

# **An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province**

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A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Public Health at the Faculty of Health Sciences, University of Venda

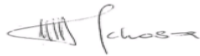
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**FEBRUARY 2024**

## Declaration

I, Ntiyiso Vinny Khosa, hereby declare that the thesis entitled “***An intervention programme to promote healthy sexual practices among Youth in Vhembe District, Limpopo Province***” for the Doctor of Philosophy in Public Health (PhDPH) degree at the University of Venda, hereby submitted by me, has not previously been submitted for a degree at this or any other university and that this is my own work in design and execution and that all reference materials contained therein have been duly acknowledged.



19- February- 2024

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Signature

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Date

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## **Dedication**

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## Abstract

In South Africa, the high rate of Sexually Transmitted Infections, Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome, and unplanned pregnancies are a serious public health concern among current school youth. Health, the well-being and the quality of youth are a serious concern for educational practitioners, health promoters, parents, as well as adolescents themselves. The absence of accurate information about the promotion of sexual health practices forces youth to patronise fake doctors. This reveals that there is a lack of knowledge of youth about healthy living skills, risky behaviours of sexual relations and the inability to reject unstable relationships that they do not want.

This study develops an intervention programme to promote healthy sexual practices among the youth in Limpopo Province. The convergent parallel mixed method was employed where exploratory-descriptive qualitative approaches were concurrently run with the quantitative approach, employing a cross-sectional descriptive design. A non-probability, purposive sampling was employed to select eligible study participants who include learners registered for the 2023 academic year, Life orientation teachers and School Governing Body members. In-depth focus group discussions interviews were conducted with 26 learners, 25 life orientation teachers and 16 School Governing Body members. Qualitative data was analysed thematically. Trustworthiness was ensured through Credibility, Confirmability, Transferability and Dependability. For the quantitative approach, a self-administered questionnaire was used to collect data where a simple random sampling was used to select learners in each grade to constitute a sample size of 531 participants. Reliability and validity of the instrument were ensured through the extensive review of literature from similar studies conducted locally and internationally. Data was analysed using Statistical Package for the Social Sciences (SPSS) version 28.0. Ethical principles were adhered throughout the study. The findings were conceptualised using a health promotion model.

The results were integrated, and the interpretation discussed. Six higher-order themes emerged from the qualitative data analysis. The merged themes from the qualitative research were confirmed by the findings from the statistical data analysis, thereby integrating both qualitative and quantitative data. The findings were presented to officials of the Department of Basic Education in Vhembe district and other stakeholders, Heads of schools, Heads of department, SGB members, social workers, and circuit managers; their inputs further confirmed and supports the findings. The findings informed the development of an intervention programme.

The intervention comprises the three components personal factors, community/school/house/church and healthy system paradigms, and health talk focusing on promoting healthy sexual practices. The developed intervention programme was validated by stakeholders and results were analysed through simple descriptive statistics where data was summarised using frequency distributions and tables.

The results revealed that the programme is adaptable and can be practiced. The programme can reduce the challenges of unhealthy sexual practices with which schools are faced. This programme also provides the opportunity to close the gap between parents, and teachers, because parents do not attend school meetings when they are requested. This programme has addressed a variety of ways that can bring parents and teachers on board, to work together. Recommendations were made and topics for future research were also addressed.

**Keyword:** Healthy Sexual Practices, Intervention Programme, Youth and Vhembe District.

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## List of acronyms

<b>AIDS</b>	Acquired Immune Deficiency Virus
<b>APHRC</b>	African Population and Health Research Centre
<b>AYFS</b>	Youth and Friendly services
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHWs</b>	Community Health Workers
<b>CSA</b>	Central Statistical Agency
<b>CSE</b>	Comprehensive Sexuality Education
<b>DHB</b>	District Health Barometer
<b>DOE</b>	Department of Education
<b>DoH</b>	Department of Health
<b>DSAC</b>	Department of Sport, Art and Culture
<b>FET</b>	Further Education and Training
<b>FGD</b>	Focus Group Discussion
<b>GET</b>	General Education and Training
<b>HEP</b>	National Health Programme
<b>HIV</b>	Human Immunodeficiency Virus
<b>HOD</b>	Heads of Department
<b>HPM</b>	Health Promotion Model
<b>HPV</b>	Human papillomavirus
<b>HSRC</b>	Human Science Research Council
<b>HTS</b>	HIV testing Services
<b>IM</b>	Intervention Mapping
<b>IPPF</b>	International Planned Parenthood Federation
<b>ISHP</b>	Integrated School Health Policy
<b>LO</b>	Life Orientation
<b>NASRH</b>	National Youth Sexual and Reproductive Health
<b>NDoH</b>	National Department of Health
<b>NGO</b>	Non-Governmental organisation
<b>NPO</b>	Non-Profit organisation
<b>NYDA</b>	National Youth Development Agency

<b>PGCE</b>	Postgraduate Certificate in Education
<b>PHC</b>	Primary Health Care
<b>POPIA</b>	Protection of Personal Information Act
<b>PRISMA</b>	Preferred Reporting Items for Systematic Reviews and Meta-analysis
<b>REDS</b>	Radical Different Spaces
<b>RNAO</b>	Registered Nurses Association of Ontario (a)
<b>SA</b>	South Africa
<b>SADC</b>	Southern Africa Development Community
<b>SAPS</b>	South Africa Police Services
<b>SAQOR</b>	Systematic Appraisal of Quality in Observation Reserve
<b>Sa-SAMS</b>	South Africa Administration and Management System
<b>SGB</b>	School Governing Body
<b>SPSS</b>	Statistical Package of Social Sciences
<b>SRH</b>	Sexual and Reproductive Health
<b>SSA</b>	Sub-Saharan Africa
<b>STATSSA</b>	Statistic South Africa
<b>STD's</b>	Sexual Transmitted Diseases
<b>STI's</b>	Sexual transmitted Infection
<b>TB</b>	Tuberculosis
<b>UN</b>	United Nations
<b>UNICEF</b>	United Nations Children's Fund
<b>UNISCEO</b>	National Education Scientific and Cultural Organization
<b>USA</b>	United States of America
<b>WHO</b>	World Health Organization
<b>YRBS</b>	Youth Risk Behaviour Survey

## **Chapter 1: Introduction of the study**

Sexual health is pivotal to the physical and emotional health and well-being of individuals, couples, families, and essential to the social and economic development of communities and countries (World Health Organisation (WHO), 2016). The Center for Disease Control (CDC) and Prevention (2019) defines sexual health as a condition of physical, emotional, and mental well-being associated with sexual practice. Sexual health entails a positive and humble approach to sexuality and sexual relationships, as well as choosing to have a congenial and safe or protected sexual experience, free of coercion, discrimination, and violence (WHO, 2015). The ability of youth to attain sexual health practices and well-being depends on them having access to comprehensive information or material about sexuality; knowledge about the risks they face and their vulnerability, such as unplanned pregnancy, Sexual Transmitted Infections (STI's), Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). Furthermore, there should be an understanding about the adverse concerns of sexual activity, access to good quality sexual health care, and an environment that affirms and promotes sexual health (CDC, 2016).

### **1.1 Background of the study**

Globally, 21 million young girls between the age of 15 to 19 years and two million young girls under the age of 15 years become pregnant in developing countries (WHO, 2018). In addition, 16 million young girls between the age of 15 to 19 years and 2.5 million young girls under the age of 16 years give birth in developing countries (WHO, 2015). Each year almost 80 million women and young females conceive unplanned pregnancies globally, 38% of which can be considered as an epidemic (Boah, Bordotsiah & Kuurdong, 2019).

A study conducted in Southeast Asian by Lopez, Mukaire and Mataya (2015) asserted that both male and female youths engaged in unhealthy sexual practices at a very young age. Further, it was reported that 50% of sexually active youth never wore condoms and 35% had incorrectly worn or used condoms (Boah et al., 2019). Sani (2018) asserted that 24% of youth lack knowledge of using condoms and they were unaware of sexual transmitted diseases (STDs), HIV and AIDS. Itodo, Viriot, Velter, Leon, Dupin, Bercot, Goubard, Lassau, Fouere, Martinet, Tosini and Florence (2020) alluded that youth in France do not trust condoms that it shields them from contracting STIs, HIV and AIDS. Thus, gonorrhoea continues to rise among youth in France (Itodo et al., 2020).

In Australia, contraceptives were used to control when an individual may conceive; it is the responsibility of youth to regularly visit the health facility as they must follow the instruction of

the contraceptive they are using (Rowe, Holton, Kirkman, Bayly, Jordan, McNamee, McBain & Sinnott Fisher, 2016). In addition, Rowen et al. (2016) revealed that the benefits of controlling when to conceive may emanate within the individual society and health system. The study conducted by Pradhan, Wynter, and Fisher (2018) revealed controls over teenage pregnancy were purposively significant, which aid in reducing the necessity of legal and illegal abortions. However, lack of accessibility to modern contraceptives and unhealthy sexual practices increases the risk factors for youth pregnancy (Kanda & Mash, 2018).

Young girls face an elevated risk of unplanned pregnancies that result in illegal abortions, with serious consequences for their lives and health. According to Ingwu, Agboh, Agba, Chiamaka and Kotoye (2020), across the globe, it was perceived that every minute, approximately 40 desperate women undergo an illegal or unsafe abortion. In developing countries, Lamina (2015) revealed that hospital records show that between 38-68% young girls were treated for abortion complications and were below 20 years. In Nigeria, an estimated 3000 women are dying as a consequent complication of illegal abortion and more than half of them are youth (Ingwu et al., 2020).

In addition, illegal abortion, in most cases, is a consequence of unplanned pregnancy; it also frequently results from unhealthy sexual practices. However, unplanned pregnancy occurs in women of all ages, youth is most affected (Yogi & Neupane, 2018). According to the Guttmacher Institute (2019), unhealthy sexual practices are now a recurrent practice among youth, such as improper and inconsistently condom use, often resulting in unplanned pregnancy that ends in illegal abortions. WHO (2018) reported that youth from developing countries delay undergoing abortions more than adult; youth choose to obtain abortions from unqualified persons, who use dangerous approaches or traditional medications and when complications arise, they delay seeking health care. Youth are more likely to experience complications, such as septicaemia, internal organ damage, tetanus, sterility, severe vaginal bleeding, incomplete abortion, septic abortion, ill health, infertility and death and life-long conditions and disabilities, such as obstetric fistula (African Population and Health Research Centre (APHRC), 2017).

Evidence from sub-Saharan Africa (SSA) indicates that 35% of pregnancies among 15–19-year-olds were unplanned because of teenage relationships, which were unstable (Muchiria, Odimegwua, & De Weta, 2017). In a study conducted in Swaziland, young girls revealed that they were expected to bear children at a young age and were competing for men's love by bearing their children. On the other hand, young boys confirmed that men are the leading decision-makers about sexual health practices (Kumi-Kyereme, 2021).

In the Southern Africa Development Community (SADC), unplanned pregnancy has been viewed as one of the significant obstructions to female learners having the option to make educational progress (Coast, Jones, Francoise, Yadete, Isimbi, Gezahegne, & Lunin, 2019). In many developing countries, like South Africa (SA), Botswana, Namibia and others, teenage pregnancy has been regarded as one of the factors that contribute to school dropout (Stats SA, 2020; Coast et al., 2019). To lessen the high rate of on-going school youth who conceive, infected by HIV/AIDS, STIs and became pregnant, the Department of Education (DoE) in South Africa (SA) has initiated sex education as a strategy to overcome these infections and youth pregnancy (Muchiria et al., 2017), although, there have been various disputes concerning the effectiveness of sex education in addressing healthy sexual practices and other sexuality issues affecting youth, such as STIs and HIV/AIDS (Dehne, 2020).

Even though the issue of high school pregnancy is a worldwide problem, its extent in SSA and particularly in SA causes an extraordinary concern. The provincial DoE in Gauteng reported that the number of learners getting pregnant is high and is really multiplying from year to year; in this way restricting better possible outcomes of the young girl's future (Stats SA, 2020). The rate of youth unplanned pregnancy in South Africa has been evaluated by Martin, de Lora, Rochat and Andes (2016) as high by international comparison. Additionally, the study conducted by Smith and Anderson (2018) revealed that the development of sexual identity and sexual doubt during this period is associated with the risk of STIs and unplanned pregnancy, with 18% of 10-19 years and 27% of 15-27 old in SA reported at least one pregnancy. The risk factors of youth unplanned pregnancy include education interruption, unsure future and poverty because of future unemployment, poor attitude, STIs and HIV infection (Stats SA, 2020).

A study conducted in Soweto, SA, found that 23% of pregnancies conceived between 13–16-year-old youth ended in legal abortions and 14.9% between 17–19-years ended in illegal abortions (Kanda & Mash, 2018). Rodríguez Ribas (2021) implies that the predictors of unsafe sexual intercourse during the early years of youth were individual, socio-demographic, familial, family patterns of early sexual experience and the lack of school or career goals, as well as interpersonal characteristics.

The SA Government and different stakeholders have worked tirelessly in attempting to educate individuals through awareness campaigns and prevention programmes highlighting the accessibility of condoms and abstinence. Yet, in SA, the number of teenagers falling pregnant and being infected with HIV remains high. The reason is most young girls will in general, have unprotected sex at a tender age. Kola (2018) shows healthy sexual practices



programmes help young girls not to practice sexual intercourse and it equip them with knowledge on how to make an informed decision regarding sexual issues. The execution of sex education in schools has been a genuine concern for some parents, religious leaders, and teachers, who view sex education as socially forbidden (Hlongwane, 2018). They believe that teaching youth about sexuality will inspire them to take part in careless behaviour (Hlongwane, 2018; Mphatswe, Maise & Sebitloane, 2016). Due to the convictions which underlie their frames of mind towards sex education, parents and teachers are not happy talking about sexual issue with teenagers (Mphatswe et al., 2016). Kola (2018) suggests that one way to conquer guardians' obstruction towards sex education is through getting them to join in the school-based programmes.

According to Machera (2017), the SA government has made progress and executed numerous interventional programmes and strategies, such as the National Youth Sexual and Reproductive Health (NASRH) and Right Framework Strategy (2014-2019) and the National HIV, AIDS and STI's Strategic Plan for SA (2007-2011), intended to educate and inspire the youth to practise healthy sexual intercourse (Hlongwa, Peltzer & Hlongwana, 2020). However, these intervention programmes and strategies establish a useful informative sexual behaviour in South African woman, but the risky sexual behaviours persist among youth (Haffeejee, Ducray, Basdav & Kell, 2023). In 2009, the HIV/AIDS life skills Education Programme was revised, converging, among other things, on risk behaviours, such as unprotected sex and multiple current sexual partners. School based support teams and school management were also established to aid implementation (Hlongwa, Mashamba-Tompson, Makhunga & Hlongwana, 2020).

A study conducted in the Greater-Giyani Municipality by Mushwana, Monareng, Richter and Muller (2015) found that 61% of the respondents did not have adequate knowledge about healthy sexual practices and 56.3% of the respondents fell pregnant because of peer pressure. In Vhembe District, the DOH revealed that 36 pupils between the ages of 10 and 19 are pregnant and 31 pupils have been infected with HIV (Maxwell, Radzilani-Makatu & Takalani, 2020). The SA government has worked tirelessly in establishing a variety of interventions to combat the rate of STIs, HIV/AIDS and unplanned pregnancy among youth. Despite these interventions, the phenomenon still persists. The Health Promotion Model is employed to guide the study to curb the phenomenon. Bartholomew, Eldridge, Markham, Ruiter, Fernández, and Parcel's (2016) intervention mapping was used to develop the intervention programme that was grounded on the findings which incorporated both qualitative and quantitative phases - 2 stage 1 and phase 2 stage 2. The programme reduces the on-

growing proportion of STIs, HIV/AIDS and unpanned pregnancy among school aged youth. Therefore, it is essential to conduct a study on developing an intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province, so that recommendations can be made to the DOH, DoE, Department of Social Development (DSD) and other stakeholders, to ensure that there is a reduction in the rate of STIs, HIV/AIDS and unplanned pregnancies among youth, especially high school learners.

## **1.2 Problem statement**

In South Africa, unplanned pregnancy was reported to be 26% in 2021 by the Department of Health's annual report. The researcher was a teacher assistant, during the teaching assistant programme initiated by the Department of Education which took place in schools. The researcher observed that over 79 learners in the schools were pregnant in the fourth quarter of the year 2020. The researcher asked the life orientation educator and chairperson of the School Governing Body (SGB) on whether they had initiated an awareness campaign to lessen unplanned pregnancy, spread of STIs and HIV/AIDS in the school. It was discovered that the school health programme was not yet initiated in rural schools. This was due to limited resources within the department to initiate these programmes. The district reported that 0.3% of female condoms and 25.3% of male condoms were distributed during the 2021/22 financial year (Stats SA, 2020). Vhembe District IDP Review (2021/22) revealed that 5.2% of females learners between age group of 14-19 years were pregnant during the 12 months before the survey. According to South Africa Administration and Management System (Sa-SAMS), Term 4 of 2021, a total number of 489 learners in public schools fell pregnant in Vhembe District Municipality (Vhembe District IDP Review, 2021/22).

According to the District Health Barometer (2020/21), many young girls (6650) had legal abortions in Vhembe District Health facilities. However, many girls did not abort and subsequently, some experienced complications, such as surgical removal of the uterus and some died, while 3570 delivered babies. Teenage pregnancy also leads to stigmatisation and isolation from their friends, poor performance at school and the abuse of substances. Therefore, there is a need for this study to guarantee the development of an intervention programme to promote sexually healthy practice among Youth in Vhembe District, Limpopo Province.

## **1.3 Rationale of the study**

A number of different policies were launched in South Africa by the National Department of Health in 2012 that are related to sexual healthy practice. These policies include the Integrated

School Health Policy (ISHP) which was co-operatively launched by the DOH and DoE, the updated National Contraceptives Guideline Policy; and a booklet titled *“Preventing teenage pregnancy”* (Qolesa, 2017). In addition to the existing policies to combat and curb youth unplanned pregnancy, STIs, and HIV/AIDS, the National Department of Health launched the Youth Health Policy in 2017 (DoE, 2017). Act 38 of 2005 affirms that condoms have been made freely accessible in the health facilities and youth were authorised to have access to condoms. Sexually healthy practice is a serious concern among youth under the age of 13-23 years in Vhembe district, especially for the on-going high school learners. Unavoidably, these sexually healthy practice problems cannot be left unattended or neglected. In literature, no known study has developed an intervention programme to promote healthy sexual practice, Vhembe District, Limpopo province, South Africa.

## **1.4 Significance of the study**

### **1.4.1 Policy Makers**

The study might also assist policy makers to provide guidelines on how to decrease the burden of unplanned pregnancy, as well as STIs, HIV/AIDS and improve reproductive health among learners. Policymakers could therefore ensure that reproductive health care services are available, accessible, and comprehensive, and provide education, counselling and be youth-friendly, allowing youth to make informed decisions about reproductive health.

