FACTORS CONTRIBUTING TO UNSAFE SEX PRACTICES AMONG YOUTH AT A SELECTED VILLAGE, LIMPOPO PROVINCE

by

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A MINI-DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF PUBLIC HEALTH (MPH)

DEPARTMENT OF PUBLIC HEALTH

SCHOOL OF HEALTH SCIENCES

UNIVERSITY OF VENDA

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May, 2021

DECLARATION

I, Khosa Mikateko Blessing (11585032), hereby declare that the dissertation titled, ***"factors contributing to unsafe sex practices among youths at a selected village, Limpopo"***, submitted to the University of Venda, for the degree of Master of Public Health is my original work and has not been submitted previously for a degree at this institution or any other University, that it is my own in design and execution, and that all reference material contained herein has been duly acknowledged.

SIGNATURE  Date 18-02-2021

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ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to my supervisor, Prof Lebese Rachel T, for the valuable ideas, advice and moral support provided throughout this research. I need to acknowledge her enduring insistence on high quality work.

Special thanks go to my co-supervisors, Mr Manganyi BS, for the rich advice, motivation and persistent support to keep up with the demands of the research practice.

I am also indebted to my family for understanding my work commitments and the support given to me during my studies. I am particularly grateful to my husband, Mr Mulaudzi HF and children, Vhudi, Vhuhwavho and Vhutsila, for their amazing love.

I'd also like to extend my immense appreciation to my colleagues and friends without whom my work would have been more difficult. Special mention goes to Fhulufhelo Nekhubvi and my brother, Siphiwe Khosa, who constantly provided the needed motivation for the study.

Finally, I am thankful to God Almighty for the life and opportunity to engage in this research endeavor.

DEDICATION

I dedicate this thesis to:

- my parents, Mrs Fokisa Patironi Khosa, for her motherly support and care in raising me up and my late father, Mr Famanda Jackson Khosa, who supported my education throughout his life, and

- My children, Vhudi, Vhuhwavho and Vhutsila.

ABSTRACT

Globally, unsafe sex practices among youth are common. Practicing unsafe sex predisposes youth to acquire STIs, including HIV/AIDS. In South Africa, youth initiate sex at the age of 17. During this period, they practice risky sexual behaviour due to poverty (exchange of money), lack of knowledge; risky behavior, such as alcohol intake and drugs. The purpose of this study was to determine the factors contributing to unsafe sex practices among youths at a selected village in Limpopo Province. The research used the qualitative approach which was explorative and descriptive. The target population was youth aged 18-24 years. Non- probability purposive sampling was used in the study. A sample of 20 participants was constituted, which targeted youths who visited the clinic for health care services. This number was ensured by data saturation. Data was collected using face-to face interview, guided by an interview guide. Data was analyzed using the thematic analysis method. The study concluded that cultural gender role definitions, social media and drug abuse contribute to unsafe sexual practices among youths. It is, therefore, recommended that culturally-constructed gender roles should be repositioned to support female youths to have control over their sexual lives. There should be close collaboration between the family, schools, health officials and the community, to teach youths on the dangers of risky sexual behaviors.

Keywords: Factors, Perceptions, Sexual practice, Unsafe sex, Youth

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ASRH	Adolescent Reproductive Health
CDC	Center for Disease Control
DHIS	District Health Information System
DOE	Department of Education
HBM	Health Belief Model
HCT	HIV Testing and Counseling
HIV	Human Immune Virus
HSRSC	Health Science Research Council
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
SABC	South Africa Broadcast Commission
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
UDHS	Uganda Demographic Health Survey
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
US	United States
WHO	World Health Organization
YFS	Youth Friendly Service
YSRH	Youth Sexual Reproductive Health

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CHAPTER 1

1. INTRODUCTION

Unsafe sex can generally be defined as sex between a susceptible person and a partner who has Sexually Transmitted Infections (STI's), without taking measures to prevent infections (AVERT, 2016). Unsafe sex cannot therefore be defined a priori (because sex is only safe with respect to the context where it occurs), or measured directly from reported behaviors (WHO, 2016). Unsafe sex with respect to adolescents is defined as the kind of sex whereby adolescents engage in sexual intercourse without considering protection such as condoms, or contraceptives, thereby increasing the risk of acquiring or causing Sexual Transmitted Infections such as HIV/AIDS, gonorrhea, syphilis, as well as teenage pregnancies (UNICEF, 2019). Unsafe sex practice among youth is the second largest health problem in the world (AVERT, 2016). Adolescent and youth sexual reproductive health is one of major public health concerns which need more attention when dealing with health problems affecting youth; hence this study explored the factors contributing to unsafe sex practices among youths at a selected village, Limpopo Province.

1.1 BACKGROUND OF THE STUDY

Sexual activities among young adolescents have been reported to be increasing worldwide. Globally, adolescents have their sexual debut between 10 and 19 years, with boys initiating sex earlier than girls (Omolola, Olusegun, Olumuyiwa, Ebun, Olufemi, Paulin & Akinbode, 2018). Young people between 15-24 years who are sexually active are at greater risk of experiencing adverse health and social outcomes, including unplanned pregnancy or STIs compares to older age (Bhana, 2017). The study conducted in Ireland indicated that 37.3% of boys and 54.5% of girls initiate sex at early age between 15-18 (Young, Burke & Gabhaim, 2018). The study conducted in Brazil affirms that early sexual intercourse is associated with unprotected sex and more partners over a lifetime.

Several studies have been done in different countries such as Portugal, Uganda and Malaysia and have reported a high level of sexual activities among unmarried adolescents of both sexes with progressively decreasing age debut, as well as risky sexual practices,

including unprotected sexual intercourse with multiple partners (Omolola *et al.,* 2018), (Reis, Ramiro, Camacho, Tome & Gaspar de Matos, 2018), (Shaya & Kalomo, 2019), (Bidin & Fuziah S, 2020). A study conducted on sexual activities in Tanzania, reported an increase in risky sexual practices, such as a high number of sexual partners among individuals (AVERT, 2016). This indicates the extent of exposure to reproductive infections among this group. The findings in Namibia show that 90% of the youth reported to have ever had sexual intercourse at the age of 12, where 35% reported to ever have had sexual activity with partners outside of their primary sexual relationships and other non-primary relationships. Furthermore, 59% of the women had vaginal intercourse; 9.1% reported anal intercourse. Condom use among these women were in-consistent, with 54,8% reporting unprotected vaginal intercourse, putting them at risk of getting STIs, including HIV/AIDS (Olusheyi, 2010).

According to the Centers for Disease Control and Prevention (CDP), the percentage of American learners using condoms hit its peak at around 60% a decade ago, and has stalled since then, even declining among some demographics. In contrast, South African teenagers are sexually active at the age of 17 (Bhana,2017). This is evident from the results of a study conducted in Kwazulu-Natal among male undergraduate learners, where 65.7% of the males were sexually active (Hoque, 2011). About 16 million women aged 15-19 give birth each year, contributing to 11% of all births worldwide. Seventy percent of all births take place in sub-Saharan Africa (WHO, 2004). Adolescents and young people represent a growing share of people living with HIV worldwide (Young *et.al,* 2018). In 2015 alone, 670,000 youth aged of 15 to 24 were newly infected with HIV, of whom 250,000 were adolescents aged of 15 to 19 (UNICEF, 2016).

In Sub- Saharan Africa, the rate of new HIV infections is highest among individuals aged 15 to 24 (UNAIDS, 2016). Despite the free condom distribution in South Africa at different public places, such as restaurants, streets venders, taverns and shops, where youth frequently visit, most youths do not use them (condoms) during sex. When they do so, it is not consistent (National Health Survey Stats, 2016). A report from a study done in Tanzania shows that most of the youths know where to get condoms, but fail to use them when they are under the influence of alcohol (Tarimo et al, 2018). This is supported by the study from Botswana, which indicates that other reasons for not using condoms were lack of condoms at the time of sex, unplanned sex or alcohol influence (Kanda & Mash, 2018).

In the study done in Vhembe District, South Africa sexual risk factors among young people at Nghomunghomu rural Village showed that 76% of the respondents had never asked their partners' HIV status, while 90% were never bothered to know their own HIV status before engaging in sexual intercourse. Thus, 76.6% had never used condoms during sexual intercourse, which contributes to the increased rate of STIs, including HIV/AIDS and teenage pregnancy (Maluleke, 2010). As all young people will confront their sexuality at some point in time, universal access to information and skills is required, to enable them to make informed choices (Bhana, 2017). Sexual risk factors are often targeted in programmes and more intensive intervention because they are more directly related to pregnancy and HIV and are more amenable to change (UNICEF, 2016).

Having the relevant knowledge on reproductive health, puberty, sexuality and the consequences of sexual and reproductive behaviour, helps adolescents and youth in making responsible decisions (Naezer, Rommes & Jansen, 2017). Young people make the most vulnerable population in terms of HIV/AIDS, owing to the number of factors, including lack of knowledge about HIV/AIDS, age of sexual experiment, risky behaviour and circumstances of physical and psychosocial development (Bhana, 2017). This contradicts the study done in Portugal, which shows that women with higher education had better knowledge about HIV transmission and prevention, but they engaged more in unsafe sexual practices than did younger women with no higher education (Naezer et al., 2017). Similarly, other studies demonstrated that young people engage in risky sexual behavior, regardless of their knowledge associated with the risk of unprotected sexual behaviour (Kanda & Mash,2018). Sub-Saharan Africa constitutes about 78% of the adolescents living with HIV. Furthermore, HIV/AIDS is the leading cause of death in this region than anywhere else in the World (UNICEF, 2016).

South Africa is one of the Sub-Saharan countries with the highest HIV epidemic infection because of unsafe sex practices, with 17.06 million people living with HIV/AIDS in the middle of 2017 (WHO, 2017). HIV is also the most critical threat to the health and overall well-being of the youth in South Africa. This is because the epidemic is driven by infections among young people and they are a crucial group to intervene, to halt the spread of infection and reduce new infections (UNIAIDS, 2016). A 2012 survey found that HIV prevalence among young South African women was nearly twice as high as that of men. The rate of new infections among young women aged 15-24 were more than four

times those of men the same age, and this age group accounted for 25% of new infections in South Africa (Shisana et al., 2014).

South Africa's mid-year population statistics 2018 estimate that the prevalence of HIV is approximately 13, 1% in the total population. The total number of people living with HIV was estimated to be 7, 52 million in 2018; however, 19, 0% of the HIV infected were adults aged 15-49 years. This indicates that youth in this age group practice unsafe sex (Statistics, South Africa, 2018). Adolescent pregnancy interferes with young women's educational attainment, resulting in fewer job opportunities for women (Psaki,2016). In addition, there is a strong association between pregnancy and HIV infection in South Africa (Chimbindi., et al.,2018). Antenatal data shows that 12, 9% of 15-19 years old pregnant women are HIV positive (Fehring, 2010).

Although there are efforts by the Department of Health on youth sexual reproductive programme, including availability of Youth-friendly services in Primary Health Care facilities, youth sexual health remains a concern at Vhembe District, Limpopo. This is because young people still engage in unsafe sex practices; hence, they contract HIV/AIDS, get pregnant, perform unsafe abortions and experience complications associated with unsafe sex practices. Vhembe District had the fifth highest teenage pregnancy rate at 7,9% of females under 18 who gave birth during the 2014/2015 financial year countrywide (Vhembe District Health Barometer, 2015). An alarming rate of teenage pregnancy at Mavalani High School (Giyani) was found when the press broke the news that 57 pupils were pregnant in 2011. Similarly, the MEC of Health, Dr Phophi Ramathuba, visited Mukhwantheli High School at Didi Village, where 37 learners were found to be pregnant (SABC news). Furthermore, many studies have been conducted on factors leading to unsafe sex practices among youth countrywide. However, few have focused on the role and responsibility of youth aged 18-24 in their first sexual encounters. It is against this background that the researcher found it important to conduct the study, to determine factors contributing to unsafe safe practices among youths at a selected village, Vhembe district, Limpopo Province in South Africa.

1.2 PROBLEM STATEMENT

Despite the availability of youth-friendly services in health care facilities, which include (free condom supply, sex education, and other health programmes), there is an increased

rate of teenage pregnancy, HIV/AIDS, and other STI's, which shows that youths still engage in unsafe sex practices. According to Robertson & Szabo (2017) from the year 2015 to 2017, the number of antenatal first booking among youth aged 18 to 24 were 52 (2015), 54 (2016) 66 (2017) at the clinic. In South Africa, HIV prevalence rate increased to 13, 1% in 2018, compared to 12, 9% in 2017. There was also an increase in HIV/AIDS among the 15-49 age group in 2018, compared to 17, 9% in 2017 (Stats South Africa, 2018). The incidences of HIV infection among youth were also found to be increasing;11 in 2015; 20 in 2016 and 46 in 2017. According to the District Health Information System, which is reported in the Primary Health Care Facilities annually, the consequences of unsafe sex practices prevail among youth (Robertson & Szabo, 2017). These are high teenage pregnancy as well as high HIV infections District Health Information System, 2015, 2016 & 2017). Wayeni clinic's annual statistics on antenatal bookings among teenagers under the age of 18 show an increase annually: 56 in 2015; 66 in 2016 & 68 in 2017 (Wayeni clinic data report, 2015, 2016 & 2017). It is against this background that present researcher found it necessary to conduct this study.

1.3. Rationale of the study

Although there have been several studies on factors leading to unsafe sex among youth worldwide, studies on checking their knowledge, to demonstrate their roles during the first sexual intercourse, are limited. The National Department of Health has developed strategies to improve youth sexual reproductive health in schools. These include sex education in schools, introducing life orientation as a subject in all grades. However, sexual health problems among youth in South Africa still prevail, as shown by the increased rate of teenage pregnancy at Mavalani High School, Limpopo, where 57 pupils were pregnant in 2011. Despite intervention to empower youth in sexual health, youth demonstrate little knowledge regarding unsafe sex practices; hence negotiation skills for safe sex are limited. Therefore, the purpose of this study was to determine factors which contribute to unsafe sex practices among youth.

1.4 SIGNIFICANCE OF THE STUDY

Youth may be aware of the consequence of unsafe sex, hence might take the right decisions before engaging in unsafe sexual intercourse. Health care professionals may

have different views with regard to health education related to safer sex practices among youth. Parents, especially grandmothers, may have less responsibility for taking care of children, while their mothers attend school. The Department of Education may rephrase the Life orientation subject in schools, based on the findings of the study. Furthermore, health policy reviewers may use the findings to develop effective programmes about the challenges of unsafe sex practices. The researcher may gain more knowledge and improve skills when dealing with health challenges affecting youth, including teenage pregnancy, HIV/AIDS and other diseases.

1.5 Purpose

The purpose of this study was to determine the factors contributing to unsafe sex practices among youths aged between 18-24 years at a selected Village, Limpopo Province.

1.6 Objectives of the study

- To explore the factors contributing to unsafe sex practice among youth at a selected Village, Limpopo Province.
- To explore the views of youth regarding factors contributing to unsafe sex practices at a selected village, Limpopo Province.

1.7 DEFINITION OF TERMS

Factors of unsafe sex: the influences and sources of attitudes and behaviours which impel people to engage in unprotected or risk sexual conduct (Alimoradi, Kariman, Simbar & Ahmadi, 2017). In this study, factors mean the influence that causes youth not to practice safe sex

Sexual practice: the execution of physical and psychological behaviours and attitudes which are a reflection of sexual orientation and identity (Rufino et al., 2017). In this study, sexual practice means behaviours and actions associated with indulging in sexual intercourse

Unsafe sex: It is sex between a susceptible person and a partner who has a sexually transmitted infection (STI), without taking measures to prevent infection, the main

outcome considered to be infection with HIV, which is responsible for the majority of the burden of mortality and morbidity associated with STI'S (WHO, 2017). In this study, unsafe sex means the act of sexual activities without a condom

Youth: According to Dei Jnr (2016), the term youth refers to the period between childhood and adulthood. In many countries, the terms "young person", "teenager", "adolescent", and "young adult" are used to describe this period. The National Youth Policy in South Africa defines youth as any person between the age of 14 and 35 (National Department of Health, 2012). In this study, youth refers to anyone aged of 18 - 24 who resides at Wayeni Village

Knowledge: Knowledge is familiarity, awareness, or understanding of someone or something, such as facts, information, descriptions, or skills, which is acquired through experience or education by perceiving, discovering, or learning (Danie, 2013). In this study, knowledge means information that youth have on the consequences of unsafe sex practices

Perceptions: Is the process whereby people select, organise, and interpret sensory stimulations into meaningful information about their environment (Odhiambo, 2015). According to Leising and Back (2017), perception refers to the process by which we form impressions of other people traits and personalities. In this study, perception refers to the view and understanding of youth regarding unsafe sex.

1.8 RESEARCH OUTLINE

This research is divided into five chapters as follows:

Chapter one is made up of the background to the problem, including the statement of the problem, research objectives, methodology, ethical considerations and limitations of the study.

Chapter two comprises of the literature review on the factors contributing to the practice of unsafe sexual practice among the youth.

Chapter three outlines the research design and methodology of the study. It also delineates the population of the study, sampling, data collection and analysis.

Chapter four presents the findings and analysis of data.

Chapter five comprises of the summary, conclusion, and recommendations of the study. It also provides suggestions for further study.

1.9 CONCLUSION

The chapter provided the background of the study with a focus on the risk behaviours of the youth which impact on their state of health. The statement of the problem was given, highlighting the precise purpose of the study. The significance of the study, objectives and definition of key terms were also discussed. Key terms included the following: youth, practice, factors, unsafe sex and knowledge. An outline of the chapters of the research was also given before the conclusion.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter presented the background of this study; this chapter presents literature on the factors contributing to unsafe sex practices among the youth. It also discusses the literature review and the theoretical framework of this study. The reasons for youth to practice unsafe sexes are discussed, which includes lack of knowledge, imbalanced power relations, socio-economic challenges and perceptions on condom use. Some of the behaviours observable in youth who practice unsafe sex are highlighted covering negative attitudes to condom use, drug abuse, shunning health centres and multiple sex partners. The chapter further presents strategies which could be implemented to improve safe sex practice among the youths.

