

Knowledge, Attitudes and Practices of High School Learners
regarding Condom Use in the Greater Giyani Municipality,
Limpopo Province

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School of Health Sciences, University of Venda

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DECLARATION

I, **CHAVALALA LAZARROS**, hereby declare that the mini-thesis entitled **Knowledge, Attitudes and Practices of High School Learners regarding Condom Use in the Greater Giyani Municipality, Limpopo Province** for the Master's degree in Public Health at the University of Venda, hereby submitted by me, has not previously been submitted for a degree at this or any university, and that this is my own work in design and execution and that all reference materials contained therein have been duly acknowledged.

Signature

Date.....

DEDICATION

I dedicate this mini-thesis to my mother, son, wife, brothers and sister.

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The almighty God who has made it possible for me to succeed because He has protected and guided me since I was born.

I would like to thank the almighty God for his presence and for giving me the strength and light to make it through my studies.

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List of Acronyms

AIDS	: Acquired Immune deficiency syndrome
ANC	: Ante-natal care
DBE	: Department of Basic Education
DOE	: Department of Education
DOH	: Department of Health
HBF	: Health Belief Model
HIV	: Human Immune Deficiency Virus
HSRC	: Human Science Research Council
MOH	: Ministry of Health
NGOs	: Non-Governmental Organisations
SPSS	: Statistical Package for Social Sciences
STATS SA	: Statistics South Africa
UNAIDS	: United Nations Programme on HIV/AIDS
USAID	: United States Agency for International Development
WHO	: World Health Organization

Abstract

Condoms protect against unplanned pregnancy and sexually transmitted infections, including HIV, among all population groups including adolescents. Correct use of condoms prevents between 80% and 95% of HIV transmission. Furthermore, the usefulness of condoms in preventing pregnancy or STIs rests on the user. Thus, the possibility of pregnancy or STI transmission is greater when condoms are not utilised appropriately and regularly with every sexual act. The aim of the study was to determine the knowledge, attitudes and practices of high school learners on the use of condoms in the Greater Giyani Municipality. A quantitative, descriptive research design was used. The researcher used a probability-stratified random sampling method to select respondents from schools that were selected to participate in the study. A self-administered questionnaire consisting of close-ended questions was used to collect data. The questionnaires were given to learners to complete. Data were analysed using the Statistical Package for Social Sciences (SPSS), version 24. Descriptive and inferential statistics were used during data analysis. Data are presented in charts and frequency tables. Most of the respondents were aged 15-17 years (57.8%). There were more female than male respondents in the study and most respondents lived with both parents (14.9%). There were more respondents in Grade 12 (37.3%) than in other grades: 27.7% of the respondents were in Grade 10, while 35% were in Grade 11. Most of the respondents (88.7%) knew that condoms offer protection against HIV/AIDS, STIs and pregnancy, but many held negative attitudes towards condoms (56.5%) because they thought that condoms reduced pleasure during sexual intercourse. The majority (77.3%) of the respondents had engaged in sex, and half of these (50%) sometimes used condoms when they engaged in sexual intercourse. Male respondents were found to have power over

their partners on the making of decisions regarding condom use. Peer pressure was found to be one of the most significant factors that influenced condom use. Parents and guardians of the respondents were discovered to have communicated about sexual issues with their children. High school learners should be encouraged to refrain from using substances such as alcohol, because when they are under the influence of these substances and engage in sexual intercourse they can be unwilling to use condoms .

Keywords: Attitudes, Condom, Condom use, High school, Knowledge, Learner, Practices

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Background to the study

Condoms can be traced back several hundred years, as they were created in the fifteenth century in reaction to a syphilis epidemic in Europe (Ross, 2010). At that time they were made of diverse kinds of materials such as leather and animal guts (Ismael & Zangana, 2012).

Since the detection of HIV and AIDS in the early 1980s, condom use has been encouraged among sexual partners. Condoms are promoted to safeguard people against unplanned gravidity and sexually-transmitted infections, including HIV, among all age and population groups, including adolescents (Nesidai, Ng'ang'a, Mwangi & Wanzala, 2011). Thus, condoms form an essential part of the prevention of sexually transmitted diseases and unwanted pregnancies, and their use has increased considerably over the past decade. However, condom use is among the most challenging issues faced in programmes that are aimed at reducing the impact of the sexual transmission of HIV in Africa. In addition, condom use remains low among young people and adolescents (Avert, 2018). The limited access to condoms also continues to be a barrier to their use among many teens (Society for Adolescent Health and Medicine, 2017).

The correct use of condoms can prevent the spread of HIV by 80 to 95%. As a result condom advertising has received significant attention in the battle against the AIDS pandemic (Silassie, Giorgis, Kahsay, Fisaha, Zerihun, Tadesse, Gerensea & Mallo, 2016). Centers for Disease Control and prevention (2010) assert that the correct and consistent use of condoms reduces the risk of STIs and HIV infection. However, the CDC advises that no method of protection is 100% effective, and thus condom use cannot guarantee protection from either STI or pregnancy. In light of that, young adolescents continue to avoid using condoms during sexual intercourse. It seems as if the lack or limited use of condoms by young adults influences their perceptions of this contraceptive. In their study, Beltzer, Saboni, Sauvage, Lydié, Semaille & Warszawski (2013) found that adolescents in France did not believe that condoms would protect them from contracting HIV. Thus, it can be assumed that low condom usage can be attributed to limited knowledge of this contraceptive among

adolescents. A study by Ehlers (2003) confirms this assumption by stating that the adolescent mothers studied did not perceive condoms as contraceptives, but rather as methods of preventing HIV infection. Condoms are often used by unmarried teenagers and married couples over the age of 30. Furthermore, condoms are used slightly more by blacks, than whites, and more by middle class than working or upper class individuals (Ross, 2010). Studies undertaken in sub-Saharan Africa, found that men saw condom use as important only for extramarital sex, while women, thought that condoms served a contraceptive purpose (Kabikira, 2010).

The usefulness of condoms in preventing pregnancy or sexually transmitted infections (STIs) depends on the user. Previous studies have found that the pregnancy rate among those who use condoms correctly is about two per cent every year (Kumar, Das, Rana, De, & Saha, 2017). The possibility of falling pregnant or being infected with an STI is higher when condoms are not utilised properly and consistently every time a person engages in sexual activities (USAIDS & WHO, 2007). Condoms alone do not protect against STIs and HIV; they work only if they are used correctly and consistently (Albritton, 2011).

UNAIDS (2009) point out that while people from high income countries are more knowledgeable about the usefulness of condoms in preventing HIV transmission, many people still do not use them regularly, especially those who engage in high risk sexual practices. A study conducted in the United States between 2011 and 2013 to establish the extent of condom use found that among the 2.5 million sexually-active teenage women who acknowledged using contraceptives, only 55% used condoms as their method of contraception (Guttmacher Institute, 2016).

Demographic and Health Surveys conducted in sub-Saharan Africa between 2010 and 2015 report that in 19 of 23 countries fewer than 60% of young women (aged 15 to 24) who had had multiple partners had used condoms during their last sexual encounter. In 15 out of 23 countries there were similar results for young men (Avert, 2018). In Kenya, 59.4 % of teenage girls aged 15-17 used condoms as their method of contraception while only 18.4% of those aged 18-19 did so (Nwaokoro, Ede, Ibe, Emerole, Nwufo, Nwaokoro, Igwe, Obare, Birungi, Undie, Wanjiru, Liambila & Askew, 2011).

Various studies have been conducted to establish the extent of condom use in South Africa. Findings of the study conducted by Abdulraheem and Fawele (2009) report that 38.1% of the adolescents in their study always used condoms, while the rest did not. Another study revealed that more than 50% of the sexually active learners interviewed never used condoms (Hartell, 2005). Condom use has declined among all groups in South Africa, according to the latest household survey released by the Human Sciences Research Council (Van der Linde, 2013). This same trend was reported by UNAIDS (2011).

According to the first South African national youth risk-behaviour survey, only 40% of male and 31% of female adolescents always used condoms. These figures are similar to national surveys undertaken in Burkina Faso, Ghana, Malawi and Uganda, which found condoms use among male adolescents during their most recent sexual encounter to be between 39% and 51%, while use among females was between 24% and 38% (Mash, Mash & De Villiers, 2010).

In South Africa, 67.5% of males and 49.8% of females aged 15–24 interviewed acknowledged condom use at their most recent sexual encounter. Furthermore, condom use among males aged 25–49 years was reported at 36.1% while among females of the same age it was reported at 32.7% (Statistics South Africa, 2015). An explorative qualitative study was conducted by Abdool-Karim, Abdool-Karim, Prestonwhyte & Sankar (1992) in order to investigate the motives for the lack of condom use among high school learners in Kwazulu-Natal. The study found that the use of condoms was not adequately understood and that condoms were not accessible or obtainable when needed.

A study conducted by Peltzer (2001) in Limpopo discovered that 29.2% of the respondents had never used a condom, 35.4% had used condoms every time, 19.8% had regularly used them and 8.5% had used condoms occasionally when they had had sexual intercourse in the three months prior to the study. Thus, it can be deduced that not all teenagers use condoms consistently.

Furthermore, a study conducted by Mudau, Nemathaga & Risenga (2014) found that 15% of teenage respondents in their study indicated that they would be embarrassed to buy condoms, while 85% said that they would not be embarrassed to do so. Moreover, the study also found that 7.5% of the respondents would be embarrassed

to suggest condom use to their partners while the majority (92.5%) of the respondents said they would not be embarrassed to do so.

1.2 Problem statement

According to the Reddy, Sewpaul and Jonas (2016) teenage pregnancy among girls aged 15 to 19 in South African far exceeds the 47 per 1000 births usually found in high-income countries . In addition, Masondo (2015) indicates that more than 99 000 teenagers fall pregnant per annum. The present researcher was a social worker at the Department of Social Development and one of his duties was to conduct awareness campaigns in schools. During one such campaign in a particular high school, he discovered that of 682 learners in the school, 45 were pregnant. The majority of these learners were in Grades 10 to 12. Being a teenage mother leads to failure at school, educational problems and school dropout (Maphothi, 2014). This situation prompted the researcher to find out more about the knowledge, attitudes and practices of high school learners in the Greater Giyani Municipality regarding condom use.

1.3 Rationale for the study

The researcher was inspired to conduct the study because other studies that have investigated the knowledge, attitudes and practices of high school learners regarding the use of condoms have been conducted globally including many other African countries, as well as South Africa. However, no studies are known to have been conducted that focused on Greater Giyani Municipality in order to investigate this phenomenon.

Condoms have been made freely available in health facilities and teenagers have been given access to condoms as stipulated in Section 134 of the Children's Act 38 of 2005. However, many teenagers continue to fall pregnant. The researcher sought to find out the level of knowledge, attitudes and practices of high school learners in the Greater Giyani Municipality regarding condom use.

1.4 Significance of the study

The study findings may add to the existing information about the knowledge, attitudes and practices of high school learners regarding condom use. The study

findings may also be used by educators to identify the learning needs of learners regarding condom use. The findings may also serve as a knowledge base for parents when they need to educate their children about condom use. Moreover, the study findings may also help teachers to determine the knowledge, attitudes and practices of learners regarding condom use, and therefore will be able to assist them in planning strategies to improve learners' condom use.. The findings may also assist the Primary Health Care Services Directorate in the Department of Health, to identify learning the needs of high school learners, and plan for effective strategies to increase condom use. The Department of Health may also use the findings to determine whether condom use still needs to be marketed, and if sufficient condoms are distributed and available to those who need them. The study findings may also help the researcher to gain more insight into the patterns of condom use, the factors that influence condom use and the attitudes of high school learners towards condom use. Finally, the results of this study might also serve as a knowledge base for stakeholders such as Government departments, Non-Governmental Organizations (NGOs), researchers and policy makers on the factors influencing the use of condoms among high school learners.

1.5 Purpose of the study

The purpose of the study was to determine the knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province.

1.6 The objectives of the study

The objectives of the study were to:

- Assess the knowledge of high school learners regarding condom use
- Determine the attitudes of high school learners towards the use of condoms
- Determine the practices of high school learners on the use of condoms
- Identify factors that influence condom use by high school learners

1.7 Definitions of concepts

High school is a school for young people between the ages of 11 and 18 (Hornby, 2010). In this study, high school means any school that accommodates learners from Grade 8 to 12 in Greater Giyani Municipality.

The learner is someone who is finding out about a subject or how to do something (Panday, Makiwane, Rarchod & Letsoalo, 2009). For the purpose of this study, learners were all people enrolled in Grades 8 to 12 in the 2017 academic year in all schools in the Greater Giyani Municipality.

Condom is a barrier device commonly used during sexual intercourse to reduce the probability of pregnancy and the spreading of sexually transmitted diseases such as HIV and AIDS (WHO, 2013). In this study, a condom means a device that is worn on the male sexual organ and inside the female sexual organs as protection against pregnancy and sexually transmitted infections during sexual intercourse.

Condom use refers to the correct application of the condom to the male and female sexual organs before sexual intercourse and the removal of the condom after sexual intercourse (Kabikira, 2010). In this study, condom use refers to wearing or insertion of both male and female condoms each time before sexual intercourse and their removal after sexual intercourse. **Practice** refers to a way of doing something, especially as a result of habit, custom or tradition (Rundell, 2006). For the purpose of this study, practice refers to the frequency with which condoms are used by learners aged between 13 and 19 years.

Knowledge refers to what someone knows about a specific subject (Rundell, 2006). For the purpose of this study, knowledge means what learners know about the use of the male and female condoms.

Attitude means the views or feelings that one holds about something, and that is expressed through actions (Kabikira, 2010). For the purpose of this study, attitude means how learners view or feel about using condoms.

1.8 Delimitation of the study

The study focused only on high school learners from high schools that fall under the Shamavunga Circuit in the Greater Giyani Municipality, Limpopo Province. The study did not include learners from other high schools in Limpopo Province.

1.9 Structure of the study

Chapter 1: Introduction and background of the study

This chapter provides the background of the study, problem statement, rational, significance, purpose and objectives of the stud, as well as the definitions of major terms.

Chapter 2: Literature review

This chapter provides literature reviewed related to the topic.

Chapter 3: Research design and methodology

This chapter provides a blue print of how the study was conducted. This includes research design, study setting, study population, inclusion criteria, sampling, research instrument, data collection, data analysis, and ethical considerations.

Chapter 4: Data analysis and presentation of data

This chapter comprises of the presentation and analysis of collected data.

Chapter 5: Discussion, summary of findings, conclusion and recommendations

This chapter provides a discussion of findings, summary, conclusion and recommendations.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

Gray (2009) defines a literature review as a report about an assortment of documents (published or unpublished) on a topic that have certain facts, ideas and evidence in relation to a particular research topic and the evaluation of these documents. This literature review covers the concept of condom use, prevalence of condom use in South Africa, knowledge, attitudes and practice of high school learners regarding condom use, factors that influence the use of condom among teenagers and South African legislations on condom use among teenagers. Finally, this section also contains a conceptual frame-work guiding the study.

2.2. The concept of condom use

A condom is a latex or elastic tubular sheath used during sexual intercourse to hinder the secretion of genital liquids and their substance, including organisms between sex partners (Ugandan Ministry of Health, 2003). Both male and female condoms are accessible. The male condom is an elastic sheath worn over an erect penis. The female condom is a removable polyurethane sheath with an adaptable ring at one end. The internal shut ring is pressed into the vagina, while the external, open ring rests outside the vagina (Macaluso, Lawson, Hortin, Duerr, Hammond, Blackwell & Bloom, 2003). Male condoms are an important part of HIV prevention. In vitro tests for the infection entrance of latex and polyurethane condoms demonstrate that condoms are on a very basic impenetrable level of sexually-transmitted pathogens (UNAIDS, 2000). Regular and correct use of condoms lessens the risk of HIV infection, while inconsistent use of condoms carries a significant risk of HIV infection (Lampthey & Goodbridge, 1998).

2.3 Prevalence of condom use in South Africa

Condom use in South African has increased from 2.5% in 1998 to 12% in 2008 in married couples (Maharaj, Neemab, Clelandc, Buszac, & Shahd, 2012). In 2009, it was found that among males and females aged 15-49 years who indicated having more than one sexual partner, condom use at last sex was over 70% in South Africa (Shisana, Rehle, Simbayi, Zuma, Jooste, & Pillay-van-Wyke, 2009). Marshall (2012)

points out that in 2005 condom use in the Western Cape was 67% in men, while in women it was 52.6%. Furthermore, Marshall (2012) further indicates that condom use by Africans was 70.75%, for coloureds, 44.77% and for whites, 66.76%. In the year 2009, people aged 16-19 who used condoms in Limpopo Province constituted 54% of males and 46% of females (Johnson, Magni, Kincaid, Figueroa, Delate, Mahlasela & Donoghue, 2013).

