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Unhealthy sexual practices among youth in Vhembe District, Limpopo province: A cross-sectional study

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Abstract

Abstinence from sexual practice among youth not only prevents infections, HIV and AIDS, and unplanned pregnancies but also promotes healthy sexual practices and positive youth development. The study aims to explore and describe interventions to improve healthy sexual practices among youth in Vhembe district, Limpopo province. The study utilized a descriptive cross-sectional design with a sample size of 531 determined by the selected formular through probability, simple random technique. Using structured questionnaires for data collection from the participants. Validity was ensured and content and face validity. Reliability was ensured. Data was analysed using SPSS version 28.0. Ethical consideration was ensured during the study. The study results showed that 57.4% of the respondents indicated that they do not discuss their choice of contraceptive with their sexual partner, 80.6% of the respondents indicated that unplanned pregnancy can be prevented by supplying contraceptives programs at clinics and school while 83.2% of the respondents revealed that programs linked with contraceptive services can help prevent unplanned pregnancy. The study highlights the lack of contraceptive choice discussions among sexual partners, exposing them to risks of STIs, HIV and AIDS, and teen pregnancy, urging for improved healthcare access. *(Afr J Reprod Health 2024; 28 [6]: 85-94).*

Keywords: HIV and AIDS, unhealthy, sexual practices, and youth

Résumé

L'abstinence sexuelle chez les jeunes prévient non seulement les infections, le VIH et le SIDA et les grossesses non planifiées, mais favorise également des pratiques sexuelles saines et un développement positif des jeunes. L'étude vise à explorer et à décrire les interventions visant à améliorer les pratiques sexuelles saines chez les jeunes du district de Vhembe, province du Limpopo. L'étude a utilisé une conception transversale descriptive avec une taille d'échantillon de 531 personnes déterminée par le formulaire sélectionné par le biais d'une technique aléatoire simple et probabiliste. Utilisation de questionnaires structurés pour la collecte de données auprès des participants. La validité a été assurée ainsi que la validité du contenu et de l'apparence. La fiabilité était assurée. Les données ont été analysées à l'aide de SPSS version 28.0. Une considération éthique a été assurée au cours de l'étude. Les résultats de l'étude ont montré que 57,4 % des personnes interrogées ont indiqué qu'elles ne discutaient pas de leur choix de contraceptif avec leur partenaire sexuel, 80,6 % des personnes interrogées ont indiqué que les grossesses non planifiées peuvent être évitées en proposant des programmes de contraception dans les cliniques et les écoles, tandis que 83,2 % des personnes interrogées ont indiqué qu'elles ne discutaient pas de leur choix de contraceptif avec leur partenaire sexuel. les personnes interrogées ont révélé que les programmes liés aux services de contraception peuvent aider à prévenir les grossesses non planifiées. L'étude souligne le manque de discussions sur le choix de la contraception entre les partenaires sexuels, les exposant aux risques d'IST, de VIH et de SIDA et de grossesse chez les adolescentes, et appelle à un meilleur accès aux soins de santé. *(Afr J Reprod Health 2024; 28 [6]: 85-94).*

Mots-clés: VIH et SIDA, pratiques sexuelles malsaines et jeunesse

Introduction

Globally, unprotected sexual practices among youth are common in developing counties[1,2]. It is attested that unprotected sexual practices is a serious concern among youth[3]. However, despite advancement intervention made in developed and developing countries, unhealthy sexual practices amongst youth remain a global epidemic and major public health concern across the world[4]. In 2019, it was affirmed that approximately 21 million youth aged 15-19 each year conceive unplanned pregnancies, which almost 50% in developed and developing countries of which 12 million results in births[5]. It was further reported that 55% of unplanned pregnancies among youth aged 15-19 years, resulted in illegal abortions which are often unsafe[6]. As results consequence of illegal abortion includes removal of uterus, health

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risks and complications due to their immature bodies 6. Globally countries are battling to maintain and achieving the Sustainable Development Goals (SDGs) related to maternal and new-born health[7].

A growing proportion of youth living with HIV globally were 8. Youth aged 10-24 years reported to be newly infected by HIV 410,000 [194,000-690,000] and aged 10-19 years 150,000 [44,000-310,000]. Recently, 25 % of youth girls and 17 % of youth boys aged 15-19 years tested positively in the last 12 months[5]. In sub-Sahara Africa an almost 1.5 million youth are living with HIV[9]. 10 identifies factors that are key determinates for youth to be vulnerable to sexual infectious diseases.