2.2 LITERATURE REVIEW

The term “literature” refers to all written sources relevant to the topic of interest (Winchester & Salji, 2016). A literature review involves finding, reading, understanding and forming conclusions about the published research and theories, as well as presenting it in an organised manner (Dela & Gross, 2017). The literature review generates a picture of what is known and not known about the research problem. It enables the researcher to learn more about the research problem. The study of relevance or literature review (theory and research) serves to develop the research problem, define and refine research concepts, and inform the researcher of existing knowledge, research needs, and previous research findings on the chosen topic (Winchester et ali, 2016).

2.3 THEORETICAL FRAMEWORK

The Health Belief Model is one of the most widely used conceptual frameworks for an HIV status, to understand health behaviour. The model was developed in the early 1950s, and it has been used with great success for almost half a century, to promote greater condom use, seat belt use, medical compliance, and health screening use (Creswell & Poth, 2018). The researcher applied this model in Table 2.1 to understand the views of youth regarding

unsafe sex practices, to avoid the negative health consequences of risky sexual behaviour, such as HIV/AIDS, unwanted pregnancies and unsafe abortion.

Table 2.1: Application of the HBM model in this study

	Concept	Definition	Application
1	**Perceived susceptibility**	One's opinion of chances of getting a condition	Define population at risk levels
2.	**Perceived severity**	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
3.	**Perceived Benefits**	One's belief on the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when, when, clarify the positive to be expected
4.	**Perceived Barriers**	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
5.	**Cues to action**	Strategies to active readiness	Provide how to get information, promote awareness reminders
6.	**Self-Efficacy**	Confidence in one's ability to take action	Provide training, guidance in performing action

Perceived Susceptibility: Perceived susceptibility will be explored with regard to unsafe sex practice among youth

1. Perceived Severity: Youth knowledge will regard to unsafe sex practices will be explored.

2. Perceived Benefits: Youth perception and knowledge with regard to the benefits of safe sex practice will be explained

3. **Perceived Barriers:** Description of perceived barriers that contribute to unsafe sex practices among youth will be explained

4. **Cues to Action:** More incentives to encourage youth to avoid unsafe sex practice through campaigns and in-service education

5. **Self –Efficacy:** Youth may have self-awareness and take responsibility with regard to safe sex practices.

2.4 Sexuality education: debates and discourses

There is an increasing in sexuality debates (Bhana, 2017). This pertains to the content of instruction, the audience and approaches which could be employed. Comprehensive Sexuality Education (CSE), has mainly been associated with the promotion of useful ideas regarding sexuality, attention to diversity and a well delineated approach to gender sensitivity, which embraces discussions of power (Kaphagawani & Kalipeni, 2017). CSE is attracting popular attention among many actors in the area of international development, and is touted as one of the most effective paths to address gender sensitivity issues at school. There is, however, a band of conservative actors who have staged an attack on this strategy. Three approaches have been identified to help understand the provision of sexuality education among young people who are single. Ponzetti (2016) distinguishes the three approaches reflecting the motivation to offer sexuality education as pertaining to morality, health and rights-based approaches. This involves conceiving education as a way to instil morals, rights to control personal sexuality and offer scientific knowledge. Sexuality and relationship education have also been increasingly linked to the development of respectful relations, emotional disposition and life skills (Chandra-Mouli, Plesons & Amin, 2018.)

2.5 Vulnerability of youths to unsafe sex practice

In human development, the phase of youth and adolescence is when one experiences new changes in life, explores and experiments with different events, situations and circumstances. It is at this stage that youths find themselves in a shifting sexual landscape due to changing attitudes towards sexuality, greater variation in sexual behaviour and increased gender equality (Ponzetti, 2016). So much research undertaken in the field of

sexual and reproductive health depicts that youth and adolescents belong to a group that is mostly at risk of dangers that come with sexual and reproductive health problems (Bhana, 2017). This emanates from their developmental characteristics. Early sexual engagement is common in young people (Psaki, 2016), unfortunately this has a number of reproductive health consequences that include early or unplanned pregnancies, abortion, sexually transmitted infections (STIs), and HIV/AIDS infection. All these conditions have high chances of further leading to physical, psychological, social, and economic challenges. Meanwhile, recent technologies and widespread internet access have further influenced ways in which young people gain awareness about sex and circumstances related to it (Ponzetti, 2016). In addition, these new technologies have an impact on how youths and adolescents conduct their sexual lives.

2.6 Reasons for unsafe sex practice among youths

This section discusses the reasons for unsafe sex practice as follows:

2.6.1 Knowledge of youth about sex and risky sexual behaviour

Sexual health is an essential part of good overall health and well-being. Sexuality is part of human life and development (Bhana, 2017). Good sexual health implies not only the absence of disease, but the ability to understand and weigh the risks, responsibilities, outcomes, and impacts of sexual actions, to be knowledgeable of and comfortable with one body. On the other hand, good sexual health is significant across the life span, and it is critical in adolescent health (Ponzetti, 2016). WHO defines youth as a young people aged 10 to

19. Pregnancy and birth among adolescents who are 10 to 14 years is rare in many countries. However, in some sub- Saharan African countries 0.3% to 12% of adolescents give birth before turning 15 (WHO, 2017).

The sexual risks behaviour among young people predisposes them to diseases such as HIV, and other STIs (Psaki, 2016). However, young people easily find themselves in situations where it is difficult to adhere to rules of sex or use of condoms (if they are having sex while drunk). These and many more endanger the health of the young women or adolescents. WHO (2014) estimates that young people contribute 11% of all births

worldwide, of which 95% occur in developing countries, and the majority occur in seven countries, one of which Nigeria.

Young people need to learn to be sexually responsible and understand their sexual roles, to make safer sexual choices (Ponzetti, 2016). Social theories such as that by Kelly and Bandura describe psychological disorders and negative emotions when people's cognitive control mechanism, such as (schemas, constructs, beliefs, and self-efficacy) cannot cope with a threatening or new environment (Naezer et al., 2017)..HIV prevalence figures indicate that the proportion of young people infected with HIV increases significantly between childhood (2 and 14 years) and youth (15 and 24 years), suggesting that as children progress from childhood to youth, their vulnerability to HIV infection increases substantially (Davidoff-Gore, Luke, & Wawres, 2014).

A notable number of adolescents are engaged in sexual activity and few use condoms during sex, even those with multiple partners, probably due to their limited knowledge about safe sex, cultural norms and unfriendly environment for condom accessibility; thus exposing themselves to STI's, including HIV, as well as unwanted pregnancy (Psaki, 2016; Kanda & Mash, 2018). The prevalence is usually high among adolescents. Several studies across Africa have reported a high prevalence of adolescents with multiple partners (Ponzetti, 2016).

2.6.2 Gender Inequality as a factor contributing to unsafe sex practice

In many regions of the world, during adolescence, the power differential between girls and boys becomes evident. Boys may develop autonomy and have more occupational and educational opportunities available to them, while adolescent girls' freedoms are comparatively limited (Chandra-Mouli, Plesons & Amin, 2018). Adolescence is a period of high risk for HIV infection, with adolescent girls generally at higher risk than males in their age group (Ponzetti, 2016). By far the higher rate of new infections occurs among adolescents, young women and girls. According to published studies, the incidence of HIV in the population group between 18 and 24 years of age has increased. This can be attributed to several factors, such as decreased condom use, increased concurrent multiple partners, low risk perceptions and age disparate relationships (Naezer et al., 2017).

The unsafe behaviours that are usually observed among boys are partly influenced by gender norms that seem to view males as brave human beings that can engage in risky circumstances (UNAIDS, 2019). Gender disparities are also perceived as dangerous to the sexual and reproductive health of girls, who are at the adolescent stage and unfortunately, may have lifelong effects. Adolescent girls are at risk of being infected by sexually transmitted infections (STIs) due to both social and biological influences. According to UNICEF (2019), adolescent girls tend to have less access to education on sexuality and normally have poorer access to health services than boys. Girls are also at high risk of engaging in unprotected sex, especially in situations where they have less control on sexual activities (Chidambaram, 2018). In addition, the risk of unsafe sex is increased by sexual violence, usually encountered by girls in their youth. Such girls are also specifically affected by some cultural practices that include child marriage and, in some regions, female genital mutilation (UNAIDS, 2019). In addition, these girls do not complete their secondary schooling or they are less likely to complete secondary school or acquire secure employment as they transition into adulthood because of the burden of household work. In some contexts, they have less decision-making independence, including restricted movement, as compared to their male counterparts. If the justifiable expansion goals are to be realised without leaving behind those that are mostly affected, tackling the gendered dynamics that shape adolescent health, and especially the sexual and reproductive rights of adolescent girls, is critical (Chandra-Mouli, Plesons & Amin, 2018).

In the sub-Saharan part of Africa, 80% of new HIV infections between 15-19-year-old individuals are girls (UNAIDS, 2019). According to Chandra-Mouli et al. (2018), studies on gender disparity in global health have paid attention to factors that operate at individual level (such as age at marriage and literacy), household level (decision-making, household composition or community level (social norms, access to services). Although gender inequality is experienced by most individuals, it is mainly caused by power relations that influence the organisation of communities, development of policies, functioning of economies, and the way ideologies are shaped (UNAIDS, 2019).

2.6.3 Socio-economic factors that can lead to unsafe sex practices among youth

Poverty is one factor that is regarded as fuelling the practice of unsafe/unprotected sex in sub Saharan Africa. This is due to extreme levels of poverty In Africa, as a result of poverty, some parents encourage their female adolescents to engage in sex for money, so that they can contribute to the family income (Psaki, 2016). These adolescents are inexperienced, and due to gender inequalities in the African culture, they do not have the necessary skills to negotiate for safer sex, even if they are aware of the risks involved (Kanda & Mash, 2018).

Lower family income was also associated with an increased risk of unprotected sex among men. There was also an association between low socio-economic status and inconsistent condom use (Davidoff-Gore, Luke, & Wawres, 2014). Financial support from older men, because of poor socio-economic conditions, can be a key factor in the development of trans-generational sexual relationships. The power and gender imbalances in these relationships and the result of unsafe sex lead to an increased risk for STI's, HIV, and teenage pregnancy (Chandra-Mouli *et al*., 2018).

Power imbalances reflected and reinforced by intimate partner violence may be skewed further when material goods/and or financial transactions are involved in a relationship (Psaki, 2016). Often, accepting material goods or money indicates an acquiescence to engage in sexual intercourse on the man's terms (Chandra-Mouli *et al.,* 2018). Furthermore, some powerful religions and faith groups still oppose sex education, despite the evidence in favour of it, and oppose condom use. In their efforts to discredit condom use and focus on abstinence and monogamy, some societies discourage condom use as unethical; some undermine condom use as unsafe and few go so far as to discredit condoms through misinterpreting the data (Kanda & Mash, 2018).

Teenage pregnancy is a socio-economic challenge and an important public health problem for communities in South Africa. It is also a risk factor for Sexually Transmitted Infections, including HIV/AIDS. In addition, it is a reflection of inconsistent use of contraceptives (Psaki, 2016; Kanda & Mash, 2018).

2.6.4 Alcohol and risky sexual behaviour among youth

There is much evidence that substantiates a strong relationship between substance abuse use and engagement in risky sexual behaviour. While literature reveals this, there is limited evidence that highlights the nature and density of such a relationship, especially as it relates to intensity and frequency of alcohol use and contextual variables such as socio-economic status, gender and age (Psaki, 2016; Kanda & Mash, 2018). Substance abuse has a number of negative influences. This includes having multiple sexual partners, engaging in risky sexual behaviour and engaging sexual intercourse under the influence of drugs that encompass cocaine and alcohol. Youths are vulnerable for a number of reasons, which include their tendency to have many sexual partners (concurrent or sequential), as well as poor access to effective STI prevention services, amongst others. In relation to this, Markowitz, Kaestner and Michael (2015) concur that alcohol consumption among young teenagers is one of the important risk factors for teenage pregnancy. This is because teenagers like to spend time in shebeens, and alcohol is known for its ability to impair judgement and be a gateway to unsafe sex. Most youth risk behaviour surveys in many communities provide useful information regarding the prevalence of mental health problems and high-risk behaviours among secondary school learners in South Africa (Wagenaar, Florence, Adams & Savahl, 2018).

2.6.5 Lack of information regarding unsafe sex among youth

Some youths engage in unsafe sex because they lack adequate information on sex and sexuality. Sex education programs that are balanced and realistic, encourage students to postpone sex until they are older. Furthermore, these programs promote safe sex practices among those who choose to be sexually active have been proven to be effective at delaying first intercourse and increasing use of contraceptives among sexually active youth (Bhana, 2017). These programs have not been shown to lead to early sexual activity or to increase levels of sexual activity, or numbers of sexual partners among sexually active youth. According to Chidambaram (2018), knowledge about sex, puberty and reproductive health among youth, helps youth make responsible decisions regarding their sexual health. In the study done in Ethiopia on factors affecting sexual behaviour among youth on sexual and reproductive health, it was found that youth benefit more on

integrated sexual health services available at youth centers, by using the library, free internet, services and other sport activities (Kumsa, 2015).

2.6.6 Perception of condom use among youth

Research shows that South African young people are especially at risk of HIV infection. This is because they begin engaging in sexual intercourse at a young age, have multiple partners, make little use of contraceptives, and have low sexual negotiation skills. Condom use also continues to suffer from stigmatization, and peer pressure and coercion limit youths' ability to abstain from sex, leading to promiscuity, infidelity, and even prostitution (Kanda & Mash, 2018). Well-informed and highly motivated individuals therefore also need to possess specific behavioural skills, including their perceived self-efficacy of using them, in order to translate information and protective motivation into actual preventive actions (Bandura, 1997).

2.6.7 Migration as a factor leading to unsafe sex practices among youth

Migration can be another reason for youth to practice risky sexual behaviour; at Wayeni Village both parents may be working in Gauteng, and may have left their families with the youth. This is supported by a study conducted in Tanzania, where the respondents suggested that many single- parents give their children too much freedom, which makes it difficult for the parents to monitor the children's behaviour (Mutasingwa & Mbirigada, 2017).

2.6.8 Socio and cultural factors leading of unsafe sex practices among youth

Sociocultural factors often lead to parents and religious leaders to avoid discussing HIV prevention in public, especially condom use and safe sex (Kaphagawani & Kalipeni, 2017). Some community members believe that guiding youth on condom use and safe sex is immoral.

Divorce or widowhood in some families force their children to get involved in risky sexual behavior, to support their families (Gonçalves, Faleiro & Malafaia, 2018). In Nigeria, a study showed that youth whose parents have an intact marriage are at a lower risk of being involved in risky sexual activity than youth living with a single parent or those living with grandparents. Unsafe sex is also perpetuated in Botswana because women lack

power in negotiating sexual relationships and because of the cultural belief that single women should prove their fertility and cleanse their womb by having a child (Kanda et al 2018).

2.6.9 Peer influence

One of the most persistent factors that has an influence on youth and adolescent behaviour is peer influence (Peci, 2017). Health behaviour theories that include the Reasoned Action Model and the Social Cognitive Theory reveal a critical influence of perceived peer norms on decision-making. Other research studies have demonstrated that changes in brain reward circuitry have the capacity to contribute in the salience of peer values at early adolescence. Even though peer influence has been associated with other behaviours that include substance abuse and deviance (Wagenaar *et al.,* 2018), it can also be relevant in matters that include sexual risk behaviour.

Although perceived peer norms are clearly important to peer influence processes, not all youths, young people or adolescents are similarly vulnerable to peer influence or pressure. Some of them can notice risky sexual behaviour among their peers but remain unaffected by such actions (Peci, 2017). Most research studies that are based on adolescent or youth sexual behaviour have critically assessed the relationship between norms and behaviour, without considering individual differences in vulnerability to those norms (Kaphagawani & Kalipeni, 2017). However, when vulnerability has been measured directly, it has often been examined through a self-report; for example, asking the youths how vulnerable they believe they are to sexually risky behaviours, introducing biased estimates, and limiting understanding of such constructs.

2.6.10. Social media use as a factor that can influence unsafe sex practices

The use of the social media and changes in risk behaviours among adolescents in the past decade might be closely related to each other. This also relates to sensation-seeking and the manifestation of adolescent risk-taking behaviour which have been seen to change, owing to broader cultural and social factors throughout history (Pew Research Center, 2018). The regular use of social media displaces the amount of time spent on behaviours related to health such as extracurricular activities, inperson social interactions

and physical activity. As suggested by the Displacement Hypothesis, it is possible that an increase in the use of social media among adolescents might replace participation in some risky behaviours, such as heightened use of illicit drugs and alcohol abuse (Ponzetti, 2016).

The increase in societal restrictions and parental monitoring regarding access to substances in the Western culture, suggests that social media might provide a novel situation in which the risk taking propensities of adolescents can be expressed. (Kaphagawani & Kalipeni, 2017). The Facebook Influence Model propositions mechanisms of peer influence through which the use of social media might raise the susceptibility of adolescents to risky behaviours (Moraes & Vitalle (2018). Broadly, the model hypothesises that the context of the social media amplifies the processes of peer influence, which affects cognition and behaviours of adolescents. The Facebook Influence Model suggests that connections among individuals and social networks influence the perceptions of individuals, as well as the construction of communities which develop and share the same risks behaviours norms and perceptions. Individuals then come to imitate those behaviours that are viewed to be rewarded or valued (Louro, 2018). The use of social media and online communities is believed to expose adolescents to behaviours which encourage risk-taking attitudes through positively portraying risky actions in the content which is posted by peers and persons who are valued.

The Facebook Influence Model indicates that while adolescents mainly post non-deviant and positive social media, a minority of social media influencers and popular peers possess a wider reach, influence and desirability. This is a result of the widespread ability, publicness and quantifiable reinforcement of the content (Pew Research Center, 2018). This exposure, which is driven by the social media, is believed to influence the favourable attitudes of adolescents towards risky behaviours and perceptions that such behaviours are desirable by the valued others. Adolescents ultimately engage in risky behaviours, both online and offline, to imitate the social norms of high status individuals. These effectively receive social reinforcement to foster a positive social identity.

2.7 Behaviours that suggest involvement in unsafe sex amongst youths

This section focuses on behaviours which suggest involvement of youths in unsafe sex practices.

2.7.1 Attitudes to advice on unsafe sex practices

One of the behaviours that may suggest to caregivers or parents that an individual could be engaging in unsafe sex is the attitude that one may show towards advice that is given pertaining to such a practice (Ponzetti, 2016). More often than not these youths tend to be defensive of such practices or may be arrogant whenever such topics arise. In relation to defending their behaviour, they often cite reasons such as, ”many people in the society are engaging in sex without protection and so why should I/we be the ones left behind?” Such attitudes may be a clear sign that the concerned youths are already engaging in unsafe sex with their partners.

