Reference category		
Parents in love with each other	**No**	.356	0.448	1.427	0.658	0.134	1.930
	Yes	Reference category			Reference category		

***Significant,** The reference category is sometimes

5.4 Adolescents' perceived benefits and risks of engaging in deviant and sexual risk behaviour in the community.

As shown in Table 5.24, three hundred and fifty two (92.0%) agreed that having unprotected sex may result in HIV infection; 22 (5.7%) are not sure while 9 (2.3%) disagreed that unprotected sex may lead to HIV infection. On whether having unprotected sex may lead to pregnancy; 346 (89.9%) agree while 22 (5.7%) are not sure and 17 (4.4%) disagree. On whether their partner will love them more when they have unprotected sex with them; 184 (49.2%) disagreed, 91 (24.3%) agreed and 99 (26.5%) were not sure.

Table 5.24 Perceived benefits and cost of condom use

Question	Frequency	Percentage
Someone can get HIV when they have sex without using a condom		
Disagree	9	2.3
Not sure	22	5.7
Agree	352	92.0
Someone can get pregnant when they have sex without using a condom		
Disagree	17	4.4
Not sure	22	5.7
Agree	346	89.9
Benefits of having sex without condom is more than the bad results		
Disagree	53	13.8
Not sure	64	16.7
Agree	266	69,5
I don't enjoy sex when using a condom		
Disagree	207	56.7
Not sure	73	20.0
Agree	85	23.3
My boy/girlfriend will love me more if I have sex without a condom with him/her		
Disagree	184	49.2
Not sure	99	26.5
Agree	91	24.3

In Table 5.25, it can be seen that 101 (26.6%) participants did not have a problem getting pregnant because it is happening among girls their age, while 226 (59.6%) disagreed. Furthermore, 279 (72.8%) disagree that the availability of HIV medication at the clinic would encourage them to take

risk but 75 (19.6%) agreed that this is the case. Forty-two (11.1%) agreed that their parents would be happy with them if they became pregnant, while 273 (72%) disagreed and 46 (16.9%) were not sure what their parents actions would be. On whether it is wrong having a baby while still at high school, 244 (64.2%) disagreed, 58 (15.3%) agreed and 78 (20.5%) were not sure. On whether having oral is safer than vaginal sex, 154 (41.2%) agreed, 87 (23.3%) disagreed and 133 (35.6%) were not sure. Similarly, 170 (45.3%) agreed that having anal sex is safer than vagina sex while 79 (21.1%) disagreed and 126 (33.6%) are not sure.

Table 5.25: Perceptions regarding the perceived outcomes of engaging in unprotected sex.

Question	Frequency	Percentage
People my age are getting pregnant so I don't mind getting pregnant		
Disagree	226	59.6
Not sure	52	13.7
Agree	101	26.6
I don't mind if I get HIV because treatment is available at the clinic		
Disagree	279	72.8
Not sure	29	7.6
Agree	75	19.6
My parents will be happy with me if I get pregnant		
Disagree	273	72.0
Not sure	64	16.9
Agree	42	11.1
There is nothing wrong in having a baby while still in high school	244	64.2
Disagree	78	20.5
Not sure	58	15.3
Agree		
Falling pregnant while not working can make me and my baby poor and suffer		
Disagree	51	13.5
Not sure	49	13.0
Agree	277	73.5
Having oral sex is safer than vaginal sex		
Disagree	87	23.3
Not sure	133	35.6
Agree	154	41.2
Having anal sex is safer than vaginal sex		
Disagree	79	21.1
Not sure	126	33.6
Agree	170	45.3

On whether people may engage in sex for incentives, such as food and shelter, 278 (75.5%) agreed, 43 (11.7%) disagreed and 47 (12.8%) were not sure. Two hundred and sixty six (71.9%) agreed that having unprotected sex may prevent them from completing their education, 38 (10.3%) disagree and 66 (17.8%) were not sure. Whilst one hundred and seventy nine (48.6%) agreed that the desire to have a baby may encourage the practice of unprotected sex; 101 (27.4%) disagreed and 88 (24%) were not sure. The majority (79.7%) agreed that taking alcohol and drugs may make people engage in unprotected sex while 29 (7.8%) disagreed and 46 (12.4%) were not sure (Figure 5.2).

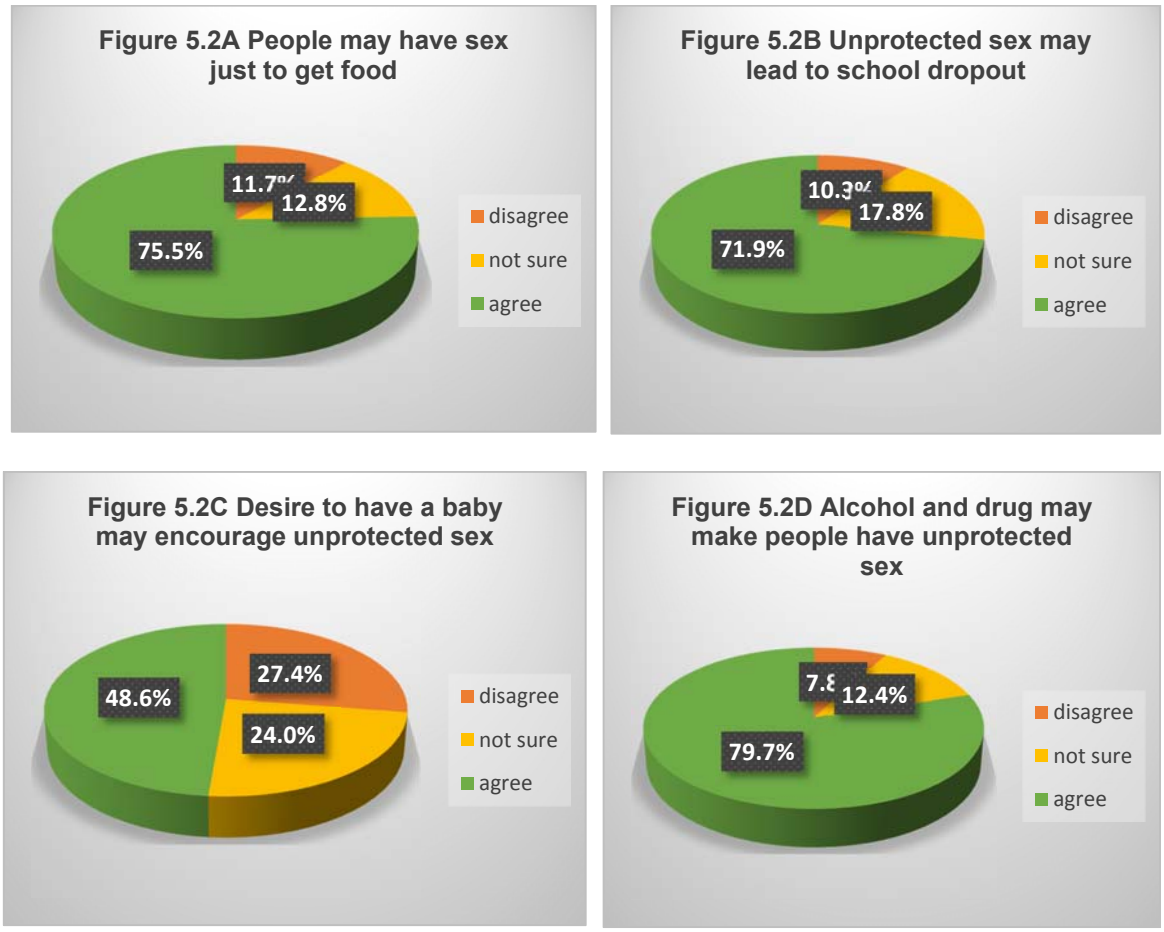


Figure 5.2 Perceptions on the benefits and costs of having unprotected sex

There was no statistically significant gender difference in the response of participants across all the questions regarding their perceived cost and benefits of engaging in sexual risk behaviours.

Table 5.26: Gender and participants perception regarding benefits and cost of unprotected sex

Question		Female	Male	Total	X^2=2.589 P=0.459
Someone can get HIV when they have sex without using a condom	D	3	6	9	
	NS	11	11	22	
	A	174	178	352	
Unprotected sex may lead to unwanted pregnancy	D	5	12	17	X^2=3.188 P=0.364
	NS	12	10	22	
	A	171	175	346	
Benefits of having sex without condom is more than the bad results	D	27	26	53	X^2=0.347 P=0.951
	NS	30	34	64	
	A	130	136	266	
People my age are getting pregnant so I don't mind getting pregnant	D	103	123	226	$X^2$3.993 P=0.262
	NS	30	22	52	
	A	53	48	101	
I don't mind if I get HIV because treatment is available at the clinic	D	130	149	279	X^2=2.433 P=0.487
	NS	17	12	29	
	A	40	35	75	
My parents will be happy with me if I get pregnant	D	131	142	273	X^2=0.392 P=0.942
	NS	32	32	64	
	A	22	20	42	
There is nothing wrong in having a baby while still in high school	D	111	133	244	X^2=4.742 P=0.192
	NS	46	32	78	
	A	29	29	58	
I don't enjoy sex when using a condom	D	102	105	207	X^2=0.513 P=0.916
	NS	33	40	73	
	A	43	42	85	
Falling pregnant while not working can make me and my baby poor and surfer	D	21	30	51	X^2=2.203 P=0.531
	NS	24	25	49	
	A	140	137	277	
My boy/girlfriend will love me more if I have unprotected sex him/her	D	87	97	184	X^2=1.693 P=0.638
	NS	52	47	99	
	A	45	46	91	

D = Disagree; NS= Not sure; A = Agree

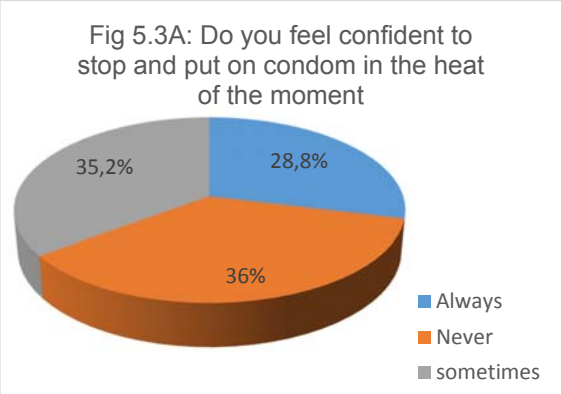
5.5 Adolescents' perceived level of skills for self-protection against deviant and sexual risk in the community.

As depicted in Table 5.27, two hundred and fifty-two (68.5%) are confident of themselves to withhold having sex until they get married, while 117 (32.0%) would not. In addition, 249 (68%) could put on condoms correctly while 117 (32%) could not. Furthermore, 148 (41.2%) said they could resist unprotected sex, even when their partner demanded it. On whether they were able to make a new partner use a condom with them, 278 (76.6%) said they could and on whether they could get their partner to get tested for HIV, 280 (77.1%) said they are confident they could and 83 (22.9%) are not confident in their ability to do so.

Table 5.27: Perceived skills for self-protection

Questions	Yes		No	
	n	%	n	%
Are you confident in yourself to remain without having sex till you marry	252	68.5	116	31.5
Are you able to put on condom correctly	249	68.0	117	32.0
Can you resist having unprotected sex when your partner demands for it?	148	41.2	211	58.8
Are you able to make your steady partner use condom with you	267	73.6	96	26.4
Are you able to ask a new partner to use condom	278	76.6	85	23.4
Do you feel confident in yourself to ask your partner to get tested for HIV	280	77.1	83	22.9

In Figure 5.3A, only about a third (28.8%) of the participants said they are confident in themselves to be able to stop and put on a condom in the heat of the moment, while 36% said they will not be able to stop and put on a condom once they have been aroused. The remaining 35.2% said they were only able to do so irregularly. Slightly more than half (52.6%) of the participants said they are never able to resist unprotected sex, while about a quarter said they are able to resist unprotected sex sometimes and about another 25% said they are always able to resist unprotected sex (Fig 5.3B).



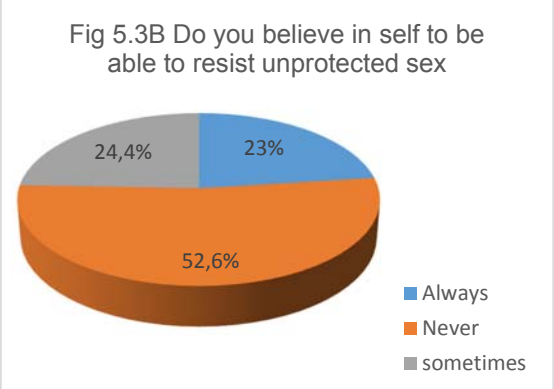


Fig 5.3 Self-efficacy on condom use

Table 5.28 shows the gender differences in the participants' level of skill for self-protection. Among the sexually-active participants, the differences between the gender groups regarding their ability to put on a condom correctly is highly significant (p=0.000). This implies that more males than females believe in themselves to effectively put on a condom. Other questions did not show a significant difference in response along gender lines.

Table 5.28: Gender differences in skills for self-protection

Question	Yes	No	X^2	p value
Are you confident to remain without having sex till you marry?				
Female	123	56	0.023	0.989
Male	129	60		
Are you able to put on a condom correctly?				
Female	103	77	19.609	**0.000*** **
male	146	40		
Can you resist having unprotected sex with your partner?				
Female	73	103	0.198	0.906
Male	75	108		
Can you refuse unprotected sex when your partner demands it?				
Female	99	81	0.177	0.915
Male	101	87		
Are you able to make your steady partner use a condom with? you?				
Female	128	51	1.571	0.456
Male	139	45		
Are you able to ask a new partner to use a condom?				
Female	131	47	1.977	0.372
Male	147	38		
Are confident to ask your partner to get tested for HIV?				
Female	136	42	0.343	0.842
Male	144	41		

***Significant**

As shown in Table 5.29, there was no significant difference across age of participants as they responded to questions on their skills for self-protection.

Table 5.29: Age difference in skills for self-protection

Are you confident in yourself to remain without having sex till you marry?	**Yes**	**No**	**X^2**	**p-value**
15	64	23	5.034	0.754
16	58	31		
17	51	24		
18	36	19		
19	43	19		
Are you able to put on condom correctly?				
15	55	31	9.716	0.286
16	59	28		
17	46	29		
18	43	12		
19	46	17		
Can you resist having unprotected sex when your partner demands? for it?				
15	31	52	9.365	0.312
16	31	54		
17	36	39		
18	20	34		
19	30	32		
Are you able to make your steady partner use condom with you?				
15	58	250	5.394	0.715
16	71	18		
17	52	22		
18	43	12		
19	43	19		
Are you able to ask a new partner to use a condom?				
15	65	19	5.311	0.724
16	71	19		
17	53	21		
18	45	10		
19	44	16		
Do you feel confident to ask your partner to get tested for HIV?				
15	64	20		
16	80	10	15.062	0.058
17	52	21		
18	44	12		
19	40	20		

5.6 The perceived influence of parents on adolescents' deviant and sexual risk behaviour in the community

Whilst the majority (65.4%) of the participants reported that their parents have always told them about HIV infection; about 43 (11.6%) said they had never been told about HIV by their parents. Similarly, 263 (70.9%) said their parents always told them about teenage pregnancy, while 30 (8.1%) said they had never been told about it by their parents (Fig 5.4).

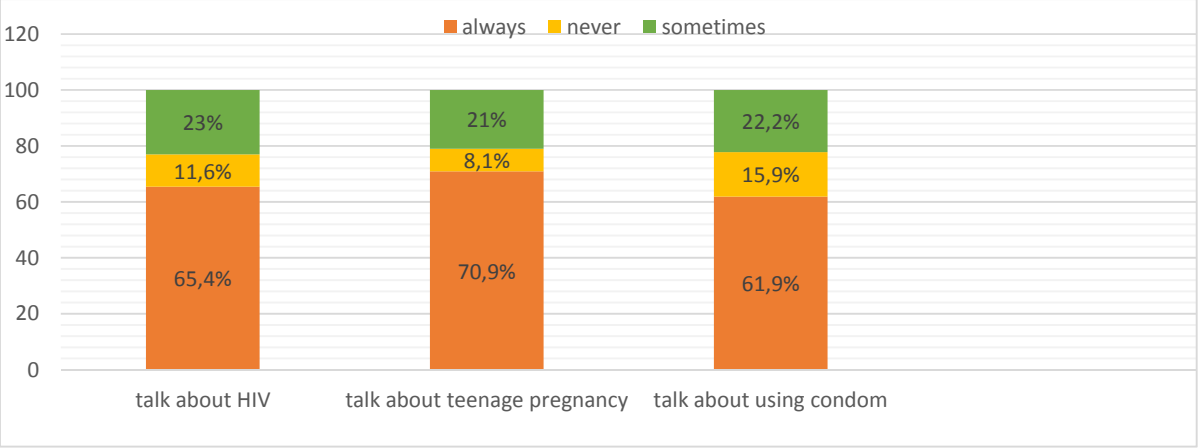


Fig 5.4 Sex education at home

As shown in Figure 5.5, 58 (15.6%) participants said that their fathers had never been part of their lives, while 16 (4.3%) said their mothers had never been part of their lives. About 20% of the participants reported that their parents or the person they live with comes home late, while about 5.9% of their parents take drugs. However, 17.7% said that their parent take too much alcohol.