### **1.4.2 Government**

The findings may assist the Department of Education to collaborate with the Department of Health, so that they can ensure that the Integrated School Health Programme, which offers oral or injectable contraceptives among female learners in high school as a method of family planning to prevent unplanned or unwanted pregnancy, is successful. The study might help the Department of Education to consider the relevance and importance of school health nurses and school social workers to address the influences of unplanned pregnancy, as well as awareness of STIs, HIV/AIDS.

### **1.4.3 Communities**

The findings might assist parents to initiate sex education to the children as well as to make the entire community aware regarding sexual transmitted infections, and for youth to take informed decisions regarding healthy sexual practices. The results of the study contributes to the body of knowledge of students who are intending to conduct research about the related topic.

#### **1.4.4 Parents and Learners**

The study might benefit parents through sharing the responsibility to come up with a policy pertaining to management and prevention of STIs, HIV/AIDS and unplanned pregnancies. The study might help parents and learners on the approach to avoid or reduce the incidents of STIs, HIV/AIDS and unplanned pregnancies. The study might also benefit government departments, particularly the DSD, in designing future parenting programmes and policies, that place priorities on the socio-environmental background of parents and due recognition of the incidents of STIs, HIV/AIDS and unplanned pregnancies, as well as researchers in review of the findings.

### **1.5 Health Promotion Model**

A Model is a set of highly abstract and related constructs that broadly explain phenomena of interest, express assumptions, and reflect the philosophical bearing (Gray, Grove & Sutherland, 2016). The current study is rooted in a specified conceptual model, namely the revised health promotion model of Pender (2006), of which an overview is given in this section. The study was conceptualised within the context of the promotion of healthy sexual practices. The study was guided by the Health Promotion Model (HPM) as the conceptual framework of Pender (1982), which is mentioned as being intensive on health-promoting behaviours by using perceptions of health and well-being to seek responses to the study objectives (George & Haag Heitman, 2011).

The HPM involves direct initiation towards developing an intervention programme to improve and promote youth's healthy sexual practices, sexual health behaviours and well-being in their disadvantaged rural schools and environments. In addition, the HPM consists of a choice-making phase and an action phase. There is a preference for the ability to encourage an individual to acquire knowledge about sexually healthy practices. Pander (1987) views healthy promotion as activity involvement considered to increase the level of well-being and self-actualisation of an individual, family, community, and society.

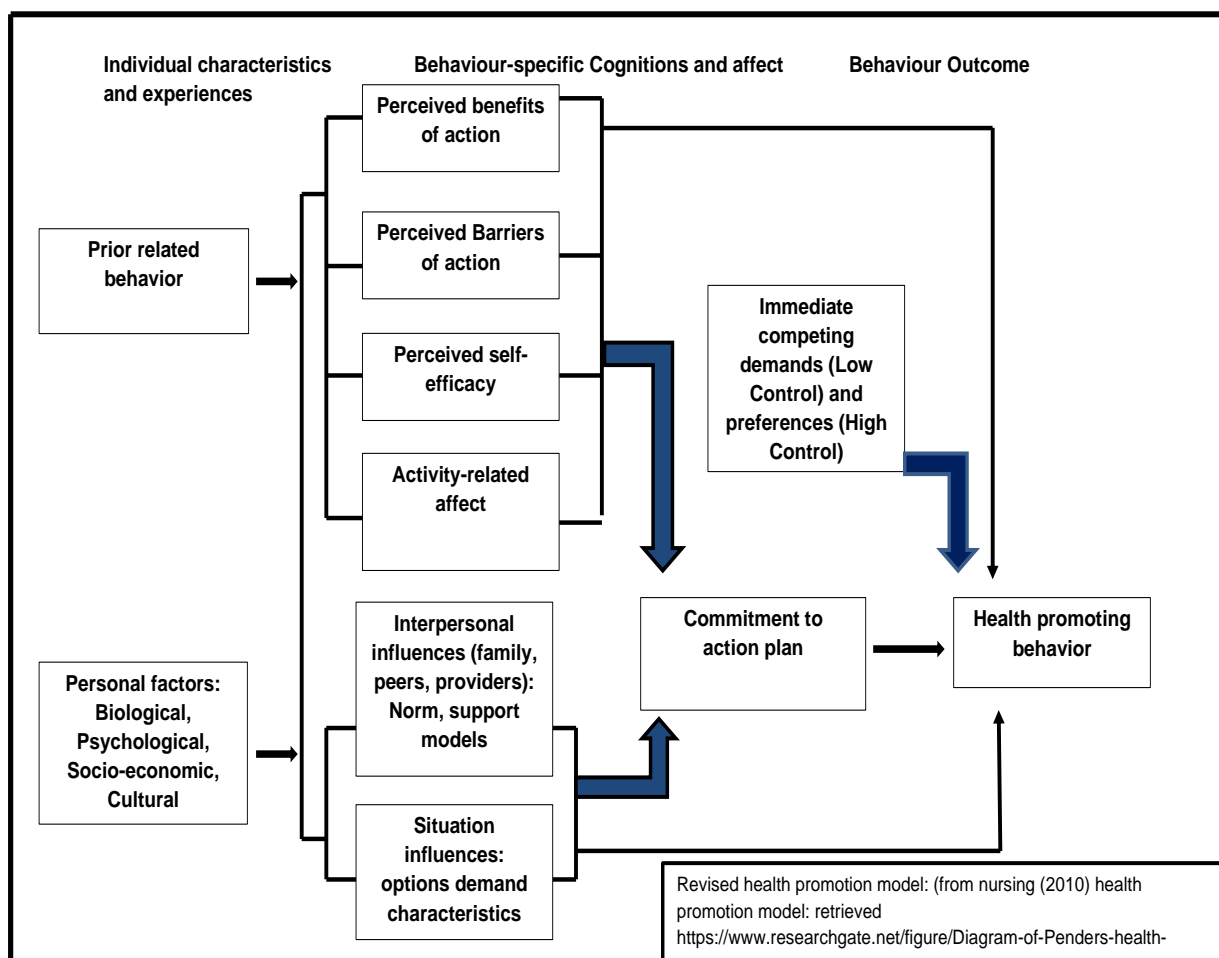
Foregrounding health as a positive dynamic state rather than simply the absence of disease, the revised model is directed at increasing a person's well-being (Guedes, Moreira, Cavalcante, Araujo & Ximenes 2020; George 2020). This health promotion model (HPM) describes the multidimensional nature of people as they interact within their environment to pursue health. Hamdan and Kawafha (2019) indicate that factors derived from the HPM predominantly centre on a person's lifestyle, such as psychological health, social and cultural

aspects, as well as biological factors. Subsequently, according to Pender's health promotion model, pursuing health is a unique approach to attaining good health and maintaining a satisfying, balanced lifestyle (Hamdan & Kawafha, 2019).

As indicated by Pender (2011), Pender's health promotion model focuses on three major concepts of health promotion, namely:

- ❖ Individual characteristics and experiences
- ❖ Behaviour-specific cognition and affect
- ❖ Behaviour outcome

The RNAO (2021) defines health promotion as the process of enabling people to increase control over and promote the improvement of their health by increasing their level of well-being and self-actualisation or by including health education, identification, and reduction of health risks for selected individuals and populations. The RNAO also indicates that this could be achieved through empowerment advocacy, preventative healthcare, and health policy development. The researcher in this study believed that these could go beyond a healthy lifestyle to well-being. The stance of McQueen and De Salazar (2020) is that when embedded in the provision of information on health, as well as the provision of education on health and the enhancement of life skills, health promotion supports personal and social development. These authors stated that approaching health promotion in this way increases the options available to people to exercise more control over their own health, and their own environment, and assists them in making choices more conducive to their own health. The redistribution of power over one's health and well-being, therefore, requires prioritising a health promotion process suitable for personal and societal empowerment and development (RNAO, 2021). Pender's health promotion model guided the study, which focused on empowering the person and augmenting the environment in pursuit of sustainable health. Therefore, The HPM was found to be an appropriate conceptual framework for the development of an intervention programme to promote healthy sexual practices and maintain the health and well-being of youth sexual health practices in the study setting. Additionally, the model guided the study from the objectives to the development and validation of the intervention programme to promote healthy sexual practices. However, consideration is given to the three major concepts of Pender's health promotion model. Figure 1 shows the three major concepts.



**Figure 1: Health Promotion Model (Pander, 2011)**

The first major concept is the **individual characteristics and experiences**, or a combination of them, that differ from the behaviours under consideration. The combination of individual characteristics and experiences is unique to each person. Guedes et al. (2020) stated that it comprises prior-related behaviours, which are important as the individual's previous habits related to the search for health are linked to the idea that personal factors and experiences affect the actions of nurses. Therefore, in nursing, previous experience is the standard condition that influences intervention or may interfere directly with individual behaviour to promote health, and personal factors are described as biological, psychological, and sociocultural (George, 2020). This study aims to assess the knowledge of youth about the promotion of healthy sexual practices. This objective was guided by the characteristics and experiences of youth when promoting healthy sexual practices.

The second concept, according to Pender's model, is **behaviour-specific, cognition, and affect** which consists of perceived benefits of action, perceived barriers of action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational

influences, commitment to a plan of action, and immediate competing demands (Brouwers, Kho, Browman, Burgers, Cluzeau, Feder & Zitzelsberger, 2019). This study explores factors and sexual risk behaviours that influence the promotion of healthy sexual practices. This objective was guided by behaviour-specific, cognitive, and effective assumptions, which consist of seven assumptions. These assumptions were used to determine the extent of the challenges youth are facing with Sexual and Reproductive Health (SRH).

**The third major concept is described by Pender (2011) as the behavioural outcome or health promoting behaviour** that is the desired behavioural end point or outcome of health decision-making and preparation for action. This study explores and describes measures that could influence the increased use of contraceptives or family planning to promote sexually healthy practices among youth. This objective guided the behavioural outcome, or health-promoting behaviour which was in line with the development of the intervention programme.

All these concepts may contribute to health promotion behaviour as well as enhance functional ability and improve quality of life at all stages of development (Pender, 2011). These behaviours should result in enhanced health. More details of this model are discussed in Phase 3: Conceptualisation of the study findings into a conceptual framework, whereby the result is used in line with the plan to develop an intervention programme to promote healthy sexual practices.

Aligning Pender's revised model with the naturalistic study design helped provide new insight into the promotion of health and well-being. According to the Ottawa Charter of Health Promotion (1999–2017), models help researchers determine the phenomenon under study and the process that enables people to increase control over and improve their health. This is seen as a resource for daily life. Pender's model assisted the current researcher in developing an intervention programme to promote the health and well-being of young girls with unplanned pregnancies and their return to school. Her impression of the model is that it is assisting young mothers, as well as youth, to change their lifestyles and progress toward a state of ideal health. In this study, the researcher seeks a way to find a means to attract youth to change unhealthy habits for healthy ones. Responsible decision-making is made, based on this model. The HPM provides steps by which a person can pursue better or ideal health, following constructivist paradigms that hold in multiple interpretations of reality (Polit & Beck, 2017). De Vos et al. (2019) maintained that constructivist researchers emphasised the dynamic, holistic, and individual aspects of human life and attempted to capture those aspects in their entirety within the context of those who are experiencing them. The current participants were actively

involved in all phases of the process of data collection to seek an understanding of the world in which they lived. The HPM guided the study objectives as well as the development of the intervention programme. The researcher views youth as holistic beings who are growing and still developing.

Their experiences regarding STIs and HIV/AIDS, as well as unplanned pregnancy, and their return to school, need to be understood. They also needed to be empowered with knowledge of reproductive health and the promotion of healthy sexual practices. The researcher views the health promotion model as relevant to the study as it aims to present ways of changing youth's unhealthy sexual practices approach to health promotion by giving them the power to make choices that would benefit their health, well-being, development, and resilience.

## **1.6 Study Purpose and Objectives**

### ***1.6.1 Purpose of the study***

The purpose of this study is to develop an intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.

### ***1.6.2 Objectives of the study***

The study objectives are divided into four phases.

#### ***1.6.2.1 Phase 1: Systematic Review***

- ❖ Review the impact of an intervention programme to promote healthy sexual practices.
- ❖ Describe the intervention programme used to promote healthy sexual practices.

#### ***1.6.2.2 Phase 2: Empirical study***

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influence the promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influence the increased use of contraceptives or family planning to promote healthy sexual practices among youth.

#### ***1.6.2.3 Phase 3: Develop the intervention programme***

- ❖ To develop the intervention programme to promote healthy sexual practices among youth.



#### **1.6.2.4 Phase 4: Validate intervention programme**

- ❖ To validate the developed intervention programme on promotion of healthy sexual practices among youth.

## **1.7 Definition of concepts**

### **1.7.1 Youth**

The National Youth Development Agency (NYDA) Act 54 of 2008 defines youth as persons between the ages of 14 and 35 years. In this study, the researcher considers youth as school learners from grade 8-12 between the ages of 13 to 23 years, enrolled in schools in the Vhembe District.

### **1.7.2 Intervention programme**

According to Mabasa (2018), an intervention is any measures planned that commences with the hope of constructing many positive ways for the group to interact. Intervention is also defined in terms of the results they produce. In this study, the intervention programme refers to a logical plan of action undertaken by the researcher in partnership with youth, teachers, school governing body members, in order to promote healthy sexual practices or to promote safe sex and to enhance health and well-being.

### **1.7.3 Healthy sexual practice promotion**

The term 'healthy sexual practice promotion' in the study refers to awareness that provides knowledge and informed decisions made by youth in order to practice safe sex.

## **1.8 Conclusion**

This chapter provides the background to the study. It includes the consequences of unhealthy sexual practices internationally, nationally, and provincially, including the Vhembe District. It also presents the problem, rationale and significance of the study and the definition of concepts. The next chapter presents a review of literature relevant to the study.

## **1.9 Study outline**

- ✓ Chapter one provides the introduction and background of the study, the problem statement, rationale, theoretical framework, together with the significance of the study, as well as definition of concepts.
- ✓ Chapter two provides the published systematic review article.

- ✓ Chapter three is the research methodology of the study, including the design, sampling, target population, study instruments, analyses, and plan for programme development, ethical considerations, and limitations.
- ✓ The fourth chapter provides the presentation and interpretation of the findings.
- ✓ Chapter five provides the discussion of the merged data.
- ✓ Chapter six provides the conceptualisation of the findings.
- ✓ Chapter seven provides the development and validation of the programme.
- ✓ Chapter eight provides a summary, strengths, limitations, conclusion, and recommendations.
- ✓ Translated appendices are available on request.

## Chapter 2: A published systematic review article

### 2.1 Healthy sexual practices among adolescents living in Africa: A Systematic Review.

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#### Abstract

**Background:** Over the past decade, intervention programs were put in place for a number of reasons. The reasons include but not limited to the promotion of healthy sexual practices among youth living in Africa; prevention of the infections; and reduction of the spread as well as the burden of Sexually Transmitted Infections, Human Immunodeficiency Virus, and unplanned pregnancy.

**Purpose:** The purpose of this consolidative systematic review was to investigate the intervention programme to promote healthy sexual practices among adolescents living in Africa.

**Methods:** The inclusive literature search was conducted on five multiple databases: PUBMED (53), EBSCOhost (1102), Google Scholar (4421), Subnet (439), and Science Direct (700). The search was restricted to articles written in English and published between 2010 and July 2022 with the key set of words such as contraceptive, sexual education, sexual reproductive health, and sexual risk behaviour as a criterion for consideration and selection.

**Results:** A total of 27 studies reported significant results in the behavioural and intervention programmes outcome assessed. The seven main themes developed from the selected articles included in this study regarding healthy sexual practice. These themes include accessibility and affordability of contraceptives, gender-power relations, inconsistent condom use, physical and sexual abuse, substance abuse, peer groups, and school environment to mention but a few.

**Conclusion:** Research into the mechanisms and underpinnings of future healthy sexual practices is urgently needed in order to lessen Sexual Transmitted Infections, Human Immunodeficiency Virus, and unplanned pregnancies.

**Keywords:** Adolescents, Health, Sexual practices.

## 2.2 Introduction

Kharsany and Karim (2016) established that in sub-Saharan Africa, adolescents are affected by the Sexually Transmitted Infections (STI's) and Human Immunodeficiency Virus (HIV) pandemic to a greater extent compared to adolescents in other regions in Africa. This is resonated by the World Health Organization (WHO) (2018) asserting that STI's and HIV/ Acquired Immunodeficiency syndrome (AIDS) remain serious concerns among adolescents aged 10-24 years in Africa. Nearly, 41% of new HIV infections and 79% of these infections occurred in sub-Saharan Africa. Krugu and van der Kwaak (2019) submitted that an effective STI's and HIV intervention program to prevent this pandemic is urgently needed. Globally, about 11% of all pregnancies are in adolescents between 15-19 years, and approximately 95% of these pregnancies occur in Africa (Namisi et al., 2013; World Health Organisation, 2021; 2022). Adolescents are also susceptible to unplanned pregnancies often resulting in illegal abortion. The sexual debut is gradually occurring within a period of early adolescence between the age of 10-14 years (Afriyie & Essilfie, 2019). Initial and unsafe sexual practices result in negative health impacts such as (STI's), (HIV), unplanned pregnancy, and illegal abortion (World Health organisation, 2021; Guttmacher Institute Fact Sheet, 2016).

Thus, a comprehensive set of programs that will be effectively transforming adolescents' sexual knowledge needs to be provided (World Health organization 2021; 2018). Moreover, Abebe et al. (2013) and Okanlawon and Asuzu (2013) stressed that absence of programs to mitigate unplanned pregnancy is evident, and lack of sex education endorses unforeseen teenage pregnancy since adolescents conceive unplanned pregnancy at a younger age, while others infected by HIV. Unless comprehensive set of programs are put in place, adolescents will be engaging in unprotected sexual intercourse and have restricted access to sexual reproductive health services in primary health care (PHC) facilities (World Health organization, 2020), and as a result, illegal abortions after coercive unplanned pregnancies will be more prevalent (Abebe et al., 2013a; Okanlawon & Asuzu, 2013; and Tarkang, 2013).

Lack of sexual education contributes to risky sexual behaviour and has become an African concern among adolescents (Abebe et al., 2013b). Netsanet (2013) and Okanlawon & Asuzu (2013) emphasize that sexual health education initiatives have been incorporated into secondary school curricula in many countries throughout the world to educate adolescents on how to make an informed decision regarding sexual activities and to increase awareness of the consequences of risky sexual behaviour.

Tarkang (2013); Ngoma et al. (2014) and Olamijuwon et al. (2021) support that sexual health education programs are significant in communicating information that adolescents need to make informed decisions associated with sexual issues during adolescence stages.

Sexual health education improves, and combats cases associated with irresponsible sexual behaviour within the adolescent age group (Zuma et al., 2020). Ngidiet et al. (2016); Cumber and Tsoka-Gwegweni (2016) state that adolescents who are sexually health illiterate are more likely to partake in underage sexual intercourse, unsafe sex, and sexual assault (Ngidiet et al., 2016; and Cumber & Tsoka-Gwegweni, 2016).

In addition, studies have found that psychological stress among adolescents is associated with increased sexual risk behaviours such as unprotected sex, multiple partners, lack of condom negotiation, substance abuse, relationship power imbalance and violent relationships, decreased and inconsistent condoms, increased number of partners as well as higher risk sexual partners, and incident of STIs (Mashaphu et al., 2018; Ngidi et al., 2016).