This factor includes socio-cultural, environmental, and economic factors, personal factors and health services related factors. Furthermore, as a results, authors alluded the provision of sex education will sensitise the communities. According to 11 emphasizes that youth girls could enrol in boarding schools where they will stay according to their gender, this suggestion could reduce youth pregnancy rates. The Ministry of health in Sub-Sahara Africa had establish youth friendly health services, it services were rendered at schools and initiated youth empowerment programs which aim in enhance positive impact[2].

In South Africa, Limpopo province has enhanced to fifth contributor to HIV and AIDS occurrence amongst the nine provinces, with Vhembe district present more than 6.9 % of the provincial problem[9]. Youth risky sexual behaviour is liable for elevated burden of HIV and AIDS. 12 reported that 55% of youth is afraid of testing HIV positive, while 69.9% of youth do not think they are at risk of being infected when having unprotected sexual intercourse. 9 revealed that youth obtain information about sexuality from social media not from the health professionals. This contributory factor includes knowledge, attitude, practices are widespread determinates to influence unhealthy sexual practices among youth. Youth attain knowledge from different sources such as media, peers, which a general information.

In Nghomunghomu village, Vhembe district, in 2010, Maluleke reported that 72.3% of non-use of HIV-testing services was found to be significantly higher amongst young who had received life skills or life orientation education during formal education, compared to those who had not 27.7% 13. 13 affirmed that youth initiate sexual intercourse at the age of 17years. During this period, they engage in risky sexual practices behaviour in exchange of money with an aim of trying to eliminate poverty, intake of substance abuse, lack of knowledge and multiple partners 14. In Vhembe District it was attested that youth likely to have unprotected sexual intercourse without any contraceptives in exchange of money or gifts/presents, and to abuse substances before they engaged in sexual intercourse 13. There was a significant difference in the use of condoms between teenagers and older youths which was higher amongst teenagers than amongst young people above 20 years of age.

The Department of Health in Vhembe District had worked tireless efforts on youth reproductive programme that includes the availability and accessibility of youth-friendly services in primary health care facilities[15]. Yet, in Vhembe district youth sexual health practices remains a serious concern. Youth still practices unprotected sexual intercourse, since they contract STI's, HIV and AIDS, obtain unplanned pregnancies which result in illegal abortion and experiences complications related to unprotected sexual intercourse[9]. In Mukhwantheli high school situated at Dididi village under Vhembe district it was attested that 37 learners pregnant by Limpopo MEC of Health (Capricorn Fm) news: on the 17th October, 2018). Therefore, this article seeks to explore and describe interventions to improve healthy sexual practices among youth in Vhembe district, Limpopo province.There is positive and strong associate between the age group and the choice of contraceptive with their sexual partners r=11.223 at P<0.004. This implies that youth and their sexual partner they discuss about the choices of not having unprotected sexual intercourse. This entails that adult youth are constantly making and informed decision to their partners by utilising contraceptives. The contrary implies that youth who engaged in sexual intercourse at the young age have no stage of making an informed decision hence they become victims of contracting STI's, HIV and AIDS and teens pregnancy[13]. As a result this leads youth to abuse substance and to engage in risky sexual behaviours which negatively impact their health[3]. A study conducted at Tshwane Metropolitan

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Municipality in South Africa among youth reported a negative statistical associated between age and knowledge regarding sexual reproductive health[16].

This study revealed that a statistical associated between school grade and the choice of contraceptive with their sexual partners. This Implies that among learners there more they transit to the next grade they are knowledgeable about healthy sexual practices and geared to make an informed decision regarding safe sex than their male counterpart whenever they engaged in sexual intercourse 15. Further findings reported that youth who have children while at school, they practice protected sexual intercourse because they do not want an additional child and they make an informed decision regarding healthy sexual practices[17]. Country findings state that whenever learners a taught about reproductive health they tend to practice, and they do not wear condoms to prevent contract of healthy sexual practices[16].