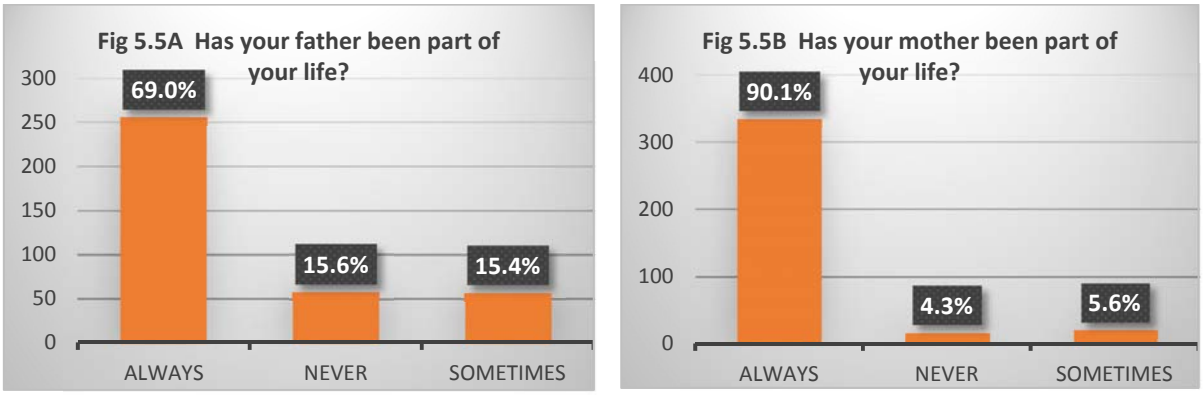


Fig 5.5 Parents' involvement in adolescents' life

As shown in Figure 5.6, about one out of five adolescents reported that their parents keeps late night while less than 6% reported that their parents or the person they live with takes drugs and almost 18% of the participants reported alcohol use among their parents.

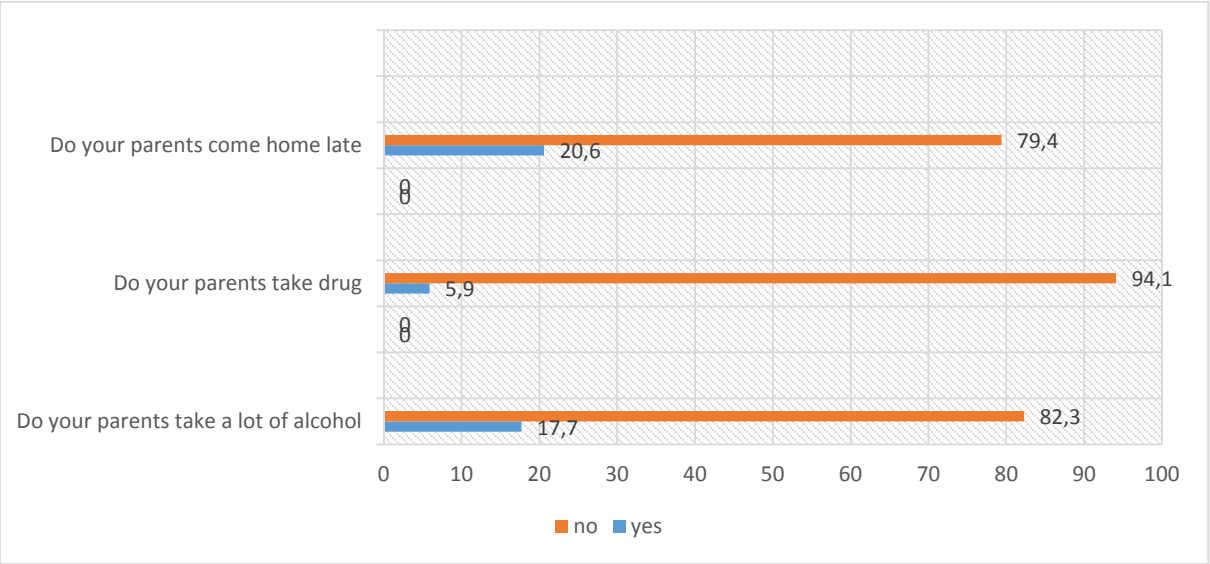


Fig 5.6 Risky behaviour among adolescents' parents/caregivers

The majority (73.0%) said they always have rules and regulations set for them by their parents, while 3.8% said their parents do not set rules and regulations for them. Similarly, the majority (77.8%) reported that their parents corrected them when they behaved wrongly, while 3.2% said they were never corrected when they behaved badly. On whether their needs are taken care of, 71.6% reported that their needs are always taken care of by their parents while 6.7% said their parents do not care for them, while 21.7% reported that their parents sometimes attend to their needs (Fig 5.7)

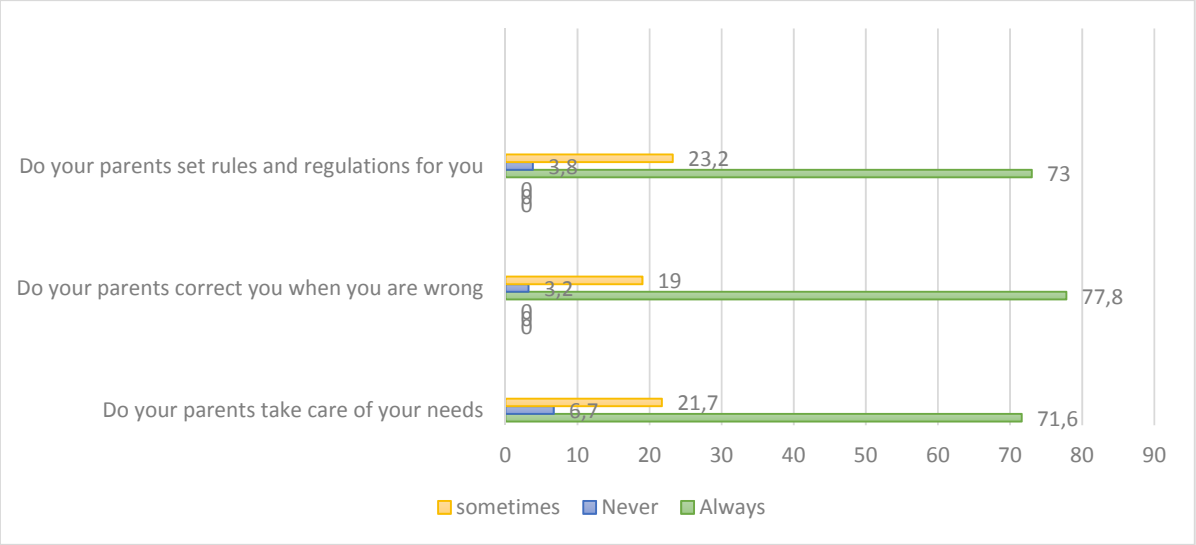


Fig 5.7. A measure of parental responsibilities

As shown in Table 5.30, 81 (22.0%) participants reported that the person they live with has multiple sexual partners while 59 (15.9%) said their parents are always fighting with other people. Furthermore, 220 (59.1%) liked the way their parents or the person they live with lived their lives but only half of the participants wanted to live the kind of life their parents led. However, 114 (31.1%) believed that parents behaving badly may encourage young people to behave badly, as well.

Table 5.30: Participants' opinion about the persons they live with and their perceived influence on them.

Question	**Yes**		**No**	
	n	%	n	%
Does the person you live with have more than one boy/girlfriend?	81	22.0	287	78.0
Are your parent always fighting with other people?	59	15.9	312	84.1
Do you like the way the persons you live with live their life?	220	59.1	152	40.9
Do you want to live your life like them?	186	50.0	186	50.0
Parents behaving badly may encourage bad behaviour in me	114	31.1	252	68.9
Do you take alcohol because people around you are taking it?	37	10.0	334	90.0
Do you have more than one partner because people around you do it?	42	11.5	323	88.5
Adolescents may take less risk if they live with their biological parents	157	43.5	204	56.5

Table 5.31 depicts the gender differences in the opinion of participants. However, there was no statistical difference in the opinion expressed by participants across gender lines.

Table 5.31: Gender differences in opinion held by adolescents regarding modelling behaviour of their parents

Question		Female	Male	Total	X^2=0.264 P=0.967
Have your parents told you about HIV infection?	Always	117	125	242	
	Sometimes	43	42	85	
	Never	21	22	43	
Have your parents told you about teenage pregnancy?	Always	135	128	263	2.943 P=0.400
	Never	11	19	30	
	Sometimes	35	43	78	
Does your parent talk to you about using condom	Always	110	119	229	X^2=1.708 P=0.635
	Never	33	26	59	
	Sometimes	37	45	82	
Do your parents take a lot of alcohol?		No	Yes	Total	0.785 P=0.675
	Female	146	35	181	
	Male	161	31	192	
Do your parents take drugs?	Female	171	10	181	0.222 P=0.895
	Male	180	12	192	
Do your parents come home late?	Female	146	35	181	0.500 P=0.779
	Male	150	42	192	
Does the person you live with have more than one boyfriend?	Female	141	38	178	5.818 P=0.121
	Male	146	43	189	
Is your parent always fighting with other people?	Female	147	33	181	7.235 P=0.065
	Male	165	26	191	
Do you like the way the person you live with live their life?	Female	78	102	180	X^2=1.262 P=0.532
	Male	74	118	192	
Do you want to live your life like them?	Female	97	83	180	5.080 P=0.166
	Male	89	103	192	
Parents behaving badly may encourage you to develop bad behaviour?	Female	117	61	178	1.590 P=0.451
	Male	135	53	188	

Table 5.32 shows the differences in the opinion of participants across age. However, there was no statistical difference in the opinion expressed by participants across their age.

Table 5.32: Age difference in the opinions held by adolescents regarding modelling behaviour of their parents

Have your parents told you about HIV infection?	always	never	sometimes	X^2	p-value
15	57	10	18	9.214	0.685
16	59	15	17		
17	47	5	20		
18	36	8	12		
19	43	5	18		
Have your parents told you about teenage pregnancy?					
15	59	7	18	5.374	0.944
16	63	8	23		
17	52	5	15		
18	41	4	11		
19	48	6	11		
Has your father been part of your life?					
15	56	11	17	7.804	0.800
16	66	14	14		
17	50	11	11		
18	39	9	7		
19	45	13	8		
Has your mother been part of your life?					
15	79	2	3	9.383	0.670
16	82	4	7		
17	63	4	5		
18	50	2	4		
19	61	4	1		
Do your parents talk to you about using condom?					
15	48	15	21	7.545	0.820
16	55	15	23		
17	47	11	13		
18	38	8	10		
19	41	10	15		

CHAPTER FIVE (B)

DISCUSSION OF THE PHASE 2 STUDY: QUANTITATIVE STUDY

Section 1: Socio-demographic profiling of participants

The majority (198; 51.8%) of the participants were born in the Limpopo Province of South Africa, and about 40.1% of the participants were born in Thabazimbi, while the remaining 59.9% of the participants have migrated from other parts of South Africa and beyond to live with their families or to seek for job opportunities in the community. The impact of this migratory pattern was not determined in the present study but this may have significant impact on the household size and subsequently affect the household economy. However, the majority of the participants continue to visit their places of birth regularly.

The demographic profile of the participants showed an almost equal gender distribution that is similar to findings in the general population in South Africa (Stat SA, 2011) but with a slightly male preponderance, as opposed to a slightly female preponderance documented in the 2011 census (Stat SA, 2011). The explanation for this could be attributed to the influx of unemployed males to this mining community in search of jobs. This argument can also be supported by the high number of adolescents who reside in the community but are not attending school. The present study also found that scholarly attainment was low for some participants, with 25 (6.5%) participants still in primary school. This is below the standard expected for learners at the age group under study. The reason for this delay was not accounted for in this study because of the scope and direction of the study. However, taking a deep view of the community, the researcher postulates that the delay in academic attainment seen in this study might be due to frequent class repetition resulting from family de-structuring, effects of HIV and AIDS pandemic and its impact on family income. Other contributing factors might be teenage pregnancy and recurrent migration experienced by these young people in their quest for a suitable and comfortable place of residence. Furthermore, it cannot be ruled out that the use and abuse of substance in the community by adolescents may have contributed to poor school attendance and performance. This assertion was supported by Ajao et al. (2014).

Strikingly, the majority of the participants lived in a two-parent home, while only 23% lived in a single-parent household and 7.3% lived with their grandparents. The remaining participants lived with a variety of people, ranging from siblings, relatives and friends. This is an indication of the

diversity seen in the family system in the community. In many communities in South Africa, the number of single parent families parallels that of dyadic families or even higher, Anyanwu et al. (2013) found that 52.2% of participants lived with both parents while 47.8% lived with either parent. The difference seen in the present study could be related to the many deaths of parents to HIV and AIDS and the subsequent roles played by grandmothers and other relatives in raising orphaned and displaced children in the community. The broader impact of this could be seen in the heightened level of deviant and sexual risk behaviour among adolescents living in this community.

Furthermore, the level of unemployment was also high, showing a remarkable gender bias. For instance, only one out of every five fathers were unemployed (19.8%) compared to one in every two mothers who were unemployed (50.3%), this finding reinforces gender stereotype that continues to feed the ills of poverty and inequality in South Africa. This implies that adolescents living in single mother led households in the community are more likely to experience poverty and increased risk of deviant behaviour.

Section 2: Family dynamics and deviant and sexual risk behaviour

The parents or caregivers can inhibit or facilitate adolescents' deviant and sexual risk behaviours through relationships and supervision. It can be said that with adequate commitment, parents are able to socialize their children to imbibe the cultural norms and value system of their society (Sooryamoothy, 2012). Bearman and Brueckner (2001) posit that in the absence of quality parental care, adolescents gravitate to a more liberal association with their peers and this may result in untoward outcome. It is however important to note that even among the parents, the mothers and fathers have different roles and different influence on the adolescent. For instance, the absence of a father in the family reduces the opportunity for adolescents to acquire skills that come from the experience of the father, his social network and the financial contribution to the family (Mackey, 2001). The ease of communication with parents, especially with the mother, has been shown to reduce early sexual behaviour (Lenciauskiene & Zaborskis, 2008)

The quality of parent-adolescent relationship and positive family routine provides a cohesive family environment that contributes to the reduction in risky sexual behaviour among adolescents (Manlove, Logan, Moore & Ikramullah, 2008). Not having a father is associated with a high rate of early sexual debut among males, while having a poor relationship with parents has been

associated with higher rate of early sexual debut for both male and female adolescents (Mmbaga et al., 2012).

In the present study, the majority of participants' claim they are in good relationship with their parents or the person they live with. However, more participants tend to gravitate towards their mother, this trend is common and may be attributed to the traditional gender role of mothers in the society (Rohner & Veneziano, 2001). Furthermore, other family dynamic variables like 'living in peace at home', 'feeling loved by family members', 'being supported financially and emotionally by the family' and 'whether parents are in love with each other' produced positive response with greater that 75% of participants responding positively. However, only about 49% reported always having money at home to take care of their needs. Although some of these parameters showed positive response, some adolescents remain vulnerable to deviant and sexual risk behavior. Their vulnerability might stem from family instability resulting from family conflict, family de-structuring and the consequent reversal of gender role, poverty and lack of social support. This finding observed in the present study has been well documented in literature (Caldwell, Beutler, Ross & Silver, 2006; Waldfogel, Craigie & Brooks-Gunn, 2010).

Furthermore, the present study found a high level of deviant and sexual risk behaviour, for instance, about 30% of the participants reported having recently engaged in a physical fight and almost 10% have used drugs, other measures of deviant behaviour that were also prevalent in the community include; 'disobedience to parents, 'sibling conflict', 'constant problems at school' and 'keeping late nights'. Furthermore, the level of sexual activity was also high with 60.1% of the participant being sexually active, 63.7% have friends who are sexually active, and 23.1% having ever been pregnant. The number of sexually active participants recorded in the present study is much higher than is reported in the USA where studies have shown a decline in early sexual activities among adolescents from 54% in 1991 to 47% in 2003 (Michigan Department of Education, 2007).

The present study demonstrates that adolescents in this community are involved in early sexual practices given the proportion of the participants who are already sexually exposed and those who have friends that are sexual exposed, this is not a good trend because it has been shown that early sexual activities increases the likelihood of multiple sexual partnerships, teenage pregnancy and HIV infection (Malhotra, 2008). Furthermore, the present study found that the level of alcohol consumption was high while regular condom use was low. Although the practice of oral

and anal sex was low in the present study. Furthermore, a small percentage (4% and 2.2% respectively) continued to engage in these acts regularly without precaution. However, this is a far cry from the figures reported among adolescents of the same age group in the USA, where Malhotra (2008) documented 50% and 11% of the participant reported engaging in oral and anal sex respectively. The present study however found a much higher levels of sexual activities than that documented by the 2nd South African National Youth Risk Behaviour Survey (2008) and that documented by Awotidebe, Phillips and Lens (2014), which found 38% and 27.2% respectively. The 2nd South African National Youth Risk Behaviour Survey (2008) also reported a lower rate of teenage pregnancy at 19%, compared to the 23.1% reported in the present study. The high level of sexual activities observed in the present study could be associated with extreme poverty and the complicated family dynamics that may have diminished the monitoring and control of adolescent activities in the community.

The existence of sexual interaction between migrant workers and members of the host communities have been argued within the research community for a long time (Wolffers et al., 2002; Cronjé et al., 2013; Gallagher et al., 2014). In most cases, these studies have been conducted among adult population, with findings consistently confirming the practice of transactional sex (Cronjé et al., 2013). Similarly, the present study found that sexual relationship also occurred between mine workers and adolescents. Sixty (15.8%) participants reported having a relationship with mine workers, from these, 55 (79.7%) had had sex with a mine worker, with only 33 (48.5%) using condoms regularly, while 26 (37.1%) claimed that they exchanged sex for money with a mine worker. Although the numbers reported in the present study are not as high as those documented among adult population in similar communities (Tiruneh, Wasie & Gonzalez, 2015), it remains a problem for the adolescent and the migrant worker because this it can serve as a source for the spread of STIs including HIV within the community as well as the sending communities, particularly because the present study reports that only 8.2% of the participants are children of cross-border migrants, with the majority of families migrating from different parts of South Africa. This in itself could also lead to the spread of HIV and Tuberculosis during the all too common seasonal migration to homelands in South Africa.

Over the years, many studies have reported a gender difference in deviant behaviour among adolescents (WHO, 2003; The Michigan Department of Education, 2007; Puente et al., 2011; Dimkpa & Wilcox, 2016). According to Puente et al. (2011), more males than females engage in sexual risk behaviour and males are more likely to have multiple sexual partners. However, the

WHO (2003) reports that the direction of gender bias is often culture specific. In the present study, chi-square analysis found a gender difference among cigarette smokers, teenage pregnancy and multiple sexual partnerships. It was shown that more males smoked cigarette and engaged more in multiple sexual activities, while more females reported being pregnant than males of similar age group that reported getting someone pregnant. Furthermore, participants also differed significantly across age on cigarette smoking, sexual activity, having friends who are sexually active, reported pregnancy and currently having a relationship.