The current review come as an attempt to find out the appropriate type of intervention that can be put in place to promote healthy sexual practice targeting adolescents which may contribute to reducing the prevalence of HIV, STI's and unplanned pregnancy in three ways: (i) by postponing sexual debut among those who are sexually inexperienced and sexually active at a younger age (Olamijuwon et al., 2021); (ii) promoting consistent use of condoms, and (iii) reducing the number of concurrent sexual partners (Ngoma et al., 2014). Furthermore, the review intends to assess how the intervention is effective in addressing the needs of adolescents. Put differently, this article aimed at identifying effective interventions to promote Healthy sexual practices among adolescents living in Africa.

## **2.3 Material and methods**

### ***2.3.1 Information sources and search strategy***

This systematic review was constructed on African scientific literature and grey literature. The review is structured in accordance with the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analysis). An appropriate study was identified by conducting an inclusive search of multiple databases which include: PUBMED, EBSCOhost, Google Scholar, Subnet, and Science Direct. Similar sets of keywords were used to extract studies from each database. The first set included keywords related to healthy sexual practice e.g., sexual health, contraceptives/family planning, teenage pregnancy, sexual education, sexual counselling, health education, school health, adolescent, sexual reproductive health, and sexual risk behaviours. The second set included keywords related to condom use, inconsistent and

correct use of condoms, interventions, behaviour, STI, or safe sex. A keyword from the first set and a keyword from the second set had to be in the title or abstract of the study. The search was restricted to articles written in English, published between 2010 and July 2022, as most studies published before 2010 will not reflect the current conditions and realities of healthy sexual practices within the selected region.

### **2.3.2 Eligibility criteria**

Studies were included if they meet the following eligibility criteria:

- I. Type of Studies included in this review: assessing the intervention programme to promote healthy sexual practices among adolescents living in Africa.
- II. Focused on adolescents aged 10-24 years in Africa.
- III. Included teachers and parents in a key intervention component (school-based programs) included at least 1 of 3 behavioral outcome measures reported by adolescents: delayed sexual activity/abstinence, condom use and inconsistent use of condoms, or parent-child sexual communication.
- IV. Statistical acknowledgment of high-risk sexual behavior among adolescents in Africa.
- V. Eligible articles must be published in English. Articles published from 2010 to 2022 (12 years).

### **2.3.3 Study selection**

The online studies extract was screened, reviewed, and examined. Studies that did not address the intervention programme to promote healthy sexual practices or focus on other populations above the selected age group and were not conducted in Africa were rejected. Articles that did not address the title and duplicates were excluded from the study. Therefore, the remaining 21 articles from the search were selected based on their relevance and meeting eligibility criteria indicated in (**Figure 1**), An in-depth review of the references of some identified articles within the search yielded an additional six articles that met the eligibility criteria.

### **2.3.4 Data abstraction**

Data extraction was carried out by the researcher through a comparison of the information that was collected. Therefore, for all selected studies that meet inclusion criteria, the following procedures were employed to outline the characteristics of the studies included: the country where the study is conducted, study design, the objective of the study, study population, sample size, outcome of the study, intervention, and control description (**Table 1**).

### **2.3.5 Appraisal of the included studies**

The quality assessment of the article was executed independently by the primary investigator employing the systematic Appraisal of Quality in Observational Research (SAQOR), an instrument that consists of six components each comprising two to five question that includes sample, control, or comparison group, exposure or outcome measurements, follow-up, confounders, and reporting of data. In table 2, a summary of quality assessment was assigned for each of the six components, and an overall summary and grade were determined based on the adequacy of these components. The overall quality of the study was classified as high, moderate, low, or very low.

## **2.4 Results**

The seven themes were developed from the selected articles included in this study regarding interventions to promote healthy sexual practices among adolescents living in Africa. The following themes were developed: Accessibility and affordability of contraceptives, Gender-power relations in partnership, inconsistent use of condoms, Physical and sexual abuse, substance abuse, and Sexual information provided by peer groups and the school environment.

### **2.4.1 Accessibility and affordability of contraceptives.**

Access to health care services for adolescents also affects the utilization of contraceptives as the distances from the most proximate clinics and payment for transport from time to time hinders adolescents from traveling to healthcare facilities for contraceptives and information (Cumber et al., 2016; Desmennu et al., 2018). Desmennu et al. (2018) further contend that most adolescent girls are financially dependent on their parents who might be unable to pay for transport to clinics.

Namisi et al. (2013) advocate that the services should be within a reasonable geographic distance and be functional in terms of adolescents' needs. As for accessibility, (Namisi et al., (2013) also commend that it could be improved by rendering services on weekends. Contraceptive services could be located at schools, clinics, or community centres accessible to adolescents (Namisi et al., 2013; and Visser, 2017).

Reproductive health care services at government institutions are free of charge and to improve access to adolescents, the services should be accessed by everyone, irrespective of sex, age, belief, colour, marital status, weakness, or any characteristic that puts individuals at a disadvantage (Ngoma et al., 2014). Services should also be provided in a respectful, non-

judgmental, and equitable way as the principles of primary health care (PHC), health services should be accessible to its users, in this case, adolescent girls (Visser, 2017).

#### ***2.4.2 Gender power relations in partnership.***

Adolescent girls are expected to submit to the desires of their boyfriends and spouses on sexual matters (Bala & Kang'ethe, 2021; and Mostert et al., 2020); as a result, lack of ability to discuss contraception and negotiate safe sex becomes highly prevalent. Ngidi et al. (2016; Cumber, & Tsoka-Gwegweni., 2016) claim that Gender-power imbalance is an important underlying cause of many problems that adolescents experience. The low level of control that adolescents have over their own lives has a critical consequence for their reproductive and sexual health (Desmenn et al., 2018). According to Mostert et al. (2020) discrimination against girls and women places them at a disadvantage in decision-making power and choices.

These decisions include sexual intercourse, contraceptive use, childbearing, and how their earnings are spent (Visser, 2017). Most adolescents are not free to make independent decisions in their relationships, including allocation of their earnings, reproductive and sexual health (Mostert et al. 2020); instead, men become the only decision-makers. They would rather risk pregnancy and sexually transmitted diseases than ask a partner to use a condom, for fear of conflict, violence, economic loss, and rejection (Ngidi et al., 2016). This shows that men are in control of family affairs as observed in (Bala & Kang'ethe, 2021).

#### ***2.4.3 Incorrect and Inconsistent use of condoms.***

Unprotected sexual intercourse among adolescents is a serious concern in Africa (Bala, & Kang'ethe, 2021). The majority of them are conscious about protected sexual intercourse (Desmennu, et al., 2018; Mostert, et al.2020) yet the pressure exerted on them causes the indulgence in unprotected sexual practices for reasons such as the non-availability of condoms at the time of sexual intercourse, failure to reject unprotected sex due to long-term relationships, and misconceptions regarding condoms (Namisi et al., 2013; Okanlawon & Asuzu, 2013).

Correct and consistent condom use is an effective strategy to combat adolescent pregnancy and sexually transmitted diseases (Afriyie & Essilfie, 2019) but the adolescents' desire for sexual pleasure causes them to continuously remain victims of both undesired and unplanned pregnancy and sexually transmitted diseases as well as increased infection of STI's and HIV.



#### **2.4.4 Physical and sexual violence**

According to Ngoma et al. (2014) physical and sexual violence are common phenomena performed by adolescent boys on adolescent girls. Violence from a sexual partner includes physical, sexual, and emotional abuse. Physical violence, often in the form of beatings, slapping, stabbing, and hair pulling can often end in some form of sexual force which may lead to the transmission of sexual infections as well as unplanned pregnancy (Kosugi et al., 2019).

In some cases, rural adolescent girls are the victims of being forced to have sex when they are not ready and when they do not feel like having sex (Bala & Kang'ethe, 2021; Ngoma et al., 2014). As much as women in such circumstances may not be prepared for sex, the societal expectation may deny them an individual rights to be able to protect themselves, thereby falling victims of HIV and unplanned pregnancies (Mostert et al., 2020).

#### **2.4.5 Substance Abuse.**

Smoking and drinking as well as engaging in risky sexual intercourse are some of the prevalent substances abused by adolescents (Desmennu et al., 2018) as an attempt to deal with some of underlying psychosocial distress they are confronted with (Visser, 2017). Alcohol taken is associated with a greater likelihood of unprotected sex (Kosugi et al., 2019). The risk of having unprotected sexual intercourse with two or more partners occurs most when people are under the influence of a substance, these leads adolescents to be more vulnerable to sexual diseases and not take proper responsibility for their actions regarding the outcome of sexual activities conducted (Bala & Kang'ethe, 2021; Kosugi et al., 2019).

#### **2.4.6 Sexual information provided by peer groups**

The perception and misconception by many adolescents that being sexually active is a fashionable thing, and that being sexually inactive is a sign of abnormality (Bingenheimer et al., 2015) perpetuates the evident tendency of being sexually active and get pregnant for acceptance by their peers. The extent to which peer groups influence sexual behaviour can be linked to the extent to which peer groups are used as sources of information on sex-related aspects (Bingenheimer et al., 2015).

Most adolescents turn to their peers as the principal source of information on sexuality. Adolescents aged 11 to 19 years received information on sexuality from school peers. Peers are the main source of sexual information among adolescents (Negeri, 2014). Peer pressure is another factor associated with adolescent sexual behaviour. Adolescents socialize with their peers, so they tend to shift from relying on their parents, teachers as well as health

practitioners, the lessons, and values they learned from home socialization to depend on their peers (Bingenheimer et al., 2015). They perceive that their friends of similar age are engaging in risky sexual intercourse, and this perception is likely to foster the same behaviour in them (Negeri, 2014). On the other hand, perceived peer norms that are supportive of sexual protective behaviors may influence adolescents to adopt and maintain protected sexual practices (Negeri, 2014; Kharsany, & Karim, 2016).

#### **2.4.7 The school environment**

There is considerable misinformation about sexual health matters among adolescents. Sexual health education in the form of life skills has been introduced as a compulsory part of the school curriculum (Krug & van der Kwaak, 2019). However, the way in which it is implemented is not successful. This is because most educators are not well-equipped with knowledge about how to implement it. Eventually, teenagers do not get the necessary information about sex education (Krug & van der Kwaak, 2019).

## **2.5 Discussion**

This systematic review focuses primarily on the seven aspects that include: Accessibility and affordability of contraceptives; Gender-power relations in partnership; Inconsistent use of condoms; Physical and sexual abuse; Substance abuse, Sexual information provided by peer groups and the school environment. The essential component of the intervention is to promote healthy sexual practices through the accessibility and affordability of contraceptives. Accessibility of contraceptives in the PHC facilities as well as public places is the most burden among adolescents. This burden includes fear of being judged by nurses, and delayed supplies of contraceptives in the PHC facilities. Adolescents had fears of being misjudged by the nurse when consulting for contraceptives. The affordability of contraceptives is a leading factor among adolescents. Lack of money influence adolescent not to practice safe sexual activity. An adolescent who lives more than 10 km away from PHC facilities, had no money for transport as well as to buy contraceptives. While others feel embarrassed to buy or use condoms and other reasons were identified by participants as barriers to condom use. Concerning the accessibility and affordability of contraceptives, this systematic review identified that adolescents had a method of mistreatment contraceptives and additionally promoting others to use when unplanned sexual activity due occurs. This method is to withdraw ejaculate during sexual activity, withdrawal method is a process of removing or separating genital organs during sexual intercourse when semen is about to be ejaculated. They even believed that the extensive use of contraceptives would increase the prevalence of

HIV/ AIDS, different STIs, and unplanned pregnancies. They concurred that the provision and accessibility and affordability of contraceptives could promote healthy sexual practices. The second intervention is physical and sexual abuse. The high incidence of unreported forced sex among adolescents is a serious concern. It is not clear whether adolescents do not seem to be aware that forced sex even by a love partner quantity to rape, which may be a crime. Hence, a few adolescents who had sex without their consent never open these cases. Forced sex which in most cases is dry, will result in friction, tear, and bleeding; therefore, exposing one to HIV and STI's. There is a need to raise awareness regarding the risks of forced sex with adolescents. Victims of such cases ought to be inspired to report the cases to relevant authorities. The third intervention is based on the correct and Inconsistent use of condoms/contraceptives. In this systematic review, adolescent girls rely on males for condom use. This is a cultural norm in Africa that women do not discuss sexual matters with males, males make the informed decision for safe sex or unsafe sex. women cannot negotiate for its use because of communication barriers between partners on issues of sexuality. However, a woman might not use condoms especially if they trust and believe that their partners are healthy and faithful. It was common among women that use emergency contraceptives to reveal the reason for not using condoms with their regular partner than their non-regular partners. Women might hinder their ability to negotiate condom use with their intimate partners by using emergency contraceptives. Attitudes that woman portray regarding condoms is that they are painful and discomforting and are linked with the vulnerability of STI's, HIV, and unplanned pregnancy. The fourth intervention is based on substance abuse as the leading factor that influences adolescents to contract STI's, HIV, and unplanned pregnancies. Adolescents that engaged in substance abuse normally have multiple partners. There is an association between adolescents who drink alcohol and having multiple partners. In addition, adolescents show that it become an accepted norm to have sexual entertainment with whoever buys them alcohol in taverns. While adolescent girls are linked with alcohol use and sexual relationship with older men. Adolescents consuming alcohol are likely to engage in intimate relationships with affording men. Additionally, immoral sexual behavior linked to alcohol among female adolescents has become a health risk, with multiple sexual partners with a high probability of unprotected sex leading to negative health impacts. Therefore, drug use and alcohol are associated with unprotected sexual activities.

The fourth intervention is based on the school environment, and a provision of healthy sexual practice in a life orientation curriculum had a positive impact among ongoing school adolescents. Teachers that offer life orientation have cultural norms that talking about sexuality aspects it's taboo. It was reported that sexual issues should be taught by school

health nurses as well as social workers at schools. Different efforts for teaching sex education and provision of workshops (peer education) regarding sexual practices at the side of addressing problems associated with sexuality are necessary for sexual health promotion estimates on age, maturity, or gender to produce maximum quality nursing interventions in relevance to adolescents' sexual health. High school completion provides the best benefits for adolescent girls, increasing their capability and motivation to curb early unplanned pregnancy, empowering them to require responsibility for their lives, and ultimately, improving health and well-being. Participation in health education remains the most vital determinant of protection against sexual issues among adolescence, as well as risk behaviors.

## **2.6 Implication for intervention**

A tireless effort to combat STI's, HIV, and unplanned pregnancies among adolescents in Africa must be sustained as it holds the courage to prevent STI's, HIV, and unplanned pregnancies in Africa. The situation where adolescents commonly perceived themselves to be at no risk or susceptible to STI's, HIV, and unplanned pregnancy besides their involvement in risky sexual behaviour needs to be addressed. This calls for a focus on interventions that help adolescents to have correct STI's, HIV, and unplanned pregnancy awareness of themselves. The first step is that a high number of adolescents had principles, particularly those who were involved in risky sexual behaviour and perceived themselves to have some risk of contracting STI's and HIV. This could be attributed to the influence of the services and stakeholders regarding the prevention of STI's, HIV, and unplanned pregnancies in the African continent. A technique of moving forward, there might be planning and developing interventions to promote healthy sexual practices that could build adolescents' belief of the seriousness of practicing risky sexual behaviours; familiarising adolescents with available interventions to promote healthy sexual practices in the continent; could build confidence in the self-efficacy interventions to promote healthy sexual practices; and sustain the involvement of the media, peers, and relatives of adolescents in the fight against unprotected sexual practices. All relevant stakeholders that include the dominant religious group, teachers, nurses, and the rural communities should not be left out as it alluded that belonging to the dominant religious organization and residing in rural areas were factors associated with having no STI', HIV and unplanned pregnancy risk perception among the adolescents.

## **2.7 Conclusion**

The interventions to promote healthy sexual practices are a platform that plays an important role in enlightening adolescents lives and futures. This systematic review highlights the

interventions to promote healthy sexual practices in Africa. The intervention aims at combating the risky sexual behaviours that are faced by the adolescent, as well as other health challenges about sexuality. However, among sexually active adolescents, risky sexual behaviour in the form of multiple sexual partners, substance abuse, inconsistent and incorrect use of condoms, and accessibility and affordability of contraceptives are effectively associated with susceptibility to STI's, HIV, and unplanned pregnancy. sexually active adolescent, inconsistently used contraceptives, had scarce knowledge of sex and had skewed insights into sexual behaviour. Although, it appears to be a gap concerning the intervention to promote healthy sexual practices to the effectiveness of an intervention to promote healthy sexual practices related to adolescents. The intervention to promote healthy sexual practice programmes in guaranteeing safe sexual practices as well as knowledge to susceptible adolescents to the massive situation. There is a necessity to measure this programme, yet there is a need to accomplish the programme through community ownership and the government at all levels across Africa. It is believed that the evidence obtained from this review is valuable in opening paths for interested parties to further explore the effectiveness of the promotion of healthy sexual practices in improving the lives of adolescents.

## **2.8 Recommendations**

- Adolescents should be given adequate information about contraceptives in terms of the advantages, disadvantages, and side effects and how to manage the side effects. This would help mitigate negative attitudes that adolescents have toward contraceptives owing to misinformation and misconceptions.
- Teachers should play a parental role by ensuring that health education programmes are presented in the schools. These programs must emphasize the positive aspects of contraceptive use which include protection against STIs and unplanned pregnancies.
- The department of education should ensure gender equality and sexual decision-making skills are needed for sustainable prevention of HIV and teenage pregnancy in schools.
- Learners trust information about HIV and AIDS received from clinics and teachers the most, programmes should consider involving teachers in peer-education programs.
- The government should implement the peer-to-peer programme, such as the Steppingstones programme could benefit the school and community.

- More studies should be conducted on the effectiveness of interventions in the promotion of healthy sexual practices in meeting the desires of adolescents.
- Guidance counselors and social workers at schools should be easily approachable so that adolescents will seek their advice regarding sex and report sexual abuse whatever the case may be. The introduction of family planning education in schools is a good start to educate young people on the availability of contraceptives and the consequences of being sexually active at a young age. Lessons on sexual activities should start before children become sexually active. This can be done in the form of role-play.
- Curriculum developers should include contraception, substance use and sexual intercourse in the Life Orientation program offered in schools to improve learners' knowledge.
- Health care workers should be sensitive to the needs of adolescents by creating supportive environments and programs to address the causes of adolescent pregnancies.

## **2.9 Limitations**

The limitations of this review, the review was that only focus on the interventions provided by the promotion of healthy sexual practices among adolescents. The systematic review only considered articles from Africa that were written in English. Studies published in other continents and written in other languages were excluded, these studies may perhaps have an impact on the review.

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### **Conflicts of Interest**

The authors declare that they had no competing intentions.