Methods

Study design

In this study, a quantitative paradigm was employed to explore and describe interventions to improve healthy sexual practices among youth in Vhembe district, Limpopo province using cross-sectional descriptive method[18]. This design and approach were used because they allow variables to be computed and compared whilst at the very same time it allows a once-off data collection[19].

Study settings

This study was conducted in Limpopo Province at Vhembe district. The province has five districts out of five only Vhembe District was selected to form part of the study. Vhembe District Municipality is divided into four Municipalities namely Makhado, Thulamela, Musina, and Collins Chabane Local Municipality. Majority of the population living in Vhembe District Municipality are Black African, they constitute 69%, Coloured 27%, and Indian or Asian 1% and white 1%. The Tshivenda speaking people constitute 69%, Xitsonga 27%, Sepedi2%, Sesotho 1%, Afrikaans 1%, and other language 1%. The district comprises of 1 Regional Hospital,1 specialised psychiatric hospital, 6 District Hospitals, 8 Community Health Centre's, 115 clinics and 19 mobiles that offer sexual reproductive health services and are user friendly for youth 20.

Population and sampling

The target population of the study comprised of all learners registered in a sixteen selected circuit from grade 8-12 at Vhembe district. Namely: Malamulele West circuit, Malamulele North-East, Malamulele East, Malamulele Central, Vurhonga 1, Vhurhonga 2, Hlanganani Central, Hlanganani South, Soutpansberg West, Soutpansberg East, soutpansburg North, Nzhelele West, Sambandou,Niani,Tshinane, and Dzindi. Who enrolled for 2022 academic year. A simple random technique was used to select circuits in Vhembe district 21. A bawl technique was employed to select sixteen circuit in Vhembe District, Names of circuit were written in a small paper and folded placed in a bawl. A neutral woman who was not part of the folding paper process was asked to pick circuits. The inclusion criteria were learners registered for the 2022 academic year from grade 8-12, between the age of 13-23 years[19].

A Slovin's formula as cited by Martínez-Mesa *et al.*[22] was used to determine the sample size of learners. According to the formula target population of 76685, a minimum sample size of n= 398 was computed [$n=N/(1+Ne^2)$] where N represents the total number of learners and n is the sample size respectively with e= 0, 05 as the margin of error. Yet, the researcher had added 10% of the sample size to n=438 to increase participants representative, to accommodate non-responses, and incomplete questionnaires. The research collected 531 questionnaires to gain more opinion from participants and for statistical analysis in the event of generalization of the findings.

Instrument and data collection procedure

Data was collected employing self-administrated questionnaire. A self-administrated questionnaires was developed aligned with the study objectives[23]. A questionnaire was translated into Xitsonga and Tshivenda by an expert. Pres-test was done amongst 10% of participants in a selected circuit which was not part of the actual study. However, being under the authority of Vhembe District. The results of pre-test were used by the researcher to modify the instrument and remove vague questions[24]. The researcher arranged for data collection with school principals of recruited schools in selected circuits. Data was collected in an arranged venue at a

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convenient time of learners, this were made to ensure that schedule of participants classes, subjects or learning area is not affected. Participants were informed about the study and were provided with information letter, those who were willing to voluntarily participate in the study were given informed consent forms to complete[25]. Those who are under 18 consents were obtained from their parents, and they completed an assert form so that they form part of the study. Completion of the questionnaire takes approximately 30-35 minutes.

Data quality control

To enhance the tool messages' comprehensibility, convenience of use, and clarity before data collection on portions that were not re-included in the study, a pretest involving 10% of the sample population was conducted. Following the pretest, participants' suggestions led to the simplification of unclear terms. Additionally, when considering the participants who returned the surveys last and first, the time taken to complete these self-administered questionnaires decreased from 5 to 10 minutes to 10-15 minutes. Two days of training on the purpose, methodology, sampling strategy, ethical concerns, data collection tool, and data collection protocol were given to supervisors prior to data collecting. To prevent one participant's privacy from being violated by another, the study participants were arranged in the classroom. Prior to analysis, every questionnaire was verified for accuracy and completeness both during and after the time of data collection. Clearance was given once the data was exported to the fitted model.

Data analysis

All questionnaires were prudently scrutinised and confirmed before being captured into the computer for analysis. Questionnaires was captured in Microsoft excel and exported to SPSS. The researcher employed Statistical Package for the Social Sciences (SPSS) version 28.0 to perform the descriptive and inferential statistical analyses. Pearson's Chi-square (χ^2) was used to test association between demographic information. Data was presented in tabular and charts using Microsoft excel 2016 and GraphPad Prism. The statistical significance level of testing (p-value) was P=0.05.