The family environment is a vital tool to shape adolescents behaviour (Estrada-Martınez et al., 2011), even when adolescents engage in risky behaviour, the family through positive modelling of good behaviour and good communication can redirect adolescents towards good behaviour (Aufseeser et al., 2006; Estrada-Martınez et al., 2011). However, many families are either de-structured or socio-economically imbalanced to be able to function as a unit (Wahyuni, 2000; Cronjé et al., 2013). Therefore, this advantage may be lost. This supports findings from the present study which found a significant difference in response across family dynamics parameter measured against deviant and sexual risk behaviour. The analysis showed that the family environment was highly significant in the deviant and sexual risk behaviour of adolescents in this community. Most parameters measured in this study showed a significant difference in response regarding physical violence, disobedience, school attendance, drug use and keeping late nights. However, ‘relationship with mother’ was the family dynamic variable that recorded a wider effect on deviant and sexual risk behaviour. This finding continues to strengthen arguments supporting the positive role played by mothers in families around the world (Rohner & Veneziano, 2001).

Using a multinomial logistic regression model, alcohol use was predicted by ‘age’, not ‘having enough money at home’ and ‘parents not loving each other’. Those who were between 15 years and 16 years of age were less likely to have taken alcohol compared to older adolescents. Interestingly, living with siblings was positively associated with alcohol consumption, meaning that those who live with their siblings were less likely to consume alcohol than those who stayed with their uncles. It has been shown that living with both biological parents is a significant protective factor against deviant behaviour (Wang et al., 2009) but this is not the case in the present study. The reason for the deviation seen in the present study might be due to the experiences of the adolescents who live with their siblings. For example, some of them might have lost their parents or loved ones to HIV and AIDS or other negative vices. Adolescents in such situations are more likely to be more careful, vigilant and focused (Germann, 2005). It may also be as a result of their

inability to afford such luxuries. In addition, having a bad relationship with mother, no money at home, no emotional support at home and homes where parents were not happy with each other were all positively associated with alcohol consumption. However, none of the variables predicted drug use among adolescents in the community.

Furthermore, engaging in sexual activities was predicted by having no financial, emotional support and non-availability of money at home (poverty) and the amount of love that exists between their parents. Those who were not supported financially and emotionally were more likely to have had sex, which may explain the desire to engage in multiple sexual partnerships and transactional sex recorded in the present study. Interestingly, those whose parents experienced regular conflicts and those who expressed poverty in their homes were less likely to have had sex. This may be due to the difficulties experienced by the participants considering the fact that they live in poverty and watch the disharmony between their parents. This may make them to be cautious in engaging in sexual activities, fearing that the possible outcomes may lead them to starting a family prematurely. In addition, the present study found that lacking emotional support at home predicted teenage pregnancy and having sexually active friends was predicted by lack of financial and emotional support at home.

In this study, having multiple sexual partners was predicted by closeness to older siblings, those who were not in a good relationship with their older siblings were less likely to have multiple sexual partners. Secondly, frequency of condom use was predicted by maternal closeness, those who never used condoms frequently reported that they were not in a good relationship with their mothers. Similar to the findings in the present study, Hamid and Nawi (2013) found that family factors were closely associated with risk behavior among adolescents.

Section 3: Perceived benefit and risks of engaging in deviant and sexual risk behaviour

Among young people, the cost and benefits of having unprotected sex is often hinged on the expected outcomes of such an act (Newby et al., 2013). Similarly, Halpern- Felsher (2006) explains that adolescents' behaviour is often motivated by a presumed positive outcome. The present study measures adolescents' perception on the benefits and cost associated with unprotected sex, the vast majority of the participants (92%) agreed that unprotected sex may result in HIV infection while 89.9% agreed it may result to unwanted pregnancy, this was similar to findings by Anyanwu et al. (2013a) where the vast majority (94.6%) agreed that unprotected

sex may result in HIV infection. However, it has been demonstrated that academic knowledge of the impact of a health behaviour does not usually translate into good behaviour (Schiro, 2008). This is supported by the present study, where the majority of the participants had high knowledge of the association between unprotected sex and HIV infection and the effect of substance abuse on unprotected sex, but only 35.6% use condoms regularly while greater than half of 52.9% consume alcohol.

Although teenage pregnancy has been shown to have adverse health consequences, create poverty and truncate educational career (Hayatbakhsh, Najman, Khatun, Al Mamun, Bor & Clavarino, 2011; Anyanwu et al., 2013b), slightly more than a quarter of the participants in the present study do not mind getting pregnant at their age simply because others are doing it. This perception needs to be frowned at because the desire to have a baby has been shown to increase the risk of having unprotected sex, and consequently, the risk of STIs including HIV infection. Strikingly, almost one out of five participants do not mind getting infected with HIV because treatment is available at the clinic, this is an expression of diminished knowledge on the part of the participants regarding HIV, AIDS and its complications. At the moment, there is no cure for HIV but only treatment to ameliorate the condition (Johnson et al., 2013). It has been shown that, depending on the characteristics and the level of their baseline CD4 count, the life expectancy for HIV positive individual on Antiretroviral therapy (ART) in South Africa can range between 10.1 years and 36.8 years (Johnson et al., 2013). Therefore, adolescents who get infected may not live to achieve their full potential.

It has been reported in some literature that some parents encourage their children to get pregnant in order to give them grandchildren (Phaswana-Mafuya, Tabane, Davids & Mbelle, 2009). This assertion was not found to be popular in the present study because only 11.1% of the participants, affirmed to this claim. This number is lower than the figures reported by Anyanwu et al. (2013c) where it was reported that almost 36% of the participants agreed that girls may engage in unprotected sex because they are pressured by their mother to do so. The lower figures reported in the present study may be linked to the tender age of the participants, most of whom were 17 years or younger. They might possibly not have had such experiences with their parents. Furthermore, most of the participants were not in support of having a baby while still in school. However, 15% agreed that it is not a bad idea to have a baby while still in school. The reason for this is not clear, it could be that these participants may have experienced teenage pregnancy without adverse sequel or that they may have friends who got pregnant and returned to school

without complications. However, it has been reported that teenage pregnancy may truncate academic ambition (Olaitan, 2010). On the other hand, some authors have argued that the effect of teenage pregnancy on adolescent education may depend on the disposition of the family towards teenage pregnancy and the timing of its occurrence (Fergusson & Woodward, 2000). It is however important to note that only about one out of three adolescents return to school after pregnancy in South Africa (Grant & Hallman, 2006).

Adolescents may be led to believe that love can be measured on the scale of sexual contact. For instance, it has been reported that girls are likely to believe that having unprotected sex would prove their love to their partner and in some cases prolong their relationship (Reddy, 2004; Ott, Millstein, Ofner & Halpern- Felsher, 2006). Almost half of the participants in the present study disagree with this view but about one out of four participants agreed that having unprotected sex makes their partner love them more. However, some girls have realised that this may be a ploy used by boys to get girl to have unprotected sex with them (Reddy, 2004). The human ability to decipher true meaning of spoken words begins during adolescence and continue to develop into adulthood, this is called social cognition, it is at this time that adolescents begin to recognize and interpret other peoples' intentions, desires and feelings towards them (Frith & Frith, 2007). In this regard, adolescents may borrow from the experience of positive role models within their social sphere, preferably their parents to be able to face these challenges. Unfortunately, as shown in the present study, some adolescents do not have the necessary social support.

Oral and anal sex have been seen by some as a way to avoid pregnancy (Halpern-Felsher et al., 2005). However, these practices have been linked to STIs, including HIV (Halpern-Felsher et al., 2005; Chng, Eke-Huber, Eaddy & Collins, 2005). Many adolescents are oblivious of the dangers involved in the practice (Anyanwu et al., 2013) and this is demonstrated in the present study where 41.2% of the participants' agree that oral sex is safer than vaginal sex. However, the present study found that in practice, 33.8% of the participants have engaged in oral sexual practices while 23.4% have experienced anal intercourse.

Furthermore, the social and economic conditions of vulnerable adolescents may force them to exchange sex for food, money or shelter, this assumption is well documented in literature (Chatterji, Murray,London & Anglewicz, 2004). Some authors have argued that transactional sex is not often a result of poverty, some women engage in this act just for life style rewards like attracting a man who can buy them expensive clothes and jewellery (Leclerc-Madlala, 2004). The

present study reports that majority of the participants' agree that adolescents may engage in transactional sex in other to survive, although this study was not designed to explore prevalence and factors leading to transactional sex, it was however shown in a small sample of participant who reported having sexual relationship with mine workers that out of the 60 (15.8%) participants who had partners that work in the mine, 26 (37.1%) of them reported exchanging sex for money. Importantly, it has been shown that young women who exchange sex for money or material items are less able to negotiate condom use, especially when the financial reward is lucrative (Leclerc-Madlala, 2004).

Although the present study found no significant gender difference in the response of participants regarding their perceived cost and benefits of engaging in sexual risk behaviours, it has been well documented in literature that males and females differ in their sexual behaviour, this has been said to be rooted in the socialization of individuals (Widdice et al., 2006; Rolleri, 2013). Liberal societies like the western world have a more open approach to child rearing, giving same opportunities to both males and females but some reserved societies have strict cultural practices that often dictates gender roles for male and female children as they grow. The perceptions expressed in the present study may not have differed significantly across gender lines but in practice, males and females differed in deviant and sexual risk behaviour.

Section 4: Perceived level of skills for self-protection against deviant and sexual risk behaviour

Sexual abstinence, whether primary or secondary, is known to reduce adolescents' risk of STIs and unplanned pregnancy (Koffi & Kawahara, 2008; Suellentrop, Palen & Ashley, 2013). The perceived confidence expressed by an adolescent in their ability to remain abstinent until they get married has been studied (Koffi & Kawahara, 2008). The outcomes of studies on abstinence is population specific (Suellentrop et al., 2013). According to Kabiru and Ezeh (2007), 33%, 42% and 85% of study samples in Côte d'Ivoire, Malawi and Ghana, respectively, practiced primary abstinence. However, the present study found that 68.5% of the participants expressed confidence in their ability to remain abstinent until marriage. There was no significant difference among participants across age or gender lines. In addition, the participants who claimed that they are confident to abstain may not actually live up to their claims when they are faced with real life situations. It has been shown that an abusive partner may influence an individual's decision to delay sex (Boafo, Dagbanu & Asante, 2014). Nevertheless, the figures recorded in the present

study gives a ray of hope that with continued efforts to encourage adolescents to build their self-confidence through programmes designed to develop self-efficacy, adolescents and young adults in this community may be able to avoid teenage pregnancy and STIs, including HIV. Research has shown that abstinence is the sure way to avoid unwanted pregnancy and STIs (Suellentrop, Palen & Ashley, 2013).

Among adolescents who were sexually active, the ability to wear condoms correctly and the level of self-confidence to negotiate safe sex is crucial (Dilorio et al., 2001). In the present study, 41.2% of the participants say they are confident in themselves to resist unprotected sexual advances from their partner while 52.6% reported that they were never able to resist unprotected sexual advances, this represents a large portion of the adolescent population who would be willing to engage in unprotected sexual activities. It therefore suggests that adolescents in this community are vulnerable and this may pose a challenge to the fight against the spread of HIV infection in the community. Furthermore, only 68% of the present sample could put on condom correctly. This response showed a statistical difference along gender lines (p=0.000), it appeared that males were more likely to report that they could wear condoms correctly. In a similar study, it was reported that males who were confident in their ability to wear and use condoms correctly were more likely to use condoms during sex (Guiella & Madise, 2007) but in a related study, it was reported that among females adolescents, the ability to use condoms effectively does not translate to safe sexual practices (Crosby et al., 2001).

The majority of the participants in the present study said they were confident in their ability to make a new partner use condom during sexual intercourse but only about a third believed in themselves to stop to wear a condom in the heat of the moment. This shows that although people may express high confidence in their ability to use condoms, this claim may be subdued by their outcome expectation. This finding is supported by the argument that individuals with a low negative outcome expectation about condom use and a high self-efficacy about condom use are more likely to use condoms regularly during sex (Schwarzer & Luszczynska, 2005). Generally, condom-use self-efficacy and self-efficacy to negotiate condom use with partners reported in the present study is lower than that documented among a population of university students (Farmer & Meston, 2006) but the present study reported a higher frequency of regular condom use. The disparity seen in two studies may be related to the age difference, the participants in the present study are younger and may not have the requisite cognitive maturity and understanding to resist sexual advances. However, a higher percentage of condom use reported in the present study

may also be explained by the age difference because it has been reported that among young people, condom use decreases with age (Anyanwu et al., 2013a).

The role of HIV Counselling and Testing (HCT) on behaviour change has been studied (Wusu & Okoukoni, 2011), but the benefit of this exercise remain an issue of great debate among researchers, some have argued that HCT reduces sexual risk taking (Sherr et al., 2007) while some argue the opposite (Arthur et al., 2007). However, the benefit of testing for HIV are numerous, ranging from knowing ones HIV status and possible access to treatment to acquiring knowledge on how to prevent HIV (WHO, 2007). The present study found that about 77% of the participants expressed confidence in their ability to make their partners take HIV test, this constitutes the majority of the participants but just over a quarter of them do not express such confidence. It has been established that HCT is the entry point to HIV treatment and other related services (WHO, 2017), it therefore implies that the success of any HIV prevention programme depends on increased uptake of HCT among young people. Adolescents who are not able to get their partners to utilize HCT services may be at risk of contracting HIV.

Although several studies have found a significant difference in self-efficacy along age and gender lines (Farmer & Meston, 2006; Redmond & Lewis, 2014; Guiella & Madise, 2007), the present study only found significant difference on one component of condom use (ability to wear condom correctly) all other variables did not show significant difference across age and gender. The reason for this finding is not apparent but similar result have been reported by Baele, Dusseldorp and Maes (2001).

Section 5. The influence of adults in adolescents' deviant and sexual risk behaviour

Adolescents learn everyday by observing their environment particularly the adults in their household and environs. It has been shown that adolescents consider their parents as their best role models (Anderson & Cavallaro, 2002), this is an important advantage in favour of parents to influence positive behaviour in their children. It has been argued that parents may reduce risk behaviour in their children when they adopt positive parenting and improve the quality of the relationship they share with their children (Bongardt, Graaf, Reitz & Dekovic, 2014). Therefore, it can be said that modelling behaviour may have both positive and negative effects on the risk behaviour of adolescents (Yancey, Grant, Kurosky, Kravitz-Wirtz & Mistry, 2011).

According to Whitaker and Miller (2000), parents who talk to their children about sex or condoms have closer relationships with them and this provides an opportunity for them to monitor their children closely. Furthermore, Somers and Vollmar (2006) argue that adolescents might increase their sexual disclosure to parents if they perceived that there is warmth and support from their families. In the present study, about two out of three participants reported that their parents always talked to them about HIV infection and teenage pregnancy, this appears to amount to a large number of people but their still remain participants whose parents have never discussed the risk of HIV and teenage pregnancy with. A similar finding is documented by Breuner et al. (2016), however, the present study did not find a significant difference in the response given by participants along age or gender lines.

Many families in South Africa are de-structured: some because the bread winner is living and working in a separate location, while for some, it is due to death and family conflicts. In some cases the children do not know who their real parents are even when such parents are still alive. The role played by the parents in raising their children have been documented by several authors (King et al., 2004; Aufseeser, Jekielek & Brown, 2006; Kim, 2008), with some highlighting the important role played by the father in the character building of adolescents (Piko & Balazs, 2012). It has been shown that adolescents who have lost their parents or are being taken care of by relatives have an increased risk of engaging in early sexual activities (Mmbaga et al., 2012). Although, more traditionally, mothers are described as the pillar of support for the family, however, fathers have been shown to contribute economic and social capital to the family. In the present study, 15.6% of the participants said their fathers had never been part of their lives while only 4.3% claim that their mothers have not been part of their lives, with no age or gender difference. The finding shows that more adolescents are without their fathers support than those who were without a mothers' support. Although the numbers recorded in the present study are low, the impact of an absent father is grave on the daily life of an adolescent (Allen & Daly, 2007).

The behaviour of parents, caregivers and older siblings are constantly being watched by adolescents, and if the behaviour portrayed by adults in the home are is, it may influence adolescents negatively. In addition, children whose parents take excessive alcohol and drugs are more likely to engage in illicit substance use (Stephens, 2007). In the present study, one-fifth of the participants reported that the person they live with keeps late nights, 6%, 17.7%, 22% and 15.9% reported that their parent or caregiver use drugs, took alcohol excessively, had multiple sexual partners and engage in fighting, respectively. Only about two-thirds of the participants liked

the way their parents or caregiver lived their lives, and interestingly, only about a third of the participants did not agree that bad behaviour could be learnt from parents. However, it has been shown that children generally would grow up to be like their parents (Stephens, 2007) and adolescents are prone to replicate what they see in their families as they grow older (Elkington et al., 2011).

Parents who show commitment in setting rules and regulations for their children provide an opportunity for good sexual practices while adolescents whose parents oversee their activities are less likely to engage in risk behaviour (O'Donnell et al., 2008). It therefore follows that parents have the opportunity to inhibit or facilitate risk behaviour through direct supervision and monitoring of adolescent behaviour. The majority of participants in the present study claimed that their parents or caregivers set rules and regulations for them always, while the majority also claimed that their parents corrected them when they behaved badly. However, a small percentage of the participants either claimed that they have no rules at their homes and that they are never corrected when they behave badly. This finding may have been caused by the prevailing circumstances surrounding families in the community under study, where many adolescents are raised without their biological parents. In these kinds of settings, there may be constraints in setting rules and ensuring discipline to support adolescents' behaviour, for instance, Gayles et al. (2009) argue that a single-parent-led family may be constrained with taking decisions to discipline or support a child's behaviour compared to dyadic families.