### **Ethical and consent for participants**

Not applicable in this systematic review

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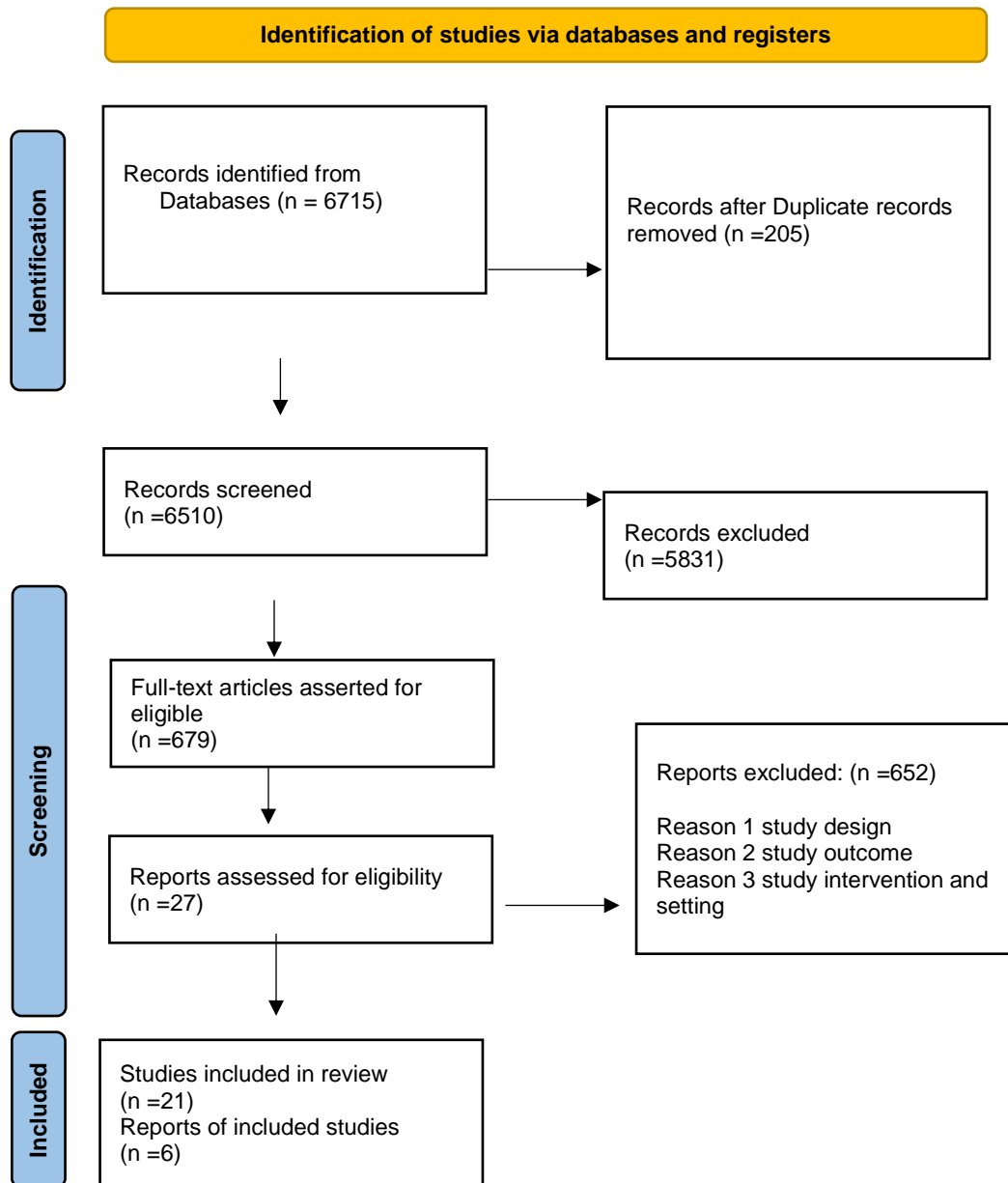
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**Figure 2: Flow diagram for inclusion criteria**

**Flow of diagram Adopted from PRISMA (2020)**

**Table 1: Characteristics of included articles**

<b>Authors, country, and design</b>	<b>Year</b>	<b>Objectives of the study</b>	<b>Participants and sample size</b>	<b>Studies key conclusion</b>
1. Abebe, M., Tsion, A., and Netsanet, F. Ethiopia. Cross-sectional design	2013	To assess sexual risk behaviours and associated factors among students living with parents in Jimma zone preparatory schools.	School students (n=273)	Alcohol consumption and religious visit were the major predictors of risky sexual behaviours. Therefore, Behaviour change communication should consider family environment and other factors which predict risk sexual behaviours
2. Okanlawon, F. A. and Asuzu M.C.Nigeria. quasi experimental design	2013	To involving adolescents in school-based health promotion activities as a strategy to improve their perception of risk in sexual behaviour	Adolescents (control group n=265 and interventions group n= 254)	Based on the outcome of the study, it was recommended that adolescents' active participation in health promotion activities should be encouraged
3. Tarkang, E.E. Cameroon. 4. descriptive cross-sectional design.	2013	To examines information on the association between condom use and number of sexual partners among female students in an urban city of Cameroon	Female student (N=210)	The proportion of female students who engage in multiple sexual partners without using condoms are at risk of HIV transmission. Sexuality education and a friendly environment for condom availability are key in addressing the risky sexual behaviours of female students.
5. Negeri, E.L. Western Ethiopia . Mixed method.	2014	to assess the determinants of risky sexual behaviour, relation between HIV risk perception and condom utilization among university students in Western Ethiopia. T	University Student (N=883)	This study has shown that, a substantial proportion of the students engaged in risky sexual. Information, education and communication/ behavioural change communication on risk perception, life, assertive and communication skills training,

				and promotion of peer-education should be strengthened
6. Ngoma et al. Cameroon. cross-sectional exploratory survey design	2014	To sequentially assess the levels of Knowledge, Attitudes and Practices of HIV and AIDS among students at the University of Zambia and the extent to which this information can be used in HIV programming on Campus to plan for appropriate interventions.	First year student (n=844)	HIV knowledge does not seem to have effected behavioural change in students, as they continue to engage in unsafe practices. HIV programmes influence knowledge, but may not necessarily change attitudes and practice of risky behaviour
7. Ngidi et al. South Africa. Qualitative design		This study was designed to explore the sexual behaviour of students in a metropolitan Durban University of Technology in KwaZulu-Natal to understand the social factors underlying their risk of HIV infection	Students (n=26)	This study draws attention to the perspectives of African university students regarding their risk-taking sexual practices and selected factors which influence such behaviour.
8. Cumber, S.N., and Tsoka-Gwegweni, J.M. Cameroon. Cross-sectional survey.	2016	To assess the knowledge, practice and barriers to condom use in Cameroon	Street adolescent (n=399)	Street adolescents in Cameroon seem to know about condoms but have insufficient information on the importance of their regular use.
9. Timol et al. South Africa. Survey technique.	2016	This study aims to assess the effect of an extensive, structured, time-limited, curriculum-based, peer-led educational programme on first-year high school learners in public schools in the Western Cape Province of South Africa	Learners (n=7709)	significant results were noted for self-efficacy in sexual relations and knowledge regarding HIV transmission. Conclusion: The findings of this study suggest that peer-education can improve adolescents' self-efficacy in sexual relations as well as knowledge regarding the transmission of HIV and therefore can contribute to the

				prevention of HIV transmission among adolescents.
10. Visser, M. South Africa. Self-reported Survey	2017	The aim of the research was to gain increased knowledge regarding the sexual risk behaviour of school-going young people in South Africa after two decades of HIV-education in schools, to contribute to the development of improved HIV prevention strategies.	Learners (n=5305)	It also revealed that HIV-prevention strategies should focus beyond educating the individual, to address community factors such as improving caregiver relationships, the culture of substance abuse, peer group norms and inequality in community gender norms. These community processes influence young people's behaviour and need to be addressed to allow the youth to make healthy behavioural choices
11. Desmennu et al. Nigeria. Qualitative design	2018	To determining the behavioural risks for sexually transmitted infections (STIs) and health seeking behaviour of street youths in Ibadan.	Youth (n=160)	Majority of the street youths were sexually active, engaged in high-risk sexual behaviours and had inappropriately treated sexually transmitted infections. Development of risk reduction and appropriate sexual health interventions targeted at prevention and appropriate treatment is recommended
12. Friyie, J.A. Ghana. Cross-sectional design.	2018	assessed the association between HIV risk perception and risky sexual behaviour among in-school adolescents in a municipality in Ghana	Student (n=706)	Except for those with multiple sexual partners, the adolescents generally did not perceive themselves to be at risk of HIV infection despite their involvement in risky sexual behaviour. Interventions that help adolescents to correctly assess their HIV risk perception and build on their susceptibility to HIV infection are needed.

13. Mostert et al. South Africa. Cross-sectional design	2020	To measure and describe learners' sexual knowledge and activities in a rural technical secondary school in North-west Province, South Africa.	Learners (N=79)	Findings point to unsafe sexual practice of learners at a school in rural South Africa, even from an early age. This concern is accompanied by the occurrence of low levels of sexually related knowledge. The learners would benefit from continued implementation of the Steppingstones programme.
14. Bala, S., and Kang'ethe, S.M. South Africa. Qualitative design	2021	To explore interplay between substance abuse and proneness to sexual related diseases among female adolescents in Butterworth, South Africa.	Adolescent (N=26)	Substance use normalises multiple sexual partners; A Nexus between alcohol use and sexual relationship with older Men; Knot between substance use and sexual violence; Minimal opportunity by female adolescents to negotiate condom use; and Substance consumption making female adolescents to demean STD palliative services.

**Table 2: Quality Assessment of included articles**

References	Quality of sample	Control or comparison group	Quality of exposure /outcome	Follow – up	Distorting influences	Reporting of data	Summary quality rating of study
Abebe, M., Tsion, A., and Netsanet, F	Adequate	<b>Adequate</b>	<b>Adequate</b>	<b>Unclear</b>	<b>adequate</b>	<b>adequate</b>	<b>High</b>
Okanlawon, F. A. and Asuzu M.C	Adequate	<b>Unclear</b>	<b>Adequate</b>	<b>N/A</b>	<b>Adequate</b>	<b>Adequate</b>	<b>High</b>
Tarkang, E. E	Adequate	<b>Adequate</b>	<b>Adequate</b>	<b>n/a</b>	<b>unclear</b>	<b>unclear</b>	<b>Moderate</b>
Negeri, E. L	Adequate	<b>N/A</b>	<b>Adequate</b>	<b>Adequate</b>	<b>Unclear</b>	<b>Adequate</b>	<b>High</b>
Ngoma et al	Adequate	Unclear	Unclear	N/A	<b>unclear</b>	Adequate	<b>low</b>
Ngidi et al	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate	<b>Moderate</b>
Cumber, S.N., and Tsoka-Gwegweni, J.M	Adequate	Adequate	Adequate	N/A	unclear	Adequate	<b>High</b>
Timol et al	Adequate	Adequate	Adequate	unclear	Unclear	Adequate	<b>High</b>
Visser, M	Adequate	Adequate	Adequate	Unclear	Adequate	Adequate	<b>High</b>
Desmennu et al	Adequate	Unclear	Adequate	N/A	Adequate	Adequate	<b>High</b>



<b>References</b>	<b>Quality of sample</b>	<b>Control or comparison group</b>	<b>Quality of exposure /outcome</b>	<b>Follow – up</b>	<b>Distorting influences</b>	<b>Reporting of data</b>	<b>Summary quality rating of study</b>
Friyie, J.A.	Adequate	Adequate	Adequate	Unclear	Adequate	Adequate	<b>Moderate</b>
Mostert et al.	Adequate	Adequate	Adequate	Unclear	Adequate	Adequate	<b>Moderate</b>
Bala, S., and Kang'ethe, S.M.	Adequate	Adequate	Adequate	N/A	N/A	Adequate	<b>High</b>
Krugu, J.k., and van der Kwaak, A.	Unclear	Unclear	Adequate	adequate	Adequate	Adequate	<b>High</b>
Kosugi et al	Adequate	N/A	Unclear	unclear	Adequate	Adequate	<b>High</b>
Zuma et al	Adequate	Unclear	N/A	N/A	Adequate	Adequate	<b>Low</b>

## **Chapter 3: Research Methodology**

### **3.1 Introduction**

This section provides a detailed justification of this study's mixed methods and procedures. The chapter also designates the study setting identified for the current study and explains the sampling technique and data collection tool used to obtain data from respondents. In addition, the chapter explains the data analysis method used and issues relating to the validity and reliability of the instrument. Ethical considerations relevant to the study are also presented.

### **3.2 Research Design**

The nature of the study was a mixed-methods approach using convergent parallel mixed-methods design to develop an intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province. Convergent parallel mixed methods allow data to be collected concurrently. It allows approaches to be triangular and merged into a single study. Mixed methods allow for more insight and a better understanding of the dilemma and yield more comprehensive data or evidence. Additionally, it allows the researcher to gain both depth and breadth of the problem. Mixed methods are well-defined as a step for accumulating, scrutinising, and integrating qualitative and quantitative data at some stage of the investigation steps within a single study or series of studies to gain more insight into a research problem (Maree, 2016).

### **3.3 Study settings**

The study was conducted in Vhembe District Municipality, Limpopo Province. Limpopo Province is one of the nine Provinces in SA. The province is divided into five (5) districts, namely, in the northern location of the province is Vhembe District Municipality, Mopani District Municipality is sited in the South-East, while Capricorn District Municipality is sited in the South-West, Waterberg District Municipality is sited in the West and lastly, Sekhukhune District Municipality is in the South-East. The province shares borders with Zimbabwe located in the North, Botswana in the North-West and Mozambique in the Eastern part of the province. It covers 18,569M<sup>2</sup> (Square metres). The population of Limpopo comprises numerous ethnic groups distinguished by culture, language, and race. 97.3% of the population is Black, 2.4% is White, 0.2% is Coloured, and 0.1% is Indian/Asian. Vhembe District Municipality comprises 282 high schools and 188 primary schools. In addition, the district has 258,296 high school learners register for the 2022 academic year. Vhembe District Municipality is divided into four Municipalities, namely, Makhado, Thulamela, Musina, and Collins Chabane Local Municipality. The majority of the population living in Vhembe District Municipality are

Black African, they constitute 69%, Coloured 27%, Indian or Asian 1% and white 1%. The Tshivenda speaking people constitute 69%, Xitsonga 27%, Sepedi 2%, Sesotho 1%, Afrikaans 1%, and other languages 1%. The district comprises of one Regional Hospital, one specialised psychiatric hospital, six District Hospitals, eight Community Health Centres, 115 clinics and 19 mobile clinics that offer sexual reproductive health services and are user friendly for youth. In addition, the district has school health programmes that are not feasible in rural schools. Some members of the community live too far from the clinic. As a result, they must travel long distances (more than five kilometres) to access the clinic. The district has traditional healers who are practicing within the community. Table 3 reveals the prevalence of STIs, HIV/AIDS and unplanned pregnancy among youth. This outlines the depth of the phenomenon over three financial years.

**Table 3: Prevalence of STI's, HIV/AIDS and unplanned pregnancy**

Financial Year	Municipality	HIV/AIDS (%)	STI's (%)	Pregnancy (%)
2018/19	Thulamela Municipality	5.4%	4.0%	7.9%
	Collins Chabane	6.9%	5.2%	7.2%
	Makhado Municipality	7.3%	8%	8.1%
	Musina Municipality	8%	6.8%	7.2%
2019/20	Thulamela Municipality	6.6%	4.9%	9.0%
	Collins Chabane	8.5%	3.2%	5.1%
	Makhado Municipality	8%	8.4%	7.9%
	Musina Municipality	10.1%	7.9%	9.2%
2020/21	Thulamela Municipality	7.6%	6.0%	4.8%
	Collins Chabane	8.1%	6.5%	5.5%
	Makhado Municipality	10.3%	8.9%	8.4%
	Musina Municipality	14.8%	11.3%	14.2%

Source: Adopted from DoH (2020).

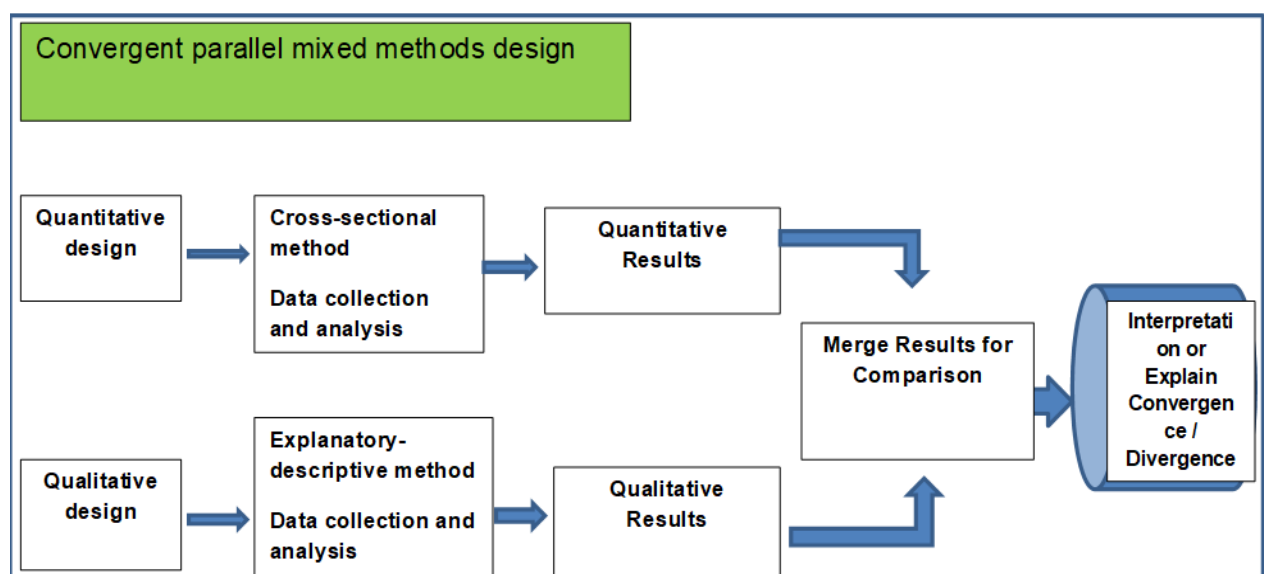


**Figure 3: Vhembe District Map**

Source: adopted from <https://municipalities.co.za/map/129/vhembe-district-municipality>

### 3.4 Phase 2 Empirical phase

Phase 2 was an empirical study. The convergence-parallel mixed methods design was used in the study to justify the issue of sexual health practice and provide a deeper understanding of the phenomenon. Creswell and Plano-Clark (2018) define convergent parallel design as requiring the investigator to simultaneously conduct both qualitative and quantitative components in the same phase of the research procedure, assess the methods equally, analyse the two components independently, and interpret the results together. (Figure 4 shows a summary of convergent parallel mixed methods).



**Figure 4: Summary of convergent parallel mixed methods.**

Adopted from Creswell and Plano-Clark (2018).