Ethical considerations

Ethical clearance was obtained from University of Venda Ethical committee (Project number: FHS/22/PH/0303). Permission to conduct the study was soughted from the Provincial Department of Basic Education (Approval number;2/2/2). Participants anonymous and confidentiality remain maintained throughout the study; there is no personal identifications that was used in reporting [23]. Participants were informed about the study, and that participation is free, voluntarily no incentives or any other benefits that will be obtained after participation. For participation informed concern were completed. This study was free from harm, if any harm occurred, they were referred to professional councillors.

Results

Demographic information

A total number of five hundred and thirty-one (531) participated in the study with an average age range of 10 to 25 years. Table 1 below presents summaries of the demographic information of learners who responded to the structured questionnaires. The results indicate that 74.0% of the participants were between the age group of 16 to 20 years, 16.4% were 10 to 15 years and the minority 9.6% were aged between 21 to 25 years. For marital status, the results indicated 100% there was no response regarding cohabiting, widowed, divorced, and married. For gender, the results indicated that 60.8% were female learners and 39.2% were male learners. For having children, 22% of participants have one child and 3.6% have two children which constituted 25.6%. for religion, the results of responded indicated that 86.3% were Christianity, 7.1 belonged to traditional religion, 5.1 % belonged to other religion other and minority 1.1% belonged to Islamic religion.

Knowledge of youth about the promotion of healthy sexual practices

Table 2 shows the knowledge of youth regarding healthy sexual practices (n=531). The results indicated that 57.4% of the respondents indicated that they do not discuss their choice of contraceptive with their sexual partner and 16.2% of the respondents indicated that they discuss the choice of

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Table 1: Summaries of the demographic information of learners

Variables	Frequency	Percentage (%)
Age		
10-15	87	16.4
16-20	393	74.0
20-25	51	9.6
Marital Status		
Single	531	100.0
Married	0	0.0
Cohabiting	0	0.0
Widowed	0	0.0
Divorced	0	0.0
Gender		
Male	20	39.2
Female	323	60.8
Having children		
Yes	136	25.6
No	395	74.4
How many		
One	117	22
Two	19	3.6
Religion		
Christianity	458	86.3
Traditional	40	7.5
Islam	40	7.5
Other	6	1.1

contraceptive with their sexual partner. furthermore, results indicated that 83.8% of the respondents indicated that abstaining from sexual activities would help to prevent unplanned pregnancy and 16.2% of the respondents indicated that abstain from sexual activities would not help to prevent unplanned pregnancy. Moreover, results indicated that 80.6% of the respondents indicated that unplanned pregnancy can be prevented by supplying contraceptives program at clinics and school and 19.4% of the respondents indicated that unplanned pregnancy cannot be prevented by supplying contraceptives program at clinics and school. Additional, results indicate that 83.2% of the respondents revealed that programmes linked with contraceptive services can help prevent unplanned pregnancy while 16.8% of the respondents indicated that programmes linked with contraceptive services cannot help preventing unplanned pregnancy.

Have you ever used any type of contraceptive?

Figure 1 indicate status of participants on whether they had ever used any type of contraceptives before (n=239 had never used any type of contraceptives and n=292 had used any type of contraceptives). The results indicate that 58.2% of the respondents indicated that they use any type of contraceptives while 142 (41.8%) of the respondents indicated that they have never used any type of contraceptives.

If yes, which methods do you use

Table 3 indicate status of contraceptives method they had used (n=292). The results indicate that 18.8% of the respondents revealed that they use condoms as methods of contraceptives, 17.9% of the respondents revealed that they abstain as methods of contraceptives. 3.9% of the respondents revealed that they use standard days methods of contraceptives, 3.7% of the respondents revealed

Table 2: Knowledge of youth regarding healthy sexual practices

Variables	Frequency	Percentage (%)
Do you discuss the choice of contraceptive with your sexual partner		
Yes	226	42.6
No	305	57.4
Abstaining from sexual activities would help to prevent unplanned pregnancy.		
Yes	445	83.8
No	86	16.2
STIs, HIV AND AIDS, and unplanned pregnancy can be prevented by supplying contraceptives program at clinics.		
Yes	428	80.6
No	103	19.4
Would programmes linked with contraceptive services can help to prevent unplanned pregnancy i.e. life orientation.		
Yes	442	83.2
No	89	16.8