2.4 High school learners' knowledge, attitudes and practices with regard to the use of condoms

2.4.1 High school learners' knowledge about condom use

The knowledge that one holds regarding the condom influences its use by an individual during sexual intercourse. A study conducted by Silassie, *et al.* (2016) found that the majority (74.6%) of the respondents who were learners knew about the condom as a contraceptive which is used to prevent pregnancy, STIs and HIV/AIDS. Their study also found that only 32% of the learners knew where they could obtain condoms. Nwaokoro *et al.* (2015) point out that teenagers learn about condoms and their use from the radio, television, friends and school while others read about them in books. Teenagers also acquire knowledge about condom use from social health magazines, posters and pamphlets, educational talks, newspapers, and health care providers (Ochieng, Kakai, & Abok, 2011).

Another study conducted by Peltzer (2000) found that secondary school pupils know about the condom as a device to protect an individual from HIV/AIDS and they know about expiry dates. On the other hand, the study found that about 30% of females among the respondents did not know that condoms are a defence against HIV and sexually-transmitted diseases. Furthermore, the study found that pupils made common mistakes with respect to condom use: this includes when to take off a condom, the correct time to put on a condom, inability to put a condom on properly and the use of oil-based lubricants. According to Albritton (2011) other mistakes with condom use included using Vaseline and other petroleum-based products instead of water-based lubricants, opening packets with teeth or sharp fingernails (thus tearing the condom), and incorrect unrolling of the condom.

2.4.2 High school learners' attitudes on condom use

Teenagers believe that condom use during sex can lessen sexual joy (Silassie, *et al.*, 2016). In a study conducted by Kakai & Abok (2011), it was reported that 42.4% of the respondents who were learners indicated that condom use meant a lack of trust in a partner. Teenagers believe that condoms are not difficult to use and they empower you to have unconstrained sex. However, not all teenagers have a positive attitude towards condoms; some believe that condoms are painful to use and are troublesome (Tantoh, 2014).

Mnyipika (2014) indicates that black South African learners perceive condoms as being too expensive to buy, as making sex less pleasurable, and that too many condoms will be required for all their sexual encounters. Masoda & Govender (2012) point out that adolescents have negative attitudes towards using condoms for contraception because condoms can tear and be retained within the vagina.

Masoda & Govender (2012) further indicate that teenagers do not use condoms because their religion does not acknowledge condom use on the grounds that it is against God's law, while other adolescents indicated that condom use can promote prostitution. Ismael & Zangana (2012) assert that teenagers believe that condom use has some harmful effects and they feel embarrassed when buying condoms. Ismael & Zangana (2012) further assert that teenagers reported finding condoms unavailable in their area when needed, and this led to their non-use.

Brown, Halpern & Engle (2005) conducted focus group discussions with 21 rural Afro-American adolescents and found that some explanations for not using condoms included forgetting to use condoms, choosing not to use a condom because the condom reduces physical pleasure, inability to afford to buy condoms, embarrassment about using condoms, and, alarmingly, wanting to die from AIDS because of the stresses of life.

2.4.3 High school learners' practices on condom use

In a study conducted by Carson (2015) it was found that 18% of female adolescent respondents never used condoms during sexual intercourse; those who used condoms every time they engaged in sexual intercourse constituted 35%, and those who used condoms occasionally constituted 23%. In another study that was conducted by Thanavanh, Harun-Or-Rashid, Kasuya & Sakamoto (2013), 70.2% of

the respondents who were high school learners reported never using condoms during sexual intercourse, while 29.8% reported using condom regularly during sexual intercourse.

Peltzer (2001) also found that 29% of the respondents in his study who were adolescents reported never using condoms, and those who always used condoms constituted 35.4%; those who regularly used them constituted 19.8% and 8.5% had used condoms irregularly during the three months before the study. The inference that he made was that adolescents used condoms whenever they engaged in sexual intercourse. Incorrect and inconsistent condom use may be the result of issues related to poor condom fit. Males reported functional challenges with regard to condom use such as condom breakage, slippage, and leakage (Albritton, 2011).

2.5 Factors that influence the use of condoms among teenagers

2.5.1 Gender

Cobb (2010) states that in many societies, young women are required to submit to the wants of their lovers in sexual issues. Consequently they do not have the capacity to discuss safe sex practice (Panday et al, 2009). Sarkar (2008) indicates that knowledge and experience of condom use among teenagers might likewise affect their choices of whether to use condoms. Cultural, social, political and gender–power dynamics all determine the ability of women to initiate condom use in their relationships, thus making condom use decisions remain mainly under the control of men (Maticka-Tyndale, 2012).

2.5.2 Economic factors

The Department of Basic Education (2010) states that economic factors may play a part in teenage pregnancies and HIV infections because poverty forces girls to submit to men’s desires for sex without a condom. Dunkle, Jewkes, Nduna, Jama, Levin, Sikweyiya & Koss (2007) argue that, owing to poverty, young girls are unable to talk about safe sex practice with their partners. Dunkle *et al.* (2007) further assert that transnational sex has been noted as a possible source of teenagers’ susceptibility to gender-based violence and sexual exploitation as they have sex in situations in which they might otherwise refrain.

2.5.3 Social and behavioural factors

The absence of social support for condom use from religious leaders, guardians, friends and health care providers is related to low possibilities for condom utilisation (Sanders, Yarber, Kaufman, Crosby, Graham & Milhausen, 2012). According to Han and Bennish (2009), social expectations hinder conversations about sex. Looking at behavioural factors, substance use does influence condom use among young people (Flisher, Mukoma, & Lottar, 2007). According to WHO (2013) a heavy intake of substances expands the chances of condoms not being used.

2.5.4 Parent-adolescent communication about condom use

According to WHO (2002), it is not easy for parents to communicate with their children about sexual issues because they may lack knowledge about sex. Mnyipika (2014) states that parents expect that talking and guiding youthful teenagers about sex will make them sexually-active. Subsequently, this leaves teenagers with no information about sex, including condom use.

2.5.5 Peer pressure

Adolescents mostly listen to and openly deliberate sensitive issues such as sexual matters with peers rather than with people older than them (Panday et al, 2009). They share sexual knowledge among themselves and influence each other in their groups. If the group has a negative attitude towards condom use, adolescents within the group are more likely to practise unsafe sex. MacPhail (2002) articulates that adolescent behaviour is shaped by what they see as a custom or what they think people believe about a particular conduct.

2.5.6 Mass media

According to Panday et al (2009), mass media campaigns in South Africa have played a seminal role in improving knowledge about sexual behaviour and, in particular, HIV. Panday et al (2011) state that three multi-media campaigns, namely: LoveLife, Soul City and Khomanani have reached high levels of coverage among young people – the former two above the 80% mark required for high intensity and high frequency coverage. Evidence of the cumulative effect of a range of mass media programmes suggests that they have been effective in shifting a number of health behaviours including condom use, self-efficacy in the use of condoms, communication with partners and peers about HIV testing and faithfulness to

partners. While there is support for the increased coverage and intensity of media programmes, a distinct focus on teenage pregnancy is required. In addition, because of the threshold effect of exposure to media programmes, such interventions need to form part of a comprehensive strategy regarding teenage pregnancy.

2.5.7 Condoms and culture

Kabikira (2010) report that using a condom in a stable relationship is considered a taboo and this accounts for about 39% of the non-use of condoms. According to UNAIDS (2008) culture plays a major role in who will use the condom and when it will be used with females being in a disadvantaged position when it comes to negotiating condom use. Culture often downgrades females to passive roles in sexual matters while male masculinity roles result in risk-taking, aggressiveness and excessive alcohol consumption, often defined by society and culture, leading men to engage in unprotected sexual escapades. In some cultures in Southern Africa, condom use is perceived as bad, especially where ejaculation of semen into the vagina is considered to be an essential, mandatory part of the sexual act, particularly in intimate sexual relationships (National Department of Health, 2011).

2.5.8 Religious affiliation

Religious affiliation is repeatedly reported in the literature as an influence on adolescents' use of condoms. It is critical to state that some religions promote the use of condoms and others discourage its use; for example Catholics are less likely to use condoms than Muslims and Protestants (Njau, Mwakalo & Mushi 2013). Religion and religious beliefs are undoubtedly important predictors of condom use among young adults (Njau et al 2013).

A study by Shakil (2011) on how sub-Saharan Africa can win the battle against HIV confirms this assertion. Its outcome revealed that a major barrier to condom distribution and usage is religious affiliation.

2.5.9 Multiple sexual partners

Multiple sexual partners relationships were also reported in the literature to influence condom use. Multiple sexual partnerships are negatively associated with reported condom use (Njau et al. 2013). This means that the more sexual partners adolescents have the less likely they are to use condoms during sexual intercourse. Such sexual practices do not only have carry the risk of adolescents contracting

sexually transmitted infections, but they also carry the risk of unwanted pregnancies. In sub-Saharan African societies, one of the greatest determinants of condom use is its association with fertility prevention.

Feelings of distrust, particularly those evoked by infidelity are frequently mentioned in the literature to promote condom use in relationships (Njau et al.2013). This suggests that condoms are less likely to be used in relationships where trust between partners prevails. The willingness to engage in unprotected sex is seen as the existence of trust. It could also be an indication of personal reasons that condoms do not only create some discomfort during sexual intercourse, but they also reduce sensitivity. It is therefore likely that condom use is less prevalent in intimate or close relationships, and more likely among casual sexual partners (National Department of Health, 2011).

2.5.10 Accessibility, stigmatisation and discrimination

Despite the high incidence of HIV in adolescents and the efficacy of condoms in preventing HIV transmission, condom use among adolescents remains low owing to their limited access (DBE, 2010). In rural areas, schools are some of the sites accessible to large numbers of youths, yet condom distribution is rarely undertaken in schools. A critical challenge to prevention efforts in adolescents is to ensure that the newly guaranteed reproductive health rights are realised. For high school teenagers in South Africa, access to condoms is limited. Barriers to access include sustained travel time and the cost of travel to sites, sites are closed when students are out of school, the judgmental and often hostile attitude of providers and the cost of condoms in shops. All these factors influence condom use (DBE, 2010).

2.6 Barriers to condom use

There are specific barriers to condom use. One relates to female passivity. Women are generally perceived as passive participants in sexual relationships (Lammers, Van Wijnbergen, & Willebrands, 2013). Thus, requesting condom use during sexual intercourse could be perceived as unfeminine. Lammers *et al.* (2013) state that requesting condom use is unfeminine, and is a major barrier to the use of this contraceptive. Masculinity on the other hand, has become associated with rejecting condoms. Apart from the notion of masculinity in Southern Africa, males perception of circumcision has been reported to influence condom use as well.

In the African region, some men believe that male circumcision could prevent the transmission of HIV (Bridges, Seick, Gray, McIntyre & Martinson, 2010). The problem is not with the procedure, but the way it is perceived by men, as they think they are immune from HIV contagion. Acknowledging this, it is critical for male circumcision programmes to include health education elements, such as prevention of the transmission of sexually transmitted infections. Additionally, circumcision programmes should reinforce a range of HIV prevention strategies, including condom use. If these strategies are not adopted, young adults will not use condoms, and may continue not to do so. This puts them at risk of contracting sexually transmitted infections, including HIV. The problem of non-condom use is usually exacerbated, particularly among young adults when under the influence of alcohol (Parks, Hsieh, Collins, & Levonyan-Radolf, 2011).

Actions to overcome these barriers to contraceptive use at various levels have recently been recommended by WHO and include: reforming laws and policies to enable all adolescents to obtain contraceptives and information; reducing the cost of contraceptive services; educating adolescents about contraceptive use; and, increasing community support for contraceptive provision to adolescents (WHO, 2011b).

2.7 Strategies to promote correct and consistent condom use

HIV and AIDS and Life Skills/Orientation programmes in South African schools were initiated in 2000 and implemented in public schools with a focus on learners in Grades R to 12 (Kumalo, Panday & Sithole, 2011). The aim of this programme is to integrate HIV and AIDS matters into the curriculum as a strategy to mitigate the spread of HIV and AIDS. The UNAIDS report (2011) states that age-appropriate sexual education increases knowledge of HIV among learners.

A study by Tschann, Flores, de Groat, Deardorff and Wibblesman (2010) examined which condom negotiation strategies were effective in promoting condom use among Latino youth. The outcome of the study by Tschann *et al.* (2010) highlighted that young women were more likely than young men to express intention to use condoms, and both verbal and non-verbal communication were noted as effective strategies for enabling young adults to use condoms during sexual intercourse encounters.

Van Rossem & Meekers (2013) conducted a study on young adults in urban Cameroon to identify which type of persons young adults look to for social approval, and establish how important social approval by these persons is for condom use among this population. The results of this study indicated that perceived approval of condom use by these persons had a significant positive effect on the frequency of condom use among young adults. The frequency of condom use was also affected by the respondents' attitudes toward condom use, socioeconomic status, self-efficacy, the range of persons with whom they discussed reproductive health matters, and perceived severity of risky sexual behaviour (unprotected sex). These results suggested that interventions targeting young adults should not focus exclusively on peers but should also include other groups, such as parents and community leaders (Van Rossem & Meekers, 2013).

Empowering the youth and their parents with information, education and counselling can contribute to reduced unsafe sexual practices. It has been suggested that a comprehensive approach emphasising both abstinence and safer sex practices should be adopted in sex education and that the programme should be adjusted according to the development stages of learners (Panday *et al.*, 2009).

2.8 Adolescent sexual and reproductive health

Adolescent sexual and reproductive health (ASRH) comprises a major component of the global burden of sexual ill health. Although overlooked historically, international agencies are now focusing on improving ASRH and are providing programme funding. ASRH rights are based in various legal instruments: in 2002, the UN General Assembly Special Session on Children recognized the need to develop and implement health policies and programmes for adolescents to promote their physical and mental health (United Nations, 2002).

In 2003, the Committee of the Convention on the Rights of the Child issued a General Comment recognizing the special health and development needs and rights of adolescents and young people (United Nations, 2003). Other supporting instruments are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the right to health—a concept included in various international agreements such as the Universal Declaration of Human Rights and the international Millennium Development Goals, which include indicators to reduce

pregnancy rates among 15–19 year olds, increase HIV knowledge, and reduce the spread of HIV among young people (United Nations,2014).

In South Africa, the Department of Education initiated the school health programme by establishing the National Policy on HIV and AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions. As a result, the HIV and AIDS Life Skills Education Programme was implemented in 2000 with the aim of reducing the vulnerability of young people to HIV and AIDS and enhancing their knowledge and skills for responsible sexual behaviour decisions. The programme was implemented through Life Orientation (LO) subjects across all grades (Kumalo et al, 2011).

In 2003, the government further introduced the National School Health Policy (NSHP) which was implemented as a health promotion and preventive school-based initiative for youth, integrating school and other district health services. However, there were problems identified with the implementation of the NSHP which included low service provision, suboptimal and inequitable nurse-to-school ratios, and the absence of referral services to respond to problems identified via screening assessments (Department of Health & Department of Basic Education, 2012). Furthermore, in 2009 the HIV and AIDS Life Skills Education Programme was revised, focusing among other things on risk behaviours such as unprotected sex and multiple concurrent sexual partners (Panday et , 2011).

Adolescent sexual and reproductive health is strongly linked to their particular social, cultural, and economic environment. In addition to regional variation, experiences are diversified by age, sex, marital status, schooling, residence, migration, sexual orientation, and socioeconomic status, among other characteristics. Access to health care and sources of education, information, and support also varies widely (Morris & Rushwan, 2015).

2.9 Adolescent sexual and reproductive health issues

2.9.1 Gender inequality

Gender-based inequalities include an individual's ability to decide on when and with whom to have sex, whether to use contraception, when and how many children to have and how to seek health care (International Planned Parenthood Federation,

2015). Gender considerations involve both men and women understanding opportunities and constraints as their decision affects both of their lives. Gender role and its definition are strictly stereotypical and also fail to reflect external changes. The uneven expectations are the root of continuing gender inequality which affects sexual health (Shaw,2009).

2.9.2 Culture and taboos

Cultural practices and beliefs highly reinforce gender roles. Sexuality, health practices and reproductive preferences are strongly shaped by the social constructs of femininity and masculinity. The social and economic roles of men and women are based on cultural values and beliefs in many countries and some of the allocated roles tend to harm the girls and young women in particular (Buvinic, Morrison, Ofosu-Amaah & Sjoblom, 2008). In many societies, the gender norms show boys and men as violent and as risk-takers while girls and young women are regarded as submissive in their sexual relationships (Khanal, 2016).

Community internal factors such as socio-cultural norms and a community's own prioritization and external factors such as influences of other communities or societies either constrain or support change. Social norms relate to social identities which influence young people's sexual behaviours and sexual and reproductive health promotions. Social norms play a particularly strong significant role in shaping young people's sexual behaviours and form a strong control upon the expression of human sexuality (UNICEF, 2012).