Moreover, the convergent design is most appropriate when a researcher wants to collect and compare quantitative statistical results with qualitative findings to completely understand the study/research problem. This method allowed the researcher to triangulate the approach into one study. A converging design enabled the researcher to merge the outcomes of both qualitative and quantitative features, compare them, and produce well-validated conclusions on the promotion of sexual health practice. Additionally, study findings were merged for the purpose of corroboration and validation; the researcher aims to triangulate the methods by directly comparing the quantitative statistical results and qualitative findings. Two datasets were obtained, analysed separately, and compared in the research process. If the results diverge, the researcher can explain the findings by re-examining the results, collecting more data, or explaining the dataset's quality. The intention of integration in a convergent design is to develop results and interpretations that expand understanding, are comprehensive, and are validated and confirmed. Convergent studies are appropriate designs for integration, as both data results are available when interpretation is planned. Additionally, integration in convergent design can be done in two ways: by presenting the findings of the qualitative study followed by the quantitative study or vice versa, or by transforming the qualitative data into counts and integrating the transformed qualitative dataset into quantitative data.

### ***3.4.1 Stage 1 of Phase 2: Qualitative Method***

Stage 1 of phase 2 adopted a qualitative method. This section outlines the study design, target population, sampling procedure, data collection procedure, inclusion, and exclusion criteria data analysis of this stage.

#### ***3.4.1.1 Study design***

In this study, an exploratory-descriptive design was used because the researcher intended to explore and understand the sexual health practices of youth before measuring and examining the phenomenon quantitatively (Creswell & Plano Clark, 2018). This helped the researcher gain acuity and comprehension in developing an intervention programme to promote sexual health practices among youth.

#### ***3.4.1.2 Study population and Sampling***

A population has been defined as all the elements that meet the criteria for inclusion in a study (Fàbregues, Hong, Escalante-Barrios, Guetterman, Meneses, & Feters, 2020). The target population in this study includes registered learners for the 2023 academic year in selected circuits, Vhembe district. The life orientation teachers facilitate life orientation subjects in

schools in selected circuits in the Vhembe district. The SGB members are serving under the selected school in selected circuits in the Vhembe district.

#### ❖ **Sample size**

According to Shetty (2018), a recommended qualitative study should consist of at least 30 participants before the researcher reaches data saturation. This provides the researcher with opinions or views regarding healthy sexual practices. Therefore, the total sample size of this study was 30 participants. In this study, thirty enrolled learners for the 2023 academic year were recruited to participate in the study. Six focus groups comprising five participants per group were conducted until data saturation was reached.

In addition, in this study, thirty educators who facilitated Life orientation subjects for the 2023 academic year were recruited to participate in the study. Six focus groups comprising five participants were conducted until data saturation was reached.

Lastly, in this study, thirty SGB members serving for the 2023 academic year were recruited to participate in the study. Six focus groups comprising of five participants were conducted until data saturation was reached.

#### ❖ **Data Saturation**

Qualitative data was collected in the top eleven schools with high teenage pregnancy rates in Vhembe district. Therefore, in the first five schools with high teenage pregnancy rates, data was collected from learners. Data saturation was reached in the third group at the third school. However, the researcher continued until the fourth FGD in the fourth school. Data was collected from grade 8 to 12 learners. From the fifth to the eighth schools, data was collected from the life orientation teachers, where data saturation was reached in the third FDG, frwho teaches from grade 8-12 in recruited schools. The researcher continued to the fourth FGD in the fourth school. For SGB, data was collected from the ninth until the eleventh schools. Data saturation was reached on the third FGD. However, the researcher rejected participants who wanted to participate without consent since they refused to sign consent forms.

#### ❖ **Sampling procedure of participants**

A purposive method has been defined as the deliberate choice of a sample with the purpose of encompassing predetermined strata of interested subjects (Colorafi & Evans, 2016). In this study, a purposive, non-probability sampling method was adopted to select eligible study participants. Learners, educators, and SGB were purposively selected to participate in this

study. In addition, participants were recruited through purposive sampling until saturation was reached. Learners were sampled based on the term 1 performance on life orientations subjects. Those who performed poorly were recruited with the assistance of life orientation teachers. Educators were purposively sampled based on their experience of teaching life orientation. SGB were purposively sampled based on their experience in the role of serving in the selected school.

#### ❖ Sampling of District

Vhembe District was purposively selected amongst other four districts, namely, Mopani District, Waterberg District, Sekhukhune District and Capricorn District, because the district in 2020/21 has recorded a high rate of teenage pregnancy and sexually transmitted infections. In addition, the district has low distributions of condoms (Table 4).

**Table 4: District Statistics of STI's, HIV/AIDS and unplanned pregnancy (Stats SA (2020)**

No.of District	Name of District	Teenage pregnancy	Sexual Transmitted Infection's	Distribution of Condoms
1	Vhembe District	5,6%	10,1%	15,7 million
2	Capricorn District	4,5%	9,3%	18,9 million
3	Mopani District	5,1%	7,8%	19,1 million
4	Sekhukhune District	5,0%	6,5%	16,5 million
5	Waterberg District	5,5%	7,8%	17,2 million

#### Sampling of Circuit

All four municipalities in the Vhembe district, namely, Collins Chabane, Musina, Makhado, and Thulamela municipalities, were given a fair chance to form part of the study. All circuits' names were written and categorised according to their municipalities. A simple random technique was employed to select four circuits for each municipality. Therefore, sixteen circuits were recruited to form part of the study. Small papers written with the names of circuits were folded and placed in a bowl to be mixed or shaken. The shaken process was made to ensure that there was equity in the selection of circuits. A man who was not part of the folding paper procedure was invited to pick one paper with the name of circuits.

#### ❖ Sampling of Schools

A purposive sample is a non-probability sample that is selected based on the characteristics of a population and the objective of the study. Purposive sampling is also known as judgemental, selective, or subjective sampling (Colorafi & Evans, 2016). Schools with the highest rate or number of teenage pregnancies was purposively recruited within a selected circuit.

### ***3.4.2 Inclusion and Exclusion Criteria***

Inclusion is defined as the criteria used to select eligible participants who have characteristics that the researcher wants the sample to possess (De Vos et al., 2019). Exclusion is defined as a principle that leads the researcher to exclude certain individuals from the sample (Maree, 2016).

#### ***3.4.2.1 Inclusion criteria***

Learners between the ages of 13 to 23 were included in the study. Educators who teach life orientation from grade 8 to 12 for 2023 was recruited to form part of the study. SGB members who served within a period of two years were recruited to form part of the study.

#### ***3.4.2.2 Exclusion of the study***

The 2023 registered learners from grade 8 to 12 who drop out were excluded from the study. Teachers who do not teach Life orientation from grade 8 to 12 were excluded. The newly elected SGB members and previously served committee members were excluded.

### ***3.4.3 Data collection tool***

An FGD interview guide was used to collect data from learners, SGB members, and Life orientation teachers. These guides were developed in English and translated into Xitsonga and Tshivenda by the experts in the Department of Linguistics. The type of language chosen from those two depended on what participants themselves felt comfortable using. The guide was semi-structured, with a series of questions that guided the inquiry in line with the objectives. A probe question was asked when seeking clarification on an issue that arose during the interviews. The instrument is attached as Appendices (Appendices 19-21).

### ***3.4.4 Pre-test***

A pre-test of the tools was conducted at France Sombani Secondary School as they share equivalent characteristics by being under the authority of Malamulele West Circuit, Collins Chabane Municipality, and Vhembe District. The one focus group interviews for learners, teachers, and SGB members were conducted. The responses were transcribed and analysed,



and necessary adjustments were made to the focus group interview guide. The data obtained from the pre-test was not included in the actual study.

### **3.4.5 Data collection**

A few days prior to data collection, the researcher liaised with the principals of high schools to discuss issues related to the research procedure, to gain access to the potential participants, and to gather data from them. The principal and the researcher made an appropriate arrangement for when data could be collected without jeopardising the schedule of the school's lessons. This arrangement was made to avoid disruptions in lessons in various classes during data collection. Suitable dates, times, and venues were arranged with the participants. Data was gathered during convenient times between lessons and after school hours.

The researcher went to morning assembly at selected schools, and the school principal introduced the researcher. The researcher explained the study, the benefits of the study, and the importance of consent forms, to learners, teachers and SGB members. Ethical considerations were explained to all participants.

Life orientation teachers assisted the researcher to identify poor performing learners in the life orientation subject in the first term from grades 8-12. Therefore, FGD were conducted in an office or private place at convenient times for both the interviewer and the interviewees. Parents were notified by the school principal about the study during parental meetings. However, the researcher contacted the parents of learners under the age of 18 to explain the procedure and the importance of the study. Thereafter, learners were given an information sheet as well as a consent form and assent form for parents to read before under-18 learners participated in the study. In addition, for participants under the age of 18, parental consent was required before they could be allowed to participate in the study. Further, when parents consented, participants under the age of 18 were requested to complete an assent form before becoming part of this study. Participants were free to withdraw from participation at any time if they wished to do so. All focus group discussions were conducted at schools.

Life orientation teachers were recruited to participate in the study during their free periods. The venue was arranged with the school and participants to schedule FGD. FGD was conducted during a convenient time so that it would not disturb lessons at the school.

The SGB members were recruited to participate in the study during their monthly and quarterly meetings with the school. For SGB members who did not attend meetings, an arrangement

was made to visit their homes for data collection. The researcher also contacted the SGB committee and informed them about the study. The researcher further arranged to conduct interviews after their meetings. Also, an office or venue to conduct interviews was arranged with the school principal.

Nyumba, Wilson, Derrick, and Mukherjee (2018) define a focus group discussion as a cluster of people who deliberate on a specific title in research under the guidance of the researcher or investigator. Six focus groups consisting of five participants in each group, including learners, teachers, and SGB members were held; these interviews were conducted using the home language of participants so that more depth could be gained and to ensure their comfort in expressing their feelings. These were done since some participants appeared to be comfortable expressing their feelings in a group setting with people who were facing similar challenges as themselves.

All FGDs were recorded on a tape recorder. All FGD data was stored and locked in a safe by the researcher. During the interviews, field notes were taken to ensure that non-verbal communication and body gestures were noted. Only the researcher and supervisor have access to the data. The researcher requested permission from the participants to use the audio recorder before the beginning of the interviews, which allowed the researcher to have full interview records.

### **3.4.6 Data Analysis**

Thematic analysis was used in the study to analyse the qualitative data. All sets of data were different for each focus group since each group has its own data collection tool. Therefore, for the overall set of data, thematic analysis was used. Maguire and Delahunt (2017) define thematic analysis as the procedure of classifying themes within qualitative data. Thematic analysis has a distinct approach. For instance, Maguire and Delahunt (2017) revealed that the techniques of data analysis include organizing and preparing data, developing a general sense of the data, coding the data, describing, and identifying themes, representing findings, and interpreting the data. Consequently, the researcher employed a thematic approach to transcribe data from the tape recorder onto paper. The researcher followed Brink, Van der Walt, and Rensburg's (2016) principles, during thematic data analysis approach. These include:

#### **3.4.6.1 Step 1: Familiarising yourself with your data**

The researcher got a sense of the whole data by reading all the verbatim transcriptions carefully. This produced ideas about the data segments and how they looked and what they

meant. The meaning developed during reading while writing down all ideas as they come to mind. The researcher carefully and repeatedly read the transcripts of all the participants and became thoroughly familiar with the context.

#### ***3.4.6.2 Step 2: Generalised initial codes***

The researcher generated the initial codes and themes. The researcher went back to the data and made abbreviations as codes were written next to the appropriate segments of the text. The researcher then observed the organisation of data to check whether new categories or codes emerged or developed.

#### ***3.4.6.3 Step 3: Searching for themes***

Themes derived from the FDG that relate to each other were grouped together. The researcher classified data by looking for categories, themes, or dimensions of information. General themes and subthemes were identified. The researcher drew columns between categories to show how they are interrelated. The categories were abbreviated into codes that were then written next to the appropriate segments of the text. The researcher tested this initiation by organising a scheme to establish whether these codes were emerging or developing.

#### ***3.4.6.4 Step 4: Reviewing themes***

The researcher reviewed the themes and made a final decision on the abbreviations of each category and the codes were arranged alphabetically or sequentially, so that they could be easily identified. Themes were made by assembling data materials belonging to each category.

#### ***3.4.6.5 Step 5: Defining themes***

The data material belonging to each theme was assembled in one place and an initially defining themes analysis was performed.

#### ***3.4.6.6 Step 6: Constructing the reports***

Constructing the reports from the existing data was made as the researcher found it necessary during the process of analysis. The researcher was able to generate themes and subthemes from collected data. The promoter was used to verify and approve the emerging theme and subthemes. Six themes were finally developed with subthemes as a result of a consensus discussion with the promoter. The promoter was used as the inclusion of external view to give the process credibility.

Participants were interviewed in Xitsonga or Tshivenda, which allowed the researcher to

present the themes in the home language and translate them into English. The type of language chosen from these two home languages depended on what participants felt comfortable using to express themselves. Thereafter, the transcripts, transcribed in Xitsonga and Tshivenda, were translated into English by the experts in the Department of Linguistics. Tape recorders were stored in a safe or a locker for safety and the management of data. Only the researcher and supervisors have access to the data or tape recorder.

### **3.4.7 Measures of trustworthiness**

Trustworthiness of the qualitative approach in this study was attained through Credibility, Transferability, Dependability and Confirmability.

#### **3.4.7.1 Credibility**

Credibility was ensured by using the most appropriate sampling method to identify and select participants who met the criteria for inclusion. This includes selecting the most appropriate method for data collection and analysis. Thus, categorising themes and discarding irrelevant themes and presenting them to participants to verify whether their views are accurately captured and well-presented. Focus group interviews using open-ended questions promote thorough engagement, which allows participants to fully contribute to the research topic. Ensuring credibility was an approximately three-month-long process.

#### **3.4.7.2 Transferability**

To ensure transferability, the researcher made a point of ensuring that participants meet the criteria of inclusion so that the data is appropriate and applicable to other settings. This is inclusive of explaining and providing verbatim themes or quotations from the focus group.

#### **3.4.7.3 Dependability**

To ensure dependability, the researcher ensured that there was no bias that influenced participants' responses by (i) thoroughly describing data collection and analysis; (ii) Explaining research protocols to research teams or research assistants; (iii) Using data collection techniques, such as an audio recorder or tape recorder, to promote the reliability of data collection. In addition, the researcher used the code-recode strategy, which involves the researcher coding the same data twice by leaving a period of two weeks between each coding. The results from the two codings were compared to see if they were similar.

#### **3.4.7.4 Confirmability**

To ensure confirmability, the researcher remained objective and maintained neutrality by

making sure that the findings were the result of the participant's views. Additionally, the researcher conducted a substantial review of the literature to compare or identify similarities and differences, as well as verified whether the research findings were supported by the literature. An audio or tape recorder was used to confirm whether the reported data is a true reflection of the data collected.

### **3.5 Stage 2 Phase 2: Quantitative Approach**

Stage 2 of phase 2 adopted a quantitative method. This section outlines the study design, target population, sampling procedure, data collection procedure, inclusion, and exclusion criteria data analysis of this stage.

#### **3.5.1 Study design**

Brink, Van der Walt and Rensburg (2016) define research design as a plan for selecting subjects, research sites, and data collection procedures to answer the research question(s). Cross-sectional design is defined as a research study that accumulates data on respondents at a once-off opinion in time (Brink, Van der Walt & Rensburg, 2016). In this study, a descriptive cross-sectional design was used. A descriptive cross-sectional design allowed the researcher to a once-off overseeing of the survey instrument to obtain data among study respondents.

#### **3.5.2 Study population and Sampling of school**

##### **3.5.2.1 Study population**

Shukla (2020) defines study population as a full cluster of people or objects that the researcher is interested in. Population in this stage includes all registered learners for the 2023 academic year.

##### **3.5.2.2 Sampling of Schools**

A purposive sample is a non-probability sample that is selected, based on the characteristics of a population and the objective of the study. Purposive sampling is also known as judgemental, selective, or subjective sampling (Maree, 2016). Schools were purposefully recruited within a selected circuit because they had recorded the highest rate or number of teenage pregnancies (Table 5).

**Table 5: Population frame (Distribution of Learners) adopted from DoE circuit Manager Vhembe district (2022).**

No	Vhembe District Municipalities	Circuits Names	School Names	Learners
1	Collins Chabane Local Municipality	Malamulele West	Khatisa high school Hlalukweni high	4878
2		Malamulele Northeast	Basopa sec Mhinga sec	6063
3		Malamulele East	Gidjana sec Nghezimani sec	8524
4		Malamulele Central	George nsoto Mbhanye Sec	5113
5	Thulamela Municipality	Vhuronga 1	Julious sec Rachikwekwete sec	3564
6		Vhuronga 2	Ongedacht sec Tshinavhe	3969
7		Hlanganani Central	Hanyani nkuzani Marholeni sec	3529
8		Hlanganani South	Yingwane- ribu sec Tiyani sec	3754
9	Makhado Local Municipality	Soutpansberg West	Sithumule sec Magoni sec	4582
10		Soutpansberg East	Rivubye sec Elim sec	5109
11		Sekgosese North	Mudumeli sec Masereni	3420
12		Ndzhele West	Patric rhamano sec Mulenga	3600
13	Musina Municipality	Sambandou	Makuya sec Sambandou sec	3894
14		Tshilamba	Mamphondo sec Malilele sec	5945
15		Niani	Niani sec Dzimanhu sec	6039
16		Tshinane	Shayandima high Khwevha sec	4702
Total				76685

### 3.5.2.3 Sampling size

Sample size is an important feature of any empirical study in which the goal is to make inferences about a population from a sample (Colorafi & Evans, 2016). The study adopted Slovin's (1960) formula to determine the sample size. The sample size was calculated using the formula below, where N is the total number of learners who are registered at Vhembe District Municipality. *n* is the sample size and *e* are the accepted level of error of 0.05. Based

on the Vhembe district total population of learners of 76,685 (Table 6) the sample size was calculated as follows:

The 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

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

$$n = \frac{76685}{[1 + (76685 \times 0.05)^2]}$$

$$n = \frac{76685}{(1 + 191.71)}$$

$$n = \frac{76685}{192.71}$$

$$n = 398$$

An extra 10% of the sample size was added to accommodate non-response. Therefore, an extra 40 learners were added to 398, the number of questionnaires that were distributed to 438 learners in Vhembe district Municipalities.