2.7.2 Type of friends attached to

Another sign that may depict involvement in unprotected sex is the type of friends that one may be attached to (Peci, 2017). If a youth has close attachments with friends who practice or who advocate for unsafe sex, then the likelihood could be high that the concerned youth could be sharing the same perceptions as his or her friends and could moreover be egaging in unsafe sex. In relation to this, Kaphagawani and Kalipeni (2017). state that the power of association cannot be underestimated when exploring the indicators of engagement in unsafe sex by adolescents and youths. In view of this, there is an African proverb which states that ‘birds of a feather flock together’. However, in some instances the youth may fall for friends who might be having different perceptions from theirs concerning the practice of unsafe sex. Due to continued association, the youth might gradually be tempted to imitate what their friends could be doing (Peci, 2017).

2.7.3 Alcohol and Substance abuse

Alcohol and substance abuse can also be regarded as one of the signs that an individual could be practising risky sexual behaviours, such as unprotected sexual intercourse

(Wagenaar *et al*., 2018). In relation to this, findings from a study conducted by Markowitz, *et al.* (2015) concluded that unprotected sex is more common during episodes of alcohol consumption, compared to when alcohol is not consumed. Based on this, it becomes more apparent that alcohol and substance abuse are influential in youths` sexual decision-making process (Markowitz *et.al*.,2015).

2.7.4 Multiple partners

Another indicator that may suggest that an individual could be practising unsafe sex is the issue of having multiple sexual partnerships (Bhana, 2017). In this case, one may succeed in practicing safe sex with a single partner but fail to persuade other partners to do the same. For example, a female youth may manage to engage in safe sex with one particular boyfriend, but be overpowered by her other sexual partners to engaging in the same practice. It is therefore important for caregivers to understand the extent to which youths are engaging in multiple sexual partnerships then assist them accordingly (Kanda & Mash, 2018). The African Medical Research Educational Foundation (AMREF) – Kenya carried out a study on sexual activity amongst youths and adolescents, and the findings confirmed that there is a very high percentage of school-going female adolescents who are not only involved in unprotected sexual activity. In fact, some even have multiple partners and this puts them at high risk of infections (Wanyonyi, 2014).

2.7.5 Early sexual initiation

Another indicator of the practice of unsafe sex amongst the youths is the timing of sexual initiation. Those that engage in sex at an early stage of their adolescence are more likely to engage in unprotected sex than those who are more mature (Kanda & Mash, 2018).This is partly because the former group could be lacking adequate information on issues pertaining to sex and sexuality than the latter (Gonçalves et al., 2018).

2.7.6 Addiction to pornographic films/videos

One other indicator of engagement in unsafe sexual activity amongst the youths is their love for, or addiction to, pornographic films and/or videos (Quadara, El-Murr, & Latham,

2017). This means that individuals who tend to prefer pornographic films are likely to be practising unsafe sex because most of these activities do not involve the use of preventive or safe sex measures. In this case social media, through its various platforms, exerts a significant influence in shaping the risky sexual lives of the youths (Campo, 2016).

2.7.7 High incidences of pregnancy and STI infection

Another clear indicator that the youths of a particular school or community are engaging in unsafe sex activities, are high incidences of early and unplanned pregnancies, abortions and STI infections. According to Wanyonyi (2014), past research in Kenya indicates high cases of unprotected sexual activity and mobility among the youth. This behaviour is manifested in high incidences of pregnancies, abortions, stress and sexually transmitted infections, including HIV.

2.8 An opportune life stage for instilling healthy behaviours

Early adolescence is believed to constitute a period of life which is relatively healthy. Young adolescents, compared with others age-groups, are considered to be least likely to encounter disability or premature death. This is also a critical period to build a positive foundation for sexual and reproductive health outcomes (Bhana, 2017). Providing interventions at this early period of life, at the formative stage of behaviours and attitudes, offers an innovative opportunity to safeguard health in the short period, but also prepares adolescents in a manner that will eventually improve their wellbeing in life (Chandra-Mouli *et al*., 2018).

The fact that adolescence is a crucial stage of gender socialisation, gives a distinctive chance to deal with harmful gender behaviours and attitudes prior to becoming entrenched (Ponzetti, 2016). Education becomes an important factor influencing the life of very young adolescents. Investment in education improves the sexual and reproductive health of young people (Bhana, 2017). A higher educational attainment is shown to be linked to a better sexual and reproductive health outcome, inclusive of deferrals in sexual initiation, marriage, child bearing and high chances of the use of contraception. Ultimately, factors at multiple levels protect as well as challenge sextual and productive

outcomes of young adults (Chandra-Mouli *et al*.,2018; Ponzetti, 2016). It is also important to understand that the context of lived experiences is central to meet their needs.

2.9 Sexual Health Promotion for Youths

Research shows that Sexual Health Promotion demonstrates that access to culturally relevant and socially inclusive sexual health education (SHE) can provide fast solutions to resolve the negative effect of marginalisation and lower HIV/ STI vulnerabilities (Orozco-Olvera, Shen & Cluver, 2019). A systematic review of 83 curriculum and group-based sexual health education programme globally established that such programmes considerably changed the sexual behaviours of youths, inclusive of reduced risk taking (Garland-Levett, 2017). A study by Kyaw Soe, Bird, Schwandt and Moraros (2018) showed that students engaged in STL prevention programmes in the United States were more prone to reflect enhanced HIV knowledge, communication skills, positive attitudes on condom use and abstinence, change in behaviour in the form of decreased number of sextual partners and an increase in the use of condoms.

The main sources of sexual health information for youths in Canada are parents, school, mass media, the internet and health professions (Naezer et al. (2017. SHE, which improves positive sexual health outcomes and lowers susceptibilities must be “accessible to all people inclusive of age, race, sex, gender identity, sexual orientation,
STI status, geographic location, socio-economic status, cultural, or religious background, ability, or housing status…” (SIECCAN, 2019:23). It is critical for children and youth to promote sexual health and well-being through forming social identities, relationships, values and to access a multitude of settings to inclusive SHE which takes care of their lived experiences, cultures, interests and to offer chances for them to improve skills of decision making (Naezer et al.,2017).

2.10 Initiatives by selected countries to control unsafe SEX practices by youths

This section presents a discussion on initiatives that selected developed and developing countries are employing to control unsafe sex practices by youth. The selected developed countries are New Zealand, Brazil and China. Developing countries focused on are Tanzania, Zimbabwe and Malawi.

2.10.1 New Zealand

One of the effective initiatives offered by New Zealand to control unsafe sex practice by the youths is sexuality education. According to Garland-Levett (2017), sexuality education is one of the key elements in the school curriculum of New Zealand. The introduction of the 1999 curriculum influenced a change in the curriculum, from the one that focused on sex education to the one that is mainly concerned with sexuality education (Rasmussen, 2016). This move to a more holistic approach drew on Māori philosophy of well-being 'defined by the hauora model, which includes physical, social, mental, emotional, and spiritual aspects' (Ministry of Education, 2015).

Sexuality education further emphasises that youths have a right to access information on sexuality and this implies that availed educational programmes should be inclusive and sensitive to the developmental needs of individuals (Garland-Levett, 2017). Changes in content delivered incorporates literature from related fields, such as health education, sexuality studies and educational sociology. Attention is also paid to
'changing social climates, recent youth health research and it further draws on the advice and experiences of schools and other related sectors of the community (Ministry of Education, 2015).

2.10.2 Brazil

In Brazil, unsafe sex practice is controlled through sex education. According to the Brazilian National Curriculum Parameters (PCNs), sex education is viewed as an aspect which should be taught in all educational areas (Menezes et al.,2019). For this to be successfully achieved, teachers must be knowledgeable of relevant content that addresses human singularities, so that students can eventually become critical individuals who can think and discuss various topics that are relevant to their developmental experiences. It is the responsibility of educators, to promote social and discussion-based actions, aimed at resolving doubts that can generate future problems, including the healthy experience of sexuality (Louro,2018).

According to the Brazilian Ministry of Education (MEC), sexual guidance that is done by the school, should consist of a formal and systematized process that needs proper and logical planning (Menezes et al.,2019). Sexuality as a theme must be approached naturally and, because there is a certain difficulty in this regard, initial and continuing

education seems to be relevant to the entire school's pedagogical team (Goncalves, Falerio & Malafia, 2018).

From the department of health viewpoint, there seems to be some contradiction between an educational intervention effort in adolescent sexuality and the actual outcomes received at the behaviour level shown by the youths (Louro, 2018). On the other hand, the increasing degree of permissiveness that depicts today's society and limited authentic and adequate support by parents, teachers, and health professionals has influenced the youths to engage in risky behaviours so as to satisfy their sexual needs (Goncalves et al., 2018).

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2.10.3 China

According to Li et al., (2017), In countries like China, the promotion of sexuality education can be traced back to the 1960s, where scientific sexual knowledge was to be impacted to adolescents and youths. Sexuality education was formally introduced into the school curriculum in 1988. Since then, it has developed into an effective prevention strategy (Naezer, Rommes & Jansen,2017). In a guideline on HIV Prevention Education for Primary and Middle School Students issued by the Ministry of
Education of China in 2008, all schools are required to dedicate 6 to 7 hours of health education in a semester, ensuring no less than 6 hours in the 3-year middle school education and 4 hours in the 3-year high school education are allocated to HIV prevention as well as sexual health education.

Such policies, however, are widely considered to be inadequate for its insufficient class hours and lacking of teaching human resources, proven by the fact that only 19.8% of Chinese college students know the scientific names for male genital organs (Li et al, 2017). Limited formal sexuality education from homes or schools has influenced most Chinese adolescents and young adults to mainly acquire relevant information about sex and sexuality from the Internet. While this move cannot be completely discouraged, some information from the internet may be misguiding and harmful to the youths' development (Naezer et al., 2017).

2.10.4 Tanzania

In Tanzania, young people aged between 10 and 24 constitute about 32% of the entire nation's population. A third of these are adolescents aged between 10 and 19. (National Youth Friendly Health Services Strategy, 2018). Their large numbers force responsible authorities to design suitable programmes needed to address adolescent health and development. For reasons such as this one, African countries like Tanzania, have formulated policies that ensure that young people's needs are catered for (Eustace, Asiedu & Mkanta, 2015). Initially, these were developed with close collaboration between stakeholders drawn from various government departments, multilateral agencies and civil society.

From an educational point of view, the Ministry of Health in collaboration with the Ministry of Education and Vocational Training ensures the provision of sexual health education through the National School Health Programme (Bilinga, 2016). Through such programs, youths are given a number of health care services that support them with information on sexual and reproductive health. Counselling services are also provided (Ponzetti, 2016). The education sector has also brought HIV education into the national school curriculum. Furthermore, in 2015, the Tanzanian government launched several sexual health education programmes that have sought to counter the negative impact of underage sex (AVERT, 2016). Such initiatives target adolescents who have not had lessons about sex before in the past. These include the establishment of sex education clubs in schools; provision of sexual health education training to school teachers, and integration of sexuality education into the school curricula (Bilinga, 2016).

2.10.5 Zimbabwe

According to Nunu, Makhado, Mabunda and Lebese (2020), in Zimbabwe there has been a joint effort by various related stakeholders in trying to improve Adolescent Sexual Health (ASH). In relation to this, there are several programs, such as condom distribution in schools, access to free family planning services and awareness campaigns, conducted by the health sector (Del Fava, Piccarreta, Gregson & Melegaro, 2016). Though these services are provided, there are some barriers, such as religion, culture and adolescent-unfriendly health institutions that seem to lower the chances of adolescents and youths to access them. For example, in Zimbabwe it has been noted that adolescents who

practice cultural initiations are highly at risk of STIs and teenage pregnancy than those who are exposed to modern ways of doing things.

Since Zimbabwe attained its independence in 1980, the two main health systems, Indigenous Health System and Modern Health System (IHS and MHS) have both been equally recognised by the country's government (Magodoro, Esterhuizen & Chivese 2016). However, collaborations between these two health systems have remained extremely constrained but they continue to run parallel. This has created tensions and conflicts since in most cases, Traditional Health Practitioners (THPs) and Health care workers do not work together for the benefit of adolescents. In many instances where the traditions and beliefs of indigenous people are questioned they tend to shun away from MHSs (Mudonhi et al., 2019). As a result, the majority of Zimbabweans rely on IHS for their health care. There is scarcity of policies that have advocated for the integration and collaboration of IHS and MHS in Zimbabwe (Nunu et al.,2020).

2.10.6 Malawi

In Malawi, youths are perceived as a special needs group in the field of sexual and reproductive health not only because of their engagement in risk-taking behaviours but also because of their lack of information and access to services (Rashid & Mwale, 2016). Youths who have limited sex and sexuality knowledge are alienated from sex and sexuality issues which concern them; hence, they are likely to indulge in reckless and unguarded sexual activities that may impact on them in a negative way. Therefore, this made it a necessity for the Malawian government and other relevant key stakeholders to include sexuality education in the school curriculum, radios, televisions and many other related platforms. This is considered as a means of helping schooling and non-schooling youths to be adequately provided with information that will help them to make wise decisions (Kaphagawani & Kalipeni, 2017)

According to Rashid and Mwale (2016), the Malawian curriculum includes sex and sexuality education in subjects like Life Skills, Social Studies, Integrated Science and Biology. It is from such subjects that issues related to STIs, HIV/AIDS and teenage pregnancy are addressed. Furthermore, there have been some programs run on television and radio stations targeting adolescents with the purpose of equipping youths with proper knowledge on issues related to sex and sexuality (Kaphagawani & Kalipeni,

2017). Among such programmes are Youth Alert and Wise Up aired on MBC radio and television just to mention a few. The use of varied methods to disseminate information on sex and sexuality education is done focusing on reducing HIV/AIDS infection rates among the youth, including raising knowledge and awareness about sex and sexuality so that adolescents refrain from risk sexual behaviours (National Youth Friendly Health Services Strategy, 2018)

2.11 General strategies that can be implemented to promote SAFE sex among the youth

This section focuses on strategies which can be implemented to improve safe sex practice among youths in the selected village as follows:

2.11.1 Religious attachment

According to Somefun (2019), there is a close association between religiosity and sexual behaviours among adolescents and young adults. The conduct of youths who perceive religion as an important aspect of their lives is normally modelled by it. This means if the doctrines of a particular religion are against engaging in sexual activity before marriage, then youths with a strong affiliation in their religions may abstain from sex until the recommended time. Hayward (2019) concurs that youths from a background with strong religious beliefs are more likely to experience decreased rates of voluntary sexual debut. This, therefore, means that parents or caregivers may constantly encourage their children from a young age to attend religious settings and groupings so that somehow they may develop moral values that will help them practice safe sex and to abstain from sex until there are mature enough.

2.11.2 Parental monitoring

Another strategy that can be adopted in order to promote safe sex engagement by youths is parental monitoring. According to Gonçalves et al. (2018), strict parental monitoring is positively associated with reduced adolescent health risk, delayed intercourse, fewer sexual partners and consistent contraceptive use. Ponzetti (2016) concurs that adequate parental monitoring is generally positively related to commended sexual engagement and

practices. Furthermore, Bhana (2017) observed a close link between parental control with adolescents` intercourse initiation and contraceptive use. It is evident from the views of these various scholars that parental monitoring and guidance is an important tool that can be employed to enable youths to engage in safer sexual practices (Mudonhi, Nunu, Ndlovu, Khumalo & Dube, 2019).

2.11.3 Improving the educational levels of parents

Another strategy that can be used to promote engagement in safe sex by youths is improving the educational levels of all parents (Gonçalves et al., 2018). When parents are literate and well-educated, they have the zeal to gather knowledge from different learning or information platforms on sex education. This teaches their youths on related issues. This, in turn, may influence positive behavioural outcomes. In addition to this, Kaphagawani and Kalipeni (2017), state that youths of educated parents tend to respond positively to HIV/AIDS information than those with uneducated ones and this reduces their chances of engaging in sexual risk behaviour like unprotected sex having several sexual partners This is probably because educated parents may spend time interacting or discussing with their youths issues to do with education, risky sexual behaviours and their negative implications (Ponzetti, 2016).

2.11.4 Discouraging youths from alcohol and substance abuse

Another way of promoting the engagement into safer sex by youths is through discouraging them from alcohol and substances abuse (Wagenaar et al.,2018). This responsibility could be assumed by different stakeholders, including parents, teachers, community health workers and other members of the community. Substance and alcohol abuse can increase the chances of youths engaging in risky behavior. In relation to this, Kanda & Mash (2018) stated that alcohol consumption and its abuse have been globally associated with risky sexual behaviours, such as unprotected sex. Therefore, discouraging youths from such practices may help in the prevention of unsafe sex. Wagenaar *et al* (2018) also note that, generally more male youths tend to abuse alcohol than their female counterparts and therefore are the ones who usually force the latter to engage in unsafe sex.

2.11.5 Provision of sex education in schools

One of the strategies that can be implemented, to promote safe sex amongst the youths, is the provision of sex education in schools. Sexual health education is not only offered or learned as the only course or conversation. Rather, it is somewhat a synthesis of knowledge and life experiences to form identities, beliefs, attitudes and values on relationships and intimacy. Through sex education, youths are guided to make sound decisions with respect to their sexuality and engagement in sexual activities (Naezer, Rommes & Jansen (2017). For example, they may opt to abstain from sexual activities altogether or use birth control methods, such as contraceptives, like condoms in preventing unwanted pregnancies and sexually transmitted diseases. According to Gonçalves et al. (2018), school-based sex education programmes may also be an effective and cost-saving tool for reducing teen pregnancy and sexually transmitted infections (STI). Additionally, sex education equips youths with desirable qualities such as being faithful to one's sexual partner and building strong, intimate, and long-lasting relationships (Naezer et al., 2017).

Those in conflict with sex education in schools frequently advance the unconfirmed theory that sex education raises the likelihood that youths will indulge in sexual practice (National Youth Friendly Health Services Strategy, 2018). However, an evaluation has revealed that sex education which covers information involving contraception and abstinence does not heighten the frequency of young people engaging in sex or highly likely to participate in it at a later stage. Sex education programmes that are comprehensive naturally start in kindergarten, embrace material which is age appropriate and progress through grade 12 (Marielle & Le Mat, 2017).