2.9.3 Communication with guardians and adults

Young people's lack of information and poor understanding of sexual and reproductive health coupled with risk-taking and their desire to experiment make them vulnerable to sexual health problems. In the meantime, socio-cultural and traditional norms make it almost impossible for young people and adolescents to talk about puberty and sex with their parents or teachers (WHO, 2004). Parent-youth communication regarding sex issues, especially in the global South, is believed to be socially and culturally unacceptable. Parents' lack of SRH knowledge, socio-cultural beliefs, faith, gender discrimination and so on makes open discussion about sexual and reproductive health even more difficult (Khanal, 2016).

2.10 Adolescent sexual and reproductive health problems

2.10.1 Sexually transmitted diseases (STDs)

Sexually transmitted diseases continue to be the major and growing public health problem in many parts of the world especially in developing countries. According to the estimation made by WHO, nearly 333 million new cases of curable STDs occur each year worldwide, of which almost 151 million occur in South and South East Asia only (WHO, 2006). STIs are among the top five disease categories and about one third of STIs globally occur among people younger than 25 years of age. In the United States, nearly half of the 20 million new cases of curable STDs each year occur among adolescents aged between 15 to 24 years (Center for Disease Control, 2015).

WHO classifies chlamydia as an adolescent infection while gonorrhoea normally occurs in subgroups such as adolescent sex workers but it is less likely to be detected in the general population of adolescents (WHO, 2004).

2.10.2 HIV/AIDS

The World Health Organization estimates that globally more than two million adolescents are living with HIV. Over 35% of all reported cases of HIV are among young people in the age group 15 to 24 years. According to the estimation made by UNICEF, about four million children are affected by AIDS. Although the overall number of HIV related death is down by 30% since the last decade estimates suggest that HIV deaths among adolescents is still rising. This increase which has been mostly in the Africa region may reflect the fact that although more children with HIV survive into adolescence to prevent the transmission of the disease and maintain good health, they still lack proper care and support (UNAIDS, 2013).

In Sub-Saharan Africa approximately 10% of young men and 15 % of young women aged 15 to 24 are living with HIV. HIV and AIDS in the adolescent population needs to be handled separately and treated as a different epidemic. Among adolescents, certain sub-groups; for instance, street adolescents and slum dwellers are most vulnerable to HIV (UNAIDS, 2013).

2.10.3 Early marriage and teenage pregnancy

Practices such as early marriage, teenage pregnancy, unmet family planning needs and unsafe abortion are prevalent all around the world. The average global birth rate among the 15 to 19 year age group was 49 per 1000 girls. Similarly, about 16 million women aged between 15 to 19 years give birth each year which is 11% of total global births (WHO, 2014).

Globally adolescents between 10 and 19 years who give birth accounts for only 11% of all births but 23% of the overall burden of disease owing to pregnancy and childbirth. Unmarried adolescents are the ones to suffer more as their pregnancy and delivery are more likely to be untended. Also unmarried women are more likely to seek induced abortion. Each year around 2.5 million adolescents have unsafe abortions (WHO, 2014).

2.11 Barriers to the utilization of SRH services by adolescents

2.11.1 Lack of SRH knowledge

To maintain sound sexual and reproductive health, every individual needs access to accurate information and a safe, effective, affordable and acceptable contraceptive method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections. When young people and adolescents are healthy and their rights are fulfilled, they can go to school, learn and gain the skills and resources they need to be healthy, productive and empowered adults. In recent decades, there have been enormous advances in girls' education, at least to the primary level, but still in most of the regions in the developing world, girls lack education up to secondary level. A significant proportion of girls become pregnant during the time that they should be at school. About 19% of girls in the developing world become pregnant before the age of 18 and about 3% become pregnant before the age of 15 (UNFPA, 2013). In sub-Saharan Africa nearly 40% of girls are married before the age of 18 (UNFPA, 2012). Girls with no education are three times likely to marry before the age of 18 than those with a secondary or higher education (UNFPA, 2012).

2.11.2 Accessibility of health institutions

Access to primary health services is seen as an important component of care, including preventive health care for adolescents. With the gap between the nature of

the services adolescents seek from health care professionals and the actual disease burden they endure, like mental disorder and sexually transmitted diseases, much work has been directed to understanding the barriers adolescents and young people face to accessing care (Khanal, 2016). Studies around the world conducted in the past two decades indicate that young people and adolescents are often unwilling or unable to obtain needed health services owing to the barriers related to the availability, accessibility, acceptability and equity of health services (WHO, 2002).

A study conducted in Nepal in 2012 shows that the reason for not accessing health care were: insufficient drugs (61%), distance to health care centres (22%), staff unavailability (19%) and money (7%). Sex, ethnicity and distance were found to be significantly associated with access to health care services (Paudel, Upadhyaya, & Pahari, 2012).

2.11.3 Health worker's behaviour

One of the major reasons behind not accessing health facilities by young people and adolescents is the fear of lack of confidentiality; for instance, being recognized in a clinic waiting room with the possible stigma attached (Kambikambi, 2014). Also adolescents fear that the health care worker will not maintain the confidentiality especially concerning parents (WHO, 2002). The fear of parents or someone from their family finding out about a visit to clinic can be a great problem for young people and adolescents. In some societies where social norms forbid premarital sex, unmarried young couple with sexual problems, like genital ulcers and unplanned pregnancies are more likely to deal with these issues themselves or with trusted friends and siblings or they visit clinics far from home. In most of these cases, the service provider acts illegally placing the care seeker in more danger for example unsafe/illegal abortions (WHO, 1999).

2.11.4 Stigmas related to sexual and reproductive health

A study to evaluate the factors that discouraged the youth from using the youth friendly services in South Africa revealed that inconvenient hours at locations, unfriendly staffs and lack of privacy were among the reason adolescents and young people are not using the services (Barnett & Schueller, 2006). Adolescents believed that when information about their clinic attendance for family planning services is shared with health workers, there is no confidentiality and the community and

parents might learn about their attendance at the clinic and they will be stigmatised as they will be believed to be sexually active. The majority of the participants in a study conducted in Nepal believed that service providers at health posts do not keep information confidential and do not behave professionally if sexual health problems are shared with them. (Regmi, Simkhada & Van Teijlingen, 2010).

2.12 South African legislation on condom use among teenagers

The Children's Act 38 of 2005 gives teenagers the privilege to access contraceptives including condoms as stated in Section 134 as a method for preventing the spread of the HIV pandemic, and teenage pregnancy (Panday et al, 2009). The Children's Act, together with South African government approaches, grants individual schools an opportunity to choose whether to distribute condoms. However, most schools and school staff are uninformed of such South African policy and regulations that control condom delivery at schools (Han & Bennish, 2009).

Because of confusing and contradictory policies and public pronouncements regarding the provision of condoms in public schools, few schools have undertaken to provide condoms, leaving students, especially those in rural areas, with few options for obtaining them (Han & Bennish, 2009). The current South African government has left the decision of whether to distribute condoms in schools to the school governing bodies of individual schools, rather than enacting a clear national policy (Han & Bennish, 2009). Reflecting these tensions, South African government policy is unclear and school staff members are often unsure whether condom distribution in schools is permissible. As a result, most schools hesitate to distribute condoms and the few that do distribute condoms do so discreetly.

2.13 Conceptual frame work

2.13.1 Health Belief Model

The underlying concept of the Health Belief Model (HBM) is that health behaviour is determined by personal belief or perceptions about a disease and the strategies available to reduce its occurrence (Hochbaum, 1958). The model proposes that for an individual to take an action to avoid getting a disease, he or she must first believe that they are at risk of getting that disease (perceived susceptibility) and the disease may have negative consequences on his or her life (perceived severity).

Furthermore, an individual must recognise that certain behaviours could be helpful in reducing the risk (perceived susceptibility) or consequences of the disease (perceived severity), and these behaviours cannot be impeded by pain or embarrassment (perceived barriers). Other researchers have expanded the HBM by adding the concept of self-efficacy, because it is believed that for an individual to adopt a new preventative behaviour, he or she has to believe in his or her capability that he or she will be able to adopt the behaviour.

When applied to condom use behaviour, HBM indicates that there are four interrelated elements that must be present for a high school learner to practise safe sex by using a condom. Firstly, a learner must perceive that he or she is susceptible to STIs, falling pregnant or impregnating. Secondly, a learner must perceive the consequences of STIs, falling pregnant or impregnating. Thirdly, a learner must perceive the benefits of using a condom. Finally, this learner must perceive that the barriers to using condom such as embarrassment, laziness to collect condoms from a clinic are outweighed by the benefits of using a condom.

The Health Belief Model

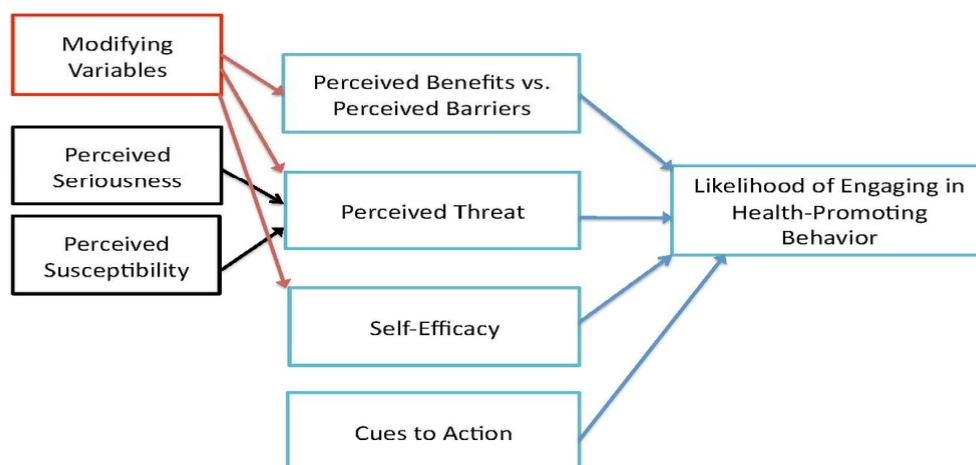


Figure 2.1: Health belief model

Image from:

<https://www.google.co.za/search?q=health+belief+model&dcr=0&source=lnms&tbm=isch&sa=X&ved>

[=0ahUKEwjmg8dxa_WAhWKLMAKHeoKACgQ_AUICigB&biw=1366&bih=652#imgrc=LhKPvIXI7WXI
LM](#)

2.14 Conclusion

In this this chapter literature related to the study topic was reviewed, and the objectives of the study were presented. This includes the prevalence of condom use in South Africa, knowledge, attitudes and practices on condom use, adolescent sexual and reproductive health, South African legislation related to condom use, and the conceptual frame work.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

Schwandt (2007) defines research methodology as a theory of how an inquiry should proceed. In this section the research approach, research design, study setting, study population, sampling and data collection instrument used in the study are addressed. Measures to ensure the reliability of the study findings, the data collection method, data analysis, and research ethics are also explained in the chapter.

3.2. Research approach

The study was quantitative in nature. Quantitative research comprises of the accumulation of information so that data can be measured and subjected to statistical treatment in order to support or disprove knowledge claims (Williams, 2007). In this investigation the researcher gathered information numerically and measured the variables under investigation.

3.3. Research Design

Babbie and Mouton (2016) define research design as a plan or blueprint of how the researcher intends to conduct the study in order to find solutions to the research problem. For the purpose of this study, cross-sectional descriptive research design was used. Cross-sectional descriptive research design describes phenomena as they exist and collects data at one point in time. It is used to identify and obtain information on the characteristics of a particular issue (Akhtar, 2016). The researcher used the descriptive research design because the study describes the knowledge, attitude and practices of high school learners regarding condom use. Data were collected at one point in time. Responses from respondents were not altered at all and are reported as given.

3.4. Study Setting

According to Bhattacharya (2012) a research setting can be viewed as the physical, social, and cultural site in which the researcher conducts a study. This study was conducted in the Greater Giyani Municipality which is situated in the Mopani District of Limpopo Province, South Africa. The municipality is located approximately 185km

from Polokwane, and has a population of 244217. The Greater Giyani municipality has 30 wards and 91 villages; 90.5% of the population is Tsonga (Census, 2011). There are 34 primary health care clinics, however, in some villages there are no health facilities and community members have to travel long distances to access health facilities. There is a level one district hospital, Nkhensani hospital, and one specialised mental health hospital called Evuxakeni. The majority (74.4%) of the people in Greater Giyani in the age group of 5 to 19 years attend school (Greater Giyani Municipality, 2012). Condoms are distributed to PHC facilities, “spaza” shops and taverns where people are able to access them whenever they need them.

3.5. Population

Population is defined as a study object and consists of individuals, groups, organisations, human products and events or the conditions to which they are exposed (Welman, Kruger & Mitchell, 2005). The target population of this study was high school learners from Greater Giyani Municipality and the accessible population was learners from high schools that fall under the selected Circuit.

3.5.1. Inclusion criteria

For learners to be included and take part in this study, they were required to be attending secondary school in the selected circuit.

3.5.2 Exclusion criteria

Learners who were in high schools that are not in the selected circuit were not included in the study.

3.6. Sampling and procedure

Alvi (2016) defines sampling as a process of extracting a sample from a population. Bless, Higson-Smith and Kagee (2006) describe sampling as a technique used to draw a sample from a given population in order to represent that particular population.

3.6.1 Sampling of site

The Greater Giyani Municipality consists of five education circuits, namely, Nsami, Klein Letaba, Groot Letaba, Manombe and Shamavunga Circuits. In the present investigation Shamavunga circuit was purposively selected to be part of this study

because it reported higher rates of learner pregnancies than other circuits in the Greater Giyani Municipality.

Table 3.1: Population framework

Distribution of high school learners registered under Shamavunga circuit

Name of secondary school	Number of learners
Chameti	222
Gija- Ngove	1066
Khomani Mbhalati	276
Mahumani	682
Malenga	704
Manghezi	202
Maphusha	519
Mukula	624
Nhluvuko	430
Nwakhada	212
Phayizani	311
Semendhe	391
Sikhunyani	337
13	Total population 5976

Source: (Shamavunga, Circuit Manager)

3.6.2. Sampling of respondents

Respondents for this study were selected using the probability-stratified sampling method. Learners were grouped according to grades in each school and the grades were treated as strata. Simple random sampling was used to select learners from each grade. The number of learners to be sampled per grade was computed by dividing the total number of learners in the grade by the sum of school population size, multiplied by the sample size per school. The number of learners to be selected from each school was obtained by dividing the total number of learners in the school by the total number of learners in the circuit, multiplied by the total sample size for the study.

Table 3.2: Sampling Framework

Name of secondary school	Total number of learners per school	Sample size per school
Chameti	222	14
Gija- Ngove	1066	67
Khomani Mbhalati	276	17
Mahumani	682	43
Malenga	704	45
Manghezi	202	13
Maphusha	519	32
Mukula	624	39
Nhluvuko	430	26
Nwakhada	212	13
Phayizani	311	20
Semendhe	391	25
Sikhunyani	337	21
Total 13	5976	375

The total sample size was calculated using the Slovin's formula below:

$$n = \frac{N}{1 + Ne^2}$$

n=sample size of adjusted population

N=population size

e=accepted level of error usually set at 0.05

$$n = \frac{N}{1 + Ne^2}$$

$$n = \frac{5976}{1 + (5976 \times 0.05)^2}$$

$$n = \frac{5976}{1 + 14.9}$$

$$n = \frac{5976}{15.9}$$

$$n = \frac{5976}{15.9}$$

$$n = \frac{5976}{15.9}$$

$$n = 375$$

$$n = 375$$

The population size (5976 learners) was added with value 1 and multiplied by level of error 0.05². After that the population size (which is the denominator) was divided by the numerator obtained after adding the population size with the value 1 and multiplying with 0.05².

3.7. The measuring instrument

A research instrument is the tool utilized by researchers for gathering information (Chia-Chien & Brian, 2012). For the purpose of this study, a self-administered questionnaire consisting of close ended questions was used as the instrument to gather information. The instrument was developed in English and was not translated into another language on the grounds that the respondents were secondary school learners and the researcher believed that they were proficient in the English language because it the language of instruction in the selected schools.

3.8. Pre-test of the instrument

Pre-testing refers to a collection of techniques and activities which allow researchers to assess survey questions, a questionnaire and/or other survey procedures before the actual data collection process is conducted (Casper, Peytcheva & Cibelli, 2011). The main aim was to determine whether the respondents would be able to understand the questionnaire and be able to answer the questions contained in the instrument. As a result of pre-testing, it was discovered that some items did not have the response options from which respondents could choose their answers. It was also found that some questions contained words which were difficult for learners to understand. The instrument was amended to complete incomplete questions and to make the whole document easier to understand.

3.9. Data Collection

Data collection is the method of collecting and assessing information on variables of interest, in a recognised systematic way that enables one to answer specified research questions, test hypotheses, and evaluate outcomes (Welman *et al.*, 2005). In this study, data were collected using a self-administered questionnaire developed by the researcher. The researcher visited the respondents at their respective schools where they were gathered in a classroom where those who consented to take part in the study were each handed a questionnaire and given time to complete it. The

researcher was present in order to collect completed questionnaires and also to clarify any misconceptions that arose.