**Table 6: Sampling frame**

No	Vhembe District Municipalities	Circuits Names	Learners	Total No.of Learners per circuit	percentages (%)
1		Malamulele West	4878	438/ 76685*4878 =28	6%
2	Collins Chabane Local Municipality	Malamulele Northeast	6063	438/76685* 6063=35	8%
3		Malamulele East	8524	438/ 76685*8524 =49	11%

4		Malamulele Central	5113	$438/76685 \times 5113 = 29$	7%
5		Vhuronga 1	3564	$438/76685 \times 3564 = 20$	5%
6	Thulamela Municipality	Vhuronga 2	3969	$438/76685 \times 3969 = 23$	4%
7		Hlanganani Central	3529	$438/76685 \times 3529 = 20$	5%
8		Hlanganani South	3754	$438/76685 \times 3754 = 21$	5%
9		Soutpansberg West	4582	$438/76685 \times 4582 = 26$	6%
10	Makhado Local Municipality	Soutpansberg East	5109	$438/76685 \times 5109 = 29$	7%
11		Sekgosese North	3420	$438/76685 \times 3420 = 20$	4%
12		Ndzhele West	3600	$438/76685 \times 3600 = 21$	5%
13		Sambandou	3894	$438/76685 \times 3894 = 22$	5%
14	Musina Municipality	Tshilamba	5945	$438/76685 \times 5945 = 34$	8%
15		Niani	6039	$438/76685 \times 6039 = 34$	8%
16		Tshinane	4702	$438/76685 \times 4702 = 27$	6%
Total			76685	438	100%

#### 3.5.2.4 Sampling of Learners

In this study, a probability-stratified sampling technique was employed to select participants. Learners were grouped according to grades in a selected school, all learners had an equal chance of being selected in the study, to avoid bias, and the grades were treated as strata. Therefore, the researcher further used simple random sampling to select learners from each grade. The sampling procedure used a folded small piece of paper with a yes or no written on it placed in the container and shaken to avoid bias, those who picked yes became part of the study, and those who picked no were automatically rejected. The number of learners to be sampled per grade was calculated by dividing the total number of learners in the grade by the sum of the 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 total learners in the circuit multiplied by the total sample size for the study. Although the sample size is 398, the sample size was increased by 10% to



make provision to cover non-responses, resulting in a sample size of 438.

### ***3.5.3 Inclusion and exclusion criteria of the Study***

Inclusion is defined as the criteria used to select eligible participants who have characteristics that the researcher wants to include in the study (De Vos et al., 2019). Exclusion is defined as a principle that guides the researcher to exclude participants in the study (Maree, 2016).

#### ***3.5.3.1 Inclusion of the Study***

Learners between the ages of 13 to 23 years were included in this study. These learners were enrolled in a selected circuit, municipalities in the Vhembe district.

Learners must be from grade 8 to 12 to be included in the study.

#### ***3.5.3.2 Exclusion of the Study***

Learners registered for 2023 academic year, who drop out from grade 8 to 12 in a selected circuit and school were excluded.

### ***3.5.4 Instrument for data collection***

A structured, self-administrated questionnaire (Appendix 17) was used to collect data. The questionnaire is an instrument employed for data collection, comprising chronological questions and other prompts with the intention of gathering information from the respondent (Maree, 2016). The researcher developed the self-administered questionnaire, guided by the study objectives and literature review. The questionnaire was translated into Xitsonga and Tshivenda by a linguist in the department of languages to cater for all learners in Grades 8 and 9. The questionnaire consisted of four sections as follows: Demographic information, knowledge of youth about the promotion of healthy sexual practices; factors and sexual risk behaviours influencing the promotion of healthy sexual practices; and measures to increase the use of family planning. The questionnaire consisted of closed questions.

### ***3.5.5 Pre-test***

Malamulele North East circuit was selected for the pre-test. Therefore, the instrument was pre-tested at Nkatini High School, as they share equivalent characteristics by being under the authority of Collins Chabane Municipality, Vhembe District. The questionnaire was distributed to 10% of the population (40 learners). Respondents' pre-testing was not part of the actual data collection. The purpose of the pre-test was to modify the questionnaire and make corrections where necessary, according to the comments of the respondents. Thereafter, supervisors customised the instrument according to the comments of the respondents; they

aligned the instrument according to the objectives.

### **3.5.6 Validity and Reliability**

Measures of the quantitative approach in this study were attained through reliability and validity.

#### **3.5.6.1 Validity**

Validity is defined as the capability of an instrument to quantify the variable that is quantified (Maree, 2016). In this study, validity was ensured by means of face and content validity.

- **Face validity**

The researcher presented the questionnaire to the supervisors, departmental seminars, and higher degree committees to ensure face validity. The researcher modified the instrument according to the feedback received.

- **Content validity**

In this study, to ensure content validity, the instrument was shaped by an extensive review of literature from similar studies conducted locally and internationally and examined by experts in the field and supervisors to provide an assurance of validity.

#### **3.5.6.2 Reliability**

In this study, test re-test methods were used to measure the accuracy and reliability of the instruments. The instrument was administered to the same participants two (2) weeks apart to measure the accuracy and consistency of the questionnaire and check if it produced equivalent results over time. The aim of administering the test two weeks apart is to avoid respondents memorising the answers they gave the first time. The correlation coefficient should be close to 1 to show the reliability of the instrument. In this study, if the coefficient is less than 0.5, the instrument is modified because there is no relationship between the instrument and what it intends to measure.

### **3.5.7 Data collection**

Data collection involves selecting respondents and gathering data from them (Maree, 2016). The researcher liaised with the principals of high schools to discuss issues related to the research procedure, to gain access to the potential respondents, and to gather data from them. The principal and the researcher make an appropriate arrangement for when data could be

gathered without jeopardising the schedule of the lessons. This arrangement was made to avoid disruptions of lessons in various classes during data collection. Learners were gathered in a classroom. The researcher administered the questionnaire to the learners. Each participant was seated in their own table, to prevent copying from fellow learners. The process of gathering data took over four months. The completion of the questionnaire took an estimated 45 minutes. The respondents completed the questionnaires in the presence of the researcher, who provided support and clarity where necessary. The researcher collected the questionnaires after their completion.

### **3.5.8 Data Analysis**

The quantitative approach endorsed data being collected in numerical format, resulting in the use of nominal, ordinal, and ratio scales. All questionnaires were prudently scrutinised and confirmed before being captured on the computer for analysis. The researcher used the Statistical Package for the Social Sciences (SPSS) version 28.0 to perform the descriptive and inferential statistical analyses. Pearson's Chi-square ( $\chi^2$ ) was used to test the association between demographic information. The data was presented in tabular charts using Microsoft Excel 2016 and GraphPad Prism. The statistical significance level of testing (p-value) was set at  $p = 0.05$  in all cases.

## **3.6 Phase 3: Conceptualisation of the study**

The conceptualisation of the study findings was collected into a conceptual framework that guided the development of the intervention programme. The conceptual framework was involved in the development of an intervention programme that is expected to be useful to stakeholders in instituting control measures to promote healthy sexual practices among youth. Stage 1 phase 2 data were analysed thematically and merged with the statistical analysis of Stage 2 phase 2. To achieve this, the researcher integrated the findings into a single study guided by HPM.

## **3.7 Phase 4: Programme development**

Intervention mapping was employed to guide the development of the intervention programme using the study findings of phases 1 and 2. Bartholomew et al. (2016) indicated an important component of the intervention mapping approach that includes the following six steps:

**Step 1: Logic Model of the Problem:** In the first step, the researcher identified the health problems that act as barriers that hinder the promotion of healthy sexual practices and the access of youth to health facilities and contraceptives.

**Step 2: Programme Outcomes and Objectives as a Logic Model of Change:** In this step, the researcher formulated objectives that were in line with the problem identified in Step 1, as well as the matrices of change.

**Step 3: Programme Design:** The researcher chose model- and evidence-based change methods, based on the study findings, and the programme was in line with the concerns of participants and the implementation of change.

**Step 4: Programme Production:** All the necessary resources that will yield positive results in the developed programme were made available to ensure the reader read and understood the programme.

**Step 5: Programme Implementation Plan:** At this stage, it was determined whether the intervention would be disseminated, adopted, implemented, and maintained.

**Step 6: Evaluation Plan:** The last step is to evaluate the intervention to determine whether it has yielded positive results and its effectiveness.

### **3.8 Plans to Validate the Programme**

To validate the intervention programme, the researcher conducted an evaluation of the objectives, design, and plan of action, implementation undertaken, literature gathered, and stakeholders who participated in the programme. The evaluation was made to validate the developed programme by identifying weaknesses and mistakes made for further improvements and establishing the success of the learning process of the programme. The developed programme evaluated the effectiveness of its objectives. Acquiring feedback by completing questionnaires or conducting interviews with the participants after each implementation for further improvement is a prerequisite.

### **3.9 Ethical consideration**

Ethical consideration is defined as the generally accepted rights of the participants or institution related to researchers which social scientists must respect (Maree, 2016). The following are ethical considerations to which the researcher adhered:

#### ***3.9.1 Permission to conduct the study***

The proposal was presented to the Department of Public Health and Faculty of Health Sciences Research Committee and then submitted to the University Higher Degrees Committee for approval. Thereafter, the proposal was submitted to the University of Venda's

Research and Ethics Committee to obtain ethical clearance (Project number: FHS/22/PH/22/0303) (Appendix 1). Permission to conduct the study in Schools was sought from the Limpopo Department of Basic Education Research Ethics, District Departments of Basic Education (REF: 2/2/2) (Appendix 5), selected circuits, and schools. Permission was also sought from all participants and ensured that they gave permission by signing a consent form. Permission was also requested from the school principal before participants were drawn. The rationale behind seeking permission to conduct the study is to ensure that it is conducted lawfully with the knowledge of stakeholders that play a role in its success (Appendices 3-15 for approvals).

### **3.9.2 *Beneficence***

Beneficence imposes a duty on the researcher to minimise harm and maximise the benefits described (Maree, 2016). The principle of beneficence was applied in the study by ensuring that the participants' privacy was maximised. The research was beneficial as it created new knowledge. The researcher ensured that no harm was done to the participants. Healthy sexual practices are a sensitive issue.

### **3.9.3 *Confidentiality***

Confidentiality is defined as the protection of participants or subjects of interest by not disclosing their identities to the public (Miles, Huberman, & Saldana, 2019). The respondents were informed that the information they provided would be treated with the highest degree of confidentiality. To ensure confidentiality, the respondents were not required to provide their names or identification numbers. The completed questionnaires were stored in a locked safe by the researcher.

### **3.9.4 *Autonomy***

Autonomy is defined as a decision that could be made by a participant as an informed choice of whether to participate in the study or not (Brink, van der Walt & van Rensburg, 2016). The respondents were given full disclosure about the nature of the study and its benefits and an opportunity to ask questions before the data collection began. To ensure Autonomy, Respondents were informed that they are free to withdraw from the study at any time, without any reason, even after they have signed the consent form.

### **3.9.5 *Informed consent***

Informed consent is defined as a voluntary respondent who agrees to participate in a research study in which the researcher has a full understanding of the study before the study begins

(Colorafi & Evans, 2016). In this study, an information sheet was designed to summarise what the whole study intends and how the data collection is going to be handled, including privacy and anonymity. Participants have gone through the information sheet before deciding whether to participate in the study. For data collection from youth (who are under 18), written consent was requested from their parents or guardians. Thereafter, participating youth agreed to participate in the study. The information sheet, consent, audio recording and assent forms are found in Appendices 14-17.

### **3.9.6 *Voluntary participation***

According to Fàbregues et al. (2020), voluntary participation is defined as an act that should be voluntary; participants should not be threatened or compelled to participate in a study, and they should do so of their own will. In this study, participation was voluntary, and the researcher informed the respondents about their right to withdraw from the study at any time if they decided not to participate.

## **3.10 Delimitations of the Study**

The study only focused on Vhembe District, Limpopo Province; other Districts in Limpopo Province were excluded. Thus, the outcome of the study cannot be generalised to the other four districts in Limpopo Province.

## **3.11 Plan for Dissemination and Implementation of Results**

A thesis copy was submitted to the library of the University of Venda for reference by other researchers. It was also given to the Provincial Department of Education, the Department of Education in Vhembe District, selected circuits, as well as high schools recruited to participate in the study. Furthermore, copies were given to other stakeholders for implementing the programme, such as NGOs, DSD, and DoH. The findings were published in accredited journals and presented at national and international conferences.

## **3.12 Conclusion**

This chapter presented the methodology used in this study, which includes the study setting, sampling methods, pre-tests, data analysis, data collection, systematic review procedures, the development of an intervention programme, plans for validation, and ethical considerations.

## **Chapter 4: Presentation, and Interpretation of the findings**

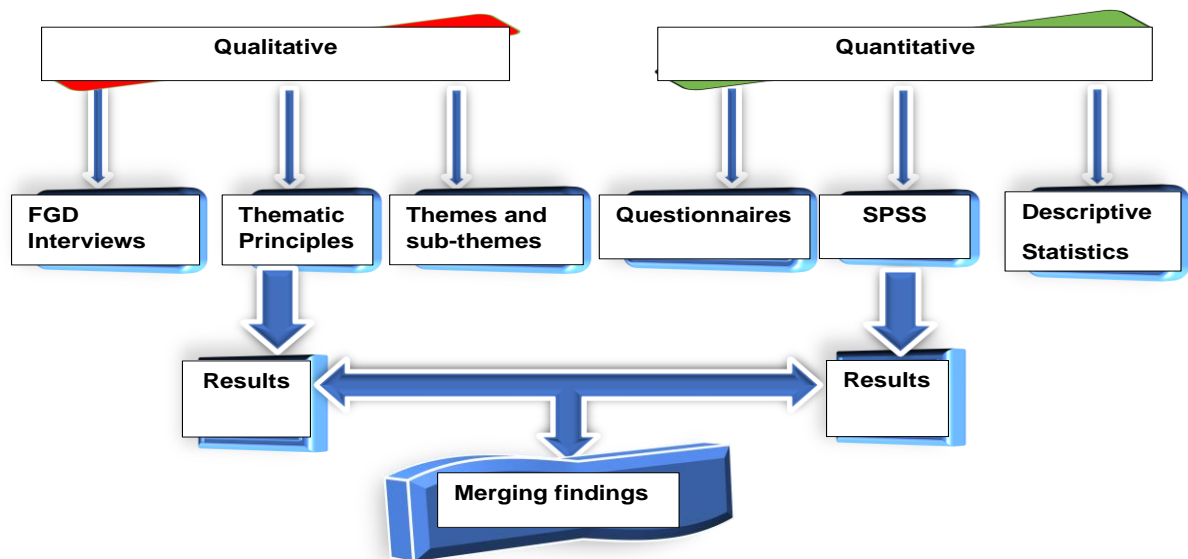
### **4.1 Introduction**

The last chapter presented the research methodology. A parallel convergent mixed method design was most significant for this study. The main aim of the study in both the qualitative and quantitative stages was explained to the participants respectively. Verbal, written and recording consent was obtained from the participants before the commencement of collecting data.

### **4.2 Data analysis processes**

This chapter further presents, interprets, merging and diverging the findings from both qualitative and quantitative stages. The Focus Group Discussion in-depth interviews were conducted with 67 participants, although 438 respondents were determined by Slovin's formula. For the quantitative strand, seven hundred (700) questionnaires were distributed to both male and female learners registered in selected circuits and schools in Vhembe district, Limpopo province for the 2023 academic year and Five-hundred and thirty-one (531) were returned and correctly completed, giving a response rate of 76%. The researcher increased the number of participants to gain more views or opinions for the statistical analysis and generalisation of study outcome. SPSS was used to analysed data. The data was presented in frequency tables, bar and pie charts. The percentages of the Likert scale are combined, and the summaries are provided.

For the qualitative strand, thematic principles were followed to analyse data; the researcher established the transcript for each FGD interview after listening to the audio recordings several times. The researcher re-read the transcripts and listened to the audio recordings to ensure that no essential information was lost or misinterpreted in the translations. During the process of reading, important topics were coded, and parallel codes were merged to create themes. Further, in discussing the themes, the citations from participants were presented to support the argument while literature serves as a benchmark. Data was analysed thematically. For both qualitative and quantitative strands, results were merged. The participants and unique numbers were used to distinguish between remarks made by SGB, Learners, and LO Teachers respectively (Figure 5).



**Figure 5: Merging of results**

#### **4.2.1 Research Methodology Approach**

Phase 2, stages one and two of the study, addressed both objectives. The first objective was to assess the knowledge of youth about the promotion of healthy sexual practices, to explore factors and the sexual risk behaviours that influence the promotion of healthy sexual practices and to explore and describe measures that could influence the increased use of contraceptives or family planning to promote sexual healthy practices among youth. A mixed-method simultaneous approach where both qualitative and quantitative phase 2 stages were used to achieve both objectives was developed. The third phase was to conceptualise the findings in the theoretical framework. The fourth phase was to develop an intervention programme to promote healthy sexual practices. The fifth phase was to validate and evaluate the developed intervention programme to promote healthy sexual practices.

#### **4.2.2 Stage 1 Phase 2 Qualitative method presentation and interpretation of findings**

The qualitative findings are presented in a narrative arrangement, therefore progressing to the narrative of the findings presented. Verbatim extracts of the participants are presented and relevant literature to aid the findings is described. Six main themes were merged during the analysis of data based on the FGDs and in-depth interviews conducted with 67 participants.



The seven main themes originated from the following study objectives:

- To assess knowledge of youth about the promotion of healthy sexual practices.
- To explore factors and the sexual risk behaviours that influence the promotion of healthy sexual practices.
- To explore and describe measures that could influence the increased use of contraceptives or family planning to promote healthy sexual practices among youth.

#### ***4.2.3 Presentation of the findings in the form of themes and sub-themes***

Table 7 shows the themes and sub-themes that emerged during data analysis. The study findings are presented with participants' direct citations alongside the themes and subthemes derived from the data. The study consists of three participant groups, namely, learners, SGB and LO teachers. All these groups has similar themes and sub-themes.

**Table 7: Themes and sub-themes merged during data analysis.**

<b>Theme 1: Lack of Knowledge to learners about STIs, HIV/AIDS and pregnancy.</b>	<b>Theme 2: Views and perceptions of learners, teachers, SGB regarding the promotion of healthy sexual practices.</b>	<b>Theme 3: Culture, beliefs, norms, and values regarding the promotion of healthy sexual practices.</b>	<b>Theme 4: The roles of teachers and SGB in promoting healthy sexual practices.</b>	<b>Theme 5: Challenges regarding the promotion of healthy sexual practices.</b>	<b>Theme 6: Strategies regarding the promotion of healthy sexual practices.</b>
Sub-theme 1: Lack of knowledge, and perception regarding healthy sexual practices. Sub-theme 2: Misconception regarding healthy sexual practices such	Sub-theme 1: Teachers to disclose risky sexual behaviours in Life orientation. Sub-theme 2: Sexual Harassment by Educators in School Sub-theme 3: Substance abuse by learners	Sub-theme 1: Early Marriage (Arranged marriage) and forced marriage. Sub-theme 2: Cultural stereotypes regarding healthy sexual practices Sub-theme 3: Culture promotes the preservation of	Sub-theme 1: Conscientise learners about healthy sexual practices	Sub-theme 1: Violation of POPIA act at healthcare facilities Sub-theme 2: Contraceptives are not 100% safe. Sub-theme 3: Poverty influences, lack of parental, family, and social support programmes.	Sub-theme 1: Family system support Sub-theme 2: Health system support. Sub-theme 3: NGO, NPO and other stakeholders' system support Sub-theme 4: Education system support

as HIV/AIDS, and pregnancy	<p>Sub-theme 4: Risk of forced sexual activity by sexual partners and older people.</p> <p>Sub-theme 5: Early initiation of sexual intercourse</p> <p>Sub-theme 6: Peer influences sexual behaviour act, such as, the improper wearing of uniform (seducing educators) and experimenting and curiosity by learners.</p> <p>Sub-theme 7: Illegal abortion performed by learners.</p>	virginity until marriage.		<p>Sub-theme 4: Challenges in the provision of contraceptives and stockout, accessibility, long waiting periods, and queues at the healthcare facility.</p> <p>Sub-theme 5: Sexual risky behaviour amongst learners</p> <p>Sub-theme 6: Lack of awareness campaigns, support, and insufficient resources to teach learners at school</p>	
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## **4.3 Demographic information**

This section provides the demographic information requested from participants during interviews.