Wamoyi, Fenwick, Urassa, Zaba and Stones (2011) posit that when children begin to provide the economic needs of the family, their parents are less able to exercise control over their behaviour. The present study reports that just about one out of five participants claimed that their parents do not meet their needs regularly while just under 7% reported that their parents never attended to their needs, there was no age or gender bias in the response given by participants. This implies that the authority of some parents in this community could be undermined by their children because it appears that a good number of the children fend for themselves and by assuming this adult responsibility at an early age, such children may become decision-makers in the household. This creates an opportunity for these children to engage in uncontrolled risk behaviour.

Chapter six

Linking of the study and validation of outcomes

6.1 Linking of study

6.1.1 Introduction

This chapter describes the linking of the two studies (Phase 1 and 2 studies) that were conducted in sequence. These studies had different but related objectives which when combined addressed the problem of family dynamics on adolescent behaviour. It was expected that the outcomes would be different but because the family dynamics variables used in the Phase 2 study were drawn from the phase 1 study, some similarities were also envisaged.

Many authors have highlighted the usefulness of mixed method research (de Vos, Strydom, Fouche & Delport, 2002; Driscoll, Yeboah, Salib & Rupert, 2007), where, a health problem could be addressed by combing a qualitative and a quantitative approach. In the present study, the qualitative study was used to gather information on the dynamics within the families where adolescents live and the outcome was used to fortify the SCT which was the template for the questionnaire design.

The studies were linked at two points as shown in Figure 6.1

1. Instrument for data collection: The family dynamics profile used in the development of the questionnaire for data collection in Phase 2 study was drawn from the outcomes of the Phase 1 study.
2. The outcomes: The outcomes of Phase 1 and 2 studies where combined to develop a public health programme.

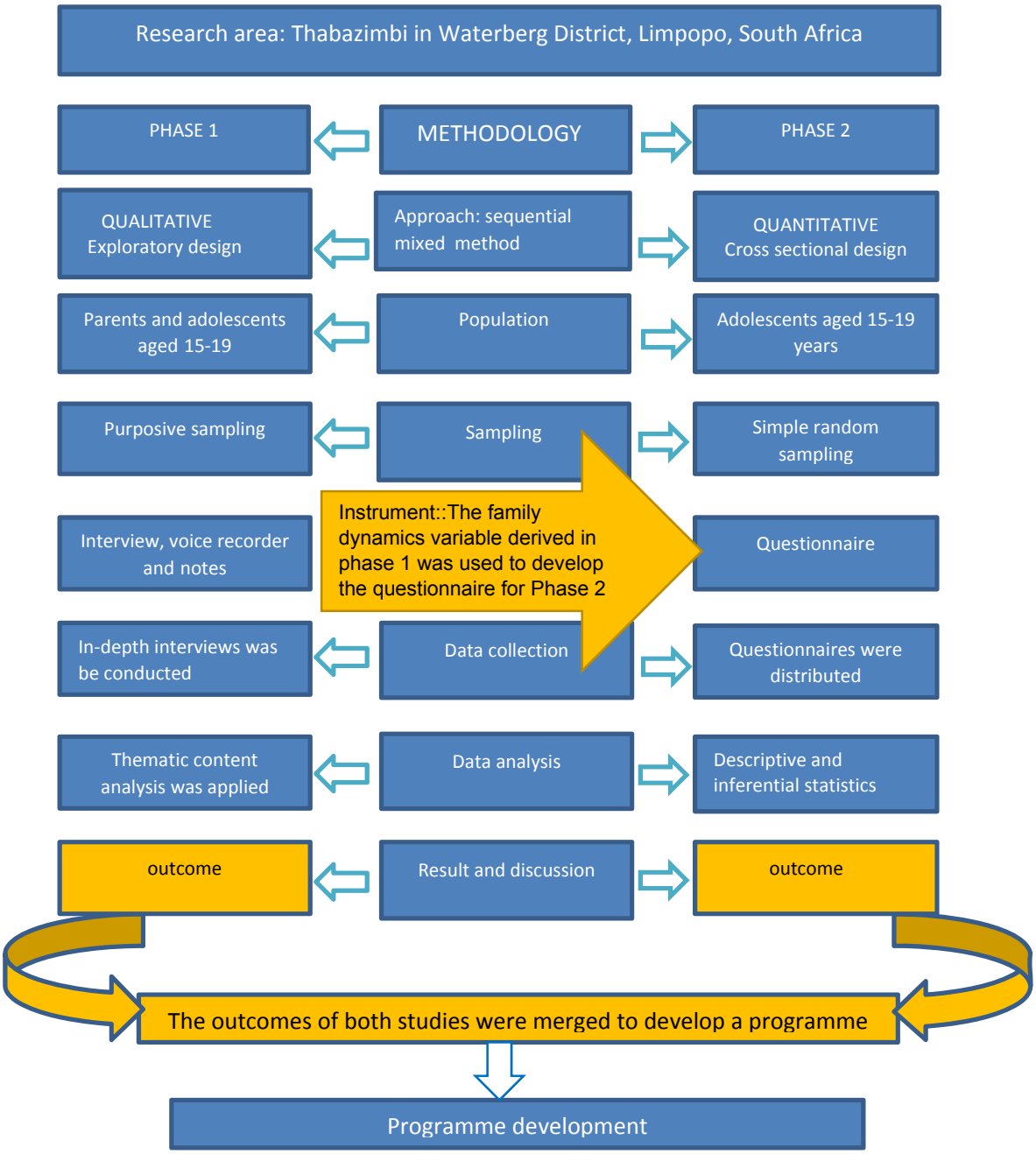


Figure 6.1: Schematic representation of the steps involved in the linking of the study.

To effectively link these studies, here are the main findings:

6.1.2 Phase 1 study (main findings)

6.1.2.1 Social support system available to adolescents.

1. The issue of conflict between parents was recurrent among participants.

2. There are vulnerable adolescents in the community, some had lost both parents and were therefore living as heads of households with their younger siblings, and some of these households claimed that nobody supported them financially, socially and emotionally.

3. Some adolescents who lived with their parent/s expressed no faith in their family (especially their father) to support them and provide for their needs, and some adolescents reported that they were abandoned by their families when they got pregnant.

4. Community members complained that social workers had not been responsive to the plight of vulnerable households in the community.

6.1.2.2 Financial support available to adolescents within the family

1. Families in this community suffer severe financial constraints, this also includes those who are employed. Participants say they are often not able to meet their financial obligations to their children and siblings even when they pool all their resources together. Worst affected are the adolescent headed households and homes where the grandmother is the bread winner.

2. Level of unemployment is high and this has forced some bread winners to migrate to other locations in search of jobs while living their families behind to care for themselves. Some families also spend their meager resources to accommodate unemployed family members thereby reducing the amount of money available to support their children.

3. Many grandmothers are frail, and all of them depend on fund transfer from the government to meet their daily needs, some even suffer from medical conditions that restrict their mobility. These grandmothers struggle to feed and care for their grandchildren, they are often not able to cater for their families even when their grants and that of the eligible grandchildren are pooled together, it becomes even more difficult when their unemployed children (some more than 40years old) live in the same house and depend on the same grant.

6.1.2.3 Parenting processes adopted by families in the community

1. Adolescents in this study expressed discomfort sharing their personal problems with their parents, some say they are afraid of what their parents might say while some worry that their parents would forbid them from having a relationship.

2. Age and cultural differences was identified as a hindrance to effective communication between parents and their children, this was particularly common among households headed by grandmothers.

3. Adolescents reported that there was little or no sex education from their parents, some say the only time their parents talk about HIV or pregnancy to them is when they are being scolded for bad behaviour at home.

4. The present study also found that parent-child closeness did not inhibit deviant behaviour among adolescents, It was obvious that the bonding involved in these relationships were not strong because as much as they claim that they were close to each other, they were also quick to say that being close to their parents has no influence on their behavior.
5. Some adolescent reported that they did not enjoy a good relationship with their family, this was common among adolescents in a sibling headed household. In addition, Many parents struggle with maintaining discipline in their family, some complained of bad behavior among children living in this community, for some it was that the children were disrespectful, while for others it was that the children engaged in drinking alcohol and smoking marijuana and taking other harmful substances.

6. The ability of some of the households to maintain discipline is diminished due to several reasons, some households are headed by elderly grandmothers who are not able to monitor or control their grandchildren, while in some households, there are no adults to monitor adolescents and these young people automatically become decision makers in their households. In some households, there is a single mother who is limited in her ability to maintain law and order in the home.

6.1.2.4 Deviant and sexual risk behaviour among adolescents living within the community.

1. Sexual risk taking is rife among young people in this community, multiple sexual partnership, and exchange of sex for money and having sexual relationship with older men were some of the sexual risk behaviors credited to adolescents in this community.

2. Alcohol and drug abuse is a common problem in the community, especially because young people are also partaking in the act, including primary school children. It was also found that some adolescents spend their grant money on alcohol. The fall out of alcohol use was linked with school absenteeism and deviant behavior among young people in the community.

3. The environment around young people in this community presents a big challenge to their development, participants were particularly worried about the proliferation of drinking spots within the community which poses a negative attraction to young people, and some say that delinquent children in the community also influence other children negatively.

6.1.3 Phase 2 study (main findings)

6.1.3.1 Family dynamics and the nature and pattern of deviant and sexual risk practices among adolescents

1. More than 75% of the participants reported a generally favourable family environment, claiming that they enjoyed a good relationship with their parents/care giver and siblings.

However about half of the participants say their family do not have enough money to take care of their needs.

2. The present study found that only 8.2% of the participants are children of cross border migrants with the majority of families migrating from different parts of South Africa.

3. The present study found a high level of recent physical violence and drug use among participants with about 30% of the participants reporting having recently engaged in a physical fight

4. The present study found that the level of alcohol consumption and drug use was high, only 47.1% of the participants have never taken alcohol and almost 10% reported using drugs.

5. The level of sexual activity reported in this study was high in the community with 60.1% of the participant being sexually active and 63.7% having friends who are sexually active and 23.1% having been pregnant. In addition, condom use among participants was low, with only 35.6% using condom regularly

6. The practice of oral and anal sex was low among participants with 66.6% and 76.6% never involved in oral or anal sex respectively. However, some participants remain vulnerable.

7. The present study found that sexual relationship also occurred between mine workers and adolescents, 15.8% of the participants reported having a relationship with mine workers, out of this, 79.7% have had sex with the mine workers with only 48.5% using condoms regularly while 37.1% claim they exchanged sex for money.

8. There was gender difference among participants on the following variables, cigarette smokers, teenage pregnancy and multiple sexual partnerships while participants differed significantly across age on the following variables, cigarette smoking, sexual activity, having friends who are sexually active, reported pregnancy and currently having a relationship.

9. The family environment was highly significant in the deviant and sexual risk behaviour of adolescents in this community, most parameters measured in this study showed a significant difference in response regarding fighting, disobedience, school attendance, drug use and keeping late nights. However, 'relationship with mother' was the family dynamic variable that recorded a wider effect on deviant and sexual risk behaviour.

10. The present study found that alcohol use was predicted by age, having enough money at home and the level of love shared among their parents. Sexual experience was predicted by not having financial support, emotional support, non-availability of money at home (poverty) and the amount of love that exist between their parents. Teenage pregnancy was predicted by lack of lacking emotional support at home, while having sexually active friends was predicted by lack of financial and emotional support at home. Multiple sexual partnership was predicted by closeness to siblings while frequency of condom use was predicted by maternal closeness.

6.1.3.2 Perceived benefits and risks of engaging in deviant and sexual risk behaviour

1. The vast majority of the participants (92%) agreed that unprotected sex may result in HIV infection while 89.9% agreed it may result in unwanted pregnancy. Although they had high knowledge of the association between unprotected sex and HIV infection and the effect of substance abuse on unprotected sex, but only 35.6% use condoms regularly while greater than half of 52.9% consume alcohol. It implies that participants are well aware of the dangers involved with their actions but they do it anyway.
2. Slightly more than a quarter of the participants would not mind getting pregnant at their age because they see it as a common occurrence in the community, likewise, almost one out of five participants do not mind getting infected with HIV because they believe they can access treatment at the clinic, these perceptions reflect a diminished knowledge of the risks associated with teenage pregnancy and HIV, AIDS and its complications.

3. It has been reported in some literature that some parents encourage their children to get pregnant in other to give them grandchildren. This assertion was not popular in the present study because only 11.1% of the participants affirmed this claim. However, 15% agree that it is not a bad idea to have a baby while still in school.

4. The belief that having unprotected sex strengthens a relationship was supported by about one out of four participants who agreed that having unprotected sex makes their partner love them more.

5. The present study found no significant gender difference in the response of participants regarding their perceived cost and benefits of engaging in sexual risk behaviours. The perceptions expressed in the present study may not have differed significantly across gender lines but in practice, males and females differed in deviant and sexual risk behaviour.

6.1.3.3 Perceived level of skills for self-protection against deviant and sexual risk

1. The present study reports that 68.5% of the participants expressed confidence in their ability to remain abstinent, there was no significant difference among participants across age or gender lines.

2. Only 41.2% of the participants say they are confident in themselves to resist unprotected sexual advances from their partner while about 68% of the present sample could put on condom correctly.

3. Although the majority of the participants in the present study are confident in their ability to make a new partner use condom during sexual intercourse but only about one out of three participants believed in themselves to stop to wear a condom in the heat of the moment.

4. The present study found that about 77% of the participants expressed confidence in their ability to make their partners take HIV test, but just about a quarter of them do not express such confidence. However, the present study only found significant difference one component of condom use (ability to wear condom correctly) all other variables did not show significant difference across age and gender.

6.1.3.4 The influence of family environment on adolescents' deviant and sexual risk behaviour

1. In the present study, about two out of three participants reported that their parents always talked to them about HIV infection and teenage pregnancy, but there still remain participants whose care givers have never discussed the risk of HIV and teenage pregnancy with.

2. Almost 16% of the participants say their fathers have never been part of their lives while 4.3% claim their mothers have not been part of their lives, with no age or gender difference. The finding shows that more adolescents are without a fathers support than those that are without a mothers support.

3. In the present study, one-fifth of the participants reports that the person they live with keeps late nights, while 6%, 17.7%, 22% and 15.9% reports that their parent or care giver use drugs, take a lot of alcohol, have multiple sexual partners and engage in fighting respectively. Only about two-thirds of the participants like the way their parents or care giver live their lives, and interestingly, only about a third of the participants did not agree that bad behaviour could be learnt from parents.

4. The majority of participants in the present study claim that their parents or care giver set rules and regulations for them, always while majority also claim that their parents correct them when they behave badly. However, a small percentage of the participants either claimed that they have no rules at their homes and that they are never corrected when they behave badly.

5. The present study reports that just about one out of five participants claim that their parents do not meet their needs regularly, while just under 7% report that their parents never attend to their needs, there was no age or gender bias in the response given by participants.

In line with the major findings of the study, some similarities and differences were documented (as shown in Figure 6.2). The Phase 2 study (P2) was designed to measure the deviant and sexual risk behaviour among adolescents in the community and the personal factors that may put

them at risk for such behaviours. As shown in Figure 6.2, there was a high level of physical violence, high level of alcohol consumption and drug use as well as high level of sexual activity among adolescents. Furthermore, it was also shown that some adolescents in the community have low risk perception and low levels of skills for self-protection. On the other hand, the Phase 1 study (P1) was designed to find reason/s for these behaviours by adolescents in the community. The plausible reasons for adolescents' deviant and sexual risk behaviour as documented in the P1 study include couple conflicts, lack of faith in the family for support, lack of support from social workers, financial constraints, ineffective parent-adolescent communication, weak parent-adolescent bonding and the influence of friends and the environment.

It therefore implies that, in developing an effective public health programme in the community, the researcher must take cognisance of the household dynamics identified in the P1 study in other to mitigate the deviant and sexual risk behaviours identified in the P2 study.

LINKING OF THE QUALITATIVE AND QUANTITATIVE STUDIES

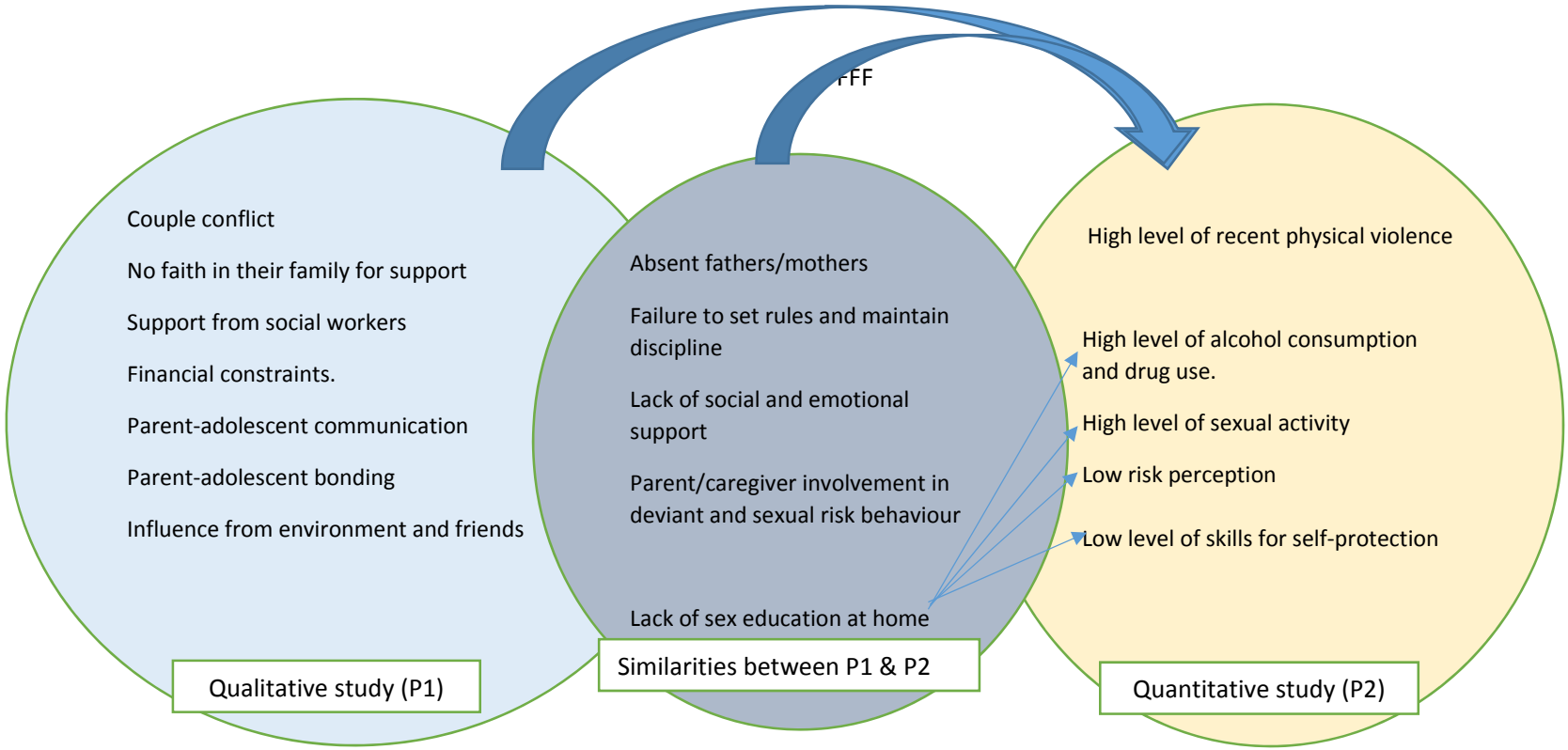


Figure 6.2 Schematic representation of the outcomes of the study

6.2 Validation of research outcomes

The present study utilized a data collection technique that involved self-reporting of activities through the use of face-to-face interviews and questionnaires. This type of reporting has been shown to be fraught with misrepresentation of facts especially when the subject matter revolves around the participant. However, steps were taken to minimise any form of underreporting or over reporting by adolescents or their caregivers (see the sections on measure of trustworthiness and validity of research instrument in Chapter Three). Furthermore, three community leaders whose families where not involved in the study were also interviewed to get a neutral perspective of the issues around the family environment within which adolescents live and a measure of the behaviour of adolescents in the community.