3.10. Data management and analysis

Flick (2013) defines data analysis as the way toward bringing order, structure and sense out of the mass of assembled data. In this study, gathered data was analysed using the Statistical Package for Social Sciences (SPSS) version 25.0. Descriptive statistics was used to analyse the data. Data were presented in the form of bar charts and frequency tables. A Chi-square test was used to determine the relationship between practices regarding condom use and the demographic factors of the respondents such as age, gender, grade and religion. The level of significance was set at $P \leq 0.05$, any value that was equal to, or less than 0.05 was regarded as significant (association), while any value above 0.05 was regarded as being not significant (no association).

3.11. Ethical considerations

3.11.1 Permission to conduct the study

The research proposal was presented to the School of Health Sciences Higher Degree Committee, and thereafter was submitted to the University Higher Degree Committee for approval (See Appendix 9). The proposal was also submitted to the University Ethics Committee for ethical clearance (See Appendix 7). Consent to conduct the study was requested from the Department of Education. Principals of all participating schools and the Circuit Manager were consulted and informed about the study (See Appendix 8).

3.11.2 Confidentiality

According to Bless, *et al.* (2006), confidentiality is an ethical obligation in most research. Information given by respondents, particularly delicate and personal information, should be safeguarded and made inaccessible to anyone other than the researcher. The researcher ensured that information from respondents was kept in a confidential manner; unauthorized access to the information was prohibited. The information obtained from respondents was locked in a safe place to which no other person had access. Respondents' personal information that might lead to the

identification of respondents has not been published anywhere in the research report.

3.11.3. Voluntary participation

According to Babbie and Mouton (2016) participation should be voluntarily, respondents should not be threatened or compelled to participate in the study, and they should do it of their own will. In this study, participation was voluntary, the researcher informed the respondents about their right to withdraw from the study at any time (See Appendix 2). None of the respondents were forced to participate.

3.11.4 Informed consent

Nijhawan, Janodia, Muddukrishna, Bhat, Bairy, Udupa & Musmade (2013) contend that informed consent means that respondents or participants are sufficiently informed of the type of information required of them, and why the information is required. In addition it means that respondents are informed of how they are expected to participate, how the study will directly or indirectly affect them, and how they will benefit from the study. The researcher ensured that written consent was obtained from each respondent after the purpose and goals of the study had been explained (See Appendix 3). The parents or legal guardians of respondents who were minors at the time of the study were asked to give consent on their behalf (See Appendix 6). Moreover, such respondents were required to complete an assent form in approval of their parents or legal guardian consent for participation in the study (See Appendices 4 and 5).

3.12. Validity and reliability of the study

3.12.1 Validity

Validity refers to the extent to which an instrument measures what it is supposed to measure (Chia-Chien & Brian, 2012). In order to ensure validity of the instrument, it was forwarded to the supervisor to validate whether it would be able to measure what it was supposed to measure. The supervisor approved the instrument as measuring the variables of the study. Construct validity as a measure of validity was maintained by ensuring that the instrument was consistent with other instruments that have been used in similar studies. Moreover, content validity was maintained by ensuring that the instrument covered all the objectives of the study as research experts tested the instrument to assess if it included the content of constructs that

would be measured in the study. The instrument was also edited by English specialists to ensure language correctness.

3.12.2 Reliability

According to Chia-Chien & Brian (2012) reliability refers to the degree to which an instrument reliably measures what it is intended to measure and that it would give the same results each time it is applied. In order to ensure the reliability of the instrument, the test-retest method was used by re-administering the instrument to 10% of the sample size (in other words, 37 learners). The tests took place on different occasions and similar results were found after the results had been compared.

3.13. Dissemination and interpretation of results

A copy of the research report will be submitted to the Library of the University of Venda, the Department of Health and the Department of Education. The findings will also be published in accredited journals and presented at both national and international research conferences.

3.14 Conclusion

The methodology of this study was discussed in this chapter. It included the study setting, study population, design, sampling, data collection process, measuring instrument, pre-testing of the research instrument, ethical considerations, validity and reliability, as well as an explanation of how the results will be disseminated.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

4.1 Introduction

In this chapter the findings of the study are presented. Responses from study respondents were compiled into frequency tables, converted into percentages and presented in charts, bar graphs and tables. This was done to facilitate easy analysis and understanding of the data of the study that sought to determine the knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo province.

The data were analysed based on the study specific objectives and results related to specific study objectives are presented in the subsequent sections. Three hundred and seventy five (375) questionnaires were distributed to respondents and 346 questionnaires were satisfactorily filled in and returned, thus the response rate was 92.2 %.

4.2 Demographic information

In order to gather demographic information about the study respondents, questions on issues such as age, gender, people living with respondents, school grade and the religion of respondents were asked in the first section of the questionnaire.

4.2.1 Respondents demographic information

4.2.1.1 Age of respondents

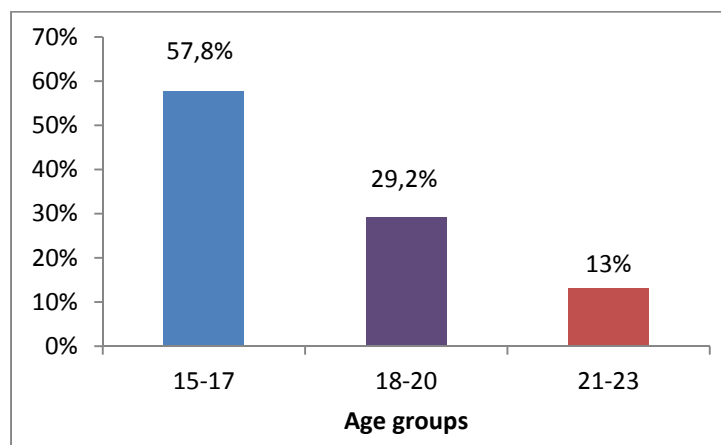


Figure 4.1: Age distribution of respondents (n=346)

Figure 4.1 shows the age distribution of the respondents. About 200 (57.8%) were aged 15-17 years and those who were aged 18-20 years numbered 101 (29.2%) while 45 (13%) were aged 21-23.

4.2.1.2 Gender of respondents

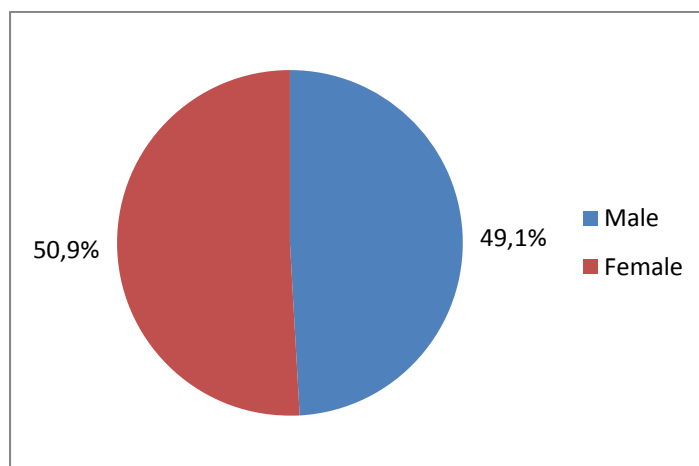


Figure 4.2: Gender distribution of respondents (N=346).

The study findings show that 176 (50.9%) of the respondents were female high school learners while 170 (49.1%) were male high school learners. This indicates that the distribution of respondents in the study was across both genders, and therefore, gender was evenly distributed.

4.2.1.3 People with whom the respondents live

Table 4.1: People with whom the respondents live

People living with respondents	Frequency	Percentage (%)
Mother	110	31.8%
Father	12	3.5%
Both parents	145	41.9%
Grand mother	49	14.2%
Grand father	3	0.9%
Alone	25	7.2%
Relatives	2	0.6%
Total	346	100%

The study findings show that 110 (31.8%) of the respondents lived with their mothers, while 12 (3.5%) lived with their fathers. On the other hand, 145 (41.9%) indicated that they lived with both parents, 49 (14.2%) lived with their grandmothers and three (0.9%) lived with grandfathers. Moreover, 25 (7.2%) lived alone while two (0.6%) lived with their relatives.

4.2.1.4 School grade levels of respondents

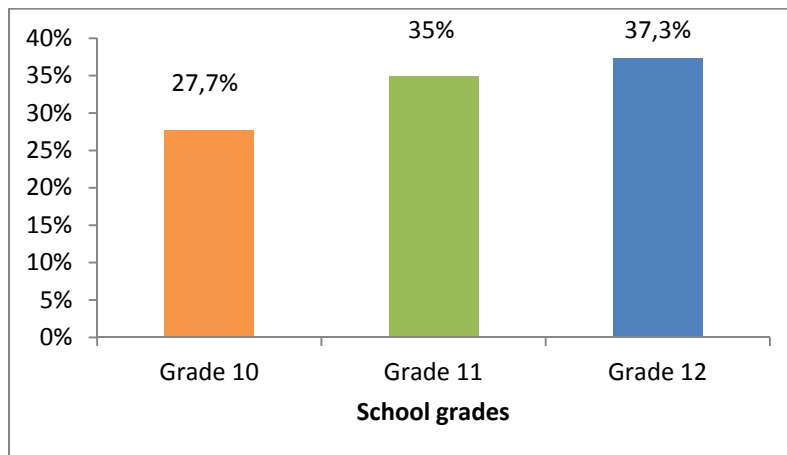


Figure 4.3: Distribution of respondents across school grades (N=346)

The study findings show that 129 (37.3%) of the study respondents were in Grade 12 while 121 (35.0%) were in Grade 11. On the other hand 96 (27.7%) of the respondents were in Grade 10. Study findings indicate that the majority of the study respondents were in Grade 12 and they constituted 37.3% which is higher than the percentages of respondents from other grades. The distribution of the study respondents was in line with the sampling procedure as it sought to select respondents from the three highest high school grades.

4.2.1.5 Religion of respondents

Table 4.2: Distribution of respondents across religions

Religion	Frequency	Percent (%)
Christianity	339	98.2%
Islam	2	0.6%
Hinduism	2	0.6%
Judaism	1	0.3%
Traditional	1	0.3%
Total	345	100%

The study revealed that 339 (98.2%) of the respondents follow the Christian religion while 2(0.6%) respondents indicated that they were Hindus. Moreover, one (0.3%) respondents followed Judaism. One (0.3%) respondent followed a traditional religion. Only two (0.6%) of the study respondents indicated that they were Muslims

4.2.1 Knowledge of condoms and their use

4.2.1.1 A condom offers protection against HIV/AIDS, STIs and pregnancy

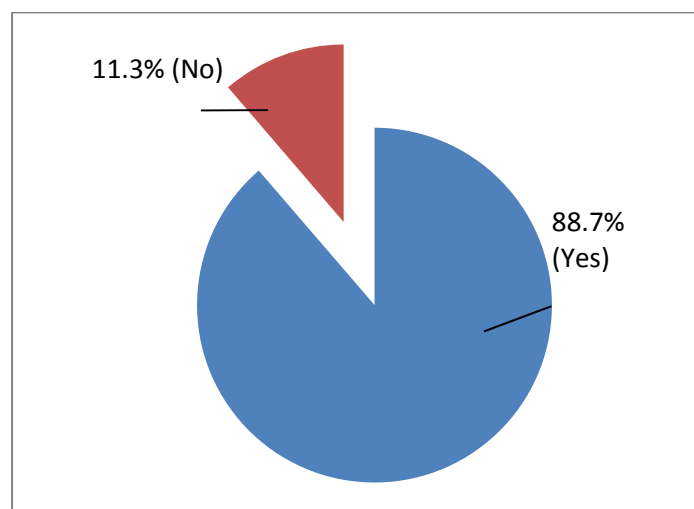


Figure 4.4: Knowledge of condom protection against HIV/AIDS, STIs and pregnancy

The findings show that 307 (88.7%) of the study respondents indicated that they knew about the protection that condoms give against HIV/AIDS, STIs and pregnancy, while 39 (11.3%) indicated that they didn't know. These findings indicate that the majority of the study respondents who were high school learners knew about the protection that condoms give against HIV/AIDS, STIs and pregnancy.

4.2.2 Knowledge of expiry dates of condoms

4.2.2.1 A condom has an expiry date

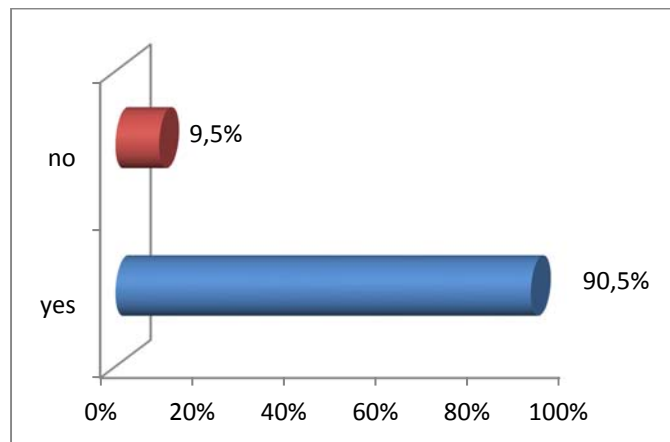


Figure 4.5: Respondents' knowledge of condom expiry date

The findings of the study revealed that 313 (90.5%) respondents knew that a condom has an expiry date, while 33 (9.5%) indicated that they didn't know that a condom has an expiry date. These findings further indicate that the majority of the study respondents who were high school learners knew about condom expiry dates.

4.2.3 Oil-based lubricant (E.g. Oil: Vaseline) can be used with a condom

Table 4.3: Cross tabulation of gender and use of an oil-based lubricant with condoms (N=346)

Gender	Yes		No	
	f	%	f	%
Male	157	50.2%	13	39.4%
Female	156	49.8%	20	60.6%
Total	313	100%	33	100%

Table 4.3 shows that 313 respondents believed that an oil-based lubricant can be used with a condom. Of the 313, respondents who believed this 157 (50.2%) were male learners while 156 (49.8%) were female learners. The table also shows that 33 respondents indicated that a condom cannot be used with an oil-based lubricant. Of the 33 respondents who indicated this, 20 (60.6%) were female learners while 13 (39.4%) were male learners.

4.2.4 It is alright to put on a condom just before ejaculation

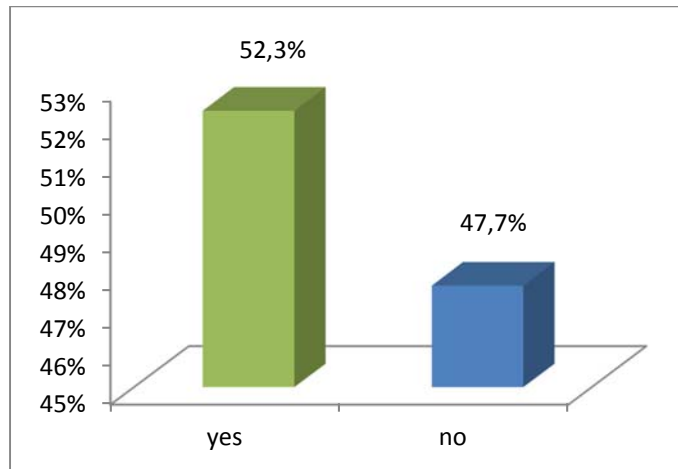


Figure 4.6: knowledge on putting a condom before ejaculation (N=346)

The study findings show that 165 (47.7%) of the study respondents did not know that it is in order to put on a condom just before ejaculation, while 181 (52.3%) indicated that they knew that it is in order to put on a condom just before ejaculation. The majority of the study respondents knew that a condom must be worn before ejaculation.

4.2.5 Condom should be unrolled before being put on the penis

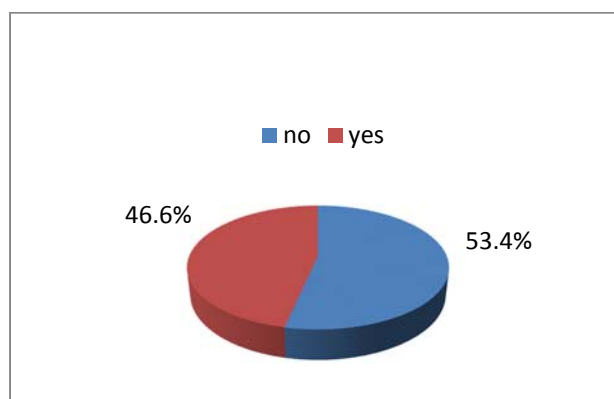


Figure 4.7: Knowledge of unrolling a condom before it is put on the penis (N=346).