### **4.3.1 Learners**

The demographic information incorporates age, gender, marital status, ethnic group, educational level, people living with participants, number of children of participants, and the religion that participants participate in. The population of the study comprised 26 learners registered from sixteen selected circuits and schools in Vhembe district, Limpopo province. The demographic information of learners shows that most participants were males. Thus, this shows that male learners are predominately participating in this study, while it is recorded that female learners dominate South African schools. Most of the participants were aged 10-15. The finding revealed that most learners are in grade 12. Furthermore, the findings revealed that most of the participants are living with their mothers. Only five participants had children while many of the participants did not have children. Most of the participants belong to the Tsonga ethnic group. None of the participants had been married and the most of them belonged to the Christian religion. Table 8 depicts the demographic information of learners in the qualitative study.

**Table 8: Demographic information of Learners in the qualitative study**

<b>Fgd no</b>	<b>Participant no</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnic Group</b>	<b>Marital Status</b>	<b>Grade</b>	<b>People living with</b>	<b>Children</b>	<b>Religion</b>
<b>FGD 1</b>	Participant 1	Male	18	Venda	Single	12	Mother	No	Other
	Participant 2	Female	19	Tsonga	Single	12	Both parents	No	Christianity
	Participant 3	Male	17	Venda	Single	12	Grandmother	No	Christianity
	Participant 4	Male	20	Tsonga	Single	12	Mother	No	Christianity
	Participant 5	Male	17	Venda	Single	12	Mother	No	Christianity
	Participant 6	Female	19	Venda	Single	12	Mother	Yes	Other
<b>FGD 2</b>	Participant 7	Female	18	Tsonga	Single	12	Mother	No	Christianity
	Participant 8	Female	18	Tsonga	Single	12	Father	No	Christianity
	Participant 9	Male	18	Tsonga	Single	11	Other	No	Christianity
	Participant 10	Male	21	Tsonga	Single	11	Other	Yes	Traditional
	Participant 11	Female	19	Tsonga	Single	11	Brother	No	Christianity
	Participant 12	Female	16	Tsonga	Single	10	Mother	No	Christianity
<b>FGD 3</b>	Participant 13	Female	16	Tsonga	Single	10	Grandmother	No	Christianity
	Participant 14	Male	15	Venda	Single	10	Mother	No	Christianity
	Participant 15	Male	15	Venda	Single	10	Mother	No	Christianity
	Participant 16	Male	17	Venda	Single	10	Grandmother	No	Christianity
	Participant 17	Female	17	Venda	Single	10	Mother	No	Christianity
	Participant 18	Female	15	Venda	Single	9	Mother	No	Christianity
	Participant 19	Male	14	Tsonga	Single	9	Grandmother	Yes	Christianity
<b>FGD 4</b>	Participant 20	Male	14	Tsonga	Single	9	Other	No	Christianity
	Participant 21	Male	16	Tsonga	Single	8	Other	Yes	Traditional
	Participant 22	Female	14	Tsonga	Single	8	Brother	No	Traditional
	Participant 23	Female	15	Tsonga	Single	8	Mother	Yes	Traditional
	Participant 24	Male	15	Tsonga	Single	8	Mother	No	Christianity
	Participant 25	Male	14	Tsonga	Single	8	Both parents	No	Christianity
	Participant 26	Male	16	Tsonga	Single	8	Father	No	Christianity

#### **4.3.2 Teachers**

This section presents the demographic information of the teachers who participated in this study. The demographic information incorporates age, gender, marital status, ethnic group, educational level, employment status, period of employment, and the religion to which participants belong in this study.

The population of the study comprised 25 teachers employed from sixteen selected circuits and schools in Vhembe district, Limpopo province. The demographic information of teachers shows that most participants were females. Thus, this shows that female teachers are predominately participating in this study, while it is recorded that female teachers dominate in South African schools. Most of the participants were aged 20-29. Most of the participants have degrees in education. Most of the participants were full-time employed. Furthermore, the findings revealed that the most of the participants had 0-5 years of working experience. The finding revealed that the most of teachers had a working period between 0-and 10 years. Most of the participants belong to the Tsonga ethnic group. Most of the participants were married. The minority of the participants had never been married and the majority of them belonged to the Christian religion. Table 9 shows the demographic information for life orientation teachers.

**Table 9: Demographic information for life orientation teachers.**

<b>FGD NO</b>	<b>Participant no</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnic Group</b>	<b>Marital Status</b>	<b>Educational Level</b>	<b>Employment Status</b>	<b>Employment Period</b>	<b>Religion</b>
<b>FGD 1</b>	Participant 1	Male	25	Tsonga	Never Married	PGCE	Private teacher	2	Christianity
	Participant 2	Male	53	Tsonga	Married	Education Degree	Full-time employment	23	Christianity
	Participant 3	Female	31	Tsonga	Married	Education Degree	Private teacher	6	Christianity
	Participant 4	Male	41	Venda	Married	Other	Private teacher	19	Christianity
	Participant 5	Female	45	Tsonga	Never Married	Education Degree	Private teacher	18	Christianity
	Participant 6	Female	51	Tsonga	Married	Education Degree	Full-time employment	29	Christianity
<b>FGD 2</b>	Participant 7	Female	28	Zulu	Never Married	Other	Full-time employment	5	Traditional
	Participant 8	Female	55	Tsonga	Living together	Education Degree	Full-time employment	17	Christianity
	Participant 9	Male	48	Tsonga	Married	Other	Full-time employment	16	Christianity
	Participant 10	Male	58	Tsonga	Married	Education Degree	Full-time employment	32	Christianity
	Participant 11	Female	29	Tsonga	Married	PGCE	Full-time employment	7	Christianity
	Participant 12	Male	55	Tsonga	Living together	PGCE	Full-time employment	29	Christianity
<b>FGD 3</b>	Participant 13	Female	40	Tsonga	Living together	PGCE	Full-time employment	18	Christianity
	Participant 14	Male	31	Tsonga	Living together	Other	Full-time employment	5	Christianity
	Participant 15	Male	42	Tsonga	Living together	Master of Education	Full-time employment	25	Traditional
	Participant 16	Female	37	Venda	Living together	Education Degree	Full-time employment	12	Christianity
	Participant 17	Female	35	Venda	Never Married	Education Degree	Full-time employment	9	Christianity
	Participant 18	Female	50	Venda	Married	Education Degree	Full-time employment	25	Christianity
<b>FGD 4</b>	Participant 19	Female	44	Venda	Married	Education Degree	Full-time employment	19	Christianity
	Participant 20	Female	51	Tsonga	Married	Education Degree	Full-time employment	27	Christianity
	Participant 21	Female	53	Tsonga	Divorced	Education Degree	Full-time employment	25	Christianity
	Participant 22	Female	52	Venda	Living together	Education Degree	Full-time employment	21	Christianity
	Participant 23	Female	25	Zulu	Separated	Education Degree	Full-time employment	4	Christianity
	Participant 24	Male	26	Zulu	Married	Other	Full-time employment	4	Traditional
	Participant 25	Female	29	Venda	Married	Honours Degree	Full-time employment	5	Traditional

#### **4.3.3 School Governing Body**

This section presents the demographic information of the school governing body that participated in this study. The demographic information incorporates age, gender, marital status, ethnic group, educational level, Employment status, period of employment, and the religion to which participants belong in this study. The demographic information of the school governing body shows that the majority of participants were males. Most of the participants were aged 20-29. The majority of the participants had secondary qualifications. Most of the participants were full-time employed. Most of the participants belong to the Tsonga ethnic group. Most of the participants were married, while other participants had never been married and the majority of them belonged to Christian religion. Table 10 shows the demographic information for the SGB.



**Table 10: Demographic information for School Governing Body**

<b>Fgd no</b>	<b>Participant no</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnic Group</b>	<b>Marital Status</b>	<b>Educational level</b>	<b>Employment Status</b>	<b>Religion</b>
<b>FGD 1</b>	Participant 1	Male	57	Tsonga	Married	Tertiary level	Self-employed	Christianity
	Participant 2	Male	33	Tsonga	Living together	Tertiary level	Full-time employed	Christianity
	Participant 3	Male	41	Tsonga	Married	Tertiary level	Full-time employed	Christianity
	Participant 4	Female	55	Tsonga	Living together	Secondary level	Full-time employed	Christianity
	Participant 5	Male	32	Tsonga	Married	Secondary level	Full-time employed	Christianity
	Participant 6	Female	50	Venda	Married	Secondary level	Self-employed	Christianity
<b>FGD 2</b>	Participant 7	Male	44	Venda	Married	Secondary level	Self-employed	Christianity
	Participant 8	Female	52	Venda	Living together	Secondary level	Full-time employed	Christianity
	Participant 9	Male	44	Tsonga	Married	Secondary level	Full-time employed	Christianity
	Participant 10	Female	45	Tsonga	Living together	No education	Casual jobs	Christianity
	Participant 11	Female	58	Tsonga	Married	Primary level	Self-employed	Christianity
	Participant 12	Male	52	Venda	Married	Secondary level	Unemployed	Christianity
<b>FGD 3</b>	Participant 13	Male	50	Tsonga	Married	No education	Unemployed	Christianity
	Participant 14	Male	53	Venda	Married	Tertiary level	Casual jobs	Christianity
	Participant 15	Male	60	Venda	Partner Deceased	Tertiary level	Pensioner	Christianity
	Participant 16	Male	60	Tsonga	Married	Secondary level	Pensioner	Christianity

#### **4.4 Theme 1: Lack of knowledge of learners regarding STIs, HIV/AIDS, and teen pregnancy**

The findings depict that there is a variety of knowledge related to STIs, HIV/AIDS, and pregnancy. This was supported by the evidence in the following sub-themes that have emerged from this theme amongst learners.

##### **4.4.1 Sub-theme 1: Lack of knowledge and perception regarding healthy sexual practices**

The findings of the study exposed learners who lack knowledge regarding STIs, HIV/AIDS, and pregnancy, which will lead them to contract sexual diseases. This is not to say learners are not protecting themselves when engaging in risky sexual behaviour. Inadequate knowledge in understanding sexual disease results in negative health consequences, such as illegal abortion, HIV positive, as well as STI diseases.

**Participant 02 (Learner), female, 19 years** supported this by asserting that *'pregnancy is a girl with tummy which has a baby inside when she was raped'*.

*'Pregnancy is when a couple has sex and the man did not wear a condom'* **Participant 24 (Learner), Male, 15 years.**

It has been shown that parents' ability to teach their children to abstain and condomise before sexual relationships was ignored or undermined by learners, as a result, learners become pregnant and victims of STIs, HIV, and AIDS.

**Participant 10 (Learner), Male, 21 years** supported this by attesting that *'I will talk about teenage pregnancy, underage children give birth to a child while they are still young. Because at home when guided they do not take guides seriously, they do not listen to their parents.'*

It has been shown that learners have mythical information regarding STIs and HIV/AIDS. This results in learners being infected with sexual diseases. Other learners point out the symptoms of STIs, however, they do not know what type of disease that is.

For instance, **Participant 17 (Learner), Female, 17 years** said *'I heard that STI is when a boy, sleeps with a girl who had performed an abortion. We call it "ku wela"'*.

**Participant 19 (Learner), Male, 14 years** reported the same notion *'I heard that is when a woman does not bath well when a man have sex with her then he gets STI then the man starts to experience swollen testes'*.

**Participant 20 (Learner), Male, 14 years** reported that *'STI's is when a girl does not bath and had an abortion then she had sex with a boy, that boy will contract STIs'*.

**Participant 23 (Learner), Female, 15 years** reported a similar opinion *'STIs is when a girl does not bath her vagina and the boyfriend contract those discharge then he starts to feel pains in the Panis'*

**Participant 02 (Learner), female, 19 years** concurred with another participant by reporting similar opinions *'STIs is regarded as weakening in sexual activities when having sexual intercourse with girls sometimes girls who don't love themselves, who don't bath their vagina then they have sex with, actually we call it to drop in English'*.

**Participant 10 (Learner), Male, 21 years** concurred with others and reported that *'I think STI is when a lady does not bath and go to sleep with boys when she sleeps with boys, the boys contract that discharges, then it causes a drop'*

**Participant 11 (Learner), Female, 19 years** reported a contrary view to another participant *'There this type of STI that is caused by abortions from the traditional healers. When a girl does an abortion in the Sangoma's and she is not yet clean, she needs boys to come and have unprotected sex then she will be cleaned; it will result in a swollen penis and testes'*.

The findings depict that learners are knowledgeable regarding the prevention measures of STIs, and HIV/AIDs. Other learners acquire more knowledge or skills on the use of condoms and to guard against it from bursting, as well as verifications of expiry date before use.

#### **4.4.2 Sub-theme 2: Misconceptions regarding pregnancy, STIs, HIV/AIDS transmission, and prevention**

The findings of the study revealed that learners have misunderstandings about the transmission of pregnancy, STIs, and HIV/AIDS, which will lead them to be infected by sexual diseases and others to fall pregnant at an early age.

**Participant 05 (Learner), Male, 17 years** asserted that *'A pregnancy only occurs for nine months, pregnancy occurs when you have unprotected sexual intercourse and you had not prevented either by injections, the morning after pills. Let's say you didn't use a condom'*

**Participant 02 (Learner), female, 19 years** contested that *'people must not sleep together or to have sex in this earth. Another thing is if you had money first test her HIV'*.

**Participant 11 (Learner), Female, 19 years** reported the myth that *'they create the artificial penis to have them, and they penetrate the virginal in the Tsonga woman initiation school'*.

**Participant 11 (Learner), Female, 19 years** said *'There this type of STI that is caused by abortions from the traditional healers. When a girl has an abortion in the Sangoma's and she is not yet clean, it needs boys to come and have unprotected sex then she will be cleaned'*.

It was revealed that learners in grades 8 and 9 show that they do not know how STIs, and HIV are being transmitted from one person to another. They do not have appropriate knowledge of their prevention because they know the types of preventative measures which include injections and pills. However, they thought it prevented both pregnancy and HIV.

**Participant 07 (Learner), Female, 18 years** asserted that *'Injection prevents both pregnancy and sexually transmitted infections that's what I know'*.

**Participant 08 (Learner), Female, 18 years** said that *'After we are done having sex with my boyfriend, he will sperm inside my vagina then later during the night I will take pills or the following day I will buy the morning after sex pills to protect myself against falling pregnancy and STIs, and HIV/AIDS'*.

**Participant 17 (Learner), Female, 17 years** had a different opinion and reported that *'Touching HIV woman's private part can cause you to have HIV and STIs, that is why in our culture we are not allowed to touch woman'*.

## **4.5 Theme 2: Views and perceptions of learners, teachers, and SGB regarding the promotion of healthy sexual practices**

The findings revealed risks that learners are exposed to, this risk includes lack of information about risky behaviours, multiple partners, and substance abuse which put learners at risk of unhealthy sexual behaviours.

### **4.5.1 Sub-theme 1: Teachers to disclose risky sexual behaviours in Life orientation**

The findings relate that learners encounter different challenges associated with their educators due to teachers not disclosing relevant information regarding healthy sexual practices. This makes learners susceptible to sexual diseases and substance abuse.

**Participant 22 (Learner), Female, 14 years** said *'Even teachers must be very serious because some of these things they do not teach us.'*

**Participant 14 (Learner), Male, 15 years** reported the notion that *'When others are taught about sex education they want to practice, so they end up having unhealthy sexual intercourse, I think that's the reason teachers hide this issue'*.

#### **4.5.2 Sub-theme 2: Sexual Harassment in Schools**

The findings revealed that female learners are being touched on their buttocks and breasts by their educators, which is a serious offence and when they report to a school-based social worker, they are not taken seriously. Sometimes, educators indicate that they have big curves and breasts, narrating sexy and romantic words to these female learners. Other learners believe that educators are hallucinating when they say they imagine themselves with them in the room.

**Participant 02 (Learners), Female, 19 years** said, *'The actions teachers used to show us, we won't respect them'.*

**Participant 06 (Learner), Female, 19 years** emphasises that *'teachers they do not respect us that they must not talk to us in a sexual way so that we can respect them because most of time they do not have respect'.*

**Participant 13 (Learner), Female, 13 years** stated the notion that *'At school, we have problems of sexual harassment, which is a problem to me when I go to the social worker and principal, they will change the topic instead of addressing my issues'.*

#### **4.5.3 Sub-theme 3: Substance abuse by learners**

Participants revealed that the majority of the youth engaged in substance abuse for several reasons. It was reported that they abuse substances because their pregnancies were rejected by the person or boyfriend who is responsible. Others demonstrated that they want money to buy cosmetics and clothes, so they drink alcohol so that they can have sexual intercourse with older people in exchange for money. It was further revealed that youth who had quick sex mostly happened in the tavern and shebeens when they were drunk and high on drugs.

**Participant 06 (Learner), Female, 19 years** said *'mostly when a person is drunk, he/she does not think straight, when a person is on drug their person becomes Horney and want to have sex. She/he will find any person whom she doesn't know to have sex with'.*

**Participant 07 (Learner), Female, 18 years** similar reports that *'others is matter of having sex as one-night stands when they are drunk'.*

**Participant 02 (Learner), Female, 19 years** said that *'smoking together as well as drinking together with girls we end up having unprotected sex because we are under the influence of alcohol'.*

**Participant 04 (Learner), Male, 20 years** reported that *'...after touching each other we start cuddling, when we are two in the room, and we are drunk we can have sex. We are at the level of not controlling ourselves. We can show it by looking at someone that I'm horny I need sex. Some other guy will tell you that I am craving for you.'*

#### **4.5.4 Sub-theme 4: Risk of forced sexual activity by sexual partners and older people.**

The participants reported that those who dance in shebeens and taverns target people who have money to buy alcohol for them in return for sex. Others stated that they offer themselves to buy alcohol and end up forcing them to have sexual intercourse, which results in contracting sexual disease while others become pregnant unwillingly.

**Participant 5 (Learner), Male, 17 years** reported that *'Most of these youth when they go to groove, they do not have money. Older people are buying them alcohol and food to eat, in exchange for sex. Is unprotected because you won't have a say or views.'*

**Participant 07 (Learner), Female, 18 years** reported that *'most of the youth are exposed to prostitution because they love money.'*

**Participant 12 (Learner), Female, 16 years** said, *'the majority of youth enter into the relationship because of looking at the status of an individual that this person has money, they are forced to have unprotected sexual intercourse with them because if they reject, they won't get money.'*

**Participant 18 (Learner), Female, 15 years** said that *'Others engaged in sexual intercourse with older people because of money.'*

**Participant 14 (Learner), Male, 15 years** said, *'They go to the tavern and shebeens with the mentality that man will buy alcohol for them, in return man want to have sexual intercourse nothing for "mahala".'*

#### **4.5.5 Sub-theme 5: Early initiation of sexual intercourse**

Participants revealed that learners engaged in sexual activities at a young age or underage, they depict that the grade 8 learners' transit to high school while they are pregnant. Older people encourage learners to have sexual intercourse at a young age and they do not have a choice of negotiating contraceptive usage during sexual intercourse.