During the interview with the community leaders, similar themes arose in comparison with the themes generated in the main study. In general, the interview with the community leaders supported findings of the main study. However, the community leaders laid emphasises on irresponsible parenting as the main factor for deviant and sexual risk behaviour among adolescents in the community. In addition, the proliferation of taverns within the community was a major concern, this was blamed on the inability of the government to effectively monitor the activities of tavern operators because many of them are operating in the community without the requisite licence to do so.

CHAPTER SEVEN

A PROPOSED PROGRAMME TO MITIGATE THE EFFECT OF FAMILY DYNAMICS ON ADOLESCENTS' DEVIANT AND SEXUAL RISK BEHAVIOUR IN A MIGRATION AFFECTED COMMUNITY.

7.1 Introduction

This chapter describes the development of a public health intervention to mitigate the influence of family dynamics on the deviant and sexual risk behaviour of adolescents in a migration affected community.

7.2 The procedure for programme development

The programme was based on the findings of a sequential, exploratory and descriptive mixed method research which involved parents and adolescents within the community. The template for the development of this programme was drawn from the work of Dickoff, James and Wiedenbach (1968). In their work, they described how a theorized concept can be transferred into practice, keeping in mind three elements, that include setting a goal of what is to be achieved, having a survey list of activities that need to be performed in order to achieve the goal and finally, defining the prescribed (directives) actions that need to be followed in other to get the job done. In accordance with the above recommendation by Dickoff et al. (1968), the following steps were involved in the programme development.

1. Developing a conceptual framework (theorized concept) from the findings of the study.
2. Using the conceptual framework to create a practice oriented platform to support vulnerable adolescents in the community.

7.2.1 Development of a conceptual framework

The outcome of the situation analysis in this community was instrumental in the development of this conceptual framework. These outcomes were aligned with the elements of practice theory, as proposed by Dickoff et al. (1968).

7.2.1.1 Goal

This element, as described by Dickoff and colleagues, highlights the content of the action that needs to be performed, in this case, a public health intervention by way of a public health programme designed along the lines of the major findings of the qualitative and quantitative studies conducted in the community. It is hoped that the programme developed may reduce the negative influence and accentuate the positive influence of family dynamics on the deviant and sexual risk behaviour of adolescents in this migration affected community.

7.2.1.2 The survey list

This includes specific activities involved in achieving the goal. They include, context, Agent, Recipient, Procedure, Dynamics and Purpose.

7.2.1.3 Context

This describes the framework within which the programme activity will take place. The core of this programme will take place in the homes where adolescents reside, while the National Youth Policy Framework of South Africa (2009) provided the legal back-up in support of the rights of adolescents and the duties of their parents and the organs of government. The rights of youths in South Africa as documented by the National Youth Policy (NYP) includes but are not limited to right to have access to education, protection and care. On the one hand, these rights are to be ensured by parents or anyone else appointed to take care of the adolescents, and on the other hand the government, through its agencies such as the South African Social Security Agency (SAASA), South African Police Services (SAPS) and other law enforcement agencies charged with the responsibility to cater for children and youth. Within this framework, an adolescent deserves to be taken care of by the person charged with such responsibility. Although the government continues to support vulnerable households in South Africa, some vulnerable adolescents remain un-catered for. The present study provides evidence that some adolescent headed households, grandparents-headed households and single-parent households are in dire need of support.

The home environment remains crucial in supporting a child as he/she grows up. The quality of parenting and the socioeconomic status of the family play a role in shaping the behaviour of children. As shown in Figure 7.1, the present study found that within the home, certain factors

were important determinants of adolescent behaviour. These factors include family unity, socioeconomic status, parent-child communication and modelling behaviour.

Families where the parents live in peace with each other are more likely to pull their resources together to support other members of their family. In this kind of setting, adolescents are more likely to be catered for than in families that frequently experience couple conflicts and sibling squabbles. Adolescents experiencing conflicts in their families are more likely to seek happiness elsewhere. Often, such adolescents gravitate towards their peers. Strikingly, this study found a high rate of sexual practices among peers in the community. Similarly, the ability of the family to support their adolescents socially, emotionally and financially impacts on the behavioural choices made by such adolescents. Furthermore, adolescents who enjoy a good relationship with their family and where the caregiver shows good examples, creates an atmosphere for interaction and bonding and are more likely to adopt safety measures to protect themselves.

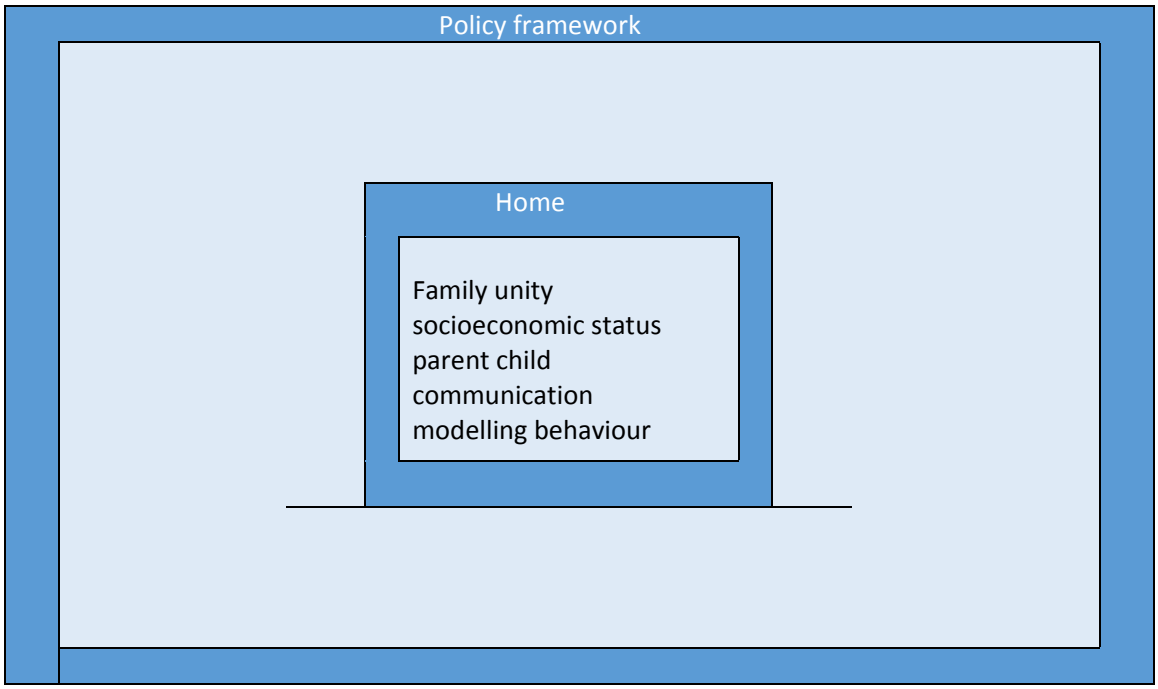


Figure 7.1 Context within which adolescents' care and support is enshrined

7.2.1.4 Agents and Recipient

Agents and recipients are both participants in the practice theory described by Dickoff et al. (1968). The individual or group of people that will be involved in the implementation of the programme are described as 'Agents' while the beneficiaries of the programme are the 'Recipients'. The agents in this programme include the Parents (who are also recipients), Non-Governmental Organizations (NGOs), government structures like the Department of Social Development and political heads, while the adolescents and their parents will remain the recipients.

Agents

In line with the findings of the present study, a link was established between 'agents' and 'recipients', this has been schematized in Figure 7.2. The family is the primary unit of socialization. It is from the family that the adolescents learn norms and value system. In a family that is de-structured or embedded in conflicts and poverty, the adolescents are presented with an opportunity to explore options for happiness outside their home. This may entangle such adolescents with delinquent friends and expose them to a range of deviant behaviours, including sexual risk taking. However, in families where the parents are united and committed to true family values, such parents will be able to provide positive parenting and therefore mitigate untoward outcome for their children. Other adults in the family also share a similar responsibility to support and monitor younger children. In situation where older siblings are delinquent, the effect on adolescents are often disastrous especially if younger siblings see their older siblings as role models

The willingness to support a programme depends on the political will of politicians. In the absence of political will, implementation of programmes to change attitude and behaviour will become unrealizable. For instance, the government could make sure that parents take responsibility for their children, especially in the face of child abandonment seen in some households in this community, the government can also ensure that social support grants are paid to deserving families to help them support their children, while also ensuring that other government agencies remain committed to supporting poor and vulnerable communities. Importantly, youth below the drinking age should not have access to alcohol.

Social workers are intricately linked with community development and behavioural change; they are supposed to support families with information when required, provide counselling when needed and help in rehabilitation of delinquent parents and adolescents when necessary. Although they are faced with numerous challenges in discharging their duties in a community, like the one under study where many families need some form of assistance or the other, they are also presented with an enormous opportunity to support and influence the conditions within a family. Non-Governmental Organizations are also key players in this community; they support the fight against the spread of HIV infection, Tuberculosis and other social issues in the community through direct partnership with stakeholders. They provide relief materials to vulnerable households and also engage in campaigns to inform and educate parents and their children, some of these NGOs also play an advocacy role to protect and solicit assistance on behalf of vulnerable individuals and groups in the community. Through their contact with families, they may be able to support parents and other caregivers to better care for their children.

Recipient

Although parents and other caregivers may also be considered 'recipients' of this programme, the ultimate recipients are the adolescents. It can be said that the relationship between adolescents and their parent is reciprocal. When adolescents get negative energy from their parents, it may result in negative behaviour. However, when a parent shows a positive attitude and support for the adolescent, they build trust and encourage good and healthy behaviour.

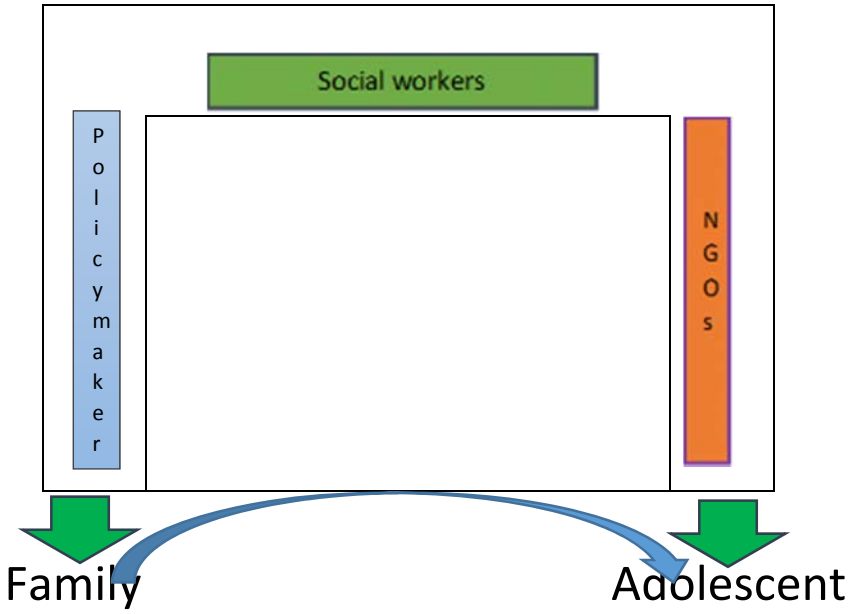


Figure 7.2 Linking of Agents and Recipients

7.2.1.5 Dynamics

Dickoff et al. (1968) describe dynamics as the power source available for the activity. In other words, it is the driving force that can either encourage/discourage an agent or recipient to perform an activity. Therefore, the dynamics in this programme include Motivation, Advocacy and Education. This has been schematized in Figure 7.3.

Motivation

Motivation has been defined as the reason/s that underlie a behaviour (Guay et al., 2010). These reasons could come from within (intrinsic) or could be an external influence (extrinsic). During the study, it was found that some parents and social workers failed in their role to sufficiently support vulnerable adolescents while on the other hand, some adolescents also failed in their duty to show respect for constituted authorities. Work-overload was reported by social workers and change agents as the reason for not being able to adequately attend to their clients. Furthermore, caregivers like foster parents and grandparents need to be financially motivated to be able to support adolescents under their care. On the other hand, adolescents' motivation for delinquent activities may come from the family or from external influence Therefore, the family environment is a great source of motivation to promote good and healthy behaviour in adolescents.

Advocacy

According to UNICEF (2010), advocacy is a deliberate process, based on demonstrated evidence to directly or indirectly influence decision makers and stakeholders to support and implement action that contribute to the fulfilment of children's and women's rights. In order to achieve good results in this community, agents need to speak out on issues that affect adolescents. Some parents are engaged in bad behaviour, such as neglect of their responsibility to their children, multiple sexual partnership, alcohol and drug abuse. These behaviours are likely to have negative influence on the adolescents who live with them. Such parents must therefore be assisted to build capacity for self-control and commitment because it is when they are able to control themselves that they may be able to control their children. This can be achieved through dialogue with parents and other stake holders.

Education

Globalization and modernization has widened the generational gap. Adolescents today are better equipped (as far as information technology goes) than adolescents before them, and many parents are playing catch up with the trends in technological development. It is therefore apparent that adolescents are ahead of their parents and caregivers in the information sphere. This makes it important for parents to acquire the necessary skills and knowledge on ways to improve communication with their children and as well as the depth of knowledge on deviant and sexual risk behaviour. A well-informed parent will be better positioned than a peer to provide true and well guided advice to adolescents. This role can be supported by other stakeholders, such as the social workers and change agents in the community who are skilled in this regard, and they can achieve this through campaigns to raise awareness.

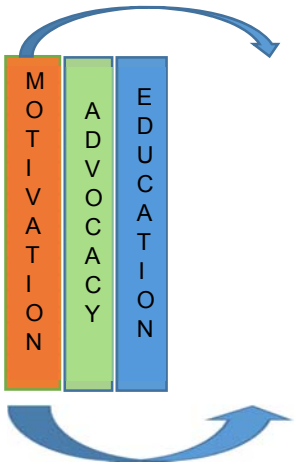


Figure 7.3. The energy source for the activities

7.2.1.6 Procedure

This emphasizes the principles, routine, path, steps and rubrics to follow in-order to accomplish the set goal (Dickoff et al., 1968). The function of procedure is to provide details of how an act can be completed successfully. During the study, it was evident that some adolescents had low knowledge about the effects of HIV and AIDS and teenage pregnancy; some had low skills for self-protection, while some associated minimal risk to unprotected sex. These findings could be attributed to low sex education, insufficient parent-adolescent communication and diminished love and support from the family. As shown in Figure 7.4, the pathway to behavioural change would involve education, communication, love and support.

Education

Parents who furnish their children with information provide an opportunity for such children to make informed decision on issues regarding their lives. Adolescents who are exposed to sex education at home are equipped with the right information about sexual practices. On the other hand, adolescents who are raised in homes where the parent/s are absent or are not involved in the affairs of their children, such children may become influenced by ill guided advice by their peers and this may result in untoward outcomes for the adolescent. In this regard, the social workers and change agents would become handy to provide the needed education to support families and their adolescents towards better decision-making. This can be achieved through campaigns and school programmes.

Communication

Communication between parents and adolescents has to be effective before any meaningful progress can be made. It was evident in this study that the lines of communication between adolescents and their parents were weak. In some instances the age difference between caregivers and their adolescents posed a challenge, while in other cases the parents were unavailable to provide needed guidance. Parents who communicate effectively with their adolescents and who create an environment for intimacy and bonding are likely to build trust in their adolescents and encourage them to open up and talk about their personal life. Some adolescents in the study reported not sharing their private lives with their parents but would rather discuss their personal issues with friends. Parents who spend quality time with their children will encourage bonding that may eventually improve disclosure by adolescents. Furthermore, effective communication would provide a channel for parents to transfer needed knowledge about safe sexual practices to their children.