The study findings indicate that 185 (53.4%) of the study respondents reported that they did not know that a condom should be unrolled before being put on to the penis, while 161 (46.6%) indicated that they knew that one must unroll a condom before putting it onto the penis. The findings indicate that the majority of the study

respondents did not know that a condom should be unrolled before being put onto the penis.

4.2.6 A condom should be put on when the penis is erect before any contact with a vagina

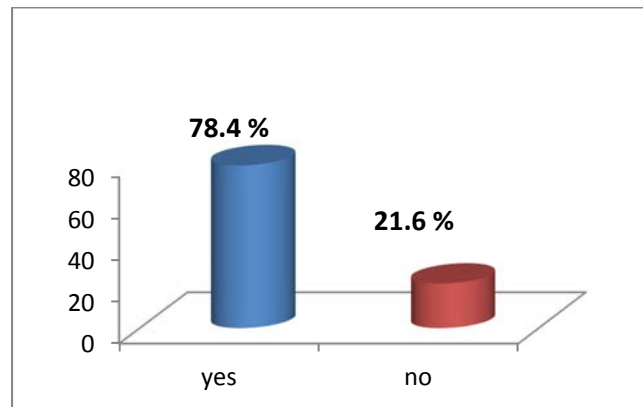


Figure 4.8: Knowledge of when to put a condom on the penis before contact with a vagina (N=346)

The study findings show that 271 (78.4%) indicated that they knew that a condom should be put on when the penis is erect before any contact with a vagina, while 75 (21.6%) indicated that they did not know that a condom should be put on when the penis is erect before any contact with a vagina. The findings revealed that the majority (78.4%) of the study respondents knew that a condom should be put on when the penis is erect before any contact with a vagina.

4.2.7 A condom can be used repeatedly

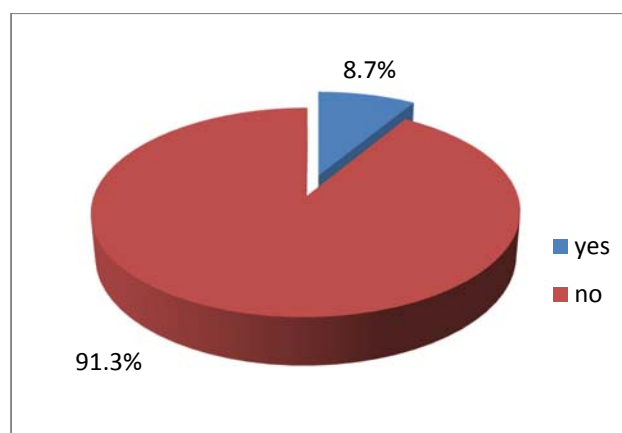


Figure 4.9: Respondents response on using a condom repeatedly (N=346)

The study findings indicated that 316 (91.3%) of the study respondents reported that a condom cannot be used repeatedly, while 30 (8.7%) reported that a condom can be used repeatedly. The findings indicated that the majority of the study respondents knew that a condom cannot be used repeatedly.

4.2.8 A person wearing a condom must withdraw his penis immediately after ejaculation

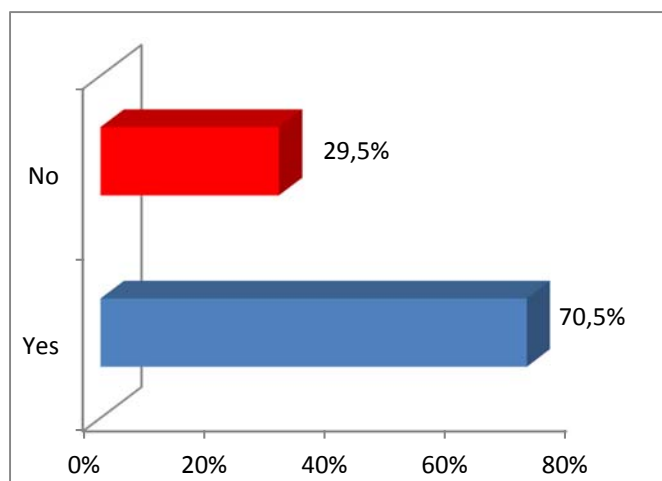


Figure 4.10: knowledge of withdrawing a penis from a condom (N=346)

The study findings show that 244 (70.5%) of the respondents knew that a person wearing a condom must withdraw his penis immediately after ejaculation, while 102 (29.5%) indicated that they did not know. The findings indicated that the majority of the respondents knew that a penis must be withdrawn immediately after ejaculation by the person wearing a condom.

4.2.9 Condoms are found in clinics

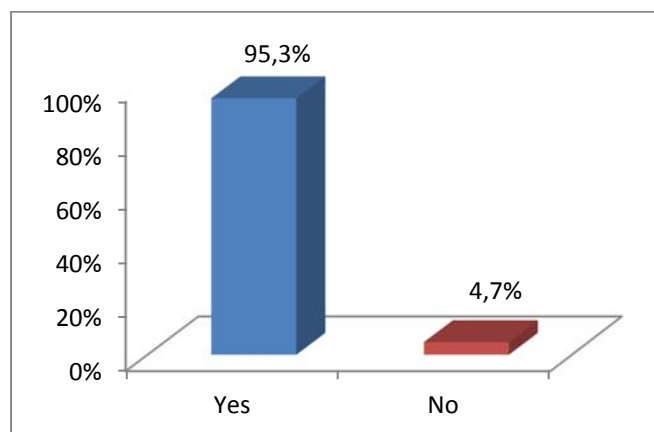


Figure 4.11: knowledge of condoms availability in clinics (N=346)

The study findings showed that 330 (95.3%) of the respondents knew that condoms can be found in clinics, while 16 (4.7%) indicated that they did not know that condoms can be found in clinics.

4.2.10 Condoms can also be found in hospitals

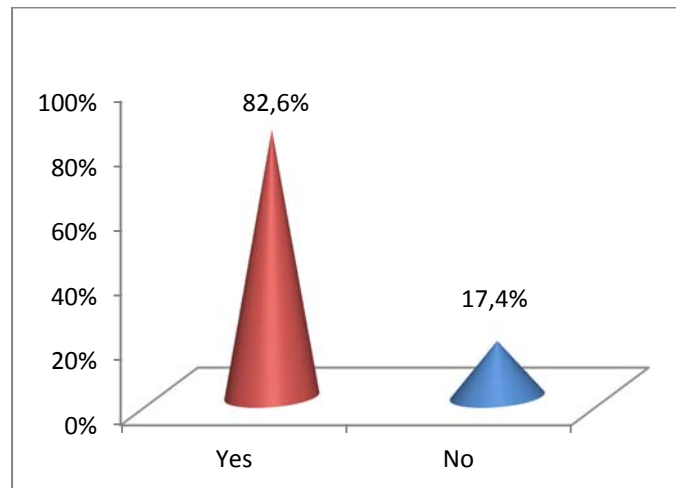


Figure 4.12: Knowledge of condom availability in hospitals (N=346)

The findings revealed that 286 (82.6%) of the respondents were aware that condoms can also be found in hospitals. However, 60 (17.4%) of them were not aware that condoms were also available in hospitals.

4.2.11 Condoms can be bought from the supermarket and shops

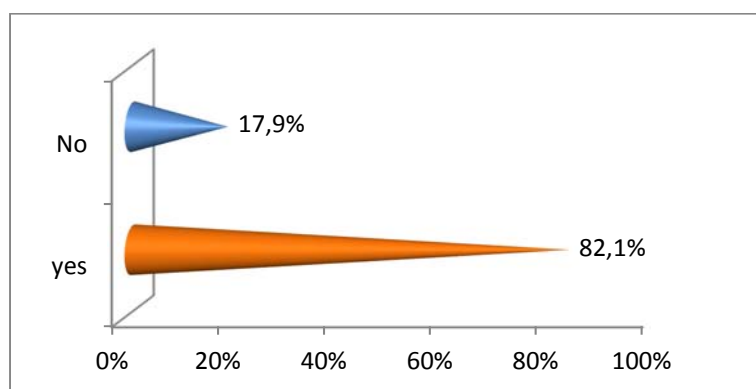


Figure 4.13: Knowledge of condom availability in supermarkets and shops (N=346)

The findings showed that 284 (82.1%) of the respondents who were high school learners indicated that they knew that condoms are sold at supermarkets and shops, while 62 (17.9%) did not know that condoms were sold in supermarkets and shops.

4.2.12 Sources of condom knowledge

Table 4.4: Respondents' sources of knowledge about condoms

Item	yes		no		Total	
	(f)	(%)	(f)	(%)	(n)	(%)
I heard about condoms from my friends	180	52%	166	48%	346	100%
I heard about condoms from the radio	224	65%	121	35%	345	100%
I heard about condoms from television	268	77.5%	78	22.5%	346	100%
I heard about condoms from health care providers	313	90.5%	33	9.5%	346	100%
I heard about condoms from educational talks	258	75%	87	25.2%	345	100%
I read about condoms in news papers	175	50.7%	170	49.3%	345	100%

The findings in Table 4.4 show that 180 (52%) of the respondents indicated that they heard about condoms from their friends, while 166 (48%) indicated that they had never heard about condoms from their friends. Furthermore, 225 (65%) of the respondents reported having heard about condoms from the radio, while 121 (35%) had never heard about condoms from the radio. Out of the 346 study respondents, only 78 (22.5%) indicated that they had never heard about condoms from the television; the rest of them, 268 (77.5%) reported having heard about condoms from television.

Moreover, 313 (90.5%) of the study respondents reported that they had heard about condoms from health care providers; however, 33 (9.5%) indicated having not heard about condoms from health care providers. With regard to educational talks as one of the sources of condom knowledge, 259 (74.8%) respondents indicated that they heard about condoms from educational talks, and only 87 (25.2%) had never heard about condoms from such talks. Furthermore, from all the study respondents (n=346), 171(49.3 %) indicated never reading about condoms in a newspaper and 175 (50.7 %) indicated that they had read about condoms in a newspaper.

4.3 Attitudes towards condoms

Table 4.5 Respondents' attitudes towards condoms

Item	Agree		Strongly agree		Disagree		Strongly disagree	
	(f)	(%)	(f)	(%)	(f)	(%)	(f)	(%)
A condom reduces pleasure during sexual intercourse	73	21.2	77	22.3	101	29.25	94	27.25
A condom makes sex painful	46	13.3	221	50	38	11.0	41	11.8
Condom use promotes having multiple sex partners (promiscuity)	56	16.2	83	24.1	102	29.55	104	29.85
Condoms smell bad during sexual intercourse	144	41.65	145	41.85	33	9.5	24	6.9
Condom tear inside vagina and remain inside	154	44.5	148	42.8	19	5.5	25	7.2
My religion does not allow people to use condoms	20	5.8	23	6.6	131	38	172	50
I am too lazy to go and collect condoms from the clinic	130	37.65	116	33.65	41	11.9	57	16.5
I feel embarrassed any time I buy condoms	176	51.2	50	14.5	55	16	63	18.3
Condoms are expensive	33	9.5	20	5.8	178	44.6	114	39.8
Using condoms means you and your partner do not trust each other	142	41	93	26.9	54	15.6	57	16.5
Condoms are for married people	14	4	10	2.9	150	36.3	165	56.8
Condoms are for elders	15	4.3	18	5.2	161	46.6	152	43.9

The study findings indicated that 73 (21.2%) of the study agreed, while 77 (22.3%) strongly agreed that condoms reduce pleasure during sexual intercourse. Moreover, 101 (29.25%) agreed while 94 (27.25%) strongly disagreed that pleasure is reduced by condoms during sexual intercourse. The study findings also indicate that 46 (13.3%) agreed and 221 (50%) strongly agreed that condoms make sex painful. Furthermore, 38(11%) disagreed while 41(11.8%) strongly disagreed that condoms make sex painful. Moreover, 56 (16.2%) respondents agreed while 83 (24.1%) strongly agreed that using condoms promotes having multiple sex partners. Furthermore, 102 (28.55%) disagreed while 104 (29.85%) strongly disagreed that using a condom promotes having multiple sex partners. The findings also reveal that

33 (9.5%) disagreed and 24 (6.9%) strongly disagreed that condoms smell bad during sexual intercourse. Additionally, 144 (41.6%) agreed while 145 (41.85%) strongly agreed that a condom smell bad during sexual intercourse.

Table 4.5 also indicates that 19(5.5%) disagreed while 25 (7.2%) strongly disagreed that condoms can tear and remain inside the vagina. Moreover, 154 (44.5%) agreed and 148 (42.8%) strongly agreed that condoms can tear and remain inside the vagina. Moreover, 131 (38%) disagreed while 172 (50%) strongly disagreed that their religions prohibit them from using condoms. Furthermore, 20 (5.8%) agreed while 23 (6.6%) strongly agreed that their religion prohibit them from using condoms.

The study findings further indicated that 130(37.6%) agreed while 116 (33.65%) strongly agreed that they are lazy to go and collect condoms from a clinic. Furthermore, 41(11.9%) disagreed while 57 (16.5%) strongly disagreed that they are lazy to go to collect condoms from a clinic. The study findings show that 176 (51.2%) agreed while 50 (14.5%) strongly agreed that they feel embarrassed to buy condoms. Moreover, 55 (16%) disagreed while 63 (18.3%) strongly disagreed that they feel embarrassed to buy condoms.

The study findings show that 33 (9.5%) agreed while 20 (5.8%) strongly agreed that condoms are expensive. Furthermore, 178 (44.6%) disagreed while 114 (39.8%) strongly disagreed that condoms are expensive. Furthermore, 142 (41%) agreed while 93 (26.9%) strongly agreed that using condoms means partners do not trust each other. Additionally, 54 (15.6%) disagreed while 57 (16.5%) strongly disagreed that using condoms means partners do not trust each other.

The findings also indicate that 171 (49.5%) respondents strongly disagreed while 150 (36.3%) disagreed that condoms are for married people. Moreover, 14 (4%) respondents agreed while 10 (2.9%) strongly agreed that condoms are for married people. The findings also show that 161 (46.6%) disagreed while 152 (43.9%) strongly disagreed that condoms are for their elders. Furthermore, 18 (5.2%) respondents agreed while 15 (4.3%) strongly agreed that condoms are for elders.

4.4 Practices of condom use

4.4.1 Have you ever engaged in sex?

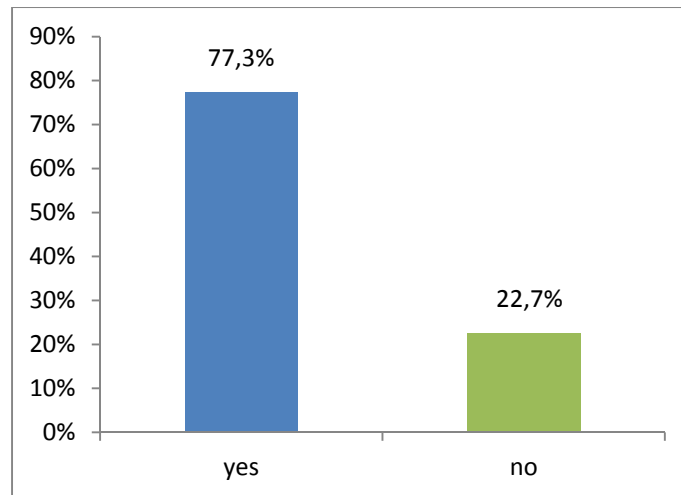


Figure 4.14: Distribution of respondents who engaged and who did not engage in sex (N=346)

The study findings show that 267 (77.3%) of the respondents indicated that they once engaged in sex, while 79 (22.7%) never engaged in sex.

4.4.2 How often do you use a condom when you have sexual intercourse?

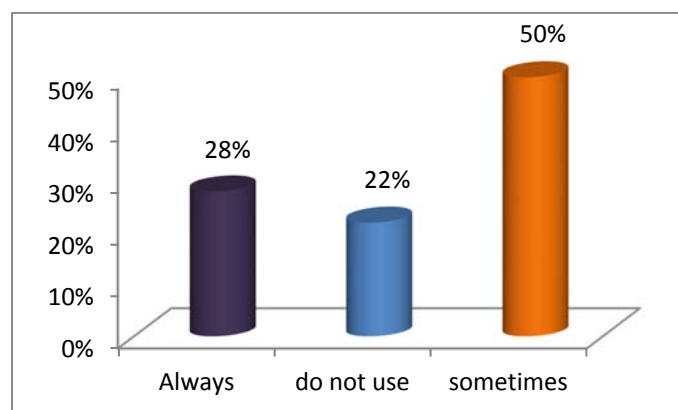


Figure 4.15: Frequency of condom use by respondents (N=282)

The findings indicate that 79 (28%) of the respondents indicated that they always use condoms while 62 (22%) do not use condoms whenever they engage in sexual

intercourse. However, 141 (50%) indicated that they sometimes use condoms when they engaged in sexual intercourse.