2.11.6 Use of mobile technology

The most modern way to positively influence the sexual and reproductive health of adolescents and youths is the use of mobile phones to spread information related to health. This approach is referred to as *mHealth*. Access to technology has increased in developing countries and this has made normative the ownership of his communication device. The employ of *mHealth* ingenuities is an innovative method of communicating in a current, truthful and confidential manner sexual and reproductive health information to young people. Interventions that use modern digital media to enhance the sexual health

of people have a positive impact on the gaining of new knowledge (Shafii, et al., 2019). The use of text messaging in health promotion campaigns is perceived to bring about an improvement in sexual and reproductive health outcomes (Naezer *et al*., 2017).

2.11.7 Use of mass media entertainment

Most countries globally have managed to use mass media as a way to encourage youths to engage in safe sex activities (Orozco-Olvera, Shen & Cluver, 2019). Mass media entertainment is a form of entertainment education. It is a type of narrative form such as sitcoms and dramas as compared to informational programmes delivered through media such as television and public service announcements. In as much as the latter is seen as involving a purposeful use of mass media, in a traditional sense, to advance development goals, edutainment also embraces commercial productions which are however, devoid of social objectives. The Social Learning Theory is the main psychological theory underpinning educational narratives, and argues that the characters in the show tend to assume the part of role models. These may assist to improve the self-efficacy of audiences in the assumption of new attitudes and behaviours (Kaphagawan &, Kalipeni, 2017)

2.11.8 Computer-based interventions

The other method which can be adopted to improve the practice of safe sex by youth is the Computer-based Intervention (CBI). This strategy has several advantages over face-to-face Counselling-based Interventions. According to Shafii, Benson, Morrison, Hughes, Golden and Holmes (2019), the initial intervention that is prescribed is delivered with devotion. There are also static costs for software and hardware, while the computerised format might be easy to revise. It is evidenced that computer-based interventions for behaviour change might be effective compared to interventions which are delivered in a face-to-face manner. Interactive computer-based interventions (ICBI) need users to enter information that needs feedback on the computer. ICBIs are fast emerging as highly effective methods targeting issues bedevilling youths and adolescents such as violence,

smoking, sexual health and alcohol abuse. The sexual health ICBs are yet to be implemented broadly to ensure they are reliable despite their potential scalability (National Youth Friendly Health Services Strategy, 2018).

2.12 CONCLUSION

This chapter discussed the literature related to factors contributing to unsafe sex practices among youth. It interrogated the concept of literature review and then presented the theoretical framework underpinning the study. The reasons for risk sexual behaviours encompass lack of knowledge among youths on the dangers of unprotected sex, drug abuse, socio-economic challenges and stigmatisation of condom use, among many. Youths also engage in behaviours which promote unsafe sex practices, such as associating themselves with friends with the propensity for irresponsible health choices. In addition, youths participate in multiple sex relationships, early sex activities and drug use. The strategies to promote safe sex practices mainly relate to school-based and community-based interventions.

CHAPTER 3

3.1 Research design and methodology

The previous chapter focused on the literature review on factors contributing to unsafe sex practices. The current chapter discusses the research design and methodology of the study. The qualitative research approach, with its focus on the views of the participants and their lived experiences, was adopted, to understand the reasons for engaging in unsafe sexual practices. An exploratory research design, which is hinged on the understanding of a more interpretive base for behavioural reflections, is discussed in this chapter. The study setting, population, sampling and sample are also presented. The chapter further interrogates measures to ensure trustworthiness of the findings, data collection and analysis, ethical considerations and the plan for disseminating findings for the study.

3.2 Methodology

Methodology is described as a group of methods which are coherent and complement each other to provide research data and findings that reflect the research objectives, research questions and the overall purpose of the study (Fetters & Molina-Azorin, 2020). Trimmer (2020) describes the methodology as consisting of a framework of principles and theories upon which the procedures and methods of research are hinged. This section focuses on the methodology used in the study inclusive of the research paradigm, research approach, study design, study population and sampling, and sample.

Research paradigm

A paradigm is a set of assumptions about fundamental aspects of reality which give rise to a particular world view (Ling, 2017) Clark and Ivankova (2016) concur that paradigms are fundamental beliefs which affect the manner in which social research, is conducted inclusive of the choice of a particular research methodology. Guetterman, Fetters and Creswell (2015) further state that researchers are guided by the philosophical frameworks, which are called paradigms. These assumptions include ontology, epistemology and methodology. Ontology is the belief about the nature of reality. This is concerned with the way in which reality exists Plano Clark & Sanders, 2015). In this case,

reality or knowledge can occur outside or external of our existence. Furthermore, it can exist independent of our observation or interpretation. This usually involves knowledge that belongs to the sciences or quantitative data. Epistemology focuses of the source of knowledge, its nature, how it is acquired and communicated. In this case the researchers can use either quantitative or qualitative methods to obtain and generate understanding. The researcher can gain knowledge from scientific observation or use psychological and cultural lenses to interpret information. Methodology relates to the methods which can be used by the researcher to collect data for understanding and interpretation (Chauvette, Schick-Makaroff & Malzahn, 2020). These include questionnaires, observation, interviews and survey. This study employed an interpretive paradigm, which utilises qualitative procedures, techniques and processes to collect and interpret research data.

The interpretive paradigm

The interpretivist paradigm advocates that reality is an outcome of multiple perspectives which emerge from the views of participants. This paradigm is also referred to as the anti-positivist paradigm Guetterman. Fetters & Creswell (2015). believe that interpretivism is a strategy that presents the social world as created and recreated by human beings on a daily basis. Antwi and Hamza (2015:218) identify features which contrast interpretive paradigm as including the fact that it is complex and multilayered. Reality is seen as actively created by people in the social world. It is also imperative for the social world to be understood in its natural setting using the eyes of participants (Plano Clark & Sanders, 2015). New meanings are created as researchers engage with the phenomenon of study and the process involves human bias and subjectivism. This implies that a single phenomenon is subject to varied interpretations. In this study, the interview technique (Annexure A) of generating data was used to solicit many realities from the youths on factors contributing to unsafe sex practice.

Qualitative approach

This study is underpinned by qualitative research approach. Qualitative research refers to a broad range of research designs and methods to a study phenomenon. This approach focuses on the qualitative aspects of meaning, experience and understanding of phenomenon. Qualitative research seeks to study human experience from participants' point of view, in the context in which the actions take place (Brink, 2018). Qualitative

research can be broadly defined as a kind of inquiry that is naturalistic and deals with non-numerical data. It seeks to understand and explore rather than to explain and manipulate variables. It is contextualized and interpretive, emphasizing the process or patterns of development rather than the product of the research (Chauvette, SchickMakaroff & Malzahn, 2020). In qualitative research, data are collected through qualitative data collection tools such as interviews, field notes, diaries and observations. In pure qualitative research, data are both collected and analysed qualitatively (Nassaji, 2020). The researcher used qualitative research approaches to explore the knowledge and views of participants about unsafe sex practice among youths. Qualitative research methods were used in this study to explore knowledge and perceptions regarding factors contributing to unsafe sex practice among youth at Wayeni Village.

3.3 Study design

Research design refers to a specific, purposeful and coherent strategic plan to execute a research project to render the research findings relevant and valid (Ling, 2017). Clark and Ivankova (2016) define research design as the strategies and plans which are developed to seek, discover and explore responses to research questions. The research design focuses on the manner in which the whole research is planned conducted and managed until the outcomes are reported (Plano Clark & Sanders, 2015). This study used a case study design to carry out an in-depth study of the views and perceptions of the youths on the factors contributing to unsafe sex practice. This design allowed the researcher to closely interact with participants to have a fuller and rich understanding of their cultural practices and beliefs on sexual behaviours.

Exploratory research is conducted to explore in-depth knowledge and understanding, of experiences and perceptions of a selected population, by asking questions, including probing, follow-up questions, to gain new insights or develop new ideas about a research topic (Plano Clark & Ivankova, 2016). An exploratory research design was used in this study to explore knowledge and perception of youth about factors contributing to unsafe sex practices among youth at Wayeni Village

Descriptive research is defined as the design that is concerned with gathering information for representative sample of the population which intend to describe the

phenomenon (Brink, et al, 2018). Descriptive studies aim at obtaining complete and accurate information about a phenomenon (Burns et al., 2015). The researcher described non-verbal communications observed during interview of the selected participants regarding factors contributing to unsafe sex practice.

3.4 Study settings

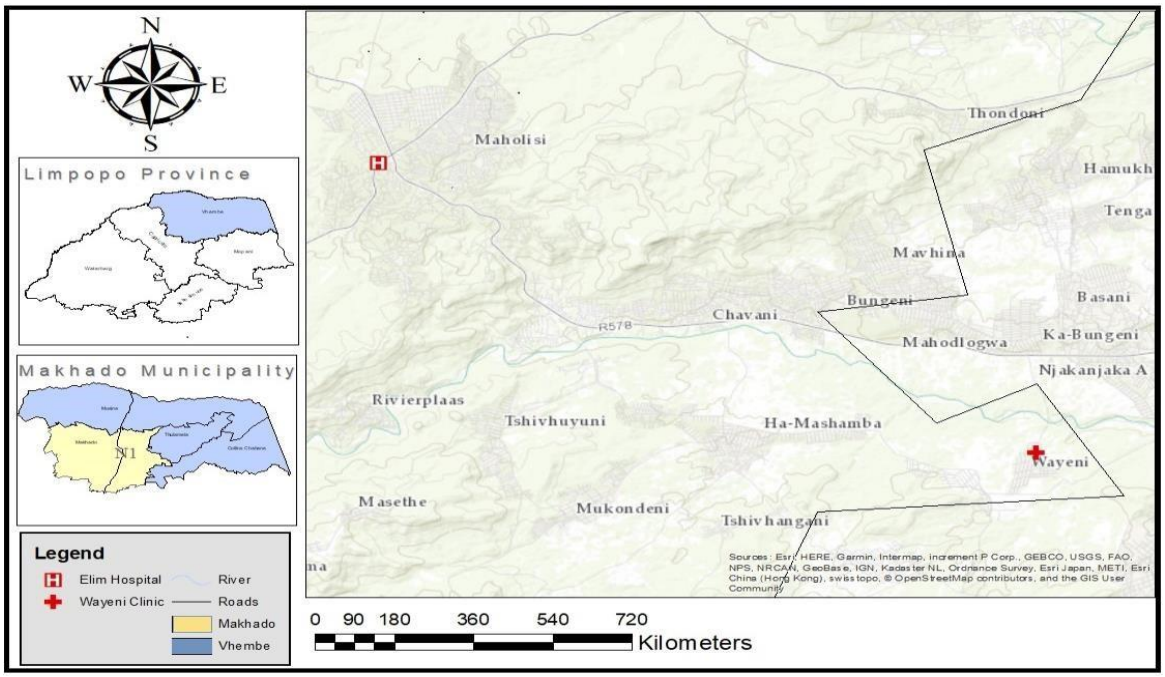

Figure 3.1: The location of Wayeni village

The study was conducted at Wayeni Village. Wayeni is one of the rural villages in the Republic of South Africa. It is situated on the far east of Makhado Municipality in Vhembe District, Limpopo Province. The Village marked at 49.3km from Makhado Town along the R578 road. A total population estimates are at 6000 in the Village, while youth aged 18-24 are estimated at about 425 of the entire population.

There is a single secondary school, one

primary school and one pre-school in the village. Many families at Wayeni depend on social grants and child support grants for living. However, the community still views education as important; hence, there is a low school dropout rate. There are two two

sports fields in the village and 1 soccer playground for recreation. During weekends, young people like visiting taverns to drink alcohol and enjoy ‘makhwaya, a Xitsonga for a traditional dance which involves stomping one’s feet. The literacy level in the context of study is low owing to the few learning institutions which also fall under quintile 1, which are rural schools that are poorly resourced. There is no vibrant youth club in the area, water supply irregular but the council is striving to ensure good hygiene in the environment through scheduled garbage collection and maintenance of sewage system.

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3.5 Study population and sampling

A population is the entire group of persons or objects that is of interest of the researcher or that meets the criteria which the researcher is interested to study (Lewis 2015). It is the collection of all individuals about whom the researcher wishes to make specific conclusions (Headley & Plano Clark, 2020. A population is also defined as the total target group that is the subject or object of research and about whom the researcher is trying to say something. The target population is the entire set of elements about which the researcher would like to make generalisations (Ling, 2017). It is however, not possible for the researcher access the entire population despite an awareness of its size. In this regard, the population which is accessible for research tends to differ in one or more aspects. This population is known as either accessible population or study population (Polit & Beck, 2017).

3.5.1 Target population

Target population of the study compromised of both male and female youths aged between 18-24 years residing in Wayeni village.

3.6 Sample and sampling

Sampling refers to the process of selecting the sample from the population to obtain information which is representative of the entire population of interest (Brink, 2010).

Sampling involves procedures which utilise techniques which researchers use to select participants from the larger population (Creswell & Poth, 2018). The choice of sampling procedures for a study depends on the selected research design, the extent of rigour desired for the study, the population characteristics and the accessibility of participants (Plano Clark & Ivankova (2016).

3.6.1 Sampling of the setting (village)

Wayeni Clinic constituted the setting of the study. The researcher identified the problem from reading the clinic's annual data during regular visits to the clinic as part of business routine. The sampling of the setting effectively emerged from the researcher's observation of the existence of challenges of unsafe sex practice among youth during the compilation of annual statistics in the District Health Information System. Unsafe sex in this age group is marked by the high rate of teenage pregnancy among the 18-24 age group as well as a high HIV infection rate in both sexes in the same age group (DHIS, 2015, 2016).

3.6.2 Sampling of participants

Non-probability sampling requires the researcher to assess and select participants who know the most about the phenomenon, and who can articulate and explain nuances (Brink, et al, 2018). Non-probability purposive sampling was used in the study. Purposive sampling is based entirely on the judgement of the researcher. Etikan and Bala (2017) contend that purposive sampling deliberately rests on a defined subset of a population and is hinged on the prior knowledge of the researcher about the population. Alvi (2016:28) mentions that the criterion for the components to be included in the study is defined in advance. This means that the items to be considered for the sample are selected deliberately by the researcher and the decision regarding the items stand supreme. The bottom line is that investigators cannot include every individual in the sample, but people who meet the pre-defined criteria. The sample consisted of an element that contained the most suitable characteristics: representative or typical attributes of the population (Brinks, et al, 2018). Purposive sampling was used to select participants. The researcher constituted the sample with the youths at Wayeni Village,

through the assistance of Community Health Care workers (Ward Based Primary Health Outreach Teams), to make appointments with participants for data collection.

3.6.3 Sample of study

Creswell and Poth, 2018) describe a sample as a sub-set of the elements which are drawn from the whole population. The sample is the actual group of people which is considered in the study and from whom the research data is collected (Headley & Plano Clark, 2020). The sample consists of individuals that are selected from the population (Ling, 2017). A sample might be chosen because it is representative of the essential characteristics of the population or aspects which are crucial in the study. The sample size comprised 20 participants; however, data were determined by data saturation

3.6.4 Inclusion criteria: All youths at Wayeni Village aged between 18 and 24 years.

3.6.5 Exclusion criteria: Youth who were pregnant were excluded in the study due to their mood swings caused by hormonal changes in pregnancy.

3.6.6 Measuring Instrument

A research instrument is the tool used to collect measure and analyse data from participants of the study related to the research topic. The interview guide was developed by the researcher to achieve the objectives of the study. Fetters and Molina-Azorin, 2020) state that interviewing concerns the presentation of information to the researcher through structured or unstructured verbal communication existing between the investigator and the participants. Headley and Plano Clark (2020) describe an interview as an approach which is commonly used to collect information from the participants. Similarly, Creswell and Poth (2018) presents an interview as referring to a method of collecting data through the presenting an oral-verbal stimuli and answers in the form of oral-verbal responses.

The central purpose of the interaction between the researcher and the participants during the interview is to gather data in a way that is contextualised, emic, holistic, immersed and interpretive. The collected data is then reduced and organised to produce outcomes which need interpretation by the researcher (Fetters & MolinaAzorin, 2020). The semi-structured interview guide (Annexure A was used because of the measure of flexibility

that it offers and helps to improve the interpersonal dynamics between the researcher and participants. This process also established rapport and trust, which yielded insights through rephrasing questions and the mother tongue for clarifications (Poth, 2018).

The interview guide was pilot-tested. A pilot study is viewed as a "small scale operationalisation of a planned investigation to bring the weaknesses of the process into light. Essentially, the goal of a pilot study is to detect any unusual deficiencies (Creswell & Poth, 2018). In this study, the pilot testing of the instrument was undertaken to develop its capacity to attain valid data, ensure ethical issues are not disregarded and to re-formulate ambiguous items

In the conduct of this pilot study, the researcher randomly selected five youths that visited the clinic in the neighbouring village as these individuals were unlikely to participate in the actual study. These individuals were asked to comment on the clearness of items and organisation of the instrument. They were also requested to make their own suggestions to infuse in the final draft. The necessary amendments were made but nothing was eliminated from the initial instrument.

3.7 Trustworthiness

Trustworthiness is a method of establishing rigor in qualitative research without sacrificing relevance. Rigor assists research in preventing error (Chauvette, SchickMakaroff & Malzahn, 2020). In this study, trustworthiness was ensured by credibility, dependability, conformability and transferability.

3.7.1 Credibility

According to Nassaji (2020), the credibility of the study involves carrying out the investigation in such a way that the believability of the findings is enhanced and credibility is demonstrated. The following techniques were established in this research to ensure credibility;

- **Prolonged engagement:** It refers to enough time in which the researcher spends with the participants to gain in-depth understanding of the phenomenon as well as specific aspects of the participants, such as perceptions culture and experiences. The researcher spent sufficient time with the participants, meeting with them a day

before a scheduled interview, to learn about their culture. This built a trusting relationship and establish rapport between the researcher and participants

- **Persistent observation:** It involves the identification of those characteristics and elements demonstrated by participants during study which is influential to the research phenomenon (Merriam & Tisdell, 2016). The researcher observed nonverbal communication during interview to understand their meaning to obtain clear interpretation
- **Triangulation:** Involves using multiple methods, sources and observers to gain more understanding of the research phenomenon being studied (Creswell & Poth, 2018). To ensure triangulation, the researcher invited two researchers, to act as peer reviewers during the interview and data analysis.
- **Peer debriefing: R**efers to seeking the opinions of peers outside the study who have similar status or colleagues who are experts in their method (Brink, et al, 2018). In this study, the researcher presented the data collected from experienced researchers to ensure honesty.
- **Member checks:** this is a technique to ensure credibility in which data, findings, interpretations are taken back to the participants for interpretation and confirmation (Merriam & Tisdell, 2016). The researcher discussed the findings to allow participants to correct errors, clarify and provide additional information.