Love and support

The family is the primary source of socialization. Children learn societal norms from members of their family especially from their parents. Families are supposed to support their members and treat them with love, and it is within this context that children imbibe their culture and learn how to treat one another with love and respect. However, family dynamics vary across households and the effect of this also varies among adolescents. Some adolescents are fortunate to have unity in their families while some live within de-structured family setting. The dynamics in these families influence love, care and support for adolescents. Families who love and support their adolescents create an environment where the adolescent would feel comfortable to share their problems, knowing that members of their family would work towards solving the problem that they might have. As documented in this study, adolescents who do not feel loved and supported have an increased chance of engaging in deviant and sexual risk behaviours. Therefore, with love and support, adolescents are more likely to receive inputs from their parents towards behaviour change.

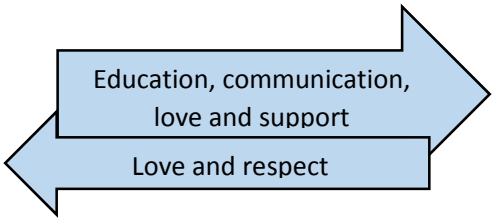


Figure 7.4 Pathway to outcome

7.2.1.7 Purpose

This describes the anticipated outcome of the programme (Dickoof et al., 1968). As shown in Figure 7.6, the programme will empower parents and adolescents by encouraging improved communication, care and support within the family. On the part of the parents, empowerment will come from the support of other agents such as the policy makers who have the powers to institute policies that can impact on the lives of people living in the community. For instance, the proliferation of taverns and sales of alcohol to minors can be controlled through policy formulation and enforcement. If this is done, it is one less problem for the parents to worry about. Social workers and change agents can also support parents and adolescents by providing tailored and specific information to address sex education, communication skills and positive parenting. An empowered parent will then be able to empower their adolescent through education, effective communication and support. Once empowered, adolescents will in turn be able to take appropriate initiative for their own health.

Figure 7.5 Empowerment

7.3 Structure of the conceptual framework

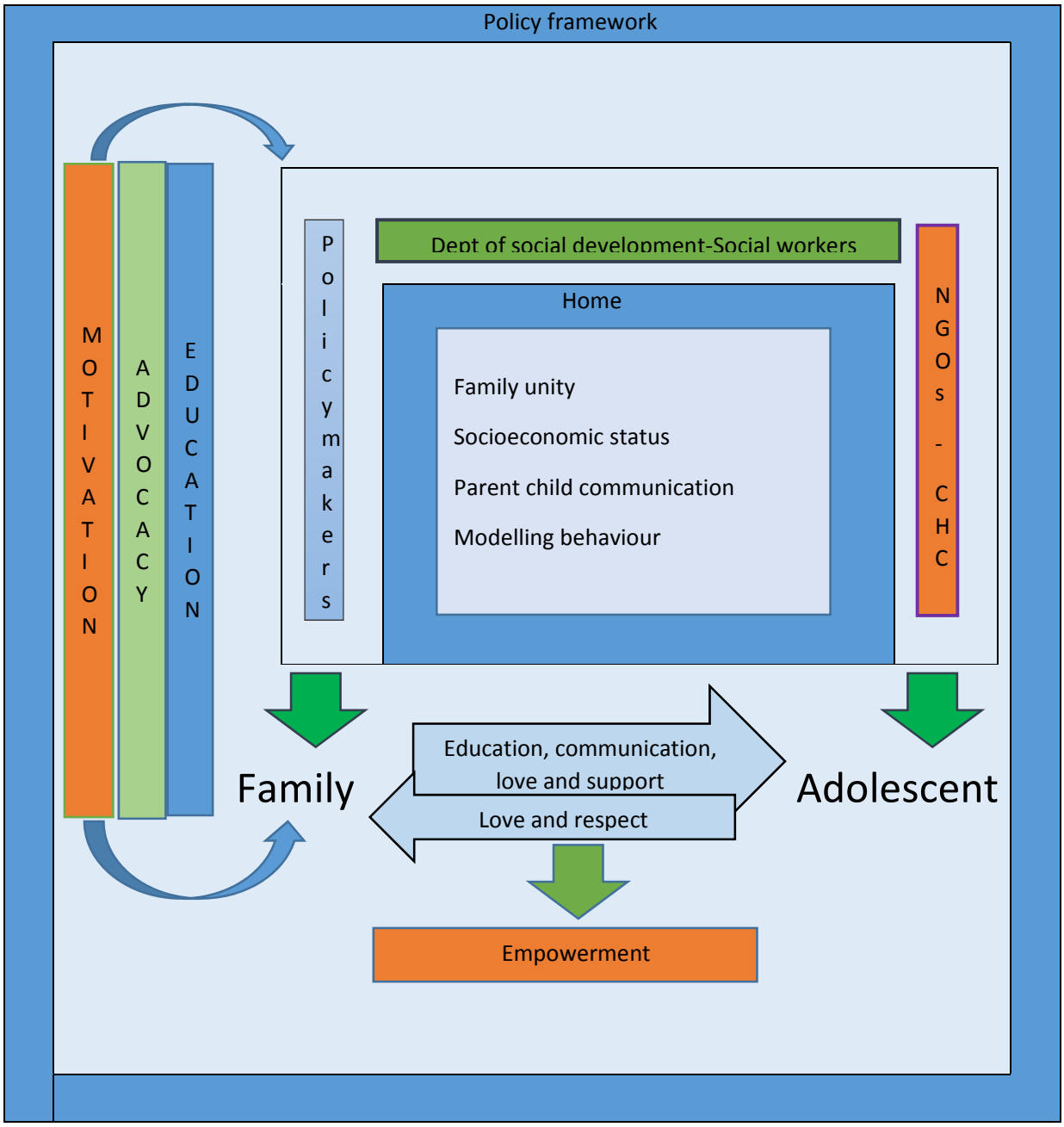


Figure 7.6 Conceptual framework

7.2.2 Transfer of concept into practice

7.2.2.1. Introduction

The conceptual framework (Figure 7.1) derived a number of elements and components which were pivotal in achieving the goal of mitigating the influence of family dynamics on adolescents deviant and sexual risk behaviour. The components include, 'Agents' and 'Recipients' while the elements include 'Motivation', 'Advocacy', 'Education', 'Communication, 'Love' and 'Support' (Figure 7.1). According to the conceptual framework, the energy that will drive the activities for behaviour change include Motivation, Advocacy and Education while the pathways through which parents and agents of change can encourage behavioural change in adolescents are through Education, Communication, Love and Support.

Researchers at the University of Kansas (CHD, 2016) have put forward an algorithm to support the development of public health intervention. In the algorithm, the following steps were outlined.

1. Identify the community problem
2. Assess the level of the problem
3. Describe the prioritized groups to benefit and those implementing the intervention
4. Indicate the source of data
5. Analyze the problem to be addressed by the intervention.
6. Set objectives that need to be addressed by the intervention
7. Identify and assess evidence-based interventions that could help address the problem
8. Specify the elements of the intervention.
9. Identify the mode of delivery through which each element of the intervention will be delivered in the community
10. Indicate how the intervention will be adapted to fit the needs and context of the community
11. Develop an action plan for the intervention.
12. Pilot-test the intervention on a small scale.
13. Implement the intervention, and monitor and evaluate the process

7.2.2.2. Situation analysis

The complexity of social and economic factors found in a community affected by migration creates an imbalance in the family where parents struggle on the one hand with coping with poverty, unemployment and in some cases ill-health. On the other hand, they also struggle with meeting their responsibility to their children. The children are caught-up in the middle of this mix. The situational analysis done in the community showed that adolescents in the community have high level of sexual activities, alcohol and drug use (inappropriate for age), high level of physical violence, low level of risk perception and low level of skills for self-protection.

7.2.2.3 Extent of the problem

Some households are not able to support their adolescents emotionally, financially and socially. In some cases, adolescents live by themselves due to the effect of HIV and AIDS pandemic. Furthermore, some adolescents have dropped out of school in-order to work and fend for themselves either because their parents are dead/absent or because their parents have neglected their responsibilities to their children.

7.2.2.4 Target group for the intervention

The groups that are most affected are adolescents in households headed by adolescents, grandparents and adolescents living with their older siblings. The implementation of the programme will be done by the following agents, Community Home-Based Caregivers (CHC), Lay counsellors, Social Workers and Parents.

7.2.2.5. Source of evidence to support the programme development

The evidence in support of this intervention was provided by the outcome of the situational analysis done through a two-phase study conducted in the community to uncover the dynamics within the family and the influence it has on adolescent deviant and sexual risk behaviour.

7.2.2.6. Characterizing the problem leading to deviant and sexual risk behaviour

The problem of deviant and sexual risk behaviour was observed in all categories of households in the community but those living in adolescent-headed households, grandmother-headed households and sibling-headed households were worst affected- in that order, and for the sake of this programme, these adolescents are referred to as vulnerable adolescents. Therefore, this

programme is targeted at adolescents living in these kinds of households. Within adolescent headed households, there is extreme poverty, the heads of household have either dropped out of school or have never been to school. Some of these households do not have access to government grants because they do not have requisite documentation or because there is no adult member of the family to assist them with the processing of the document. These adolescents also lack social and emotional support. In the grandmother-headed households, the adolescents may receive emotional and social support depending on the age and the health status of the grandmother, but they also lack sufficient financial support, and in most cases, there is not adequate monitoring of adolescent activities. Finally, adolescents living with their older siblings may also suffer neglect as shown in the present study. The older sibling have to cater for their own children before they can attend to the needs of the adolescents. In some extreme cases, the older sibling sees them (adolescents) as grown-ups who should be taking care of some of their personal needs especial female adolescents. This often results in these adolescents looking for other means to meet their needs.

7.2.2.7. Objectives to be addressed by the Programme

It is hoped that this programme would be able to:

- Improve adolescents access to parental care and attention
- Improve parent-adolescent communication
- Reduce use of alcohol and drugs among adolescents
- Reduce early sexual activities among adolescents

7.2.2.8. Method of programme delivery

The community-based health campaigns have not always been successful in this community. Agents of change within the community have complained that when such campaigns are organized, few people will attend the programme and a good number of those who attend will only come to the venue when refreshments are served. Therefore, the purpose for which the campaign is organized would not be achieved. However, a Door-to-Door campaign would bring the agent of change in direct contact with individuals in their home environment where they are relaxed and are more likely to listen to what the agent of change has to say.

7.2.2.9. The elements that guided the programme

The core components of the programme are derived from the 'dynamics', 'procedures' and 'purpose' of the conceptual framework. The dynamics are the energy source that will drive the activities, they include motivation, advocacy and education. The Procedures on the other hand are the pathways through which the goals will be achieved, they include education and skill training, communication, love and support. Purpose is the intended outcome of the programme which is to empower the parents and their adolescents

7.2.2.10. The ways through which the elements can be used to achieve the objectives of the programme

Motivation: This is an energy source which influences productivity and may also bring about change in behaviour. Motivation may come from political figures in the community, employers of agents of change and parents. It may come in the form of salaries, promotions, incentives and rewards for good behaviour.

Advocacy: This describes the determination to change a behaviour. This element is achieved through direct dialogue with a failing agent or a recipient who needs to change his/her behaviour. It may also come in the form of counselling for behaviour change thereby empowering the individual to build self-confidence to take better decision.

Education: This is achieved through health campaigns to improve knowledge among agents, parents and adolescents. Every stake holder needs to improve on their knowledge on a regular basis. This could be in the form of new techniques for better parenting, new methods of preventing pregnancy or new technologies available for information dissemination.

Communication: Effective communication is vital if parents are to monitor and guide their adolescents. Efforts would have to be made by parents to engage their adolescents in conversations that may bring about transfer of knowledge. Parents may also be assisted by agents of change on better ways to make their communication effective, and this can be achieved through door-to-door campaigns.

Education: Parents and their adolescents need to be knowledgeable on issues about deviant and sexual risk behaviour. The agents of change would have to capacitate parents and adolescents through knowledge sharing and this can be achieved through door-to-door campaign,

when parents are capacitated, they may be able to take a lead on advising and assisting their adolescents on making good choices.

Love and support: It is the responsibility of the parents to love and support their adolescents, this activity is achieved through encouraging bonding between the parents and their adolescents. It is through bonding that the parents will be able to get closer to the adolescents and begin to understand their needs and make efforts to satisfy these needs. Furthermore, when parents show love and affection to their adolescents, it brings the adolescent closer to the family unit rather to their peers.

Empowerment: This is the goal of the programme, the effective implementation of the other elements in this programme will result in empowerment of the parents to be able to provide positive parenting to their adolescent. Likewise, adolescents will be empowered to make better choices regarding their behaviour.

7.2.2.11. Adapting the programme to fit the needs and context of the community

This is a resource scare community where there is shortage of manpower and financial resources. Therefore, the implementation of the programme will be limited to vulnerable households. Efforts will be made to engage more agents of change from NGOs rather than relying on social workers whose recruitment may be slow due to protocols within the government structures.

7.2.2.12. The action plan for the programme.

The agents of change would have to be trained on the use of the proposed programme (Table 7.1).

7.2.2.13. Validation of the programme.

The action plan for the programme was presented to the stakeholders in the community and their input was used to improve on the guidelines for the implementation of the programme.

Table 7.1 Proposed Programme to mitigate the influence of family dynamics on adolescents deviant and sexual risk behaviour

Target group	Identified problems	Programme objectives	Activities/Expected action	Who should be responsible	Expected outcome
Vulnerable Adolescents In Thabazimbi community	1. Lack of support by parents	1. Improve Adolescents access to support	a. Identify households where adolescents are at risk of neglect, particularly adolescent- headed households, grandmother-headed households and single-parent households b. Conduct regular visits to vulnerable households to ensure that the financial, emotional and social support of adolescents are addressed. c. In the case of households headed by adolescents, a close family member should be appointed caretaker of the adolescent and his/her siblings, where non is available, a reputable adult member of the community may also be appointed caretaker	a. All agents of change b. CHC and social worker c. The Department of Social Development, Social workers and CHC	It is hoped that as adolescents get more support, love and care from their parents/caregivers, they will be motivated to have a positive outlook on life and define a healthy trajectory for themselves.

			d. Those who are eligible for grants but are currently not receiving money from government should be assisted. e. Encourage parents to show more concern in the affairs of their adolescents vis-à-vis paying more attention to the personal needs of adolescents, helping them out with their homework (where possible) and other activities at school. f. Adolescents should be discouraged from making unrealistic demands for luxury items from their parents just to fit in among their friends without considering the financial situation of their parents, but they should be encouraged to exercise patients with their parents and be hopeful that their needs would be attended to in due time	d. Social worker e. CHC and social worker f. CHC and social worker	

Target group	Identified problems	Programme objectives	Activities/Expected action	Who should be responsible	Expected outcome
Vulnerable Adolescents In Thabazimbi community	2. Adolescents are unable to discuss their personal problems with their parents.	2. Improve adolescent-parent communication	a. Encourage parents to improve on the quality of the relationship they share with their adolescent by spending quality time with them and creating an environment that would allow the children to feel comfortable to discuss their problems. b. Parents should encourage their adolescents to speak freely about issues that bother them without the fear of being reprimanded or punished. c. Parents should give their undivided attention to their adolescents when they talk about their problems d. Parents should not undermine the rights of their adolescents. As adolescents grow older, they will require more freedom from their	a. Social worker and CHC b. Parents Social worker CHC c. Parents Social worker CHC d. Parents Social worker CHC e. Social worker CHC	Improved adolescent-parent communication will in-turn improve adolescents' access to information. Therefore adolescents' will be able to make informed decision concerning their behaviour

			parents. e. Adolescents should be encouraged to respect and obey their parents and also try to understand issues from the point of view of the parents.		
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Vulnerable Adolescents In Thabazimbi community	3. Little or no sex education by parents.	3. Improve on sex education at home	a. Parents should be encouraged to talk to their children about sex, parents should also understand why it is important for the children to hear such talks from their parents. b. Parents should be informed that this exercise (sex education) should not be practiced only when a child is being reprimanded for bad behaviour but a conscious effort should be made to directly pass information about the consequences of having unprotected sex and how to	a. Social worker CHC b. Social worker CHC	Adolescents will become empowered to take the right decision regarding their sexual and reproductive health.

			prevent HIV infection and pregnancy. c. Start sex education early in the life of an adolescents and these teachings should be repeated consistently. d. Sex education should cover topics such as i. Where to obtain condoms ii. How to use a condom iii. How to refuse unwanted sexual advances etc.	c. Parents Social worker CHC d. Parents Social worker CHC	
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Vulnerable Adolescents In Thabazimbi community	4. Low risk Perception among adolescents	Change the perception of adolescents	a. Provide health education to adolescents at home, at the drop-in centre and at school. Emphasizing: i. The benefits of condom use ii. The consequences of drinking alcohol or using drugs before engaging in sexual activities iii. Avoid unprotected oral and anal sex.	a. Parents Social worker CHC	A positive change in adolescents' risk perception may reduce the desire to engage in deviant and sexual risk behaviour.

			b. Dis-abuse the minds of adolescents on having unprotected premarital sex. c. Educate adolescents on the consequences of teenage pregnancy on their academic attainment and the possible neglect that the baby may face. d. Educate adolescents on the need to avoid getting infected with HIV. They should know that though there is treatment for the virus, there is no cure. The HIV treatment is life-long and being infected will require them to make significant adjustment to their social life to be able to enjoy the benefits of HIV treatment. e. Encourage adolescents not to be swayed by what their friends are doing because what works for one	b. Parents Social worker CHC c. Parents Social worker CHC d. Social worker CHC e. Parents Social worker CHC	

			person may not work for another. f. Parents should improve on the quality of the relationship they have with their adolescents because this will facilitate effective communication and eventually result in the change of perception.	 f. Social worker CHC	
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Vulnerable Adolescents In Thabazimbi community	5. Low level of skill for self- protection	5. Improve the skills for self-protection	a. Build self-confidence in adolescents by i. Teaching adolescents how to put on a condom correctly especially the females ii. Teaching adolescents where to obtain condoms iii. Teaching adolescents how to avoid unwanted sexual advances. b. Teach adolescents that it is in their best interest to abstain and defer sex until when they are more mature to handle the responsibility	a. Parents Social worker CHC b. Parents Social worker CHC	Adolescents who have acquired skills on how to obtain a condom, and those who know how to use a condom are more likely to protect themselves during sexual intercourse. It is also expected that adolescents may decide to remain abstinent as their knowledge on the risks associated with

			that comes with it. c. Re-direct adolescents focus on career pursuit because this may motivate them to pay more attention on achieving a career rather than engaging in sexual activities	c. Parents Social worker CHC	unprotected sex improve. This also applies to other deviant behaviours such as alcohol and drug abuse.
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Vulnerable Adolescents In Thabazimbi community	6. High level of alcohol and drug abuse among adolescents	6. Reduce the level of alcohol and drug use	a. Provide information to raise awareness among adolescents on the inherent danger associated with alcohol and drug abuse. b. Parents should identify negative influence on their adolescents and discourage such relationships c. Set up a taskforce to monitor the activities of tavern operators in the community, especially with regards to the sale of alcohol to minors	a. Parents Social worker CHC b. Parents c. The government through the Limpopo Provincial Liquor Board should provide	A reduction in the consumption of alcohol and the use of other illicit substances would reduce physical violence and sexual risk taking such as having sex without using a condom.

				leadership in the regulation of licences and sale of alcohol in the community.	
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Vulnerable Adolescents In Thabazimbi community	7. High level of sexual risk behaviour among adolescents.	7. Reduce the level of sexual activities.	a. Parents should identify negative influences on their adolescents and discourage such relationships. b. Parents should show good example to their children and also provide financial, emotional and social support. c. Commence sex education early and remain consistent d .Parents should be encouraged to improve communication with their adolescents because it is through effective communication that sex education can become possible.	a. Parents b. Parents c. Parents d. Social worker CHC	When early sexual activities are reduced, it diminishes occurrence of unplanned pregnancy, which may result in school dropout. It also reduces HIV infection among adolescent population.