4.4.3 Did you use a condom the last time you had sexual intercourse?

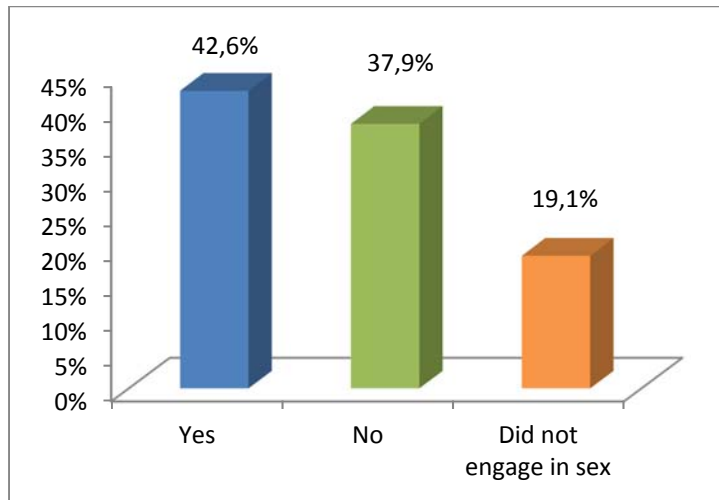


Figure 4.16: condom use at last sex (N=345)

The study findings indicate that 131 (37.9%) of the respondents did not use a condom while 147 (42.6%) indicated that they used a condom the last time they had sexual intercourse. Despite that, 67 (19.1%) indicated that they do not engage in sexual acts.

4.4.4 Which one do you prefer to use: Male or Female condoms?

Table 4.6: Preference of condom type

Responses	(f)	(%)
Male condom	251	74%
Female condom	22	6.5%
Do not engage in sex	66	19.5%
Total	339	100%

The table above indicates that 251 (74%) respondents indicated that they prefer male condoms while 22 (6.5) prefer female condoms. Despite that, 66 (19.5%) indicated that they do not engage in sex; thus, they do not prefer any condom.

4.5 Factors that influence condom use

4.5.1 Between you and your boyfriend who decides on whether a condom should be used or not?

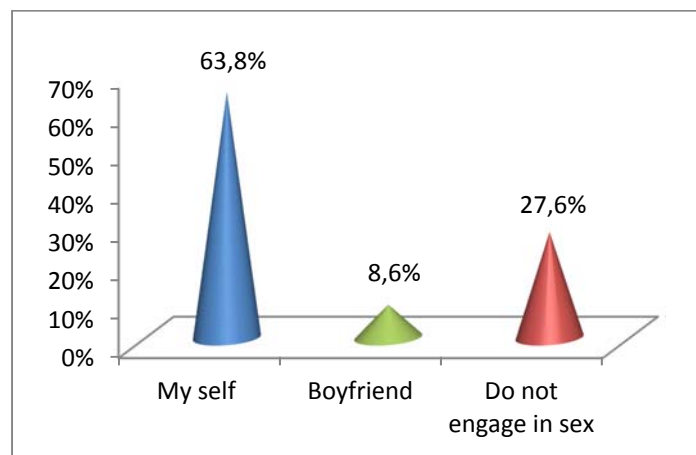


Figure 4.17: Decision on condom use for girls (N=174)

The above figure indicates that 111 (63.8%) of the female respondents are the ones who decide on whether to use condoms or not instead of their boyfriend, while 15 (8.6%) indicated that their boyfriends decide on whether a condom should be used or not. However, 48 (27.6%) of the female respondents indicated that they do not engage in sex, thus no decision about condom use is made.

4.5.2 Between you and your girlfriend who decides on whether a condom should be used or not?

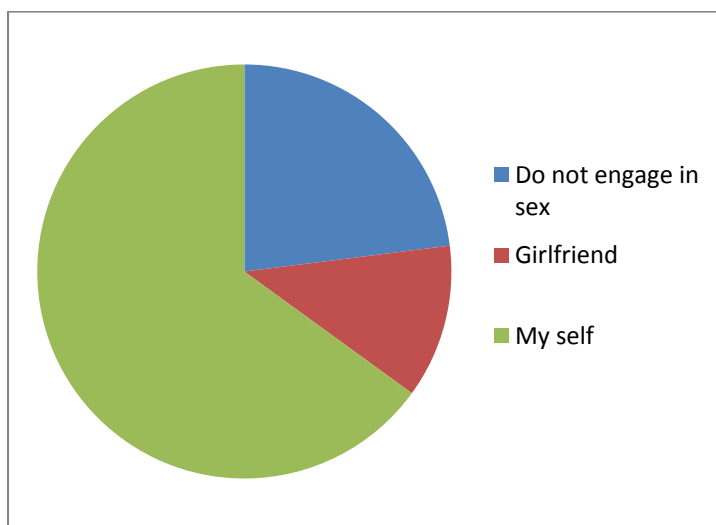


Figure 4.18: Decision on condom use for boys (N=162)

Figure 4.18 indicates that 105 (65%) of the male respondents indicated that they decide on whether a condom should be used or not, instead of their girlfriends, while 37 (23%) indicated that it is decided by their girlfriends whether a condom should be used or not. Despite that, 20 (12%) of the male respondents indicated that they do not engage in sex, therefore no decision about condom use is made.

4.5.3 Is your boyfriend the person who buys everything you want?

Table 4.7: Responses to whether boyfriends buy everything females want

Responses	(f)	(%)
Yes	50	28.7%
No	74	42.5%
Do not have a boyfriend	50	28.7%
Total	174	100%%

This question was for female respondents only and therefore only female responses were considered. The table above indicates that 74 (42.5%) respondents indicated that their boyfriends were not the persons who buy everything they wanted, while 50 (28.7%) of the female respondents indicated that their boyfriends were the persons who buy everything they want. However, 50 (28.7%) indicated that they do not have boyfriends.

4.5.4 If your boyfriend is the person who buys everything you want, do you let him decide on whether condoms should be used or not?

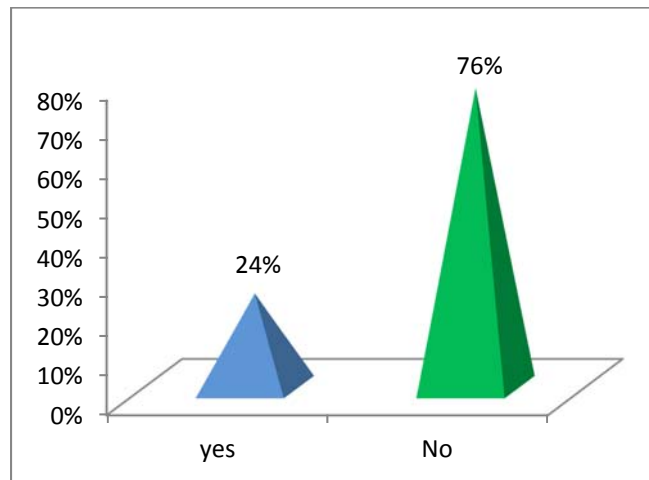


Figure 4.19: Distribution of respondents who allow and do not allow their boyfriends to decide on when to use condoms although their boyfriends buy everything they want (N=50)

This question was for female respondents who indicated that their boyfriends buy everything they want. The above figure indicates that 38 (76%) of the female respondents indicated that they do not allow their boyfriends to decide on whether a condom should be used although their boyfriends buy everything the respondents want. On the other hand, 12 (24%) of the respondents indicated that they allowed their boyfriends to decide whether a condom should be used as they buy everything their girlfriends want.

4.5.5 Did your friends tell you to use condoms?

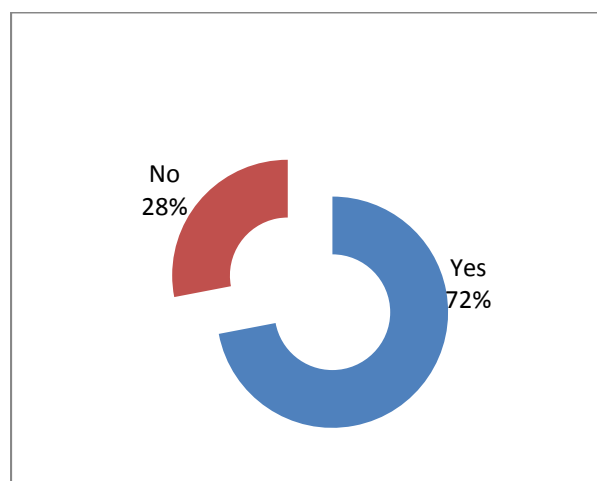


Figure 4.20: Distribution of respondents who were told and not told to use condom by friends (N=336)

The above figure indicates that 242 (72%) of the respondents were told while 94 (28%) were not told to use condoms by their friends.

4.5.6 Were you advised to use condom by your church?

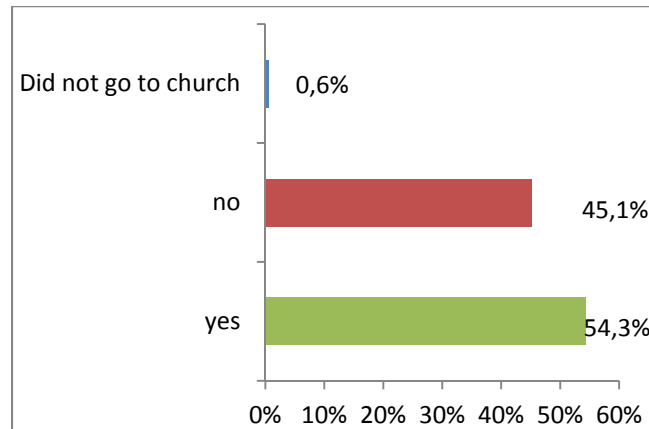


Figure 4.21: Distribution of respondents advised and not advised to use condom by their church (N=237).

Figure 4.21 indicates that 183 (54.3%) were advised, while 52 (45.1%) were not advised by their church to use condoms. However, 2 (0.6%) indicated that they did not go to church.

4.5.7 Have you ever used substances?

Table 4.8: Response to whether respondents had used substances

Responses	Gender	Frequency(f)	Percent (%)
Yes	Male	90	47%
	Female	71	
No	Male	78	53%
	Female	103	
Total		N=342	100%

Table 4.8 shows that 161 (47%) of the respondents indicated that they once used substances. Of the 161 respondents who indicated that they once used substances, 90(26%) of them were males while 71 (21%) were females. Moreover, 181 (53%) indicated that they had never used substances. Of the 181 (53%) 53% who had never used substances, 78(23%) of the respondents were males while 103 (30%) were females.

4.5.8 Which of the following substances did you use?

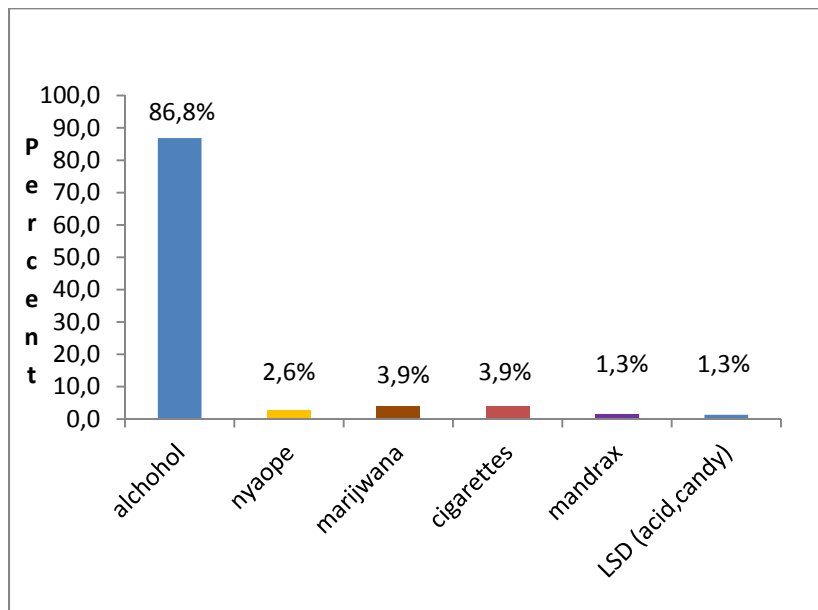


Figure 4.22 Substances used by respondents (N=152)

This question was for respondents who indicated that they once used substances. Out of 161 respondents who indicated that they used substances, only 152 indicated the type of substances they once used. The above figure shows that 132 (86.8%) of the respondents consumed alcohol, while 4 (2.6%) used nyaope. Furthermore, 6 (3.9%) used marijuana, while another 6 (3.9%) smoked cigarettes. Despite that, two respondents (1.3%) once used mandrax while the same percentage (1.3%) also once used LSD (acid, candy).

4.5.9 Did you use a condom at the time that you engaged in sexual intercourse while under the influence of a substance?

Table 4.9: Condom use during sexual intercourse while under the influence of substances

Responses	(f)	(%)
Yes	58	27%
No	65	30.2%
Do not engage in sex while under influence of substance	43	20%
Never engaged in sex	49	22.8%
Total	215	100%

Table 4.10 shows that 58 (27%) of the respondents indicated that they used a condom while 65 (30.2%) indicated that they did not use a condom at the time that they engaged in sex while under the influence of substances. Furthermore, 43 (20%) indicated that they did not engage in sex while under the influence of substances, while 49 (22.8%) had never engaged in sex.

4.5.10 Did your parents/legal guardians talk to you about sexual issues at home including using condoms?

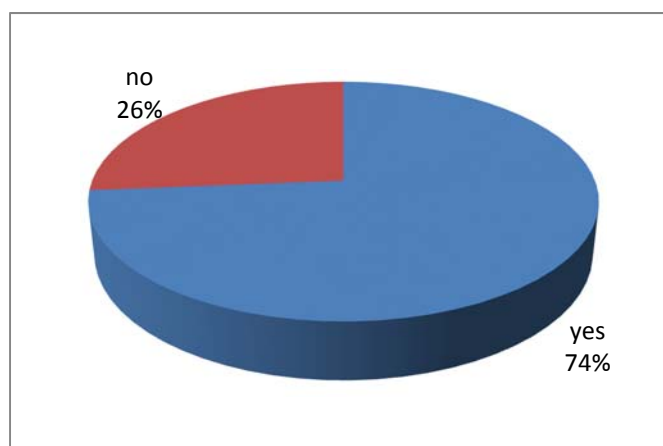


Figure 4.23: Parents/legal guardians and respondents communication about sexual issues including condom use with the respondents (N=342)

Figure 4.23 shows that 74% (253) indicated that their parents or legal guardians talk to them about sexual issues including condom use, while 89 (26%) indicated that their parents or legal guardians or legal guardians do not talk to them about sexual issues including condom use.

4.5.11. Did your friends tell you that you miss a lot of enjoyment because condoms reduce your pleasure if you use them during sexual intercourse?

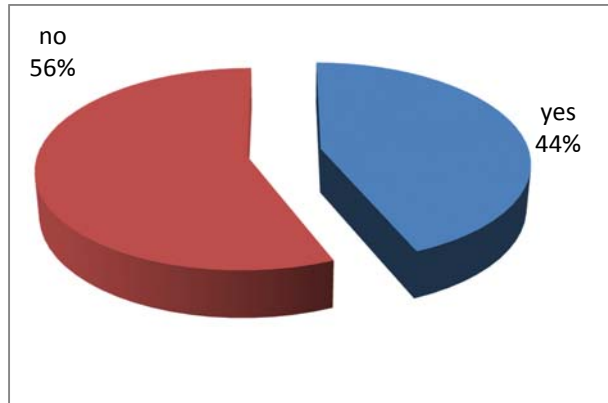


Figure 4.24: Responses on whether respondents were told that they miss enjoyment if they use condom during sexual intercourse.

Figure 4.25 shows that 147(44%) indicated that they were told by friends that the use of condoms reduced sexual pleasure while 187 (56%) were not told this by friends.

4.6 Condom use versus demographic factors

Table 4.10: Association between respondents' demographic features and the frequency of condom use

Variables	Condom use			P-value
	Always N (%)	Sometimes N (%)	Do not use N (%)	
Age				0.572
15-17	40 (26%)	76(49.4%)	38 (24.7%)	
18-20	23(26.7%)	45(52.3%)	18 (20.9%)	
21-23	15(34.9%)	22(51.2%)	6 (14%)	
Gender				0.000*
Male	41(28.6%)	92(60.1%)	20(13.1%)	
Females	37(28.5%)	51(39.2%)	42(32.3%)	
School grades				0.084
Grade 10	21(34.4%)	26(42.6%)	14(23%)	
Grade 11	26(24.8)	49(46.7%)	30(28.6%)	
Grade 12	31(26.5%)	68(58.1%)	18(15.4%)	

Religion				0.446
Christianity	68(30.1%)	108(47.8%)	50(22.1%)	
Protestantism	0(0)	3(100%)	0(0)	
ZCC	9(19.6%)	27(58.7%)	10(21.7%)	
Catholic	1(50%)	1(50%)	0(0%)	
Islam	0(0%)	2(100%)	0(0%)	
Hinduism	0(0%)	0(0%)	1(100%)	
Judaism	0(0%)	1(100%)	0(0%)	
Traditional	0(0%)	1(100%)	0(0%)	

About half (49%) of the learners between the ages of 15 and 17 indicated that they sometimes use a condom. Slightly over half of the respondents aged 18 to 20 and 21 to 23 reported using a condom sometimes. However, there was no statistically significant relationship between the age of respondents and condom use ($p=0.572$) as indicated in Table 4.6. Furthermore, a high number of male learners (60.1%) indicated that they sometimes used a condom, unlike female learners. However, there was a statistically significant relationship between the gender of respondents and condom use ($p<0.001$).