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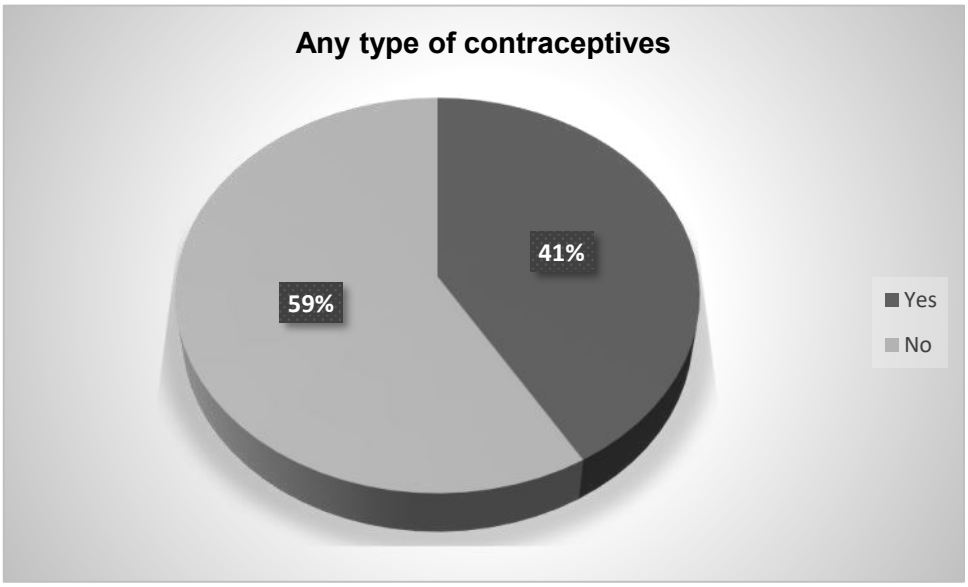


Figure 1: Status of participants on whether they had ever used any type of contraceptives before (n=239 had never used any type of contraceptives and n=292 had used any type of contraceptives)

Table 3: Status of contraceptives method they had used (n=292)

Responses of methods used on contraceptives	Frequency	Percentage (%)
Condoms	100	18,8
Abstain	93	17,9
Standard days method	21	3,9
Pills	20	3,7
Natural Method	20	3,8
Injectable	13	2,4
Progestogen only contraceptives	5	1,7
Emergency Contraceptives	5	1,7
Implants	4	0,7
Male Sterilize	4	0,7
Combined hormone Contraceptives	3	0,5
Intra-uterine Contraceptive Device (IUD)	2	0,4
Female Sterilize	2	0,4
Non-response	239	44
Total	**531**	**100**

that they use pills as methods of contraceptives. 3.7% of the respondents revealed that they use natural method as methods of contraceptives. 2.4% of the respondents revealed that they use injectable as method of contraceptives. 1.7% of the respondents revealed that they use progestogen only contraceptives of contraceptives, 1.7% of the respondents revealed that they use emergency contraceptives as methods of contraceptives. 0.7% of the respondents revealed that they use implants as methods of contraceptives. 0.7% of the respondents revealed that they use male sterilize as method of contraceptives. 0.5% of the respondents revealed that they use combined hormone contraceptives as methods of contraceptives. 0.4% of the respondents revealed that they use intra-uterine contraceptive device (IUD) as methods of contraceptives .0.4% of the respondents revealed that they use female sterilize as method of contraceptives. There were non-responses of 44% to the question posed in relation to which method did you use, if yes. The summary is as shown in Table 3.

Association between study variables

The chi-square test was employed to check the strength of the relationship and the statistical significance with the probability level of 5% and conducted for the elected variable. Only results where there was a significant level of $p<0.05$ were reported and presented.

The Pearson rho (r) correlation coefficient was used in this study. Correlation tests indicated the relationship between age group and the choice of contraceptive with your sexual partner. Correlation tests indicated the relationship between school grade

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and the choice of contraceptive with your sexual partner.