Target group	Identified problems	Programme objectives	Activities/Expected action	Who should be responsible	Expected outcome
Parents of Vulnerable adolescents	1. Households Experiencing couple conflicts	1. Improve Adolescents access to parental care and attention	a. Identify households that are prone to conflicts and attempt to find an amicable solution to their problem. b. Provide counselling to traumatized partner where necessary c. De-sensitize adolescents who have been exposed to such conflicts or who have been victims of transferred aggression and rage. d. Such households where repeated physical violence is observed must be reported to the relevant authority e. Remove children from such high risk households should the problem continue, this is to prevent prolonged exposure to violence because this may lead to internalizing and externalizing problems in adolescents	a. Social worker CHC b. Social worker Lay counsellor c. Social worker Lay counsellor d. Social worker e. Social worker	A family where the parents are not at peace with each other may result in neglect and abandonment of parental responsibility to the adolescent, it may also lead to transfer of aggression to adolescents. Therefore amicable resolution of conflicts among parents facilitates care and attention to the adolescent.
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**

Parents of Vulnerable adolescents	2. Some families in this Community suffer severe Financial constraints	2. Poverty alleviate Through Community engagement.	a. Identify families at risk and train heads of household on how to manage their scarce financial resources b. Set up a vocational training centre to train unemployed parents on skills that would enhance their chances of getting employed. This would also reduce gender inequality as more females would be able to gain employment after the training. c. Facilitating access to loans to assist youth and women to start their own business. d. Improve community access to the food parcels programme provided by SASSA. e. Infrastructural development should be advocated for, this will facilitate diversification of opportunities away	a. Social worker CHC b. Municipal government c. Municipal government d. Social worker CHC e. All stakeholders	A parent is more likely to support his/her adolescent financially when there is the means to do so. Providing employment opportunities in the community would empower parents to be able to provide for their children.

			from the current mining and agro-based economy in the community.		
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Parents of Vulnerable adolescents	3. Some parents engage in bad behaviour. For instance alcohol and drug use, neglecting the needs of their children	3. Encourage Behavioural change among parents.	a. Parents should be educated on the impact of their behaviour on the growth and development of their children. Particularly when this behaviour is observed by the adolescents on a daily basis, It serves as a reinforcement of such behaviour as norms within the society. b. Parents should be made to understand that constant drinking creates artificial poverty in the home because a significant part of family income would be spent on purchasing alcohol and drugs instead of purchasing textbooks and uniforms c. Offending parents should be reported to the appropriate	a. Social worker CHC b. Social worker CHC c. Social worker CHC	When parents acquire positive parenting skills, they become better placed to influence their adolescents positively.

			authorities in the best interest of the adolescents.		
Target group	**Identified problems**	**Programme objectives**	**Activities/Expected action**	**Who should be responsible**	**Expected outcome**
Parents of Vulnerable adolescents	4. Inability of some families to maintain discipline among their children	4. Improve the level of monitoring and control of adolescents activities	a. Parents should be encouraged to set rules to guide their children. This will help to maintain order and also help the adolescent to be able to differentiate what is right from what is wrong. b. Parents should be encouraged to set realistic rules that are commensurate with the age of an adolescent and maintain a sustained level of discipline, such that he/she does not give the adolescent the impression that they can flaunt an order without being reprimanded. c. Parents should be encouraged to show good example to their adolescents by living responsibly.	a. Social worker CHC b. Social worker CHC c. Social worker CHC	Monitoring and controlling of adolescents' activities may reduce peer influence on the adolescent.

7.3 IMPLEMENTATION OF THE PROGRAMME

7.3.1 Preambles

Although many communities in South Africa are affected by migration in one way or the other, some communities are prone to receiving more migrants due to the job opportunities that are available in such communities. Thabazimbi is one of such communities, and like other migration affected communities, there are problems with housing and other infrastructural amenities, youth unemployment, excessive alcohol and illicit substance use. Importantly, the population continues to grow faster than the development of infrastructure. This worsens the state of unemployment and increases inequality within the communities.

However, the government continues to make an effort to improve the living standards of its people by providing safe havens in the form of drop-in centres and providing food parcels to the most vulnerable in the community and the payment of grants to support the most vulnerable in the community. The family has a role to play in securing the future of its members (especially children) in these communities. The parents should take responsibility for their children and promote positive parenting practices. This programme is not meant to replace existing programmes of its kind in the community but rather to complement any ongoing programmes in the community.

7.3.2 Training of Agents

The agents in the implementation of this programme include social workers, community home-based caregivers, ward counsellors, lay counsellors and parents. The social workers have an immense role to play in the implementation of this programme, they have the training and skills that is required to perform most if not all the activities in the programme. Unfortunately, there is a shortage of social workers in the community. Therefore, the researcher would recommend that the CHC and lay counsellors are trained to perform the activities and report to the social worker. This training should be administered by someone who understands the rudiments of the programme preferably the researcher or some who has been trained to do so.

7.3.3 Strategies for implementation of the programme

The activities in the programme would be delivered through door- to-door campaign rather than the community-based campaign that is common practice within the community. The agents will

identify vulnerable adolescents and their families, approach them with respect and dignity. The agents will explain the reason for the campaign and the benefits that will accrue to them if they choose to participate. Households that are willing to participate will be recruited to the programme. The agents will recruit about 15-20 vulnerable households to pilot the programme, this exercise will help evaluate the programme.

7.3.4 Funding

The University of Venda, International Organization for Migration (IOM) and the Department of Social development are likely financiers of the programme.

7.3.5 Key areas of focus

The door-to-door campaign will focus on those variables of interest identified in the community. The agents will identify households at risk, targeting adolescent-headed households, grandmother-headed households and single-parent households. Adolescents living in grandmother headed households should more or less be treated as adolescent headed households because in most cases, these grandmothers are often detached from the environment. They are either too old or too fragile to effectively monitor or control the children who live with them.

Agents must identify single parents with needs, particularly those that are unemployed and have no legitimate means of income. These parents should be engage in dialogue to encourage them to refrain from such activities that may expose their adolescents to bad behaviour but rather seek legitimate means of livelihood and provide positive parenting to their adolescents. Parents should not shy away from talking to their adolescents about sex, use of condom and physical violence. Many parents failed in this responsibility as documented in this study, some claim the teachers should do that at school while some said that the adolescents were too young for them to discuss such issues with.

Emphases should be placed on improving adolescents' relationship with their mother, this was a key predictor of deviant and sexual risk behaviour in the present study. Furthermore, agents should emphasize that adolescents who are close to delinquent older siblings are more likely to engage in deviant and sexual risk behaviour and adolescents who are not supported financially and emotionally are also more likely to engage in deviant behaviours. Agents should also inform

the families that when the parents shower each other with love, it helps to reduce deviant behaviour in their children because when parents are happy, they will show love and affection to their children.

7.3.6 Plan for dissemination of findings

The findings of the study and the proposed programme will be presented to the community and a copy will be made available to the office of the Mayor of Thabazimbi Municipality. Copies will also be made available to the institutions that provided funding for this study in other for them to disseminate the findings through their platforms. The researcher will also present the findings at local and international conferences. Finally, the findings of the study will be published in peer-reviewed journals.

CHAPTER EIGHT

CONCLUSION, LIMITATION AND THE CONTRIBUTION OF THE STUDY TO KNOWLEDGE

8.1. Concluding remarks

This study was designed primarily to explore the dynamics that shape the family environment of adolescents living in a community affected by migration, and the level of influence that this kind of environment might have on their behaviour. In order to achieve this set objective, a robust methodology that combined qualitative and quantitative research approaches were used, thereby ensuring a more comprehensive enquiry spanning the length and breadth of the research topic. The conclusion below is drawn from the combined findings of the qualitative and quantitative studies

Households within the community experienced some conflicts, a fact that most adult participants were not proud of, and some participants made some effort to under report its occurrence. Although this finding was common among single parent households, it was also seen among married couples. Such conflicts have the potential to influence adolescent behaviour negatively. In this study, deviant and sexual risk behaviour was reported in households that experienced some conflicts. However, similar deviant behaviour was found in households where minimal or no conflicts were reported. This suggests that the deviant behaviour observed in the study may have other contributing factors in the community. Significantly, the occurrence of conflicts among parents may diminish the level of social support available to their adolescents. Furthermore, adolescents whose parents engaged in frequent fighting expressed shame and disappointment, and this kind of exposure to violence sets a dangerous precedence for adolescents' health trajectories.

Largely, social support in this community is a privilege for a few, especially those who live in households where there is relative peace and unity. Some adolescents claimed that they had no social and emotional support in their homes and the reason for this may not be farfetched. Some adolescents live by themselves without the guidance of an adult, while some live with their old grandmothers, some of whom are not physically capable of supporting the adolescents. Interestingly, the social workers who are supposed to provide support to vulnerable households

were not often available to attend to the needs of the members of the community. This however was attributed to work overload and shortage of manpower.

Similarly, many households suffered severe financial constraints, which may be a result of the high rate of unemployment or financial misappropriation. To this end, many participants expressed their inability to meet their financial commitment to their children. Some families depend on the child support grant that they receive from the government and this money is not enough to provide for the needs of all members of the family. Interestingly, some families accommodate and feed other adults relatives who are not employed. This creates a situation of artificial poverty, even when the head of the household is gainfully employed, and consequently, the needs of the children in these households may become neglected. This may force adolescents to seek other means to meet their personal needs.

Adolescents in this community expressed their inability to discuss intimate issues with their parents. For some, it was due to the generational gap between them and their parents, while for some it was because they felt that their parents would not approve of their behaviour. However, it was obvious that some parents did not create a conducive environment for fostering communication with their adolescents. As shown in the study, some parents did not feel comfortable to discuss sex education with their children; they only talked about sex when they admonished the adolescent for bad behaviour. For this reason, some adolescents preferred to discuss their pressing intimate issues with their friends, and this may provide an avenue for bad peer influence. This may explain why parent-child closeness reported in the present study did not inhibit deviant behaviour among adolescents. It was clear that the bonding involved in these relationships were not strong because as much as they claimed that they were close to each other, adolescents were also quick to say that being close to their parents had no influence on their behaviour. Unfortunately, this might have resulted from parents having no idea of what was going on in the personal lives of their adolescents and therefore could not advise them appropriately.

As noted in the present study, some parents struggled to maintain discipline among their adolescents. This was common among households headed by single mothers (including elderly grandmothers) and adolescent headed households. It was also observed that as the adolescents became older, it became more difficult for the parents to monitor and control them. Some

adolescents acknowledged that their parents set rules for them at home but they did not always obey the rules because they had to go out and spend time with their friends.

The quantitative study (phase 2) corroborated the findings of the qualitative study (phase 1). The phase 1 study showed that some participants did not enjoy a good relationship with their family. The Phase 2 study showed that this claim was reported by only about 25% of the adolescent participants. However, about half of the participants reported that their parents do not have enough money to take care of their needs. This also supports the claim of financial constraints reported in the phase 1 study. Furthermore, the findings on deviant and sexual risk behaviour made in the phase 1 study were also confirmed in the phase 2 study, where about 30% of the participants reported being involved in a physical fight; 52.9% have used alcohol and about 10% reported using other illicit substances. In addition, 60.1% of the participants said they have been sexually engaged, while 63.7% have friends who are sexually active and 23.1% have been pregnant. Furthermore, the use of condom was low, with only 35.6% reporting regular use of condom

Almost 16% of the participants reported having intimate partners with mine workers, with only 48.5% of them using condoms regularly at the time of their last sexual intercourse with their partners. Although, the percentage of those who engaged in sexual relationship with mine workers may be low in this study, but it is a matter of great concern, considering the age group of the participants, with some of them being under the legal age to consent sexual intercourse. Furthermore, these adolescents may not be able to negotiate safe sexual practices with their partners who are often much older and more financially empowered to dictate the pace and direction of the relationship. This is supported by the claim that 37.1% of those who are sexually engaged with mine workers have exchanged sex for money.

The present study found that there were gender and age differences in the deviant and sexual risk behaviour reported among adolescents in the community. Also, the quality of the relationship adolescents shared with their mother was a significant determinant of adolescent deviant and sexual risk behaviour. For instance, those who enjoyed a good relationship with their mothers

were less likely to engage in a wider range of risky behaviour than any other family dynamic variable.

Despite the high level of knowledge expressed by adolescents regarding the impact of having unprotected sex, only 35.6% of the participants used condoms regularly. This shows that participants were well aware of the dangers involved in having unprotected sex but they do it anyway. This corroborates the argument made in the study that participants had low risk perception. Furthermore, this study found that participants had low skills for self-protection. For instance, only 41.2% of them were confident in themselves to resist unprotected sexual advances from their partners, while only one out of three participants believed in themselves to be able to stop to wear a condom in the heat of the moment, and only about 68% could put on condoms correctly, with males more likely to do so than females.

The level of sexual activities, violence and alcohol use that was seen in the present study are somewhat alarming, considering the age bracket of the study participants. However, the picture is not totally gloomy because some adolescents expressed knowledge and understanding of skills for healthy behavioural practices, even in the face of negative family environment. Furthermore, the majority of the participants reported a generally favourable family environment that encouraged strong moral, emotional and financial support. However, some adolescents remained vulnerable in households where family conflicts and extreme poverty remained a challenge to their progress and happiness.

Psychologically, some adolescents remained under prepared to negotiate safe sex practices with their partners. This unpreparedness may be related to the low risk perception and low levels of skills for self- protection seen in the study. In addition, parents have not sufficiently engaged their children in health talks that could help raise their awareness and help them develop skills for self-protection. Instead, some parents engaged in deviant and sexual risk behaviours themselves. For instance, excessive alcohol and drug use was reported among parents. Some adolescents also reported that their parents kept late nights and some engaged in multiple sexual partnerships. These findings suggest that some parents may become a negative influence on their adolescents, instead of using their parental influence to chart a positive health trajectory for their adolescence. These findings have shed light on the family dynamics that contribute to adolescents' risk

behaviour. It has also shown that adolescents are capable of defining positive health trajectories for themselves even in the face of difficulties. However, some adolescents remain vulnerable and need to be supported.

8.2. Contribution of the study to knowledge

The present study was designed to explore and describe the influence of family dynamics on adolescents' deviant and sexual risk behaviour in a community affected by migration. Secondly, the study aimed to apply the findings of the study in the development of a public health intervention that might mitigate the effects of family dynamics on adolescent risk behaviour.

It can be said that the study provided scientific evidence that informed the strategies applied in the development of the programme. To this end, the public health programme is unique to the community, and it is hoped that policy makers in the community would find this programme useful in their quest to improve the health trajectories of adolescents in the community. Furthermore, this programme can also find application in other communities affected by migration with similar cultural and socio-economic characteristics. Although the implementation of the programme is mainly within the context of the family, the findings of this study may inform strategic school health programmes targeted at young adolescents to mitigate negative modelling behaviour and encourage positive health behaviour among adolescents.

However, further research is needed to evaluate the effectiveness of this programme and its feasibility in the community in terms of its financial implication and acceptability.

8.3 Limitations of the study

This study draws strength from the mixed method approach applied in sample selection, data collection and data analysis. The application of these approaches eliminated bias, where the weakness of one method was compensated for by the strength of the other. However, the researcher acknowledges that the choice of the study area may create some bias. This is because participants were drawn from only one migration affected community. The reason for this choice was based on using a community that could provide the following:

1. A large migrant population that would provide a rich sample size for the study

2. A stable population (a place where people are not frequently in transit), so that they researcher could always go back to the community and collect more data if the need arose.
3. Ease of access to participants.

Furthermore, the researcher acknowledges that due to the sensitive nature of the issues explored in the study, it is possible that some participants may have either over reported their activities in order to boost their egos (especially among the male adolescents) or under-reported their activities for fear of being reprimanded for bad behaviour. However, the researcher made some effort to reduce the likelihood of this happening to the barest minimum, as documented in chapter three.

Finally, the public health programme proposed in this study was developed based on the evidence provided by the findings within the community. Therefore, this programme is not a fit-all intervention, it is community-specific and can be best applied in a migration affected community but may be adapted to suit the needs of similar communities. Despite the limitations listed above, the outcomes of the study raise questions on how adolescents are raised and the behavioural outcomes that may be associated with it.