A high number of learners who were in Grade 12 indicated that they sometimes used a condom unlike those who were in Grade 10 and 11. However, the relationship was not statistically significant ($p=0.084$). Furthermore, 100% of respondents who followed Islam, Judaism and a traditional religion indicated that they sometimes used a condom unlike respondents of other religions. However the relationship was not statistically significant ($p=0.446$) as indicated in the table.

4.7 Conclusion

In this chapter the data which were collected from high school learners in the Greater Giyani Municipality within the Limpopo province of South Africa were presented and analysed. High school learners' knowledge, attitudes and practices regarding condom use were presented. An association was drawn between the use of condoms and the demographic distribution of high school learners in this municipality. In the next chapter the findings presented and analysed in this chapter are discussed.

CHAPTER FIVE

DISCUSSION, SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The present study sought to determine the knowledge, attitudes and practices regarding condom use among high school learners in the Greater Giyani Municipality, Limpopo province. In this chapter the findings of the research are discussed together with a summary of the findings. Conclusions are drawn from the findings and the recommendations are made.

5.2 Discussion

5.2.1 Demographic information

The results of the study show that most of the respondents were aged between 15 and 17 years with 57.8%, 50.9% were females, and 37.3% were high school learners in Grade 12. Just under 15% (14.9%) of the respondents lived with both their parents. Furthermore, the majority (98.2%) were Christians.

5.2.2 Knowledge of condoms and their use

The study found that the majority (88.7%) of the respondents knew that condoms offer protection against HIV/AIDS, STIs and pregnancy. These findings concur with the findings of the study conducted by Silassie, *et al.* (2016) who found that most respondents 259 (74.6%) in their study knew that condom use can prevent both pregnancy, STIs and HIV/AIDS. This knowledge suggests that high school learners understand the benefits of condom use as a protection against the risk of contracting STIs and falling pregnant. Furthermore, the study found that the majority (90.5%) of the respondents knew that condoms have an expiry date. These findings are in line with the findings of the study conducted by Masoda (2010) who found that high school students knew about the expiry dates of condoms.

However, the majority of the high school learners (90%) did not know that condoms cannot be used with oil-based lubricants. It is not surprising that the majority of the respondents did not know this as they were adolescents, a stage which is characterised by experimentation. Another reason could be that African parents often find it difficult to talk about sexual issues with their children as they believe that it will make them sexually active (Mnyipika, 2014).

The low level of knowledge was seen as a perceived barrier to condom use because such lack of knowledge could affect the correct use of condoms. It is not easy to use an object that one does not know how to use. As a result high school learners might decide not to try to use condoms because they do not know how to use them correctly. However, it became apparent from the study that most high school learners (52.3%) knew that condoms should be applied before ejaculation. This information can probably be ascribed to various school programmes, including Life Orientation that was introduced into the school curriculum in 2000 (Vethe, 2011).

However, it was found that many high school learners (53.4%) did not know that a condom should be unrolled before being put on the penis. This finding was highly unexpected as the respondents were between 15 and 23 years of age, and should have had the benefit of the school programmes mentioned above.

On the other hand, the study found that most of the high school learners knew that one can put a condom on only onto an erect penis (78.4%), and that a condom cannot be used repeatedly (91.3%). These findings concur with Ochieng, Kakai & Abok (2011) who found that the majority of the respondents in their study knew that condoms cannot be used more than once. In addition, the present study found that most high school learners (70.5%) knew that a penis should be withdrawn from a condom immediately after ejaculation.

One of the issues that was investigated in the study was whether learners knew about the availability of condoms. It was evident that most learners were aware that condoms are readily available. The majority of the respondents (95.3%) knew that condoms were available at clinics, while 82.6% indicated that they knew that condoms were available at hospitals. In addition, 82.1% of the high school learners knew that they could buy condoms from supermarkets and shops. It is not surprising that the majority of learners knew where condoms could be found because these products are displayed in visible positions in shops, supermarkets, hospitals and clinics, and they are advertised in the media as well as on social media.

With regard to the source of knowledge about condoms, the study found that the majority of the high school learners had gained information from health care providers (90.5%), television (77.5%) and educational talks (75%). In addition, most of the learners had heard of condoms from radio advertisements (65%), friends

(52%) and newspaper advertisements (50.7%). These findings are similar to those of a study conducted by Ochieng, Kakai, & Abok (2011) that found that teenagers also acquired knowledge about condom use from social health magazines, posters and pamphlets, educational talks, newspapers, as well as health care providers. The various sources that provided information about condom use to high school learners seems to have had positive results, as it seems that they have all motivated high school learners to use condoms.

5.2.3 Attitudes towards condom use

The study found that most high school learners held negative attitude towards using condoms (56.5%). This can be interpreted from responses that indicated that the respondents thought that condoms reduced pleasure during sexual intercourse. These findings confirm those of the study conducted by Lins, Santos & Vieira (2013) in which 54.2% of the respondents indicated that they did not like using condoms because they reduced sexual pleasure. These researchers also found that 63.3% of high school learners said that a condom made sexual intercourse painful. The negative attitudes discussed above proved to be barriers to condom use; the respondents would probably not use condoms because of the reduction of sexual pleasure and pain caused during sexual intercourse.

It was also discovered in the present study that 59.4% of high school learners perceived condom use as discouraging them from having multiple sex partners. These findings differ from those of the study conducted by Ochieng, Kakai, & Abok (2011) that found that high school learners indicated that using condoms meant that they did not trust their partners.

The present study discovered that 83.5% of high school learners thought condoms smelled bad during sexual intercourse. This perception is unexpected as a new generation of condoms with different flavours and smells were introduced by the South African government.

Another negative attitude held by high school learners towards condoms stemmed from the idea that condoms can tear inside the vagina and remain inside. This perception was held by 87.3% of the high school learners. These findings confirm those of a study conducted by Masoda and Govender (2012) which found that

adolescents had negative attitudes towards using condoms for contraception because they thought condoms can tear and be retained in the vagina.

Another study found that religion does not discourage teenagers from using condoms as reported by the majority (88%) of high school learners. These findings are in contrast with the study of Masoda & Govender (2012) which found that teenagers avoid using condoms because their religion discourage it. Alarmingly, (71.3%) of most high school learners were found to be lazy to collect free condoms from clinics. These findings are similar to the findings of the study done by Mnyipika (2014) that, although high school learners knew that they can obtain condoms free of charge in hospitals and clinics, these facilities were too far away and that money was needed for the taxi fare. It was also discovered that most (65.7%) high school learners feel embarrassed when buying condoms. This is supported by the findings of a study conducted by Ismael & Zangana (2012) which revealed that teenagers feel embarrassed when buying condoms. The Society for Adolescent Health and Medicine (2017) pointed out that those with the greater embarrassment may purchase fewer condoms and purchase them less often. In South Africa, teenagers were given a mandate to have access to condoms as stated in Section 134 of the Children's Act 38 of 2005. It is, however, surprising to find teenagers being embarrassed when buying condoms. It is important that condoms be sold in private locations in South Africa. Furthermore, the majority (84.4%) of high school learners perceive condoms as being not expensive. These findings concur with the findings of a study conducted by Nesidai, Ng'ang'a, Mwangi & Wanzala (2011) who discovered that the majority of high school students who were respondents in their study disagreed that condoms are expensive.

Another bad attitude that was discovered by the study is that most (67.9%) high school learners perceived that using condoms means there is no trust between partners. On the other hand, the study found that high school learners held positive attitudes because the majority (93.1%) of them did not perceive condoms as being made for married people only, but that also high school learners may also use condoms. The majority (90.5%) of high school learners did not perceive condoms as being made only for their elders, but also for anybody who engages in sexual activity, including people of their own age.

The bad smell of condoms, condoms tearing and remaining inside the vagina, laziness to collect condoms from clinics, embarrassment when buying condoms, perceiving condoms as expensive, associating condom use with lack of trust between partners were found to be barriers to condom use by high school learners.

5.2.4 Practices of condom use

The study discovered that the majority (77.3%) of high school learners engaged in sex once and most (50%) of them sometimes used condoms when they engaged in sexual intercourse. Regular use of condoms was at a lower rate than that for the occasional use of condoms. These findings differ from the findings of a study conducted by Thanavanh, *et al.* (2013), who found that most (70.2%) of the respondents who were high school learners reported never using condoms during sexual intercourse.

It was discovered that high school learners had used condoms the last time they had sex, and 42% used condoms when engaging in sexual activity. These findings differ from the findings of a study conducted by Cumber and Tsoka-Gwegweni (2016) that revealed that condom use was lower during the most recent sexual activity since only 6% of the participants reported having used a condom. Furthermore, the male condom was discovered to be preferred by most (74%) of high school learners.

The study found no association between the age and practice of condom use ($P=0.572$). Moreover, an association was found between gender and condom use practice ($P=0.000$), while no association existed between school grade and condom use. ($P=0.084$). The study also measured the association between religions of high school learners and condom use ; no association was found between these variables ($P=0.446$).

5.2.5 Factors that influence condom use

The study revealed that most (63.8%) of the female high school learners who participated in the study were the ones who decided over their partners whether a condom should be used. On the other hand, about 65% male high school learners also held the power to decide over their partners about condom use. These findings show male learners having more power to make the decision whether or not to use condoms. These findings are supported by Maticka-Tyndale (2012) who stated that cultural, social, political and gender–power dynamics all deter women’s ability to

initiate condom use in their relationships, thus making condom use decision remain mainly in the control of men. Gender proved to be a barrier to condom use for female learners as they have less power than their partners to make the decision.

The study also found that most (42.5%) female high school learners did not rely on their boyfriends to buy the items they wanted. It was also discovered that the majority (76%) of female high school learners were able to negotiate the safe sex practice of using a condom rather than their partners even though their partners were the ones who bought items that female learners wanted. These findings are in contrast to the statement made by Dunkle *et al.* (2007) who argue that owing to poverty, young girls are unable to talk about safe sex practice with their partners.

Moreover, the study revealed that most high school learners were influenced to use condoms by their peers. These findings are supported by the statement made by the Panday *et al* (2009) that adolescents share sexual knowledge among themselves and influence each other among their groups. If the group has a negative attitude towards condom use, adolescents within the group are more likely to practise unsafe sex practice. Other studies that were conducted in Kenya and South Africa identified the support of friends to be a significant factor for encouraging condom use among adolescents (Health Communication Capacity Collaborative, 2014).

Furthermore, the study revealed that most (54.3%) high school learners were encouraged to use condoms at their respective churches. Peer pressure and advice given at church about the use of condoms proved to be cues to action because most high school learners were advised by their peers and churches to use condoms in order to reduce the risk of pregnancy or of contracting STIs.

The study discovered that most high school learners never used substances. The majority (86.8%) of those who used substances once drank alcohol. Condom use during sexual intercourse while learners were under influence of substances was low since most (30.2%) of learners who engaged in sex did not use a condom on the occasion that they engaged in sex while under influence of substances. These findings are supported by a statement made by WHO (2013) which states that the heavy intake of substances increases the chances of not using condoms. However, a study conducted by Twa-Twa, Oketcho, Siziya & Muulain (2008) in Uganda discovered alcohol use to be associated with condom use among adolescents.

Furthermore, the study revealed that parents/legal guardians communicate with their teenagers about issues pertaining to sex including condom use as most (74%) high school learners indicated having communicated with their parents about issues pertaining to sex. These findings differ from the findings of a study by Ayalew, Mengistie & Semahegn (2014) that found that parents do not openly discuss about the facts about human reproduction with their children. On the other hand, a study conducted by Martinez et al (2010) supports the findings of this study because it discovered that a higher percentage (70% of male teens and 79% of female teens) received at least some sexual and reproductive health information such as how to say No to sex, methods of birth control, STIs, where to get birth control, how to prevent HIV infection and how to use a condom from their parents.

There is a need for sex education to be encouraged in families and for the improvement of communication between parents and their adolescent children on sex-related matters. The study discovered that most high school learners were never told of missing enjoyment by friends when they use a condom during sexual intercourse.

5.3 Summary

The following is the summary of the study on which conclusions and recommendations were made.

5.3.1 Demographic information

The results of the study show that most of the respondents were aged 15-17 years (57.8%) and most (50.9%) were females. Many (41.9%) respondents were living with both parents. Moreover, most (37.3%) respondents were high school learners who were in Grade 12 and the majority (80.5%) follow Christianity as a religion.

5.3.2 Knowledge of condom and its use

The majority of school learners knew that condoms give protection against HIV/AIDS, STIs and pregnancy (88.7%) and that every condom has an expiry date (90.5%). Moreover, the majority (90%) of school learners lacked the knowledge that a condom cannot be used with an oil-based lubricant. However, most high school Learners knew about putting on a condom before ejaculation (52.3%) but they didn't know that a condom should be unrolled before being worn by male partners (53.4%).

The majority (91.3%) of high school learners knew that they can put on the condom only once the penis is erect.. It was also discovered that most learners (70.5%) but not all high school learners knew about withdrawing the penis from the condom immediately after ejaculation. Knowledge about where condoms can be found was high; above 80% of the learners knew about places where condoms can be obtained. The study discovered that most high school learners obtained knowledge about condoms from friends (52%), radio advertisements (65%) and newspaper advertisements (50.7%). Apart from that, the study also discovered that the majority of high school learners obtained knowledge about condoms from television (75%), educational talks and health care providers (90.5%).

5.3.3 Attitudes towards condom

The study discovered that most high school learners held negative attitudes about condom use because it reduces pleasure during sexual intercourse (56.5%), make sex painful (63.3%), and because using condoms means there is no trust between partners (67.9%). Furthermore, the study also found that the majority of high school learners who held bad attitudes toward condom use perceived condoms as smelling bad during sexual intercourse and it can tear and remain inside the vagina.. Most learners with negative attitudes about condoms (71.3%) were lazy to collect condoms from a clinic and there were other factors such as the distance to clinics. Most (65.7%) of these learners also felt embarrassed when buying condoms.

Moreover, the study discovered that there were also learners who held positive attitude about condoms because their religions do not restrict them from using condoms (88%), condoms are not expensive(84.4%), they are made for everyone who engages in sexual intercourse and not only for married people (93.1%) and their elders (90.5%). Most of those who held positive attitudes towards condom use (59.4%) did not perceive condoms as leading people to have multiple sexual partners.

5.3.4 Practices on condom use

The majority (77.3%) of high school learners were found to have engaged in sexual intercourse and a condom was sometimes used when they did so. The study also discovered that condoms were used by 42% of those who engaged in sexual acts. The male condom was found to be preferred by most (74%) high school learners

rather than the female condom. There was no association found between condom use and age, school grade and condom use. Moreover, no association found between religion and condom use. However, it was found that there was a link between gender and condom use..

5.3.5 Factors that influence condom use

The study found that male high school learners hold more power than females to make decisions about condom use. Moreover, 42.5% of female learners were found not to be reliant on their boyfriends to buy items they want. The study also found that the majority (76%) of high school learners were able to negotiate safer sex practice with their partners although boyfriends would buy everything the girls wanted. Peer pressure was found to be among the factors that influence condom use among the high school learners. Churches were also found to be a factor influencing condom use among high school learners. The use of substances was low among the learners as most of them never used them. Alcohol was discovered as the substance used by most of those who used substances. Furthermore, most learners who engaged in sex while under the influence of substances did not use condoms. It was discovered by the study that parents/legal guardians of the learners were able to discuss condom use with learners.

5.4 Limitations of the study

Twenty-seven respondents did not return the questionnaires that they were given to complete while two respondents withdrew from participating in the study. The study was conducted in the Greater Giyani Municipality, therefore the findings cannot be generalised to all high school learners from other municipalities.

5.5 Conclusion

The purpose of the study was to determine the knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province. The study found high school learners to be knowledgeable about condoms although they still lack knowledge in some areas about condom use, such as unrolling a condom before it is used and using a condom with an oil-based lubricant. Learners held both negative and positive attitudes about condoms and their use. Condom use was found to be low with regard to learners who consume

substances like alcohol and then engage in sexual intercourse. A range of factors that influence condom use were assessed. Peer pressure, parent-adolescent communication, religious practices and gender were identified as factors that play a role in condom use by high school learners.