3.7.2 Confirmability

This is a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Chauvette, SchickMakaroff & Malzahn, 2020)

Confirmability refers to the potential for congruency of data in terms of accuracy , relevance or meaning. It is concerned with establishing whether data represent the information provided by the participants and that the interpretations are not fuelled by the researcher's imagination. The data will reflect a participant's views, not the researcher's perceptions or views (Brink et al, 2018). In this study, the researcher used audit trails in which the data collection methods, as well as decisions about data to be collected, would be carefully documented so that an expert researcher would arrive at the same results with the researcher. An independent coder was hired to do data analysis to ensure that it yields same results.

3.7.3 Dependability

Dependability of qualitative data refers to the stability of data over time and conditions (Nassaji, 2020). To achieve dependability, the researcher submitted the collected data to two different researchers to examine it officially and comparing results for similarities. In this study, the researcher presented the collected data to the participants, peer researchers, supervisor and co-supervisors for auditing to confirm if correct.

3.7.4 Transferability

Transferability refers to the generalizability of the data (Headley & Plano Clark, 2020). It also refers to how transferable or applicable are the findings to another setting or group of people (Nassaji, 2020). Brinks, et al, (2018) showed that transferability refers to the ability to apply the findings in other contexts, or to other participants. In order to achieve transferability, the researcher provided a thick description of the nature of the study participants, their reported experiences and researcher observation during the study. It entails the collection and provision of sufficiently detailed description of data within a given context, and their reportage Brink, et al, 2018). The researcher enhanced this by selecting participants with rich information and collected data until saturation occurred, providing in-depth accounts of phenomena under study; hence description of research data.

3.8 Data collection methods

In a qualitative study, data collection methods are exploratory, descriptive in nature, aiming in gaining insights and understanding on underlying reasons and motivation. Data collection methods used was face to face interview which were guided by an interview guide. Face to face interviews were conducted, based on a personally developed interview guide (Refer to Annexure B) to gather information from participants (Brink, et al, 2018). Data collection is the process of selecting participants and gathering information from them (Burns et al., 2015). The researcher was the only one who collected data. Interview questions were in English and the home language of participants, to enhance understanding. The questions were planned and arranged systematically in a sequence, to ensure that all information which is necessary was collected. The researcher used a voice recorder to record data, as it gives full and accurate records than notes (Brink, et

al, 2018). Probing follow-up questions was utilised to increase detailed explanations. The interview period lasted 20 to 30 minutes per participant.

Field notes were gathered on a diary by the researcher when observing the participant's non-verbal communications, such as facial expressions, signs of restlessness and so on. This was important in data analysis and interpretation to understand the meaning of behaviour.

3.9 Data analysis

Data analysis refers to a systematic way of organising and synthesising research data (Merriam & Tisdell, 2016). In qualitative research, data is non- numerical and was presented in the form of writing and audiotapes, hence the analysis of data involved an examination of texts, rather than numbers. The researcher pondered and reflected on possible meaning and relationships of data which is called 'hands-on' process, when the researcher becomes immersed in the data (Brink et al, 2018).

3.9.1 Data analysis process

Data were analysed using thematic analysis method (Braun & Clarke, 2013). Thematic analysis is the process of identifying patterns or themes within qualitative data (Plano Clark & Sanders, 2015). This is a detailed and thorough process in which the researcher is able to identify a number of cross references between the available data and the developed themes. Thematic analysis measures the frequency of various themes and categories from the generated content, and these themes form the basis of the research report (Judger, 2016). The six steps which were engaged in the process are as follows:

Step 1: Familiarisation with data

This step involves the transcription of raw data which is obtained from participants. The researcher was involved in reading and re-reading of transcripts which were made from the information recorded in audio tapes. Some of the collected data was recorded in Xitsonga and had been translated into English for the understanding of the wider audience. In this study, the researcher transcribed the recorded verbatim statements from

the youths who participated in the study within the month of data generation to ensure original ideas are reflected in the narratives.

Step 2: Generating initial codes

The researcher identified preliminary codes which are interesting features of data in a systematic fashion across the data-set. The collected data was organised through the use of codes as a strategy to segment it. Interesting data that tackled similar issues was coded. Provisional codes were assigned, some of which were modified as the analysis progressed. The codes were also employed to categorise data as the meanings and patterns gave guidance. Information that was relevant specific codes was then collated. In this study, the researcher used numbers to identify interviewees in the study. The codes were developed as guided by the research questions, literature review and information from participants.

Step 3: Searching for themes

The researcher developed patterns to find significant data. Themes refer to concepts which emerge from the collected data (Fetters & Molina-Azorin, 2020). This step entailss defining and ascribing names to themes which result from data. The themes were developed from collapsing codes to form working themes and collating information per existent themes. The themes continued to be refined as informed by the contained details. In this study, three major themes and their associated sub-themes were developed.

Step 4: Reviewing the themes

In this step, the researcher reviewed the themes to ensure that they made sense and reflected the content thereof. The researcher continuously compared the data collected from one participant with that obtained from others to shape the final theme. All data were gathered and checked to ensure their relevance to each theme.

Step 5: Defining and naming themes

The researcher provided definite theme names which captured the essence of information contained in each theme. The researcher ensured that the names attached to each theme were not overlapping.

Step 6: Producing a report

This is the final stage in the analysis process. It involves the synthesis of data as well as the reporting of the findings. This step attracts the creativity of the researcher in critically analysing information. The quality of the collected data determines the quality of results Fetters & Molina-Azorin, 2020). In this study, the verbatim excerpts that were transcribed from the collected data were used in reporting the results. These verbal statements were meticulously produced through the process of reading, re-reading and member checking. The researcher employed such statements to complement narrative discussions.

3.10 Ethical considerations

Ethics is a discipline dealing with the principle of moral values and moral conduct (Anne-Marie et al, 2018). The researcher applied some ethical principles and ethical codes when conducting the research. These ensured a reduction of harm to participants.

3.10.1 Permission to Conduct Research

The research proposal was presented to the supervisor. It was also presented to the Department of Public Health and the School of Health Sciences Higher Degree Committee. The research was further submitted to the University Higher Degree Committee for approval, then to the Research Ethics Committee of the University of Venda for ethical clearance (Refer to Annexure E).

Ethical clearance was obtained from the University of Venda Research Ethics Committee and permission for field entry was attained from Limpopo Department of Health, Supervisor of Wayeni Village (Refer to Annexure D). The study participants were made to complete consent forms as evidence of voluntary acceptance to participate in the study (Burns et al., 2015). The permission to conduct research study was done for quality control purpose.

3.10.2 Informed consent

Participants were informed that participation is voluntary, and that detailed information on what the study is all about, were clearly indicated and explained. These included explanations regarding the benefit that the participants would get in the study and what is the positive change that the study would make to the community (Chauvette,

SchickMakaroff & Malzahn, 2020. Participants were also informed about how data would be disseminated. Participation by researchers was voluntarily and participants were free to withdraw from the study during the process if they felt uncomfortable or unsecure without any charges made against them (Merriam & Tisdell, 2016). The researcher explained to the participants that there was no form of rewards including money that they would receive for participating in the study.

The objectives of the study were explained to the participants (Refer to Annexure D). A consent form was offered to participants to sign as a form of agreement for one to participate in the study (Refer to Annexure F).

3.10.3 Confidentiality and anonymity

Anonymity is ensured when the participants' specific responses and information including their identity cannot be linked in any way to participants (Burns et al., 2015) Participants were assured that their identity would not be revealed when the study is published. The codes were given to participants instead of names and were kept safely in a locked place to maintain privacy and anonymity.

Confidentiality means that the information obtained during the study will not made available to any other people (Fetters & Molina-Azorin, 2020). This right is waved in the time when consent form is signed by participant and the anonymity of participant is also protected. The researcher ensured that no harm to the clients was made and findings would be kept safe. The participants' responses were never shared with anyone outside the context of benefits.

3.11 Plan for dissemination of results

A hard copy of research findings would be filed at the University of Venda Library. Publication of findings would depend on the decision made from UHDC & the Department of Health and respondents' privacy would be protected. The hard copy would also be submitted to the Department of Health.

3.12 Conclusion

This chapter discussed the research design and methodology used in this study. The qualitative research approach, with its focus on the views of the researched and their lived experiences was adopted to understand the reasons for unsafe sexual practices among the youths. The study setting, population and sampling and sample were also presented. The chapter further interrogated measures to ensure trustworthiness of the findings, data collection and analysis, ethical considerations and the plan for disseminating findings for the study.

CHAPTER 4

4. FINDINGS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

The previous chapter discussed the research methodology; this chapter focuses on the presentation and interpretation of the findings of the study. It investigates the reasons that lead youth to engage in unsafe sex, inclusive of lack of information; personal reasons, such as proof of affection, need to enjoy unprotected sex and to raise money for sustenance. Youth also participate in unsafe sex owing to pressure from external forces which involve pressure from partners, peers, drug abuse and the social media. Unsafe sex practice was shown to transpire through the existence of unfriendly environment for condom use, imbalanced sexual relationships, laxity in condom use as well as substance abuse. Strategies to improve the practice of safe sex include school-based and community-based methods, and these are clarified in the chapter.

4.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

The study comprised of 20 participants who participated in the interviews. This number was determined by data saturation. Of these, 10 were females and another 10 were males. Five youths were between 18 and 19 years. Eight were between 20 and 21 years while 4 ranged between 22 and 23 years. Only 3 participants were aged 24. All the participants fell within the age group as per criteria set for eligible youth who could participate in the study. Table 4.1 shows the demographic distribution of participants.
Table 4.1

Name	Age	Sex
Participant 1	18	Male
Participant 2	20	Male
Participant 3	19	Female
Participant 4	21	Female
Participant 5	20	Female

Participant 6	22	Female
Participant 7	18	Female
Participant 8	22	Male
Participant 9	23	Female
Participant 10	24	Male
Participant 11	20	Male
Participant 12	24	Male
Participant 13	21	Female
Participant 14	23	Male
Participant 15	24	Male
Participant 16	22	Female
Participant 17	19	Male
Participant 18	21	Female
Participant 19	20	Female
Participant 20	20	Female

4.3 ANALYSIS OF CONTEXTUAL ISSUES ON UNSAFE SEX PRACTICE

This section discusses the findings of the study based on the information obtained from the youth aged between 18 and 24. This is hinged on the three major themes which emerged from the collected data. These are the following; the reasons for practicing unsafe sex, ways in which youth practices unsafe sex and strategies used by youth to improve safe sex practices. The participants were numbered per sequence of the interview process, from participant 1 to 20. Table 4.2 shows the themes and subthemes that emerged from data.

Table 4.2 Themes and sub-themes

Themes	Sub-themes
Reasons for practicing unsafe sex	Lack of information on dangers of unsafe sex Personal reasons related too unsafe sex practice Pressure from external forces
Ways in which youth practice unsafe sex	Unfriendly environment for condom use Involvement in gender imbalanced relationships Multiple sex partners Laxity in the practice of safe sex Substance use/abuse during sexual practices
Strategies that can be implemented by schools	School- based strategies; implanting sex education in the school curriculum, creating place for health workers in schools, regular invitation of health personnel to schools and empowering teachers on health educational skills. Community-based strategies; holding of awareness programs by community
	health workers and implementing household health campaigns

4.3.1 Reasons for practising unsafe sex

The related sub-themes are; lack of information, personal reasons and pressure from external forces.

4.3.1.1 Lack of information on dangers of unsafe sex

The study revealed that most youths lack information regarding the dangers of practising unsafe sex. This means that there are inadequate lessons offered in homes, schools and the larger community on sexual and reproductive health education. This was confirmed by participant 1(female age 18) who said "…*some of us are not taught that unprotected sex can transmits viruses like HIV, STI'S''...* It was established that some parents and caregivers are shy to discuss issues of sex with their children and they tend to trust that schools are satisfactorily assume this role. On the other hand, some schools do not prioritise lessons on sex and sexuality with the belief that as children grow, they naturally learn what they should and should not do in their sexual relationships. This scenario makes youths lack adequate information pertaining to critical issues on sex, unwanted pregnancy, HIV/AIDS and other related Sexually Transmitted Infections including the proper use of condom. Participant 2 said:

> *"…We feel like we have grown up enough and end up having sex without protection due to lack of knowledge about sex. We do not go to clinic for information"*

This is supported by literature, which shows that sex education programs encourage youths to postpone sex until they are older, promote safe sex practices and increasing use of contraceptives among sexually active youth (Kirby, 2007). This implies that knowledge empowers youths to practice a responsible sex practice which prevents contracting diseases and unwanted pregnancies.

The study further established that in some situations the information will be availed to the youths but they may resort to ignoring it for reasons best known to them. This means that, some homes and schools make deliberate efforts to ensure that the youths are aware of the dangers of engaging in unsafe sex but they may pretend to be taking note of the advice given but proceed to do the opposite of what is required of them. In this regard, participant 2 (male, 20 years) said that "… *unprotected sex ... (mmm) first thing is ignorant..."* In the same vein, participant 15 (female24 years) added that "*You know we are doing what our friends are doing*". Bernstein (2001) stated that the power of association cannot be underestimated when exploring the indicators of engagement in

unsafe sex by adolescents and youths. This means that the lure of friendly associations may cause youths to ignore teachings given to them on safe sex practice. The study conducted at University of Venda shows that learners use some HIV transmission and prevention measures. However, they do not use condoms during sex(Mbunda, Lebese, Maputle & Chauke, 2015).

4.3.1.2 Personal reasons related to unsafe sex practice

The study further showed that some youths engage in unsafe sex for personal reasons. One of these is that they believe doing unprotected sex with their partners is a way of showing their pure love and being faithful. This is confirmed by what participant 14 (male, 23 years) , who stated that "*It is because we want our boyfriends to love us more and trust us, most of the times the boys refuse to have protected sex*" In other words, they feel that using some protective measures like condoms creates some distance and compromises the love shared between them and their loved ones. In relation to this, some participants asserted that besides being a sign of unconditional love, engaging in unprotected sex makes youths believe that they trust and hence can do anything with each other. Furthermore, some participants perceived that another reason for engaging in unsafe sex is fear of being dumped by their partners. Participant 15 (female 24 years) concurred that "you know we *have unprotected sex because we don't want to be dumped by our boyfriends*". In this case, we receive some threats that will leave some girls or boys who are more ready to engage in unprotected sex than them. As a result, they may then succumb to such demands. In view of this, participant 3 (female 19 years) said:

> *"When you tell him to use protection (condom) (mmm) he feels that you do not love him or you do not trust him or you are not sure about him".*

The literature confirms that sex education equips youths with desirable qualities such as being faithful to one's sexual partner and building strong, intimate, and long-lasting relationships (Turnbull, 2010). It was further revealed that some youths engage in unprotected sex because they feel it is more enjoyable than protected sex. In other words, they have an attitude that the use of condoms or other protective measures limit the extent to which they would enjoy and get satisfaction from sexual intercourse.

Participant 9 reiterated that youth practice unsafe sex because "…*I want to feel the pleasure of unprotected sex*". Furthermore, it was ascertained that some youths perceive engagement in unprotected sex as a way of proving their maturity and ability to make their own decisions that are independent of the views and opinions of others. In relation to this, participant 7(female 18 years) said: *"Most youths engage in sexual activities at the age of 13. At this age they feel like they are mature, especially those in grade 7".*

In addition, the findings revealed that some girls engage in unprotected sex because they want to raise money for their needs. In this case, some would want to live lives that are beyond their means, or what their parents could afford for them. As a result, they get involved with maybe older people or adults who are prepared to sponsor them financially in exchange of unprotected sex. This is confirmed by participant 6 (female 22 years), who said:

> *"ok…We often have relationship with people older than us, (mmm smiling) even when I tell myself that I will use protection during sex, older people promise us money so we end up having sex without condoms, oh!! difficult to control as we need money".*

In some cases, the girls might be forced to engage in such relationships because of their poor backgrounds. Participant 13(female 21 years) said "*eish …coming from a poor background then resorting to sex as a way of making money*". Nonetheless, the consequences remain unfavourable. In this regard, participant 8(female 22 years) said most of the *girls are desperate and like fashion stuff, so we never think of using condoms when we have sex, if we get the money, it is enough for us".* The literature concurs that financial support from older men, because of the poor girls' socio-economic conditions, can be a key factor in the development of trans-generation sexual relationships (Davidoff-Gore, Luke, & Wawres, 2014). The implication is that social lack and poverty tend to drive youths, especially female youths to engage in unprotected sex so that they get money for their own needs.

4.3.1.3 Pressure from external forces

The study also found that some youth engage in unsafe sex due to pressure from external forces. One of these could be from their partners or peers. Usually, girls are victims in

such circumstances. The male being physically stronger than the female may force the females to engage in sex without protection. In other situations, males may not use their masculine power, but instead some girls do engage in unprotected sex as a way of proving their love and commitment to the relationship. In this regard, participant 9 (female 23 years) said: *"some of us were forced to have unprotected sex by our boyfriends or something".*

It was also revealed that some youths engage in unprotected sex due to peer pressure. In such cases, their friends may influence them to have unprotected sex citing reasons of enjoyment or having children while there are still young. In some situations, this pressure might not even come from friends but relatives and parents who believe in giving birth at an early age. In this regard, participant 2(female 20 years) said "*…Yes, (mmm) peer pressure is the major cause of unsafe sex practices".* This is supported by the study done at university of Venda, which revealed that when students have friends or group mate that have children, it influences those without children to feel like they do not belong to the group, as the topic for those with children is mostly around children. As a result, those without children eventually engagein unprotected sex and get pregnant, in order to fit into the group of those who are mothers (Lebese et al, 2015). Similarly, imitating peers pushes also females youth to indulge in unsafe sexual practices either because they perceive themselves to be of their own age or able to reproduce like other girls. This is confirmed by participant 4(female 21 years) in the following excerpt:

> *"… Eh! I don't know if we discuss this issue (mmm), because it happens that we compete with our friends, saying that because my friend has a child, she cannot defeat me because she is younger than me (mmm)".*

Another external force that may lead to unprotected sex is drug abuse. The study affirmed that youths who abuse drugs, such as high alcohol intake, have a tendency of engaging in unprotected sex and more often than not, they will be unaware of the dangers that they will be exposing themselves to (Cooper, 2000). As a result, they contract sexually transmitted infections or get unplanned pregnancies.
In this regard participant 8 said:

"Youth like to go to tavern to drink alcohol (mmm) and when they are drunk, they do not use condoms. When a male knows that he is HIV positive, he intentionally has sex with youths to infect them".