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APPENDIX 1: Interview guide for the Phase 1 study

Section A: Socio-demographic data

1. Sex

2. Age

3. Religion

4. What is your race?

5. What is your grade?

6. Who do you live with?

7. Marital status

8. How would you rate your academic performance on a scale of 1-10? 1 being very poor performance and 10 being excellent performance

9. Were you born in this community?
10. Were your parents born in this community?
11. Where does your father work?
12. Where does your mother work?
13. Have you enjoyed growing up in this community?
14. How long have you lived in this community?
15. Before coming to live in this community, where did you live?
16. Why did you come to live in this community?
17. How often do you visit your home?
18. How many siblings do you have?

19. What is your position among your siblings?

Section B

Probing questions for parents

1. The relationship between the type of parental union and the level of adolescent supervision in the community.

- How would you describe your relationship with your partner? Has this relationship affected the way you bring up your child? Does he/she make you pay less attention to your child?
- How would you describe your partner's role in the upbringing of your child?

2. The socio-economic support system within the family and how it contributes to adolescent deviant and sexual risk behaviour, prevent it or mitigate its effect.

- As a father/mother/guardian, how much time do you spend with you adolescent? How often do you support them with their school work? Would you say that spending more time with them have changed their behaviour? How?
- As a father/mother/guardian, how much of your adolescents' financial need do you attend to? Do they sometimes contribute to your family upkeep or take care of themselves? Do you think that this may prevent or encourage him/her to engage in unacceptable behaviour and sexual risk practices?
- As a father/mother/guardian, how often do you attend to the difficulties they may have at school or with their friends? How would you describe their level of trust in you to solve their problems?
- As a father, do you have a good relationship with your adolescent? Would you say your relationship with him/her has influence on his/her decision to engage in unacceptable behaviour and sexual risk practices? How?
- As a mother, do you have a good relationship with your adolescent? Would you say your relationship with him/her has influence on his/her decision to engage in unacceptable behaviour and sexual risk practices? How?

3. Parenting processes within families in the community and how it affects adolescents deviant and sexual risk behaviour.

- Would you say you create an environment where your children would feel free to discuss their personal issues with you? Would you say that this has made them open up to you more about their sexual life?
- How well do you know your adolescents? How well are you in setting rule and time limits for outings for your adolescents? Do you discuss sex education with your adolescents? Would you say this has influenced his/her sexual risk behaviour?
- Would you describe yourself as a strict disciplinarian (no nonsense parent)? How has this influenced your child's behaviour?
- Would you describe yourself as a parent who allows adolescents to make mistakes and learn from them? In your opinion, has this changed their behaviour?
- Would you describe yourself as a parent who does not care what adolescents do as long as they do not hurt themselves? Has this made them engage in sexual risk behaviour?

4. The experiences of families regarding deviant and sexual risk behavior among adolescents living within the community.

- As a father/mother/guardian, how would you describe adolescents living in this community?
- Are you happy that your child/ward is growing up in this community?.....why?
- As a father/mother/guardian, are there particular behaviours that you have observed among adolescents living in your community? Do you think that this community has affected the way your child/children behave?...how?

Questions for adolescents

1. The relationship between the type of parental union and the level of adolescent supervision in the community.

- How would you describe the type of relationship that exist between your parents or the people you live with? Would you say that their relationship has affected your upbringing?

Do they pay more or less attention to you? Would you say they just don't care about what you do?

2. The socio-economic support system within the family and how it contributes to adolescent deviant and sexual risk behaviour, prevent it or mitigate its effect.

- How much time does your father/mother/guardian spend with you adolescent? How often do they support you with your school work? If your father/mother/guardian spent more time with you, would that affect your behaviour towards sexual risk taking? How?
- How much of your financial need does your father/mother/guardian attend to? Do you sometimes contribute to your family upkeep or take care of yourself? Do you think that this may influence your sexual behaviour? How?
- How often does your father/mother/guardian attend to the difficulties you have at school or with your friends? How would your level of trust in them to solve your problems?
- How would you describe your relationship with your father? Would you say your relationship with him has influence on your decision to engage in unacceptable behaviour and sexual risk practices? How?
- How would you describe your relationship with your mother? Would you say your relationship with her has influence on your decision to engage in unacceptable behaviour and sexual risk practices? How?

3. Parenting processes within families in the community and how it affects adolescents deviant and sexual risk behaviour.

- Would you say your father/mother/guardian creates an environment that enables you to discuss your personal issues with him/her? Would you say that this has made you open up to him/her about your sexual life?
- Does your father/mother/guardian set rules and time limits for your outings? Do they discuss sex education with you? Would you say that this has influenced your decision to engage in unacceptable behaviour and sexual risk practices?
- Would you describe father/mother/guardian as a strict disciplinarian (no nonsense parent)? How has this influenced your behaviour?

- Would you describe your father/mother/guardian as someone who allows adolescents to make mistakes and learn from them? In your opinion, has this prevented or motivated your decision to engage in unacceptable behaviour and sexual risk practices?
- Would you describe your father/mother/guardian as someone who does not care about what adolescents do as long as they do not hurt themselves? How has this encouraged you to engage in sexual risk behaviour?

4. The experiences of families regarding deviant and sexual risk behaviour among adolescents living within the community.

- As an adolescent, how would you describe the way young people your age behave in this community?
- Are you happy growing up in this community?.....why?
- Are there particular behaviours that you have observed among young people your age in this community? Do you think that this community has affected the way you behave?...how?

APPENDIX 2: Questionnaire for Phase 2 of the study

Phase 2

Section A: Socio-demographic data

1. Sex: male ☐ 1 female ☐

2. Age.....

3. Religion: Christianity ☐ Islam ☐ others ☐

4. What is your race: Black ☐ White ☐ ndian ☐ loured 4 ☐

5. What is your grade at school? ……

6. If you do not go to school, please give your reason.....

……

7. Relationship status: Single ☐ Married ☐ Cohabiting 3 ☐

Others? Please specify.....

8. Where is your place of birth? .....

9. Where is the place of birth of your parents?……

10. Where does your father work? ……

11. Where does your mother work? ……

12. How long have you lived in this community? ……

13. Have you enjoyed growing up in this community?

Yes ☐ 1 No ☐

14. Please explain your reason……

……

15. Before coming to live in this community, where did you live?

……

16. Why did you come to live in this community? .....

17. If you are not from this community, how often do you visit your home? ……

18. Who do you live with? …….

19. How many siblings do you have? .....

20. What is your position among your siblings? .....

21. Do you have a baby? YES ☐ No ☐

22. If your answer above is YES, how many children do you have? ……..

23. Are you in a good relationship with your father?

YES ◯ NO ◯

24. Are you in a good relationship with your mother?

YES ◯ NO ◯

25. If you are living with someone else, are you in a good relationship with him/her?

YES ◯ NO ◯

26. Are you in a good relationship with your siblings?

YES ◯ NO ◯

27. Is there peace in your home?

YES ◯ NO ◯

28. Do you feel loved by your family?

YES ◯ NO ◯

29. Do your parents or the person you live with support you financially?

YES ◯ NO ◯

30. Is there always enough money at home to take care of the needs of everyone in the family?

YES ◯ NO ◯

31. Do your parents or the person you live with support you when you are down emotionally?

YES ◯ NO ◯

32. Do your parents love each other?

YES ◯ NO ◯

Section B: The nature and pattern of deviant and sexual risk practices among adolescents in the study setting (Behaviour capabilities).

33. Have you been involved in a fight with someone lately?

YES ◯ NO ◯

34. Do you smoke cigarette?

YES ◯ NO ◯

35. Have you used drugs e.g daga?

YES ◯ NO ◯

36. Have you ever changed your school because you have problems with fellow students or teachers?

YES ◯ NO ◯

37. Are you always obedient to your parents or the person you live with?

YES ◯ NO ◯

38. Do you attend school regularly?

YES ◯ NO ◯

39. Do you often have problems with your siblings?

YES ◯ NO ◯

40. Do you sometimes come back home very late in the night?

YES ◯ NO ◯

41. Do you often have problems with your friends?

YES ◯ NO ◯

42. Do you often have problems with your neighbours?

YES ◯ NO ◯

43. Have you ever had sex?

YES ◯ NO ◯

44. How old were you at that time when you first had sex?

……..

45. When was the last time you had sex?

……

46. What is your relationship with the last person you had sex with?.....

47. How old was this female/male you had sex with the last time?

……..

48. Have you ever been pregnant or made your girlfriend pregnant?

YES ◯ NO ◯

49. If your answer to the above question is YES, how old were you when you got pregnant? Or how old were you when you got someone pregnant? ……

50. How did that pregnancy end?

I. A baby was born

2. I/We got rid of the pregnancy

51. Do you have friends who have sex with their boy/girlfriend?

YES ◯ NO ◯

52. Do you currently have a boy/girl friend?

YES ◯ NO ◯

53. Do you have more than one boy/girlfriend?

YES ◯ NO ◯

54. How many boy/girlfriends have you had in the last 12 Months?

……

55. Do you take alcohol?

Always ◯ Sometimes ◯ Never ◯

56. How often do you and your partner use condom?

Always ◯ Sometimes ◯ Never ◯

57. Do you have oral sex?

Always ◯ Sometimes ◯ Never ◯

58. Do you have anal sex?

Always ◯ Sometimes ◯ Never ◯

59. Have you had a boy/girlfriend who works in the mines?

YES ◯ NO ◯

60. If your answer to the above is YES, how old was this person when you had a relationship with him/her?.....

Answer the following questions only if you have a boy/girlfriend that works in the mines

61. Have you had sex with him/her?

YES ◯ NO ◯

62. Do you have oral sex with this person? (Using your mouth on his/her private part)

YES ◯ NO ◯

63. Did you receive oral sex from him/her? (Using his/her mouth on your private part)

YES ◯ NO ◯

64. Did you have anal sex? (Penetration into his/her anus)

YES ◯ NO ◯

65. Did you or your partner use alcohol before having sex?

YES ◯ NO ◯

66. Did you use condoms regularly with him?

YES ◯ NO ◯

67. Did he/she give you money so that you can have sex with them?

YES ◯ NO ◯

Section C: Adolescents' perceived benefits and risks of engaging in deviant and sexual risk behaviour in the community (Outcome expectations).

68. Someone can get HIV infection when they have sex without using a condom?

Disagree ◯ Not sure ◯ gree ◯

69. Someone may get pregnant when they have sex without using a condom?

Disagree ◯ Not sure ◯ gree ◯

70. The benefits of having sex without using a condom is more than the bad results of having sex without using a condom.

Disagree ◯ Not sure ◯ gree ◯

71. People my age are getting pregnant so I do not mind if I get pregnant at my age

Disagree ◯ Not sure ◯ gree ◯

72. I really don't mind if I get HIV infection because treatment is available at the clinic

Disagree ◯ Not sure ◯ gree ◯

73. My parent/parents will be happy with me if I fall pregnant or if I get someone pregnant

Disagree ◯ Not sure ◯ gree ◯

74. There is nothing wrong with having a baby while still at high school

Disagree ◯ Not sure ◯ gree ◯

75. I don't enjoy sex when using a condom.

Disagree ◯ Not sure ◯ gree ◯

76. Falling pregnant while not working is not good because it can make me and my baby poor and surfer.

Disagree ◯ Not sure ◯ gree ◯

77. My boyfriend/girlfriend will love me more if I agree to have sex without condoms with him/her.

Disagree ◯ Not sure ◯ Agree ◯

78. Having oral sex rather than vaginal sex is safer because I will not get pregnant or get someone pregnant.

Disagree ◯ Not sure ◯ Agree ◯

79. Having anal sex rather than vaginal sex is safer because I will not get pregnant or get someone pregnant.

Disagree ◯ Not sure ◯ Agree ◯

80. Oral and anal sex rather than vaginal sex is safer because I will not get sexually transmitted infection, including HIV.

Disagree ◯ Not sure ◯ Agree ◯

81. People may engage in sex sometimes just to get food to eat or place to sleep

Disagree ◯ Not sure ◯ Agree ◯

82. I do not want to engage in unprotected sex because the outcomes may prevent me from completing my schooling.

Disagree ◯ Not sure ◯ Agree ◯

83. The desire to have a baby may motivate young people to have sex without a condom

Disagree ◯ Not sure ◯ Agree ◯

84. Taking alcohol or drugs may make people get into danger, for example fighting.

Disagree ◯ Not sure ◯ Agree ◯

85. Using alcohol and drugs may make someone have sex without using a condom

Disagree ◯ Not sure ◯ Agree ◯

Section D: Adolescents perceived level of skills for self-protection against deviant and sexual risk in the community (Self-efficacy).

86. If you have not had sex, do you feel confident in yourself to remain without having sex until you are ready for marriage?

YES ◯ NO ◯

87. Are you able to put on a condom correctly?

YES ◯ NO ◯

88. If you have had sex, can you resist having sex even when your boy/girlfriend demands for it?

YES ◯ NO ◯

89. Can you reject having sex without a condom even when your partner demands for it?

YES ◯ NO ◯

90. Are you able to make your steady partner use condoms with you?

YES ◯ NO ◯

91. Are you confident in your ability to ask a new partner to use condoms during sex?

YES ◯ NO ◯

92. Do you feel confident in yourself to ask your partner to get tested for STIs, including HIV?

YES ◯ NO ◯

93. Do you feel confident in yourself to stop to put on condoms on yourself or on your partner in the heat of the moment?

Always ◯ Sometimes ◯ Never ◯

94. If condoms are not available, do you believe in yourself to resist unprotected sex even in the heat of the moment?

Always ◯ Sometimes ◯ Never ◯

95. Is there a reason why you may not be able to resist having unprotected sex with your partner?

……..

……..

Section E: The perceived influence of parents and other adults in adolescents' deviant and sexual risk behaviour in the community (modelling behaviour).

96. Have your parents or the person you live with told you about HIV infection?

Never ◯ Sometimes ◯ Always ◯

97. Have your parents or the person you live with told you about teenage pregnancy?

Never ◯ Sometimes ◯ Always ◯

98. Has your father been part of your life?

Never ◯ Sometimes ◯ Always ◯

99. Has your mother been part of your life?

Never ◯ Sometimes ◯ Always ◯

100. Does your parents or the person you live with talked to you about using condom?

Never ◯ Sometimes ◯ Always ◯

101. Do your parents or the person you live with take a lot of alcohol?

YES ◯ NO ◯

102. Do your parents or the person you live with take drugs, e.g. daga?

YES ◯ NO ◯

103. Do your parents or the person you live with come home late?

YES ◯ NO ◯

104. Do your parents or the person you live with take care of your needs?

Never ◯ Sometimes ◯ Always ◯

105. Do your parents or the person you live with correct you when you do something wrong

Never ◯ Sometimes ◯ Always ◯

106. Do your parents or the person you live with set rules and regulations for you at home

Never ◯ Sometimes ◯ Always ◯

107. Does the person you live with have more than one boy/girlfriend?

YES ◯ NO ◯

108. Does your parent or the person you live with always fighting with other people?

YES ◯ NO ◯

109. Do you like the way the person you live with live his/her life?

YES ◯ NO ◯

110. Do you want to live your life like them?

YES ◯ NO ◯

111. Do you think that by seeing your parent or the person you live with behaving badly may encourage you to develop bad behaviour?

YES ◯ NO ◯

112. Do you take alcohol or other drugs because people around you are taking it?

YES ◯ NO ◯

113. Do you have more than one boy/girlfriend because you see people around you doing it?

YES ◯ NO ◯

114. Is it your opinion that adolescents may take less sexual risk if they live with their biological parents than when they live with single parents?

YES ◯ NO ◯

115. Do you envy the way the mine workers live their lives?

YES ◯ NO ◯

116. If your answer above is YES, please explain why you envy them? ……

……

117. Are you motivated to become friends with the mine workers?

YES ◯ NO ◯

118. If your answer above is YES, please explain why you envy them? ……

……

APPENDIX 3: Consent form

Consent Form

My name is Chima Anyanwu. I am a post graduate student from the Department of Public Health, school of Health Sciences, University of Venda. I would like you and your child to participate in my study. This study aims to explore the effect of family dynamics on adolescents deviant and sexual risk behaviour in a high risk environment such as where you live now. There will be no invasive procedures required in this study and I can assure you that no harm will come to you. You will be required to participate in a one-one interview with the researcher and his assistants, you will also be asked to complete a questionnaire. A voice recorder will be used during the interview, this is to allow the researcher capture all the information that you will provide.

I assure you that any information obtained from you will be treated as confidential. Your participation in this study is voluntary and you are free to withdraw from the study should you feel unsatisfied with the way the study is being conducted.

Researcher's signature _____ Date_____

Participant

I_____ have read through the content of this form and hereby voluntarily consent to participate in this study.

Participants' signature _____ date_____

Researcher' contact – 0710952820

APPENDIX 4: Letter to community leaders

Dear Sir/Ma,

Request to conduct a study in your community

I am a post graduate student from the University of Venda. I humbly request your permission to engage members of your community in my current study which aims to explore the effect of family dynamics on adolescent deviant and sexual risk behaviour. This study will only involve interviews and use of questionnaires, there will be no invasive procedures and as such there will be no harm to participants. Data collection is set to begin in late march 2016 and will be complete by the end of October, 2016.

I look forward to your cooperation

Yours Faithfully

Chima Anyanwu

APPENDIX 5: Ethics clearance certificate

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Dr FC Anyanwu
Student No: 11616398

PROJECT TITLE: "The influence of family dynamics on the occurrence of adolescents deviant and sexual risk behaviour in a migration affected community in South Africa: An evidence for public health intervention".

PROJECT NO: SHS/16/PH/06/2305

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof HA Akinsola	University of Venda	Supervisor
Dr AK Tugli	University of Venda	Co-Supervisor
Dr FC Anyanwu	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: May 2016
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

APPENDIX 6: Photographic illustrations of the Area of Study.

Figure 3.2: Google earth image of the Thabazimbi Mountain. Mining operations and mine access roads can clearly be seen in the area that contains the cave. Source: Cairncross (2011).

APPENDIX 7: Photographic illustration of a typical street in the informal settlement

Figure 3.3: A typical street within the informal residence

APPENDIX 8: Photographic illustration of a typical street in the formal settlement

Figure 3.4: A typical street in the formal residence