Table 3 shows the association between demographic information and the choice of contraceptive with your sexual partner. A cross-tabulation was performed on a pair of variables (i.e. association between age group and the choice of contraceptive with your sexual partner). From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the age group and do you discuss the choice of contraceptive with your sexual partner r=11.223[a], *p*=0.004*. It, therefore, indicates that age groups were linked with the respondents choice of contraceptive with their sexual partner. Therefore, this implies that the null hypothesis was rejected, which stated that there is no statistical difference between age groups and ignorance on the use of contraceptives.

A cross-tabulation of a pair of variables (i.e. association between school grade and the choice of contraceptive with your sexual partner). From the table, the Pearson Chi-square Test of Independence indicated that there was a statistically significant difference between the school grade and the choice of contraceptive with your sexual partner r=28.259[a], *p*=0.001*. This indicates that school grades were linked to the choice of contraceptive with your sexual partner. Therefore, this implies that the Null hypothesis was rejected which stated that there is no statistical difference between school grades and the choice of contraceptive with your sexual partner.

Discussion

This paper aims to explore and describe the interventions to improve healthy sexual practices among youth in Vhembe district. The study examines 531 leaners from different selected circuits in the Vhembe district in Limpopo province. The findings were that most of the participants had never used their choice of contraceptives. Alimoradi *et al*[26] conducted a study in Iran which concurred with the findings that high-risk sexual behaviour exposes youth to risk of sexually transmitted infections (STI) including Human Immunodeficiency Virus (HIV), unplanned pregnancy and being in a sexual relationship at a young age before being matured adequate to make an informed decision regarding contraceptives usage to make a healthy relationship. A Study conducted in Ghana by Ganle *et al*.[27] concurs with the findings that 52.5% of respondents reported that there is no need for a birth control method if a girl has sex once. In Iran. A study by Alimoradi *et al*[26] contrary to the findings reported that the absence of sex education is one of the major reasons youths are more vulnerable to STI, HIV and AIDS and unplanned pregnancy.

The findings indicate that most of the participants reported that they are abstaining from sexual activities will help to prevent STIs, HIV and AIDS and unplanned pregnancy. The findings were contrary that female youth may not have the informed decision, communication and negotiation skills required to engage in STIs, HIV and AIDS and unplanned pregnancy prevention behaviours, particularly with older and more experienced partners[28]. The findings concurred with the study conducted by Kirbas *et al*.[29] reported that 56.6% of the respondents were very confident that they could not be engaged in sexual activities until when they are married. A study conducted by Goesling *et al*.[30] concurred with the findings by stating that participants' concerns did not support the effectiveness of abstinence-only programs in lessening unplanned pregnancies among youth. The findings indicate that most of the participants reported that STIs, HIV and AIDS, and unplanned pregnancies can be prevented by supplying contraceptive programs at clinics and schools. A study conducted in South Africa reported concurred findings by stating that an undesirable opinion concerning when to use condoms might elevate participants' probabilities of indulging in unprotected sexual intercourse, which consequently may increase their chances of having unwanted pregnancies and contracting STIs including HIV and AIDS[2]. Healthy sexual practices education must be cooperated into the school curriculum, establishing health education in all schools to promote protected sexual intercourse[10]. Ganle *et al*.'s[27] findings concurred with the findings by stating that 60.3% of the study respondents were extremely using a reliable method to avoid STIs and pregnancy by using condoms regularly. Flanagan *et al*.[31] contrarily reported that youth visiting clinics often encounter limited contraceptive choices and inadequate proper counselling. A study conducted by Shabani and Tshitangano[16] concurred with the findings that there is a need for contraceptive education even though it is evidence that condoms and injectables are the most used methods by youth. 32 Youth attain

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healthy sexual practices knowledge through sex education in school, among friends, parents, extended family, and local organizations including healthcare clinics, NGO, and media. School-based comprehensive sex education increases knowledge of healthy sexual practices.

The findings indicate that most of the participants reported that they use any type of contraceptives. 33 contrarily urged that all available contraceptive methods have both strengths and weaknesses (Both advantages and disadvantages when using it. Ndinda *et al.*[34] concurred that government spheres played a significant and visible role in promoting healthy sexual practices and legitimizing the provision and use of contraceptives and reproductive healthcare services and the use of specific methods that are commonly used by youth (Condom, injectable and pills).