The study also revealed that another reason why youths engage in unprotected sex is the influence of social media, like certain television programmes and films, influence the youths to have a desire to explore sexual activities. Other social media platforms that are influential include Facebook and You Tube. These social media outlets have some pornographic programmes that may attract but eventually mislead the youths. In view of this, participants 10 (male 24 years) said: "…*We watch movies like naked scenes with nude scenes, which makes us to practice unsafe sex. There is pornography in Facebook (and) soapies".* The literature concurs that social media through its various platforms exert a significant influence in shaping the risky sexual lives of the youths (Jones, Baldwin & Lewin, 2012). This shows the influence of social media in encouraging risky sexual behaviours.

4.3.2 Ways in which youth practice unsafe sex

This section discusses the ways in which youth practice unsafe sex at Wayeni village in Limpopo province. The findings are presented under the following themes: unfriendly environment for safe sex practice, involvement in imbalanced relationships, multiple sex partners, laxity in the practice of safe sex and substance abuse.

4.3.2.1 Unfriendly environment for condom use

The study revealed the existence of an unfriendly environment which encourages youth not to access sexual health services and consequently promote unsafe sex practices. The health workers working in the local health centres are known members of the community, and this makes it difficult for young people to visit such clinics for assistance regarding sexual and reproductive health matters. The youth tend to be reluctant to approach familiar faces at the clinics, on suspicion that their private sexual lives would be shared with other members of the community, particularly their parents or guardians. Participant 2 (female 20 years) said "*Wayeni is a small Village, obviously the possibility of getting people that you know is very high, (mmm) We are too shy to go to the clinic, as*

the nurses are from the same village and we feel that there is no privacy and confidentiality when we use the clinic. We are afraid that we will meet people that we know; we feel that there will be no privacy there". This scenario also prevents the youth from visiting clinics to access various forms of contraceptives as well as to collect condoms. This was echoed by participant 4 (female 20 years), who stated that "*We do not go to the clinic to collect contraceptives such as condoms or to use injections for birth control because we fear a breach of confidentiality".* Chabalala, Lebese and Tshivhase, in their study, revealed that lack of confidentiality and privacy make access to sexual health services is challenging, as they worry that their secrets will be revealed by the health workers(

This suggests that youth would rather rely on information from lay persons within the community or from peers on reproductive health, instead of obtaining it from health professionals. In this regard, the practice of unsafe sex practices may be exacerbated. Durojaiye (2011) observes that many adolescents are engaged in sexual activity and few use condoms, because of limited knowledge on safe sex, cultural norms and unfriendly environment for condom accessibility.

4.3.2.2 Involvement in gender imbalanced relationships

It emerged that some girls date men or youth that are older than themselves. This exposed them to the effects of power differentiation, wherein their ability to have control over their sexual choices is limited. Gender imbalance or inequality normally erodes the power of the girls to determine the courses of actions in relationships. This emanates from societal role definitions or stereotypes, where boys are taught to exude authority in life, while girls are exposed to submissive cultural practices and expectations. In reference to this statement, a female youth aged 19 years, participant 17 indicated that "*most of us are forced by our boyfriends to have unprotected sex".* Participant 6 (female 22 years) added that "*most of the time we tell ourselves that the man will ejaculate outside the vagina or withdraw penis and emphasis is on pregnancy and the risk of infection is ignored..eish you know these things".* These responses expose the passive role of female youth in a relationship, as they usually succumb to unsafe sexual decisions. Literature confirms that female adolescents are inexperienced, and due to gender inequalities in the

African culture, they do not have the necessary skills to negotiate for safer sex (Essex, 2002). This implies the socially established gender roles render female youths susceptible to unsafe sex practices as they are less empowered to negotiate for safe sex with their male partners.

4.3.2.3 Multiple sex partners

Multiple sexual practices, mostly with many partners contributes to unsafe sexual practices among youth. This may come through succumbing to peer pressure and gender imbalance. This is where individuals are forced to engage in sexual activities because of lthe influence of voices of encouragement from peers. This was confirmed by participant 2 (male 20 years) , who said that "*Ok, I could say that most of the time we end up having having unprotected sex due to peer pressure, because …of some friends who are doing it. " We are encouraged to do that, and one would like to belong you know"*.

The literature confirms that peer pressure and coercion limit the ability of youth to abstain from sex, leading to promiscuity, infidelity, and even prostitution (Varga, 2000).

The practice of unsafe sex can also occur because of irresponsible behaviour of the youth who indulge in sexual orgies. This participation in sexual party's open room for non-use of condoms during sexual practices and is usually laced with the intake of intoxicating substances. There is also a high incidence of individuals exchanging partners in the process. This further increases the risk of contracting sexually transmitted infections, such as HIV. Participant 9 (female 23 years) indicated that the male youth rob their partners through indulging in sex "they normally *call it a one night stand and by having sex with those girls is for fun without being in love with them".* This is said to be their intention "…*just to push time*" (P9). Involvement in such practices exposes the youth to sexual intercourse with multiple persons, which is not safe for all the parties involved. The literature reports high levels of risky sexual activities among unmarried adolescents of both sexes, including unprotected sexual intercourse with multiple partners (Ola, 2001; Kane & Wellings, 1999; Olusheyi, 2010). This implies that participation in multiple sexual relationships increases the risk of exposure to unprotected sex and associated health risks among the youths.

4.3.2.4 Laxity in the practice of safe sex

The study also revealed that the youth is not committed to the practice of safe sexual practices. In some instances, there is a deliberate intention to be oblivious of the dangers of unsafe sex. This was suggested by participant 4 (female 24 years), who stated the following:

> "*Ya' we do know that at clinics we can get things to help us preventa unsafe sexual practices. Condoms are always available…, meaning that some of us engage in these unsafe sexual practices intentionally".*

The idea is that the youth is aware of the existence of places where they can access tools that can help them practice safe sex, but they choose to ignore them. This was further supported by participant 6 (female 23 years), who noted the following: "ma'am, it's difficult most of the time we *agree to use the withdrawal method, but when the sperms come, the guy fails to withdraw and we just accept the situation".* Instead of the youth upholding the proper use of contraceptive materials, they prefer to use outdated and ineffective sexual practices. In this regard, the literature states that although there is free distribution of condoms in South Africa most youth do not use them during sex;, and when they do, it is not consistent (National Heath Survey Stats, 2016).

Participants also reported that unsafe sex is sometimes caused by negative perceptions towards condom use. The use of condoms is said to be stigmatised. Condoms are believed to obstruct the natural pleasure which is supposed to be experienced during sexual intercourse without use of condoms. This was revealed by participant 3 (male 19 years), who said that "you know *others say that condom use interferes with the pleasures that one gets from the activity and they disturb them".* The feeling of being disturbed by condoms in sexual practice leads to their avoidance, and is a strong contributor to the practice of unsafe sex. Participant 10 (male 24 years) also indicated that some youth indicated that they "*want it the way nature has given it to them, without condoms, believing*

that nature gives pleasure by not using condoms". The literature states that in South Africa, condom use continues to suffer from stigmatisation and peer pressure, leading to promiscuity and infidelity (Chabalala, Lebese and Tshivhase

4.3.2.5 Substance use/ abuse during sexual practice

The study found that the engagement in substances is a contributory factor to unsafe sexual practice. The use of drugs, such as alcohol, cannabis, dagger and other types of intoxicating substances, impairs good judgement and decision making regarding safe sex. This renders youth, particularly females vulnerable to unprotected sexual conduct, which may further lead to contracting infections and other life complications. Participant 8(male 22 years) echoed similar sentiments by stating that " another *problem is the use of drugs, most of the youth are addicted and their level of thinking is impaired, leading them to engage in risky behaviours… of not using condoms during sex and multiple sex in parties".* Research has showed that men who practice unprotected sexual intercourse also tend to engage in other risk behaviours, such as fighting, smoking cigarettes and using drugs (Mabunda, Lebese and Chauke). Irwin, Morgenstern, Parsons, Wainberg and Labouvie (2006) concluded that unprotected sex is more common during episodes of alcohol consumption, compared to when alcohol is not consumed. This confirms that the intake of drugs and alcohol is contributory to the practice of unsafe sex and related negative impacts.

4.3.3 Strategies that can be implemented by schools

School-based and community based strategies which are also used in the community to promote safe sex among youth.

4.3.3.1 School-based strategies

Implementation of school health programmes in school includes of giving information with regard to sex and sexuality to learners.

4.3.3.1.1 Implementing sex education in the school curriculum

The study revealed that schools should also implement strategies to promote safe sex amongst the youths. One of these is the introduction of sex education in schools as early as possible, to prevent early infections and unwanted pregnancies. In view of this, most participants suggested that teachers must act as parents in schools and teach their learners on issues of growing up, which encompass health education, sex and the need to act responsible as they mature to young adults. Participant 11(male 20 years) confirmed this, sating "*Even at school, teachers should teach us…talk about sexual life and advise us on how to prevent infections and teenage pregnancy*". In this regard, various methods can be employed, including taping on the personal experiences and confessions of other peers. Participant 15(male 24 years) said "*some of us who have already experienced the negative effects of unsafe sex should advise them about having safe sex*".

The literature contends that it is through sex education, that youths are guided to make sound decisions with respect to their sexuality and engagement in sexual activities (Getnet, 2005).

4.3.3.1.2 Creating place for health workers within schools

The study also discovered that another way of promoting safe sex amongst youths is ensuring the availability of health workers in school settings. These workers must be responsible for delivering lessons on sex and sexuality to the learners. Participant 3 (female 19 years) said "*I think if we have health workers who are placed schools to provide health services to school children without specifically going to the clinic.*" Most participants emphasised that the significance of health workers in schools was indisputable since these professionals have more knowledge and experience of working with victims of unprotected safe who later have to face challenges related to unsafe sexual practices. Through the lessons of such professionals, the youths may be made aware of the dangers of practising unsafe sex. Turnbull (2010) states that the youths may learn to abstain from sexual activities or use birth control methods, such as

contraceptives, like condoms, to avoid the dangers of unwanted pregnancies and sexually transmitted diseases.

4.3.3.1.3 Regular invitation of health personnel to schools

It was further revealed that, in cases where health workers cannot be based in schools, then the schools themselves must regularly invite these professionals to deliver lessons on sexuality and safe sex to learners. This emerged during an interview with participant 15 (male 24 years), who indicated that "*some nurses can agree to be invited to schools to teach us about safe sex*". In this case, health workers will be incorporated in the education system as resource persons. Other participants also felt that apart from using health personnel as resource persons, schools could invite people who have had unsafe sex before, and had to later face challenges that emanated from their actions, to give advice to the youths. In view of this, two participants said: "*I think that people who work at the clinic should be the ones to come and teach the learners because they are the ones who have a deeper understanding of this topic" (Participant 12 male 24 years).*

4.3.3.1.4 Empowering teachers on health education skills

On the other hand, some participants suggested that in cases where health personnel can hardly go to the schools, then the schools should send representatives to the health settings to seek information, guidance and advice on how they can promote safer sex amongst the youths. In this case, they may also ask for reading materials that will be related to dangers of unsafe sex then distribute them to the concerned youths. In relation to this, participants 12(male 24 years) said "*Although it (safe sex) is done during Life Orientation, it seems as though most teachers are not comfortable teaching such things''*. The implication is that teachers and health workers should collaborate in the quest to enforce safe sex practice among the youth. In this regard, participant 11 (male, 20 years) reported as follows:

> *"the clinic (staff) and the teachers have to sit down and talk to the learners especially those who have not yet started having sex and teach them how unprotected sex can affect their lives and on the effects of protected".*

Studies show that the youth benefit more from the integrated sexual health services available, where teachers and other health personnel work together and use the library, free internet services and sport activities in the teaching (Kumsa, 2015). Therefore, teachers need to work with health professional to adequately assist the youth regarding healthy sexual behaviours (Lebese, Mulaudzi, Maluleke, Chabalala and Mabunda). School-based sex education programmes may also be an effective and cost-saving tool for reducing teen pregnancy and sexually transmitted infections (STI). Additionally, sex education equips youths with desirable qualities such as being faithful to one's sexual partner and building strong, intimate, and long-lasting relationships (Naezer et al., 2017). This is supported by another study conducted at rural community of St. Thomas, Jamaica, which found that sex education programmes at school play a significant role in delaying sexual activities among adolescence and more work needs to be done to strengthen the overall impact (Simonds, 2019).

4.3.3.2 Community-based strategies

Community engagement also plays a vital role in enforcing the behavioural change of the youth in the community. It promotes safer sex through awareness campaigns on the dangers of unsafe sex.

4.3.3.2.1 Holding of awareness programmes by community health workers

Participants further suggested that community health workers should also play an active role in educating the youths on dangers of unsafe sex. This can be done through arranging and holding awareness campaigns on sex, sexuality and health education. In such campaigns and programs, the youth must be encouraged to take active, rather than passive, participation; so that they may fully internalize what they would have been taught. In relation to this, participant 15(male 24 years) said "*some of us who have already experienced the negative effects of unsafe sex should advise…*" Bandura (1997) argues that informed and highly motivated individuals need to also possess specific behavioural skills to translate information and protective motivation into actual preventive actions.

4.3.3.2.2 Implementing household health campaigns

It was also viewed as noble that community health workers should periodically visit homes where there are youths, then seek an opportunity to teach them as individuals on issues of growing up, what is expected of their behaviour and the advantages of safe sex. In some instances, these health workers may deliver their teachings in collaboration with the parents, or hence they may act as advisors to the parents on how to handle issues of sex education with the youths. Participant 3 believed that "*community health workers from ward-based outreach teams must go out to the community to teach the youth on health issues; not focus only on youth, but also include our parents, as we live with them".* Participant 17 echoed similar comments that "*a community meeting can be called to teach the youth not to have sex before they are ready (and) to use protection when having sex".* This implies that parents need to play a monitoring function, to prevent their children from engaging in unsafe sex. Animaw (2009:13) concurs that adequate parental monitoring is generally positively related to commended sexual engagement and practices. Furthermore, Kotchick, Shaffer, Forehand and Miller (2007:493) observe a close link between parental control with adolescents` intercourse initiation and contraceptive use.

4.4 CONCLUSION

The chapter presented and analysed the findings of the study on factors that influence engagement in unsafe sexual practices among youth in Wayeni village. The study established that there are different facors that promote youth practice unsafe sexual practices among youth, including lack of knowledge, show of love and need to enjoy sex among others. Some youth are pushed into unsafe sex practice through the pressure exerted by their partners as well as by peers. The unequal power dynamics from cultural and social role modelling tend to give male youth the authority to determine sexual practices while relegating female youth to submissive and passive roles. Drug abuse and the influence of the social media also emerged as some of the reasons pushing youth into unsafe sex practices.

There are discernible behaviours for youth which are caught up in the practice of unsafe sex and these are propelled by the unfriendly environment for the use of condoms. The involvement of youth in imbalanced relationships, and particularly with multiple concurrent

and secondary partners, fuel unprotected sex. The youth also lack commitment in the correct use of condoms, which leads to their laxity in safe sex practice. To ensure that youth use condoms, schools, families and the community should be active in imparting knowledge, skills and positive attitudes necessary, to acculturate the expected behaviour. Finally, schools should implement a sound health curriculum for youth, which may see teachers collaborating with health workers and the community to teach youth about safe sex.

Chapter 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter discussed findings of the results. This chapter provides the summary of the findings, conclusion and recommendations for improved practice. Suggestions for future research are also offered based on the potential breath and scope of the field. Conclusions will be drawn from the findings of the investigation and the literature review. These would enable recommendations to be made regarding factors contributing to unsafe sexual practice among the youths. The chapter concludes with a summary of the main issues discussed.

5.2 SUMMARY OF FINDINGS

The summary of the study is based on the themes of the study, as informed by the research questions and related objectives.

5.2.1 Reasons for the practice of unsafe sex

This section provides a summary of findings on the reasons for the youths to practice unsafe sex as follows:

5.2.1.1 Lack of information on dangers of unsafe sex

The study revealed that most youths lack information on the dangers of practicing unsafe sex. This means that there are inadequate lessons on sexuality in homes, schools and the community. It was also established that some parents and caregivers are not eager to discuss issues of sex with the youth, assuming that schools should play that role. Some schools also do not prioritise lessons about sex and sexuality, believing that children naturally acquire such knowledge in the course of their maturation in relationships. The

study further established that in some situations, such information is availed to the youths, but they choose to ignore it, for reasons best known to themselves.

5.2.1.2 Personal reasons

The study also revealed that some youths engage in unsafe sex for personal reasons. One of the reasons is the belief that engaging in unprotected sex with their partners is a way of showing their strong affection and is a sign of faithfulness. They feel that using some protective measures, like condoms creates some distance and compromises the love shared between them and their loved ones. Unprotected sex is also interpreted as a sign of trust, fear of being jilted by their partners, and as an ingredient for enjoyment and proof of maturity. In addition, the findings of the study revealed that some girls engage in unprotected sex because they want to raise money for their needs. The poor backgrounds of some youth influences them to engage in unsafe sex.

5.2.1.3 Pressure from external forces

The study revealed that some youths engage in unsafe sex due to external forces. Female youth tend to be victims in most circumstances. The male being physically stronger than the female may force his partner to engage in sex without protection. Males may not use their masculine power, but instead beg girls to engage in unprotected sex as a way of proving their love and commitment to them.

It was also revealed that some youths engage in unprotected sex due to peer pressure. In this case, their friends may influence them to have unprotected sex, citing reasons such as enjoyment or having children while there are still young. In some situations, this pressure might even come from relatives and parents. Similarly, the imitation of colleagues or peers pushes female youth to indulge in unsafe sexual practices either because they perceive themselves to be age-appropriate or be able to reproduce like other girls.