5.6 Recommendations

Based on the findings of the study the following recommendations were made in order to increase the knowledge of high school learners about condom use and to change the negative attitudes of high school learners towards condom use and increase their use by high school learners during sexual intercourse.

For Primary Health Care services

- ❖ The Department of Health should organise educational campaigns in schools specifically designed to educate high school learners about condoms and their use.
- ❖ Social messages encouraging condom use among high school learners should be circulated through the media.
- ❖ Free condoms should be further distributed at places where they are easily accessed by high school learners such as local “spaza” shops.
- ❖ Since most of the learners had already had sex at the time of this study, programmes should also target those who are not sexually active to ensure that they do not begin to engage in sex while still in adolescence.
- ❖ Further improvements are needed to ensure that free government condoms do not reduce sexual pleasure and that pain is not inflicted on users of condoms during sexual intercourse.

For the Department of Education

- ❖ The life orientation programme offered in high schools by the Department of Education should include substance use and contraceptives, including condoms, in their curriculum in order to improve knowledge of high school learners regarding condom use.

For parents

- ❖ Parents of high school learners should be encouraged to communicate openly with their children about condom use.

For the Police Department

- ❖ The police should work hand-in-hand with community members to ensure a strict enforcement of policy that restricts teenagers from accessing substances such as alcohol to prevent high school learners from drinking alcohol and then engage in sex.
- ❖ Liquor shops and individuals selling alcohol should be monitored by working hand-in-hand with communities to ensure substances are not sold to minors

For high school learners

- ❖ High school learners should be encouraged to refrain from using substances such as alcohol because substances contribute to reduced condom use when engaging in sexual intercourse while under the influence of substances.
- ❖ High school learners should also be encouraged to use condoms with every sexual act to prevent pregnancy and the spread of STIs.

For research

- ❖ Further research should measure the effectiveness of running programme designed to promote adolescent sexual health which includes condom use among adolescent learners.

For shops and supermarkets

- ❖ Shops and supermarkets selling condoms should sell condoms in a private place in order to reduce the embarrassment that high school learners experience when buying condoms.

For communities

- ❖ Communities should be educated about the rights of children aged 12 and older to access contraceptives as stated in Section 134 of the Children's Act 38 of 2005. This could help in reducing the embarrassment and stigma associated with being seen carrying condoms in public.

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Appendix 1: Research instrument

SECTION A: DEMOGRAPHIC INFORMATION

Write the number that represent your response in to the provided box which is the same row with the question.

	Questions	Response
1	What is your age group? 1=15-17years 2=18-20years 3=21-23years 4=24-26years	<input type="checkbox"/>
2	What is your gender? 1=male 2=female	<input type="checkbox"/>
3	Who are you living with at home? 1=mother 2=father 3=mother and father 4=grandmother 5=grandfather 6=other specify.....	<input type="checkbox"/>
4	In which grade are you in? 1=grade 10 2=grade 11 3=grade 12	<input type="checkbox"/>
5	What is your religion? 1=Christianity 2=Protestantism 3=ZCC 4=Catholic Church 5=Islam 6=Hinduism 7=Judaism 8= Bahá'í Faith 9=other specify.....	<input type="checkbox"/>

SECTION B: KNOWLEDGE OF CONDOM AND ITS USE

Mark only one (1) response per statement by putting an X in the box of your chosen response

Is the following statements true?

	Statements	Response	
		yes	no
6	A condom offers protection against HIV/AIDS, STIs and pregnancy		
7	Condom has an expiry date		
8	Oil-based lubricant (eg. oil. Vaseline) can be used with a condom		
9	It is alright to put on a condom just before ejaculation		
10	Condom should be unrolled before being put on the penis		
11	condom should be put on when the penis is erected before any contact with a vagina		
12	Condom can be used repeatedly		
13	A person wearing a condom must withdraw his penis immediately after ejaculation		
14	I heard about condoms from my friends		
15	I heard about condoms from the radio		
16	I heard about condoms from television		

17	I heard about condoms from health care providers		
18	I heard about condoms from educational talks		
19	I heard about condoms from news paper		
20	Condoms are found in clinics		
21	Condoms can also be found in hospitals		
22	Condoms can be bought from the supermarket and shops		

SECTION C: ATTITUDE TOWARDS CONDOM

Tick only one (1) response per statement by putting an X in the box of your chosen response

1=Agree, 2= strongly agree, 3=Disagree and 4=strongly disagree

	Statements	Response			
		1	2	3	4
23	A condom reduces pleasure during sexual intercourse				
24	A condom makes sex painful				
25	Condom use promotes having multiple sex partners (promiscuity)				
26	Condoms smell bad during sexual intercourse				
27	Condom tear inside vagina and remain inside				
28	My religion does not allow people to use condoms				
29	I am too lazy to go and collect condoms from the clinic				
30	I feel embarrassed any time I buy condoms				
31	Condoms are expensive				
32	Using condoms means you and your partner do not trust each other				
33	Condoms are for married people				
34	Condoms are for elders				
35	Condoms are obtained free from public health facilities				

SECTION D: PRACTICES ON CONDOM USE

	Question	Response
36	Have you ever engaged in sexual intercourse? 1=yes 2=no	<input type="checkbox"/>
37	How often do you use a condom whenever you have sexual intercourse? 1=always 2=sometimes 3=do not use	<input type="checkbox"/>
38	Did you use condom the last time you had sexual intercourse? 1=yes 2=no	<input type="checkbox"/>
39	Between male and female condom, which one do you prefer the most? 1=male condom 2=female condom	<input type="checkbox"/>

SECTION E: FACTORS THAT INFLUENCE CONDOM USE

	Question	Response														
40	Between you and your boyfriend who decides on whether you use condoms or not? 1=me 2=boyfriend	<input type="checkbox"/>														
41	Between you and your girlfriend who decides whether you use condoms or not? 1=me 2=girlfriend	<input type="checkbox"/>														
42	Is your boyfriend the one who buys everything you want? 1=yes 2=no	<input type="checkbox"/>														
43	If yes on question 45, do you let him decides on whether you use condoms or not? 1=yes 2=no	<input type="checkbox"/>														
44	Did your friends tell you to use condoms? 1=yes 2=no	<input type="checkbox"/>														
45	Do they advise you to use condoms at church? 1=yes 2=no	<input type="checkbox"/>														
46	Have you ever used substances? 1=yes 2=no	<input type="checkbox"/>														
47	Which of the following substances did you use? <table border="1" data-bbox="255 1585 694 1915"> <tbody> <tr><td>Alcohol</td><td></td></tr> <tr><td>Nyaope</td><td></td></tr> <tr><td>Marijuana</td><td></td></tr> <tr><td>cigarettes</td><td></td></tr> <tr><td>Mandrax</td><td></td></tr> <tr><td>crack</td><td></td></tr> <tr><td>LSD (acid,candy)</td><td></td></tr> </tbody> </table>	Alcohol		Nyaope		Marijuana		cigarettes		Mandrax		crack		LSD (acid,candy)		
Alcohol																
Nyaope																
Marijuana																
cigarettes																
Mandrax																
crack																
LSD (acid,candy)																
48	Did you use a condom the time you engaged in sexual intercourse while under influence of the substance(s)? 1=yes 2=no 3= do not consume substances	<input type="checkbox"/>														

49	Do your parents/legal guardians talk to you about sexual issues at a home including using condoms? 1=yes 2=no	<input type="checkbox"/>
50	Have your friends told you that you miss a lot of enjoyment that condoms reduce if you use them during sexual intercourse? 1=yes 2=no	<input type="checkbox"/>

Appendix 2: Respondents' information letter



Information sheet for respondents

Introduction

My name is Chavalala Lazarros. I am a Masters student at the University of Venda carrying out research on a study entitled 'Knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province. I am requesting a permission from you to participate in the study by giving information on knowledge, attitude and practices regarding condom use.

How will you participate in the study?

If you voluntarily accept to participate, you will be required fill a questionnaire on the study topic. Completion of questionnaire will last for approximately 45 minutes. Responses will not be evaluated as wrong or right because people have different knowledge, attitude and their practices regarding condom use differ.

What are your rights as a research participant?

The decision to take part in this study is totally voluntary, that is, you will be free to accept, or refuse to take part in the study if you have some doubts or think that participation could leave you emotionally disturbed and uncomfortable. Furthermore, should you agree to take part but change your mind later, you will be allowed to withdraw from the study at any stage and time, without being asked any question.

How will your personal privacy and confidentiality be protected?

All your responses in the study will be handled in a strictly confidential manner: First, you will not be required to put your name in the questionnaire, and gathered

information will not be linked to any name in the report of the study. Second, the gathered information will only be used for this study and not disclosed to any unauthorised people.

Appendix 3: Respondents' Consent letter



Consent form for respondents

My name is Chavalala Lazarros, a Masters student at the University of Venda, School of Health Sciences in the Department of Public Health. I am conducting a study entitled: **'Knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province'**. I would like you to participate in this study. Information obtained from you will be treated as confidential. Your participation in this study is voluntary and your decision in taking part in this study will not negatively affect life or health.

Informed consent declaration

In terms of the ethical requirements of the University of Venda, I now invite you to complete this form as an indication of your permission to voluntarily participate in this study.

I _____ hereby confirm that I have been fully informed about the purpose, procedures, and activities of the study. I was given full opportunity to ask any questions and I understand that participant can withdraw from the study at any stage and time, without giving any reasons.

I therefore hereby freely **Give/Do not give** my consent take part in the study as outlined.

Participant Signature _____

Date _____

Researcher's signature _____

Date _____

Appendix 4: Assent form



Assent form for minors

Introduction

I am Chavalala Lazarros, a Master's student at the University of Venda who is doing research on the topic "Knowledge attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province".

What is RESEARCH?

Research is something we do to find new knowledge about the way things (and people) work. We use research projects or studies to help us find out more about a topic we research. Research also helps us to find better ways of helping, or treating children who are sick.

What is this research all about?

I want to find out about how much knowledge learners have about condoms and how they are used. I also want to find out about the attitudes that high school learners have towards condom use, whether learners use condoms and how often they use them.

Why you have been invited to take part in this research project?

You were invited to participate in this study because you are a high school learner and have the right information that is needed in the study.

What will happen to you in this study?

You will complete a questionnaire that will be given to you only after you have consented to participate in the study. The questionnaire will have statements regarding knowledge, attitude and practices of condom use, and you will be required

to express your view by indicating whether you agree or disagree with each statement.

Can anything bad happen to you?

You may have an emotional problem if you have been sexually abused as the some statements may remind you of the event.

Can anything good happen to you?

There is not benefit for you from participating in the study except the experience you will gain by evaluating yourself on your knowledge of and practices regarding condom use.

Will anyone know that you were participating in the study?

No one will know that you participated in the study because you will not be required to put your name on the questionnaire. Information in the research report will not be linked to your name. Completed questionnaires will be kept in a safe to which only I will have access.

Who can you talk to about the study?

Should you have further questions about the study, you can contact me at 0786598161 and I will answer your questions.

What if you do not want to participate?

Participation is voluntary. You are allowed not to take part in the study, even if your parents/legal guardians have agreed that you can participate. You can also stop being part of the study at any time without being asked any questions.

Do you understand what this research study is about and are you willing to take part in it?

 YES NO

Has the researcher answered all your questions?

 YES NO

Do you understand that you can leave the study at any time?

 YES NO

Signature of Child

Date

Appendix 5: Parents information letter



Information letter for parents

Introduction

My name is Chavalala Lazarros. I am a Master's student at the University of Venda carrying out a research study entitled 'Knowledge, attitude and practices of high school learners regarding condom use in the Greater Giyani Municipality, Limpopo Province'. I am requesting permission from you to allow your child to participate in this research.

How will your child participate in the study?

If your child voluntarily accepts to participate, he/she will be required to complete a questionnaire on the topic. This activity will take approximately 45 minutes. Responses will not be evaluated as wrong or right because people have different knowledge and attitudes and their practices regarding condom use differ.

What are the rights of the child as a research participant?

The decision to take part in this study is totally voluntary, that is, your child will be free to accept, or refuse to take part in the study if he, she or you have any doubts or if you think that participation could leave him/her emotionally disturbed. Furthermore, should you agree that your child may take part in the study but change your mind later, your child will be allowed to withdraw from the study at any stage, without being asked any questions.

How will personal privacy and confidentiality of your child be protected?

All responses in the study will be handled in a strictly confidential manner: Firstly, learners will not be required to put their names on the questionnaire, and gathered

information will not be linked to any name in the research report. Secondly, the gathered information will be used for this study only and will not be disclosed to any unauthorised people.

Appendix 6: parents' consent form



Consent form for parents

My name is Chavalala Lazarros, a Master's student at the University of Venda, School of Health Sciences in the Department of Public Health. I am conducting a study entitled: '**Knowledge, attitudes and practices of high school learners regarding condom use in the Greater Giyani Municipality**'. I would like your child to participate in this study. Information obtained from a child will be treated as confidential. Your child's participation in this study will be voluntary and your decision will not negatively affect his or her life or health.

INFORMED CONSENT DECLARATION FORM

In terms of the ethical requirements of the University of Venda, I now invite you to complete this form as an indication of your permission to voluntarily allow your child to participate in this study.

I _____ hereby confirm that I have been fully informed about the purpose, procedures and activities of the study. The rights and risks of respondent have also been fully explained to me. I was given the opportunity to ask questions and I understand that participants can withdraw from the study at any stage, without giving any reasons.

I therefore hereby freely **Give/Do not give** (Delete the inapplicable) my consent for my child to take part in the study, as outlined above.

Parent's signature: _____ **Date:** _____

Researcher's signature: _____ **Date:** _____

Appendix 7: Ethical clearance

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Mr L Chavalala

Student No:

11627488

PROJECT TITLE: **Knowledge, attitudes and practices of high school learners regarding condom use in the Greater-Giyani Municipality Limpopo Province.**

PROJECT NO: SHS/17/PH/20/0510

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof RT Lebeso	University of Venda	Supervisor
Mrs SE Tshivhase	University of Venda	Co-Supervisor
Mr L Chavalala	University of Venda	Investigator – Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: October 2017

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Senior Prof. G.F. Ekosse

UNIVERSITY OF VENDA DIRECTOR RESEARCH AND INNOVATION 2017 -10- 17 Private Bag X5050 Thohoyandou 0950



University of Venda

PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8564/8313 FAX (015) 962 9063

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Appendix 8: Approval letter from Limpopo Department of Education



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF
EDUCATION

Ref: 2/2/2 Enq: MC Makola PhD Tel No: 015 290 9448 E-mail: MakolaMC@edu.limpopo.gov.za

Chavalala L
P O Box 4861
Giyani
0826

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

1. The above bears reference.
2. The Department wishes to inform you that your request to conduct research has been approved. Topic of the research proposal: **“KNOWLEDGE, ATTITUDE AND PRACTICES OF HIGH SCHOOL LEARNERS REGARDING CONDOM USE IN THE GREATER-GIYANI MUNICIPALITY, LIMPOPO PROVINCE”**.
3. The following conditions should be considered:
 - 3.1 The research should not have any financial implications for Limpopo Department of Education.
 - 3.2 Arrangements should be made with the Circuit Office and the schools concerned.
 - 3.3 The conduct of research should not anyhow disrupt the academic programs at the schools.
 - 3.4 The research should not be conducted during the time of Examinations especially the fourth term.
 - 3.5 During the study, applicable research ethics should be adhered to; in particular the principle of voluntary participation (the people involved should be respected).

REQUEST FOR PERMISSION TO CONDUCT RESEARCH: CHAVALALA L

CONFIDENTIAL

Cnr. 113 Biccard & 24 Excelsior Street, POLOKWANE, 0700, Private Bag X9489, POLOKWANE, 0700
Tel: 015 290 7600, Fax: 015 297 6920/4220/4494

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Appendix 9: Approval letter from University Higher Degree Committee

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS I. CHAVALALA
SCHOOL OF HEALTH SCIENCES

FROM: PROF J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 24 OCTOBER 2017

DECISIONS TAKEN BY UHDC OF 24TH OCTOBER 2017

Application for approval of Master's research proposal in Health Sciences: L. Chavalala (11627488)

Topic: 'Knowledge, Attitudes and Practices of high school learners regarding condom use in the Greater-Giyani Municipality, Limpopo Province.'

Supervisor	UNIVEN	Prof. R.T Lebese
Co-supervisor	UNIVEN	Mrs. S.E Tshirhase

UHDC approved Master's proposal



Prof J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

Appendix 10: proof of editing by the Editor

Jean Mitchell Consulting

J.E. Mitchell (PhD)
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22 June 2018

DECLARATION

To whom it may concern

This is to declare that I have edited the Masters' dissertation of Mr L. Chavalala entitled *Knowledge, Attitude and Practices of High School Learners regarding Condom Use in the Greater Giyani Municipality, Limpopo Province*.

To my knowledge the manuscript is free of language errors.

Yours faithfully



Dr J. E. Mitchell