The findings indicate that the majority of the participants reported that condoms are the most common contraceptive method by both male and female youth. A study conducted in Botswana University reported that most of the youth continuously engaged in unprotected sexual intercourse, and risky sexual behaviour, contraceptive practices by engaging in unprotected sexual activities[35]. The study in Ethiopia reported contrary findings that about 93.3% uses pill as their contraceptive methods, followed by injection. In Botswana, it alluded that the distribution of condoms must be increased and available all over the country because the country is mostly affected by HIV and AIDS.

There is positive and strong associate between the age group and the choice of contraceptive with their sexual partners r=11.223 at P<0.004. This implies that youth and their sexual partner they discuss about the choices of not having unprotected sexual intercourse. This entails that adult youth are constantly making and informed decision to their partners by utilising contraceptives. The contrary implies that youth who engaged in sexual intercourse at the young age have no stage of making an informed decision hence they become victims of contracting STI's, HIV and AIDS and teens pregnancy[13]. As a result this leads youth to abuse substance and to engaged in risky sexual behaviours which negatively impact their health[3]. A study conducted at Tshwane Metropolitan Municipality in South Africa among youth reported a negative statistical associated between age and knowledge regarding sexual reproductive health[16]. This study revealed that a statistical associated between school grade and the choice of contraceptive with their sexual partners. This Implies that among learners there more they transit to the next grade they are knowledgeable about healthy sexual practices and geared to make an informed decision regarding safe sex than their male counterpart whenever they engaged in sexual intercourse[15]. Further findings reported that youth who have children while at school, they practice protected sexual intercourse because they do not want an additional child and they make an informed decision regarding healthy sexual practices[17]. Country findings state that whenever learners a taught about reproductive health they tend to practice and they do not wear condoms to prevent contract of healthy sexual practices[16].

Conclusion

The study found that there is no discussion between sexual partners about the choice of contraceptives, which enlightened that partners expose themselves to the risks of contracting STIs, HIV and AIDS, and teen pregnancy. The government must be vast in the programs that will enhance more knowledge or information to youth. Healthy Sexual practices of some of the participants or youth remain at risk, as the majority of youth engage in unprotected sexual intercourse. Contraceptive use must be elevated, even though there were cases of infrequent use, the most used method being condoms. The South African government should establish healthy sexual practices in the disadvantage rural areas and schools. The provision of contraceptives in the PHC facilities must be adequately monitored to avoid stock blackout. Regular awareness programs in schools must be conducted by health professionals accompanied by social workers to offer social support and counselling youth before they take contraceptives.

Recommendations

The DoH, DOE and DSD should collaborate to establish website which youth should use to consult about healthy sexual practices where health professionals should monitor and provide responses. This will champion the healthy sexual practices

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information to youth since youth relays in media and internet for information.

The DoH should establish a youth zone in the disadvantaged rural areas, where youth will consult for healthy sexual practices. They should ensure that health professionals working with youth must be dedicated in working with youth for provision of youth use friendly.

Comprehensive sexuality education should be provided to young people in schools and communities. This will equip them with the necessary knowledge and skills to make informed decisions about their sexual health.

Access to affordable and youth-friendly healthcare services should be improved. This will ensure that young people have access to contraception methods and STI, HIV testing.

Parents should be encouraged to have openly discussion with their children regarding sexual issues. This will aid solve the taboo and cultural norms in relation to sex and promote healthy sexual practices and communication between parents and their children.

Limitations of the study

Even though the current study closely follows scientific protocols, it contains certain shortcomings. For instance, the study did not include data from the other four districts in Limpopo Province because it was restricted to only one district. Moreover, incomplete, and biased data may be gathered using self-report instruments. Finally, we were unable to consider the temporal correlations between variables because the study was cross-sectional in nature.

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Competing interest

The author asserted that they have no conflict or interest of competing.

Data sharing statement

The corresponding author can provide the data set utilized in this work upon reasonable request.

Authors contributions

All authors participated in the drafting, revising, or critical review of the article; they gave final approval of the version to be published; they agreed on the journal to which the article has been submitted; and they all made a significant contribution to the work reported, whether that be in the conception, study design, execution, acquisition of data, analysis, and interpretation, or in all these areas.

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