Another external force that may lead to engagement in unprotected sex is drug abuse. The study affirmed that youths who abuse substances, such as alcohol, have a tendency to engage in unprotected sex. Furthermore, such youths may be aware or unaware of the

dangers that they were exposing themselves and others to. Doing so may expose these youths to sexually transmitted infections or unplanned pregnancy. Social media, such as certain television programmes and films that somehow explicit sexual activities, influence the youths to want to explore sexual activities. Thus, social media can also trigger unsafe sexual behaviours. This is because social media platforms such as Facebook and YouTube allow youths access to pornographic programmes, which misguide the youths to engage in unprotected sex.

5.2.2 Ways in which the youth engage in unsafe sex practice

The following section presents a brief overview of ways in which the youths engage in unsafe practices:

5.2.2.1 Unfriendly environment for condom use

The study revealed the existence of an unfriendly environment which discourages youth to access requisite services for safe sex practices. Health workers manning the local health centres are known members of the community, making it difficult for youth to visit such clinics in search of protective sex services. The youth therefore tend to be afraid of approaching familiar faces whom they least trust with their private health information. They suspect that such health officials will discuss the youths' private sexual lives in the community. There is a noted reliance on information from lay persons rather than from professional health practitioners.

5.2.2.2 Involvement in gender imbalanced relationships

The findings showed that some girls date partners who are much older than themselves. This created power disparities, which impaired the ability of females to have control over their sexual choices or decisions. Cultural gender stereotypes, which compel females to assume submissive roles, were also identified. This inhibits their quest to practice safe sex.

5.2.2.3 Multiple sex partners

The youth also reported that they engage in multiple sex partnerships, which contributes to unsafe sex practices. This may involve enlisting in many concurrent relations or having sex with secondary partners. The youth also succumbed to peer pressure, wherein they were overwhelmed by the desire to fit into a certain group of individuals with defined characteristics. Some youth were irresponsible, such that they got involved in sexual orgies or parties. This further increased the chances of contracting sexual infections such as HIV.

5.2.2.4 Laxity in the practice of safe sex

Some youths are not committed to safe sexual practices. In some instances, there appears to be a deliberate move to ignore the dangers of unsafe sex. The idea is that most of the youth is aware of the existence of places where they can access tools for safe sexual practices but they choose to ignore them. It emerged that some did not use contraceptive materials properly or preferred to use ineffective sexual practices, such as penis withdrawal before ejaculation. Unsafe sex practices are sometimes caused by negative perceptions towards condom use. Condoms are regarded as a hindrance in the expected experience of natural sexual pleasure.

5.2.2.5 Substance abuse during sexual practice

The study revealed that the engagement of youth in substance use/abuse is also contributory to the practice of unsafe sex. The use of drugs such as alcohol, cannabis, and dagga impairs good judgement and decision-making regarding safe sex. This makes youths vulnerable to unprotected sexual conduct, and consequently exposed them to sexually transmitted infections and unplanned pregnancy.

5.2.3 Strategies to improve the practice of safe sex

This sub-division focuses on strategies which can be adopted to enhance safe sex practices among youths in Wayeni village.

5.2.3.1 School-based strategies

The study revealed that schools should introduce sex education in schools as early as possible, to prevent early infections and unwanted pregnancies. Furthermore, teachers need to act as parents in schools and teach learners on various health education issues. Various methods can be employed to ensure such knowledge is well understood. In addition, health workers need to be infused within the school settings, to deliver lessons on sex and sexuality to the learners. It was further revealed that, in cases where health workers cannot be based in schools, then the schools themselves must regularly invite these professionals to deliver lessons on sexuality and safe sex to learners. In this regard, health workers should be incorporated into the education system as resource persons. In cases where this is not possible, some participants suggested that the schools should send representatives to the health settings, to seek information, guidance and advice on how they can promote safe sex amongst the youths.

5.2.3.2 Community-based strategies

Participants also suggested that community health workers should play an active role in educating the youths on dangers of unsafe sex. This can be done through arranging and holding awareness campaigns on sex, sexuality and health education. The findings also showed that community health workers should periodically visit homes where there are youths and use this opportunity to teach them as individuals and in groups on health-related matters. In some instances, these health workers may deliver their teachings in collaboration with the parents.

5.3 CONCLUSIONS OF THE STUDY

This section presents the conclusions of the study regarding factors which contribute towards unsafe sex practices among the youths.

5.3.1 Reasons for the practice of unsafe sex

The study concluded that most youths lack information on the dangers of practising unsafe sex. This implies that there are inadequate lessons which are provided in the homes, school and the community on health education. Some parents and caregivers are not eager to discuss issues of sex with the youth with the hope that schools satisfactorily play that role. Some schools also do not prioritise lessons about sex and sexuality, while other youths may chose to ignore the lessons on safe sex that would have been taught.

The study further showed that some youths engage in unsafe sex for personal reasons: as a way of showing true love and affection, as a sign of trust, for fear of being jilted and as proof of maturity. Unprotected sex was also used by youths to raise money for personal needs, particularly youths from poor backgrounds.

It is further concluded that some youths engage in unsafe sex because their male partners force them to engage in sex without protection. Other youths engage in unprotected sex due to drug abuse and peer pressure from friends or even relatives and parents. There are social media platforms such as Facebook and YouTube, which allow access to pornographic programs that misguide the youths to engage in unprotected sex.

5.3.2 Ways in which the youth can practice safe sex

The study concluded that the existence of an unfriendly environment discourages youths from engaging in safe sex practices. The health workers manning the local health centres make it difficult for youth to visit clinics in search of protective sex services, as they are well known and familiar faces in the community. In this regard, they were not willing to trust them with their private health information. There is a noted reliance on information from lay persons, rather than from professional health practitioners.

The dating of much older partners by some female youths contributes to the practice of unprotected sex. This limits the power of females to negotiate for safer sex and increases exposure to STIs and unwanted pregnancies. The cultural gender stereotypes may also

significantly assist in disempowering female youths, as it encourages them to assume submissive roles regarding safer sexual decisions. Involvement in multiple sex relationships also contributes to unsafe sex practices. This may involve enlisting in many concurrent relations or having sex with secondary partners.

It can further be concluded that some youths are not committed to safe sexual practices. However, youths chose to ignore the information on safe sex practices, despite having been taught about the effective requisite skills. The negative perceptions towards condom use may also help to expose the youths to unprotected sex, as these are perceived to hinder natural sexual pleasure. In addition, engaging in substance abuse is contributory to the practice of unsafe sex among the youth. This makes youths vulnerable to unprotected sexual conduct.

5.3.3 Strategies to improve the practice of safe sex

The study concluded that not all schools introduce sex education as early as possible to prevent early infections and unwanted pregnancies. Furthermore, not all teachers assume parental roles in the teaching of health education to learners. In addition, most schools have not yet taken steps to infuse the function of health workers within their structures, to offer the needed lessons to learners. There is also a need for community health workers to play an active role in educating the youths on the dangers of unsafe sex.

5.4 RECOMMENDATIONS

The recommendations of the study are informed by the findings and conclusions of the study as follows:

- The homes, schools and the community health care workers should provide adequate information to the youths on the dangers of practising unsafe sex. This implies that parents and caregivers need to play active roles in imparting relevant sex education to their children instead of relegating that role to schools, which have academic functions to perform.

- There needs to be a shift in mind-set, where youths should not sacrifice safe sex practices on the altar of personal reasons, such as engaging in unsafe sex practices to show true love and trust, or for fear of being jilted by their partners.
- The government should introduce the youths to self-help projects and teach them to be self-reliant rather than expecting to raise money for personal needs from engaging in unsafe sex.
- The Department of Health and Social Service should empower youths to resist pressure from their peers and even parents regarding engaging in unsafe sex either to fit in a social group or to bear children at an early age.
- Parents should closely monitor their children to address early emergence of negative sexual risk behaviours such as drug abuse and the influence of some social media platforms which may expose youths to pornographic programmes.
- Government agencies and public health workers should create a conducive environment which encourages youths to visit health centres to access services and materials to facilitate the use of condoms.
- All schools should introduce sex education as early as possible in the lives of learners, to prevent early infections and unwanted pregnancies. This implies that teachers must assume active parental roles with regard to the teaching of health education
- There must be close collaboration among parents, schools and communities in ensuring that the youths, particularly females, are appraised on the dangers of unsafe sexual behaviours. Campaigns and outreach programmes have to be implemented by health professionals, learners and community members, to conscientise the public on risky sexual practices.

5.5 LIMITATIONS OF THE STUDY

There are several factors which served as limitations of the study. Firstly, the participants comprised only of youths aged of 18 to 24, and this made it impossible to triangulate the findings in terms of sources of information. In addition, the scope of the study was small, limited to practices and experiences at Wayeni village, and not the entire province. This prevents generalisation of the outcomes to a wider context. However, despite the noted

shortcomings, the researcher believes the scenario reflected in the findings is relatively relevant to most youths in Limpopo Province in general , and Vhembe District in particular.

5.6 SUGGESTIONS FOR FURTHER STUDY

The findings of this study provide fertile ground for further study on other relevant aspects in the field, such as the role of parent- youth communication, parental levels of education and social media in impacting the practice of risk sexual behaviours. Future research can also be conducted with other participants such as teachers, parents/guardians and public health officials.

5.7 SUMMARY OF THE CHAPTER

This chapter presented a summary of the findings of the study based on the factors which contribute to unsafe sex practice among youths. These focused on the reasons for youths to engage in unsafe sex, ways in which youths practice risky sexual behaviours as well as the strategies that can be adopted to mitigated unsafe sexual practices. Conclusions based on the summary of the findings were also made, and these guided the suggested recommendations for improved practice. The chapter also offered suggestions for future research in the field of study.

LIST OF REFERENCES

Alimoradi, Z., Kariman, N., Simbar., M. & Ahmadi, F. 2017. Contributing Factors to High Risk Sexual Behaviors among Iranian Adolescent Girls: A Systematic Review, international Journal of Community Based Nursing Midwifery, 5 (1), 2-12.

Animaw, A. 2019. Assessment of sexual risk behaviours of in-school youth: effect of living arrangement of students; West Gojam zone, Amhara regional state, Ethiopia

Alvi, M.H. 2016. A Manual for Selecting Sampling Techniques in Research**.** Karachi: Iqra University.

Anne-Marie, R., Brown, J.M., Smith, J.M., Cope, A.C and Jamiesd, S. 2018. Ethical Dilemmas and reflexivity in qualitative research. Perspectives Med Education, 7 (1), 6975

Avert. 2016. HIV AND AIDS IN Tanzania: Global information and advice on HIV & AIDS. Retrieved September 15, 2016, from http://www.avert.org/professionals/hivaround-world/sub-saharanafrica/tanzania#footnote16_i9h45mp

Bandura, A. 1997. Self-efficacy: The exercise of control, New York: W.H. Freeman

Bhana, D. 2017 Love grows with sex: teenagers negotiating sex and gender in the context of HIV and the implications for sex education, African Journal of AIDS Research, 16:1, 71-79, DOI: 10.2989/16085906.2016.1259172

Bilinga, M. J. 2016. Sexuality Education for Prevention of Pregnancy and HIV Infections: How do Tanzanian Primary Teachers Deliver it? International Journal of Sciences: Basic and Applied Research, 26(3), 66–87

Bidini, M.S.S, Fuziah, S, 2020. Associated factors among unmarried pregnant Adolescents in Malysia. vol 4(1). http://dx.doi.org/10.30690/ijssi.41.01

Braun, V. & Clarke, V. 2013. Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. The Psychologist, 26(2), 120-123.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2018. Fundamentals of Research Methodology for Health Professionals.4th edition. Juta and Company (PTY) Ltd. Cape Town, South Africa.

Burns, N., Grove, S. K., & Gray, J. 2015. Understanding nursing research: Building an evidence-based practice. St. Louis, MO: Elsevier

Campo, M. 2016. *Children and young people's exposure to pornography*. Retrieved May 15, 2019, from https://aifs.gov.au/cfca/2016/05/04/children-and-young-peoplesexposure-pornography

Chandra-Mouli V, Plesons M, Amin A. 2018. Addressing harmful and unequal gender norms in early adolescence. Nat Hum Behav 2018;2:239-240. doi:10.1038/s41562-0180318-3

Chauvette, A., Schick-Makaroff, K and Malzahn, A.E. 2020. Open Data in Qualitative Research, International Journal in Qualitative methods, 18 (1), 1-6

Chidambaram, P. 2018. Gender-based inequities in health in India. In: Ravindran T, Gaitonde R, eds. Health inequities in India. A synthesis of recent evidence. Springer

Chimbindi, N., Mthiyane, N., Birdthistle, I., Floyd, S., McGrath, N., Pillay, D. et al. 2018 Persistently high incidence of HIV and poor service uptake in adolescent girls and young women in rural KwaZulu-Natal, South Africa prior to DREAMS. PLoS ONE 13(10): e0203193. https:// doi.org/10.1371/journal.pone.0203193

Center for Disease and Control Prevention, 2010, Sexual Transmitted Disease Surveillance htttp://www.cdc.gov/std/stats 10/surv.pdf Accessed July 25, 2013.

Cooper, M. L. 2002. Alcohol use and risky sexual behaviour among college students and youth: evaluating the evidence. Journal of Studies on Alcohol 14:101–117

Creswell, J. W. & Poth, C. N. 2018. Qualitative inquiry and research design: Choosing among five approaches (4th ed.). Thousand Oaks, CA: Sage

Danie, M. E. 2013. The shape of knowledge in children and the visual culture of literacy and numeracy, science in context, 26 (2), 215-245.

Davidoff-Gore, A. Luke, N. & Wawres, S. 2014. Dimensions of poverty and inconsistent condom use among youth in urban Kenya. AIDS care 23(10)1282-1290 Department of Education draft on HIV and AIDS, 2010.

Del Fava, E., Piccarreta, R., Gregson, S., Melegaro, A. 2016. Transition to parenthood and HIV infection in rural Zimbabwe. PLoS One. 11(9):e0163730.

Dela, C.C and Gross, J.J. 2019. An Integrative Literature Review Framework for Postgraduate Nursing Research Reviews. European Journal of Research in Medical Sciences. Vol 5 (1): 7-15.

Eustace, R. W., Asiedu, G. B., & Mkanta, W. N. 2015. Sexuality education in Africa. In J. J. Ponzetti Jr. (Ed.), *Evidence-based approaches to sexuality education: A global perspective* (pp. 164–179). New York: Routledge.

Etikan, I. & Bala, K. 2017. Sampling and Sampling Methods. Biom Biostat International Journal, 5(6): 149-151.

Fehring, R. 2010. The association of religiosity, sexual education, and parental factors with risky sexual behaviours among adolescents and young adults. Journal of Religion and Health, 33:167-192

Fetters, M. D., Molina-Azorin, J. F. 2020. Utilizing a mixed methods approach for conducting interventional evaluations. Journal of Mixed Methods Research, 14(2), 131144.

Garland-Levett, S. 2016. Exploring discursive barriers to sexual health and social justice in the New Zealand sexuality education curriculum, Sex Education, 17:2, 121134, DOI: 10.1080/14681811.2016.1233396

Gonçalves, R.C., Faleiro, J.H. & Malafaia, G. 2018. Sexual education, family and school: challenges and impasses. Holos. [Internet]. 2013 [cited 2018 Sep 11]; 5: 251263. Available from: http://www2. ifrn.edu.br/ojs/index.php/HOLOS/article/view/784.

Guetterman, T. C., Fetters, M. D. & Creswell, J. W. 2015. Integrating Quantitative and Qualitative Results in Health Science Mixed methods Research Through Joint Displays. Annals of family medicine**,** 13(6): 554-561.

Hoque, M. E., 2011. Reported risky sexual practices among female undergraduates in Kwazulu- Natal South Africa, African journal primary health care fam med. (3)1

http://www.dx.doi.org/10.4102/phcfm.v3i1.281

Hammersley, M. 2015. On ethical principles for social research. International Journal of Social Research methodology, 18, 443-449

Hayward, G.M. 2019. Religiosity and Premarital Sexual Behaviour among Adolescents: An Analysis of Functional Form. Journal for the Scientific Study of Religion. 58 (2): 439458

Headley, M. G., Plano Clark, V. L. (2020). Multilevel mixed methods research designs: Advancing a refined definition. Journal of Mixed Methods Research, 14(2), 145-163

Jones, K., Baldwin, K. A. & Lewis, P. R. 2012. The Potential Influence of a Social Media Intervention on Risky Sexual Behavior and Chlamydia Incidence, Journal of Community Health Nursing, 29(2) 106-120.

Judger, N. 2016. The Thematic Analysis of Interview Data: An Approach Used to Examine the Influence of the Market on Curricular Provision in Mongolian Higher Education Institutions. West Yorkshire: University of Leeds.

Kanda, L., Mash, R. 2018. Reasons for inconsistent condom use by young adults in Mahalapye, Botswana. Afr J Prm Health Care Fam Med, 10(1), a1492. https://doi.org/10.4102/phcfm.v10i1.1492

Kaphagawani, N.C., Kalipeni, E. 2017. Sociocultural factors contributing to teenage pregnancy in Zomba District, Malawi. Glob Public Health. 12 (6):694– 710. https://doi.org/10.1080/17441692.2016.1229354

Kumsa, M. 2015. Factors affecting the sexual behaviour of youth and adolescents in Jimma Town, Ethiopia: European scientific journal, November, 11 (22) 1857-7881

Kotchic, A.B, Shaffer, A, Miller, S.K, 2007. Adolescent sexual risk behavior. Clinical psychology review 21 (4): 493-519 DOI:1016/S0272-7358(99)00070-7

Leising, D., Back M.D. (2017) Person Perception and Accuracy. In: Zeigler-Hill V., Shackelford T. (eds) Encyclopedia of Personality and Individual Differences. Springer, Cham. https://doi.org/10.1007/978-3-319-28099-8_707-1

Leung, L. 2015. Validity, reliability and generalisation in qualitative research, Journal of Medical Primary Care, 4 (3), 324-227

Lewis, S. 2015. Quantitative, Inquiry and Research Design: Choosing Among Five Approaches. *Health Promotion Practice*, 16 (4), 473-475

Ling, L. 2017. The Power of the Paradigm: methods and paradigms in Education Research. IGI Global: Australia.

Li, C., Cheng, Z. & Wu, T. *(2017).* The relationships of school-based sexuality education, sexual knowledge and sexual behaviors—a study of 18,000 Chinese college students. *Reprod Health* **14,** 103 (2017). https://doi.org/10.1186/s12978-017-0368-

Louro, G.L. 2018. Gender, sexuality and education: from political affinity to theoreticalmethodological tensions. [cited 2018 Sep 11]; 46: 201-218. Available from: http:// www.scielo.br/pdf/edur/n46/a08n46

Mabunda, T.J., Lebese R.T., Maputle, M.S, & Chauke, P.K, 2015. Perceived Risk Behaviours
Related to Teenage Pegnancy among Students at University Students in Limpopo Province, South Africa

Magodoro, I.M., Esterhuizen, T.M., Chivese, T. 2016. A cross-sectional, facility-based study of comorbid non-communicable diseases among adults living with HIV infection in Zimbabwe. BMC Res Notes. 2016; 9:379.

Maluleke, T. X. (2010) Sexual risk behaviour amongst young people in the Vhembe district of the Limpopo province. University of Walter Sisulu, South Africa.

Marielle, L. J. & Le Mat. 2017. (S)exclusion in the sexuality education classroom: young people on gender and power relations, Sex Education, 17:4, 413-424, DOI: 10.1080/14681811.2017.1301252

Markowitz, S., Kaenester, R. & Michael, G. 2015. An investigation of the effects of alcohol consumption and alcohol policies on youth risky sexual behaviour: American Economic Review (95)263-266).

Merriam, S. B., & Tisdell, E. J. 2016. Qualitative research: A guide to design and implementation. San Francisco, CA: Jossey-Bass

Ministry of Education (2015). Sexuality Education: A Guide for Principals, Boards of Trustees, and Teachers. Wellington: Ministry of Education.

Moraes, S.P. &Vitalle, M.S.S. 2018. Sexual and reproductive rights in adolescence. Rev Assoc Méd Bras. [Internet]. 2012 [cited 2018 Sep 11]; 58: 48-52. Available from: http://www.scielo.br/scielo.

Mutaswinga, A. M. 2012. Factors contributing to unsafe sex among teenagers in the secondary schools of Botswana.

Mudonhi, N., Nunu, W.N., Ndlovu, B., Khumalo, N & Dube, O. 2019. Adolescents and parents' perceptions of condom distribution in selected secondary schools in the highdensity suburbs of Bulawayo, Zimbabwe. Sexuality & Culture. 2019:1–19.

Naezer, M, Rommes, E. & Jansen, W. 2017. Empowerment through sex education? Rethinking paradoxical policies, Sex Education, 17:6, 712-728, DOI: 10.1080/14681811.2017.1362633

Nassaji, H. 2020. Good Qualitative Research. Language Teaching Research, 24 (4), 427-431

National Department of Health. 2012. National Mental Health Policy Framework and Strategic Plan 2013–2020. Pretoria: Government of South Africa.

National Heath Survey Stats, 2016. Pretoria: Government of South Africa.

National Youth Friendly Health Services Strategy. 2018. Malawi Ministry of Health. Lilongwe, Malawi. 2015–2020. Available at: https://www.healthpolicyproject.com/pubs/673_YFHSStrategyFINALWEB.pdf. Accessed 15 Nov 2018

National Youth Policy 2020-2030 Department of women, South Africa

Nunu, W.N., Makhado, L.,Mabunda, J.T. & Lebese, R.T. 2020. Strategies to facilitate safe sexual practices in adolescents through integrated health systems in selected districts of Zimbabwe: a mixed method study protocol. *Reprod Health* **17,** 20 (2020). https://doi.org/10.1186/s12978-020-0862-y

Odhiombo, M.W. 2015. Perceived psychological Contract and Job Satisfaction of Secondary School Teachers in Gem District, Kenya. International Journal of Academic Research in Business and Social Sciences, 5 (5), 127-143

Olusheyi, O., Lawoyin, R. & Kanthula R. M, 2010. Oshana health regional office, Oshakhati, Namibia, Ben Guria School of the Nev. Faculty of the health science. Medical science for International health. African journal of Reproductive Health, 14(1) 55

Omolola, F.F, Olusegun, F.A, Olumuyiwa, O, Ebun, A.S, Olufemi, A.T, Paulin, O.T & Ankibonde, O.O, 2015. Prevalence of early sexual debut among adolescents in

Ogbomoso, Nigeria. American journal of public health research, vol 6 (3) 148-154. DOI: 10.12691/ajphr-6-3-4

Orozco-Olvera, V., Shen, F. & Cluver, L. 2019. The effectiveness of using entertainment education narratives to promote safer sexual behaviors of youth: A metaanalysis, 1985-2017. PLoS ONE 14 (2): e0209969. https://doi.org/10.1371/journal. pone.0209969

Peci, B. (2017). Peer Influence and Adolescent Sexual Behaviour Trajectories: Links to Sexual Initiation. European Journal of Multi-disciplinary Studies. Vol 2, Issue 3, Page 96 -105.

Pew Research Center 2018. Teens, social media, and technology 2018. Retrieved from Pew Research Center: http://www.pewinternet.org/2018/05/31/teenssocial-mediatechnology-2018/

Plano Clark, V. L., Ivankova, N. V. 2016. Mixed methods research: A guide to the field. Thousand Oaks, CA: Sage

Plano Clark, V. L., Sanders, K. 2015. The use of visual displays in mixed methods research: Strategies for effectively integrating the quantitative and qualitative components of a study. In McCrudden, M., Schaw, G., Buckendahl, C. (Eds.), Use of visual displays in research and testing: Coding, interpreting, and reporting data (pp. 177-206). Charlotte, NC: Information Age Publishing.

Polit, D.F & Beck, C.T, 2017. 10th edition. Nursing research generating and assessing evidence for nursing practice. Wolters Kluwer Health, Phildelphia, 784. https://doi.org/10.1016/j.2015.01.005

Ponzetti, J. J. 2016. Evidence-based Approaches to Sexuality Education: A Global Perspective. New York: Routledge: Taylor & Francis Group.

Poth, C. (2018). Innovation in mixed methods research: A practical guide to integrative thinking with complexity. Sage.

Psaki, S. 2016. Addressing child marriage and adolescent pregnancy as barriers to gender parity and equality in education. *Prospects* **46,** 109–129. https://doi.org/10.1007/s11125-016-9379-0

Quadara, A., El-Murr, A. & Latham, J. 2017. *The effects of pornography on children and young people: An evidence scan*. Retrieved from the Australian Institute of Family Studies website: https://aifs.gov.au/sites/default/files/publicationdocuments/rr_the_effects_of_pornography_on_children_and_young_people_

Rashid, S., Mwale, M. 2016. The Effects of Sex Education on the Risky Sexual Behaviour of School Going Adolescents: A Case Study of Mbenjere Secondary, Ntaja and Nsanama Community Day Secondary Schools. *Psychology and Developing Societies*. 28(1):126-138. doi:10.1177/0971333615622910,

Lebese, R.T., Maputle, S.M., Ramathuba, D.U., & Khoza, L.B., 2013, Factors influencing the uptake of contraception services by vatsonga adolesecntsin rural communities of Vhembe District in Limpopo Province, South AfricaHealth Gesondheid 18(1), Art. http//dx.doi.org/10.4102/hsag.v188i1.654

Rasmussen, M. L. 2016. Progressive Sexuality Education: The Conceits of Secularism. New York: Routledge.

Reis, M, Ramiro, L, Camacho, I, Tome, G & Gaspar de Matos, M, 2018. Trends in Portuguese Adolescents' Sexual Behaior from 2002 to 2014: HBSC Portuguese study. Portuguese journal of public health vol 36(1). DOI:10.1159/00048014.

Robertson, L.J. Szabo C.P. 2017. Community mental health services in Southern Gauteng: An audit using Gauteng District Health Information Systems data. South African Journal Psychiatry, 15. 1-6

Rufino, A.C., Madeiro, A., Trinidad, A., Santos, R. & Freitas, I. 2017. Sexual Practices and health Care of Women who have Sex with Women: 2013-2014. Epidemiol. Serv. Saude, Brasília, 27(4), 1-10

Shafii, T., Benson, S.K., Morrison, D.M., Hughes, J.P., Golden, M.R. & Holmes, K.K. 2019. Results from e-KISS: electronic-KIOSK Intervention for Safer Sex: A pilot randomized controlled trial of an interactive computer-based intervention for sexual health in adolescents and young adults. PLoS ONE 14(1): e0209064. https://doi.org/10.1371/journal. pone.0209064

Shayo,F.K, & Kalamo, M.H, 2019. Prevalence and correlates of sexual intercourse among sexualy active in-school adolescents: an analysis of five sub-Sahran African countries for the adolescent's sexual health policy implications. BMC Public Health vol 19(1285). Http://doi.org/10.1186/s12889-019-7632-1

Shisana, O., Rehle, T., Simbayi, L.C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D. & Onoya, D. 2014 South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press.

SIECCAN 2019. Canadian guidelines for sexual health education. Toronto, ON: Sex Information and Education Council of Canada (SIECCAN) . Retrieved from http://sieccan.org/ wp-content/uploads/2019/08/Canadian-Guidelines-for-Sexual-Health-Education.pd

Simonds, D., I. 2019. Effects education on sexual behaviours of adolescents in rural Jamaica, Walden University

Somefun, O.D. 2019. Religiosity and Sexual Abstinence among Nigerian youths: does parent religion matter? BMC Public Health. 19, 416: 1-11

Statistic South Africa. 2018. Pretoria: Government of South Africa.

Tarimo, E.A.M., Moyo, G., Masenga, H., Magesa, P., & Mzava, D. 2018. Performance and self-perceived competencies of enrolled nurse/midwives: A mixed methods study from rural Tanzania. BMC Health Services Research, 18 (1), 1-14

Trimmer, K. 2020. Skilling up: Evaluation of a design-based research methodology. The Australian Educational Researcher, 47, 357-37

Turnbull, S. P. 2010. Adolescents' preferences regarding sex education and relationship education. Health Education Journal 69 (3):277-286.

UNAIDS. 2019. Women and HIV: a spotlight on adolescent girls and young women 2019. https://www.unaids. org/sites/default/files/media asset/2019_womenandhiv_en.pdf

UNIAIDS. 2016. Global statistic on addictive behaviours: 2016 status report

UNICEF. 2016. Seventh stock taking report 2016, HIV/AIDS statistics tables.

UNICEF. 2019. Child marriage. https://data.unicef.org/ topic/child-protection/childmarriage/

Vhembe District Health Barometer. 2013. Limpopo, South Africa.

Wagenaar, C., Florence, M, Adams, S and Savahl, S. (2018). Factors influencing the relationship between alcohol consumption and risky sexual behaviour among young people: A systematic review. *Cogent Psychology*. 5:1-26

Wanyonyi, H. S. 2014. Youth sexual behaviour and sex education. *International Journal of Education and Research, 2*(3), 1–14.

WHO, 2014, Adolescent pregnancy, Fact sheet teenage pregnancy

WHO. 2017. Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access. Geneva, Switzerland.

Winchester, C.L. & Salji, M. 2016. Writing a Literature Review. Journal of Clinical Urology. Vol 9 (5): 308-312

Young, H., Burkle, L., Gabhahim, S.N. 2018. Sexual intercourse, age of initiation and contraceptives among adolescents in Ireland, 18(36), 1-9.

ANNETURES

ANNETURE A: INTERVIEW GUIDE

INTERVIEW GUIDE FOR YOUTH BETWEEN AGED 18-24 YEARS AT WAYENI VIILAGE

TOPIC: FACTORS CONTRIBUTING TO SAFE SEX PRACTICES AMONG YOUTH AT A SELECTED VILLAGE, LIMPOPO PROVINCE

- What youths' reasons youth for engaging in unsafe sex?
- What practices do the youth normally use when engaging in sex?
- What can be done to assist youth to engage in safe sex?

ANNEXTURE B: INFORMATION SHEET

Title Factors contributing to unsafe sex practice among youth at a selected Village, Limpopo Province.

INFORMATION SHEET

Good Day

My name is **Khosa Mikateko Blessing.** I am a student at the University of Venda, conducting a study on **"Factors contributing to unsafe sex practice among youth at a selected village, Limpopo Province",** as partial fulfilment of the requirements for my Masters in Public Health(MPH).

The purpose of this study is to determine the knowledge and perceptions about factors contributing to unsafe sex practice among youth at Wayeni Village, Vhembe District, South Africa. I am hereby inviting you to participate in the study.

The interview will last for 15 minutes to one hour. If you agree to participate, I will ask you some questions. As a researcher, my role is to listen and understand your point of view and not to show any judgement during the interview. If, however, during interview you will feel uncomfortable in answering some of the questions, you are free to express your discomfort; you will not be penalized for such.

Confidentiality

The information that you give will be kept confidential. No names will be used when transcribing the interviews. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you will say will be remain private and confidential and no one will know your answers, except the researcher. The answers given by participants will be combined and analysed according to common themes and categories and will form a report

Consent

Ethical clearance has been obtained from the School of Health Sciences Higher Degrees Committee, University of Venda Higher Degree Committee, and University of Venda Ethics Committee. Permission to conduct the study will be sought from Wayeni Clinic Operational Manager. You will be requested to give written consent to

participate in the study, as well as permission to record. The researcher will appreciate your willingness to give consent and participate in sharing the information.

Benefits and risks of participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates. Participants are free to withdraw from the study at any point, or refrain from answering questions which you feel violates your rights; and no penalty will be imposed. However, I would really appreciate it if your thoughts and feelings in relation to the questions asked. Are provided

Recording the interview

I would like to furthermore ask for permission to audio record the interview because it is not possible to write down all your answers quickly enough to capture all the important information. I might misrepresent your responses to some of the questions that you will be asked if recording is not done. It is crucial to inform you that all voices and notes will remain confidential and your identity will not be disclosed. I am only interested in your honest response to the questions.

Recordings and digital data of the interview will be listened to only by the researcher and the co- coder and will bear no names of the interviewees. The information will be analysed and organised in accordance with the national requirements. The voice recordings and digital data will be destroyed two years after the publication of the research findings.

Contact details

I will be happy to respond to any questions or give clarity about any issues you may have regarding this study.

Researcher: Miss Khosa MB

Cell: 0609101606

ANNEXTURE C: REQUEST FOR PERMISSSION TO CONDUCT THE STUDY FROM WAYENI CLINIC

P.O. Box 910

Mashamba

0942

10 August 2018

Operational Manager (Wayeni Clinic)

RE: APPLICATION FOR A PERMISSION TO CONDUCT THE STUDY

The letter serves as a request for permission to conduct a study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN), doing Masters in Public Health. The research is conducted to fulfil the requirements for the degree mentioned above. The title of my research is: **"Factors contributing to unsafe sex practice among youth at a selected Village, Limpopo Province."** The purpose of the study is to determine the knowledge and perceptions about factors contributing to the unsafe sex practice among youth at Wayeni Village. The participants for the study will be the youth that come in Wayeni clinic for consultation in different services, antenatal visits, postnatal care, and youth sexual reproductive health. The study outcome may help the Department of Health to improve the youth sexual health programmes so that they may make right decisions before engaging in sexual intercourse. Data will be collected during working days.

My contact details, including those of my promoters, are provided, should there be any issues pertaining to the study or in case you need more clarification.

Researcher: Miss Khosa MB (0609101606)

Promoter: Professor Lebese RT

Co- promoter: Mr Manganye BS

Your assistance will be greatly appreciated

Yours faithfully

……

Miss Khosa

ANNEXTURE D: PERMISSSION TO CONDUCT STUDY FROM WAYENI CLINIC

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Eqn: **KHOSA M.B**

Cell No: **060 910 1606**

PERMISSION TO CONDUCT A RESEARCH PROJECT

PROJECT TITLE: FOCTORS CONTRIBUTING TO UNSAFE SEX PRACTICE AMONG YOUTH AT SELECTED VILLAGE IN LIMPOPO PROVINCE

PROJECT NO: **SHS/19/PH/27/0811**

I **Leshabane M.M** working at Wayeni clinic as Acting Operational manager allows **Ms Khosa M.B** to conduct a research project at our facility which is scheduled as follows.

Date: 07/12/2019.

Time: 12H00

Signature of Acceptance

MM Leshabane

DEPARTMENT OF HEALTH
WAYENI CLINIC
2019 -12- 07
WAYENI, 0960
LIMPOPO PROVINCE

ANNEXTURE E: ETHICAL CLEARANCE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms MB Khosa

Student No:
11585032

PROJECT TITLE: **Factors contributing to unsafe sex practice among youth at a selected village, Limpopo Province.**

PROJECT NO: **SHS/19/PH/27/0811**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof RT Lebese	University of Venda	Supervisor
Mr BS Manganye	University of Venda	Co - Supervisor
Ms MB Khosa	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: November 2019
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -11- 08
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXTURE F: CONSENT FORM

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (*name of researcher*), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

I…… …… …… ……..

(*Name of researcher*) herewith confirm that the above participant has been fully

Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Signature…… Date……..

Full Name of Witness (If applicable)

Signature…….. Date ……

Full Name of Legal Guardian (If applicable)

Signature…….. Date……..

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

SCHOOL OF HUMAN AND SOCIAL SCIENCES

9 February 2021

School of Health Sciences

University of Venda

Private Bag X5050

Thohoyandou

0950

Dear sir/madam

This letter serves to confirm that I have proof-read Ms M.B. Khosa's mini-dissertation titled, "Factors Contributing to Unsafe Sex Practices Among Youth at a Selected Village, Limpopo Province".

The proof-reading entailed editing some parts of it, where I felt it would make the document more understandable; for example, to avoid wordiness, redundancy, etc. However, I have not tampered with the content of the mini-dissertation, except where I found that this constitutes repetition or made the content confusing.

After the suggested editorials, the mini-dissertation will be ready for submission and/or examination.

Thank you for your time.

Sincerely

V.T. Bvuma

UNIVERSITY OF VENDA

PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA

TELEPHONE (015) 962 8172 **FAX** (015) 962 4749

E-mail: Vincent. Bvuma@univen.ac.za

"A quality driven, financial sustainable, rural-based comprehensive University