**Participant 11 (Learner), Female, 19 years** reported a notion that *'my friend started intimacy with girls and I saw them kissing each other, they also going out to have fun in the resorts.'*

**Participant 10 (Learner), Male, 21 years** said *'I will talk about exchanging of girls, I sleep around with girls.'*

**Participant 18 (Learner), Female, 15 years** said *'I wanted to speak about peer pressure, there is this young girl she's in grade 7, she's the type of person who goes to town by taxis, she knows all the taxi drivers by their names. This girl smokes and drinks alcohol and people whom she associates with smoke and drink. Boys exchange her for having sexual intercourse with her.'*

#### **4.5.6 Sub-theme 6: Peers influence sexual behaviour act such as the improper wearing of uniform (seducing educators), and experimenting and curiosity by learners.**

Participants revealed that most learners who are sexually active at school display elements of sexual acts, they always hug boys, sometimes boys touch their breasts at school. They wear short dresses so that they seduce boys at school.

**Participant 06 (Learner), Female, 19 years** said a notion that *'They touch our thigh, boobs, waist, rubbing our hands 100% of girls are so sensitives. Sometimes you can go to an appointment where you will need to have sex with'.*

**Participant 08 (Learner), Female, 18 years** reported a similar notion that *'during break, boys touch the breast of girls and the bums' others will smile about the touches.*

**Participant 20 (Learner), Male, 14 years** said *'Ladies wearing mini skirt or dress which leads to them being raped'.*

**Participant 22 (Learner), Female, 14 years** said *'When ladies wear miniskirts or dress it increases the number of people to be raped in the villages'.*

**Participant 24 (Learner), Male, 15 years** reported that *'wearing short dresses, it leads to rape, due to in the village we had a bush, boys smoke dagga everywhere, so you might bypass where they are smoking, and they crave your thighs then they come to you and rapes you in the bush'.*

**Participant 05 (Learner), Male, 17 years** reported the notion that *'Young girls seduce older people, and they hang out with boys, hugging and kissing'.*

Participants revealed that they have been disowned by their friends because of not engaging in sexual activities. It was stated that those who do not contribute to the sexual debate conservation are isolated and are being called by names. So, they were influenced to experience sexual activities to please and strengthen their friendships.

**Participant 06 (Learner), Female, 19 years** reported the notion that *'mostly we regard these boys as stupid because I can visit them and we don't have sex. So, I have to move to the next partner for intimacy'*.

**Participant 07 (Learner), Female, 18 years** said, *'Friends influenced me to at least have one-night sexual intercourse so that I can share the experiences and they called me names that I am stupid because I never have sexual intercourse'*.

**Participant 18 (Learner), Female, 15 years** reported the notion that *'I was forced to drink alcohol because I want to please my friends to have sex my first sexual intercourse while I am drinking'*.

The findings revealed that participants when they were taught healthy sexual practices and abstinence wanted to test or experiment with sexual activity at the end of the lesson. They experience sexual desires, and they always want to engage in sexual activities. They claim to be addicted to having sexual intercourse.

Participants revealed that whenever they teach healthy sexual practices topics learners tend to be over-excited and they no longer listen to what you are saying. They will share their experiences and how they feel about sexual activities.

**Participant 03 (LO teacher), Female, 31 years** observed that *'learners tend to misbehave in class, they tend to share how they have sex with their partners'*.

**Participant 15 (LO teacher), Male, 42 years** expressed that *'learners stated that I will never wear a condom, I wanted to test if I can have a child at this young age'*.

**Participant 09 (LO teacher), Male, 48 years** observed that *'Learners' dressing codes are unaccepted especially because they are male teachers. Sometimes you can even see panties. Sex education ruined these kids'*.

Participants reported that learners developed an attitude of undermining teachers, while other learners feel like they are at the very same age as their educators. Furthermore, participants indicated that female learners seduce male educators.

**Participant 14 (SGB), Male, 60 years** said, *'Behaviour you can tell that they have learned something, since they grow in front of us, so we can see the changes, sometimes bunking of classes and being absent, especially in female students, so we can see that something intervened'*.



**Participant 12 (SGB), Male, 50 years** mentioned that *'yeah, at school we can see the behaviour of these learners by checking the concentration point, always troubling, always going up and down, it is not taking instruction from the teachers we quickly conclude that the learner is sexually active at that stage called adolescent'*.

**Participant 03 (SGB), Male, 41 years** expressed that *'Female learners began to wear short uniforms, and they always outside classes they move around staff where there are male educators, we had a case of an educator who had sex with grade 10 learner so improper wearing of uniform lead to sex'*.

Participants reported that they had different cases of learners engaging in sexual intercourse in the ablutions block during school hours and studies. It was indicated that during disciplinary hearings at school, learners were caught touching each other's private parts as a way of romancing each other. Female learners spend time with boys during lunch breaks.

**Participant 05 (SGB), Male, 32 years** mentioned that *'The way they behave inside classes you can tell that there is sign language, they hug each other, during hug they, boys touch bums, and have baby kiss in the lips, you can tell after school there are more doable activities at home'*.

**Participant 08 (SGB), Female 52 years** stated, *'You saw that these learners are now sexually active because they will be roaming around with boys or vice versa'*.

**Participant 16 (SGB), Male, 40 years** mentioned that *'They usually go outside, they are no longer disciplined, the discipline we saw in grades 8 and 9 had vanished. At some point we saw them hugging each other boys and girls, we once caught others having sex at the toilet during classes'*.

#### **4.5.7 Sub-theme 7: Illegal abortion performed by learners**

Participants revealed that they are afraid to go to health facilities for the termination of pregnancy, so they choose to go to traditional healers. They end up suffering the consequences.

**Participant 05 (Learner), Male, 17 years** said *'sometimes this may lead to abortion and abortion is not that hundred percent. You can perform an abortion then you find that you do not have a chance of having a child anymore. Sometimes you can lose your life, or you die'*.

**Participant 07 (Learner), Female, 18 years** said *'Mostly on the traditional they mix herbs, you must drink that medication to release pregnancy and you bleed blood a lot'*.

**Participant 11 (Learner), Female, 16 years** said *'at the traditional healers they do not have blood to supplement whenever you bleed too much, they are not going to provide you with blood'*.

#### **4.6 Theme 3: Culture, beliefs, norms, and values regarding the promotion of healthy sexual practices**

The findings of the study underlined the role of cultural practices which are linked to the promotion of healthy sexual practices in school. The role of cultural practices is further outlined in the following sub-themes.

##### **4.6.1 Sub-theme 1: Early Marriage (Arranged marriage) and forced marriage**

Participants revealed that culture does not promote healthy sexual practices among learners. Learners are being exposed to unhealthy sexual practices because of early and forced marriage and away from families to get rid of poverty by initiating early marriage for which they will be paid 'lobola'. The findings revealed that parents influence young girls to marry man because of poverty that affects the family. So, parents encourage early marriage and forced marriage to get money to sustain the families.

**Participant 08 (Learner), Male, 18 years** stated that *'in my view, I say no. because previous our grannies were married at the age of 12 years. And that time there was no school. When you start to see your periods, they just prepare you for marriage. So, I do not see culture promoting healthy sexual practices.*

**Participant 06 (Learner), Female, 19 years** said *'When I saw culture promotes early marriage, when I spoke with my mom, she was married at a younger age. At the age of 13 years. Even others within the society are married at younger ages.*

**Participant 05 (Learner), Male, 17 years** emphasises the notion that *'for us black people it was a way of getting rid of poverty that whenever a young girl start to see their mistral cycle, they must be married in exchange for gaining cows "lobola issues" '.*

**Participant 11 (Learner), Female, 19 years old** *'I do not think so because some of the cultures want children to be married at a younger age. When ladies start to see their mistral cycle'.*

**Participant 15 (Learner), Male, 15 years** stated that *'culture promotes youth to be vulnerable because it influences early marriage'*.

**Participant 16 (Learner), Male, 17 years** reported the notion that *'culture exposes youth to be pregnant because they want us to prove that we can bear children'*.

Participants revealed that parents promote early and arranged marriage; it was stated that a 15-year-old child is being married and parents are happy about such a union. Parents must guide these children not to practice sexual intercourse until they are properly married, not the issue of situational marriage, such as being pregnant. It is the responsibility of parents to ensure their children engage in safe sexual activities or abstain completely.

**Participant 05 (LO teacher), Female, 45 years** mentioned that *'When they are now told they grown-ups infect they know sometimes they tell them straight that you can now sleep with a man, you have reached a stage'*.

**Participant 07 (LO teacher), Female, 28 years** stated that *'sometimes they go on to look for a man for them'*.

**Participant 13 (LO teacher), Female, 40 years** expresses that *'sometimes they can get an older man to marry them this issue of 'vhoshtifara thonga' they can marry the young once. To go and revive the old man'*.

**Participant 15 (LO teacher), Male, 42 years** said, *'They can sell their kids in exchange for money just to say you can be married by this, so it promotes sexual instability'*.

**Participant 25 (LO teacher), Female, 25 years** said, *'I think that we must indicate the disadvantages and consequences of such clearly, some do it due to the stereotypical behaviour'*.

#### **4.6.2 Sub-theme 2: Cultural stereotypes regarding healthy sexual practices**

Participants revealed that when girls went to initiation school, culture influenced them to engage in sexual intercourse. On the other hand, culture teaches them to preserve their virginity until they are married. Culture further influences boys to be the deciders on whether to engage in protected sexual intercourse or not and to have polygamy.

**Participant 17 (Learner), Female, 17 years** said a notion that *'culture allows boys to be decision makers regarding protected sexual intercourse and also to have multiple sexual partners'*.

**Participant 07 (Learner), Female, 18 years** reported that *'previous women were not allowed to see man, without parent consent because they used to decide who must marry you. In the Zulu culture, when you reach the age of 12, they check whether you are still a virgin, when you reach 18, they further check you'*.

**Participant 03 (Learner), Male, 17 years** said that *'culture does not play a significant role, my problem is that I grew up in Botswana but I'm a Tsonga so at Botswana we do not have woman's initiation school. Like Tsonga's. those who went to initiation school for women they told me that they are being taught to have sex and to open their legs whenever boys want to have with you'*.

**Participant 12 (Learner), Female, 16 years** similar reported *'My culture allows me to be 21 years and when I am at university, I can do what I want regarding sex'*.

**Participant 08 (SGB), Female, 52 years** added the notion that *'I feel like culture is destroying the youth. I feel like the culture is being destroyed, and we as a parent must strengthen our rules. We must sit down with our children and educate them about sexuality and a change in the body, so here you must protect yourself during sexual activity.'*

**Participant 09 (SGB), Male, 44 years** supported the notion that *'Our culture does not promote safe sex that much, though we still have parents, but our culture does not allow much of us to talk with children about these matters'*.

**Participant 12 (SGB), Male, 50 years** expressed that *'when it comes to cultural practices, I think these days even their parent speak with their learners about sexuality. Parents are open to telling their children about sexuality and prevention, things have changed, and there is no more taboo of sex talk between a child and the elderly'*.

**Participant 16 (SGB), Male, 40 years** added by expressing that *'so that's where the problem starts because we don't tell them the truth and then they go outside they experiment and then they come back pregnant, so I think we need to change it in our culture'*.

Participants reported that if the SGB and the community at large work together to establish healthy sexual practices programmes within schools and communities, the outcome will lower the phenomenon of HIV, STIs, and teen pregnancy. Parents who leave children alone at their homes must assign guardians to monitor their children, because boys take advantage and engage in sexual activities. Culturally, we must ensure that as parents regardless of not being biological parents, we are a parent to any child in the community.

**Participant 03 (SGB), Male, 41 years** emphasises that *'...from a school point of view we're not that much away open because mostly culturally is being done in their communities so here at school we are 80% based on on the Academy so every time we have to check if you have a cultural this can promote and the issue of STIs and the HIV...'*

**Participant 06 (SGB), Female, 50 years** said *'I think this one I cannot make any justifications. When it comes to HIV/AIDS and our African culture they normally think somebody has been witched by someone and they do not have proof'*.

Participants reported that cultural initiation school is no longer adding value to promoting healthy sexual practices. The issues of dignity and respect are no longer taught. In recent years women and men were taught to maintain values and morals. When they are in the initiation school, as well as to promote safe sex, being a man, you must be responsible for taking care of the woman you impregnated.

**Participant 12 (SGB), Male, 50 years** thought that *'culture gives woman right to run after boys. It will give her the impression of running after boys or having multiple sexual partners. But we mustn't criticise culture let's take responsibility and make informed decisions while culture is there. Culture did not ruin anything but is how children conduct themselves regarding culture'*.

**Participant 11 (SGB), Female, 58 years** expressed that *'I think we have diverted into new South Africa, now we have this initiations school for ladies and boys and so on. Those things are no longer being practiced It its only that we just read from the pamphlet and we listen to the radio'*.

**Participant 07 (SGB), Male, 44 years** said *'So I think tradition is not contributing to the promotion of healthy sexual practices. Culture is fueling teenagers to be more vulnerable to teenage pregnancy and HIV'*.

**Participant 08 (SGB), Female, 52 years** reported that *'Regarding both initiation school for woman and men we also have a problem that if we don't tell them to prevent, these learners a very naughty and they are in the rural area where they are not exposed to many things so it is waste of time to say go and get advice, use condoms they don't do that'*.

Participants revealed that religion and cultural norms should promote healthy sexual practices. Pastors must not prohibit healthy sexual practices' discussions in churches and schools nor discourage educators from teaching their children about sexuality issues, while in the other side, cultural norms and values prohibit discussions of healthy sexual issues with parents and children. Participants revealed that culture teaches men and women morals and values. It

further teaches them to protect themselves when engaging in sexual intercourse. It was further reported that cultures do not allow children to have children at a young age. Most of these girls suffer from rejection by irresponsible boyfriends or their sexual partners when they are pregnant and they remain a single parent.

**Participant 23 (LO teacher), Female, 25 years** mentioned that *'Culture plays a role in boys, it plays a huge role because when they go to initiation school, they are taught how to be a man. To be a man doesn't mean you must have many girlfriends aaa being a man is about taking care of yourself and looking after your health and when they come back to society display those moral values and knowledge they got from the initiation'*.

**Participant 24 (LO teacher), Male, 26 years** expresses that *'...You sort of being scared as a teenager that if I do sex, it is against the culture and I will be embarrassed or embarrassed my culture. It will be criticised for doing this, so it makes us preserve ourselves and not put ourselves in a high risk'*.

**Participant 07 (Learner), Female, 18 years** said that *'...at the churches we play that no sex before marriage. At some point, we disobey the rules. When you are pregnant at church, they cut you from the activities of the church for several months'*.

**Participant 08 (Learner), Female, 18 years** reported the notion that *'...night conferences at church, cause youth to be exposed to this sexual disease. It is possible for youth to go and book rooms at lodges or motels so that they have sex so religions expose youth to be more vulnerable'*.

Participants revealed that healthy sexual practices should be taught in the communities, and health workers should educate parents at home that sexual education is not a taboo to discuss with children. Learners should have appropriate information regarding sex issues which will lead them to make an informed decision, parents should not hide information by stating unclear information to their children, for instance, by stating that girls must not play with boys when they see that girls are sexually active.

**Participant 10 (Learner), Male, 21 years** reported that *'in my culture, I can be married at the age of 20 years. The issue of having sex at a younger age my culture does not allow that'*.

**Participant 13 (Learner), Female, 16 years** stated that *'my culture allows me to be married and start to please myself with sex at the age of 21 and above'*.

**Participant 14 (Learner), Male, 15 years** said that *'my culture allows me to be married and engaged in sex when I'm 21 years'*.

Participants revealed that there are boundaries between learners and their educators in terms of sex education. Teachers do not want learners to embarrass them about sexual issues. So, they keep information regarding sexuality, as it is confidential at all times and during lessons. This does not help learners to obtain appropriate knowledge regarding healthy sexual practices.

**Participant 17 (Learner), Female, 17 years** reported that *'I wish life orientation be taught by young educators, we could learn important issues regarding sex. The one who is teaching hides sensitive information'*.

**Participant 23 (Learner), Female, 15 years** reported that *'teachers are afraid to teach us, while they know it is their responsibility to give us this information and skills'*.

**Participant 03 (Learner), Male, 17 years** reported that *'teaching us about sex, if it embarrasses them; they must teach us using technology so that we learn, the issue of a child not speaking to elderly about sex makes us to have shallow information'*.

Participants revealed that pastors must also promote healthy sexual practices because many of the congregants' trust and believe what pastors are saying. In the youth conferences, pastors must teach youth about healthy sexual practices and underline it with the bible as a way of promoting abstinence. It was further stated that they invite motivational speakers regarding the promotion of healthy sexual practices if pastors have a negative impact on healthy sexual practices discussion in their congregations in the absence of pastors'.

**Participant 12 (LO teacher), Male, 55 years** expresses that *'Aaah sometimes we encourage these learners to go to church, sometimes in church, they can get advice from the elders to take themselves seriously and keep healthy relationships'*.

Participants reported that parents and pastors must play a significant role in promoting healthy sexual practices because they host youth conferences, must invite stakeholders to teach our children. Pastors provide holistic counselling at churches, so children trust and believe them more than us as a parent.

**Participant 07 (SGB), Male, 44 years** stated that *'Usually in some churches there are health workers, usually they call then that today is a health week let us do this awareness, where you find that they invite people to lecture about health practices, these issues of sexuality are being included'*.

**Participant 04 (SGB), Female, 55 years** expressed working together a relationship that *'So sometimes we work with the clinic, churches, hospital, sometimes with the community structures'*.

Participants reported that culture hinders the promotion of healthy sexual practices at home and school. Teaching sex education by some professional educators is taboo, which results in a high rate of sexually transmitted infection and teenage pregnancy. Lack of communication between children and parents regarding healthy sexual practices influences children to practice sexual intercourse at a younger age. Parents should value their children's lives and futures by discussing sexual issues with their children by ensuring that they abstain or condomise during sexual intercourse.

**Participant 10 (SGB), Female, 45 years** expressed that *'I think when it comes to health the department of health must provide training, workshop continuously for parent and teachers to also deal with the cultural norms offensive concern regarding sexual activity talk with children. Because you find that it is done once in a year. They must offer sustainable education, and programmes to reduce the infections of sexual diseases and teenage pregnancy among learners'*.

**Participant 05 (SGB), Male, 32 years** mentioned that *'Because without working together, we experience challenges. It is not simple to realise that there is a problem but by working together we can see there is a problem, and we try to promote healthy sexual practices, we must revive our cultural norms.'*

#### **4.6.3 Sub-theme 3: Culture promotes the preservation of virginity until marriage**

Participants revealed that Tsonga and Venda cultures must adopt the virginity-preserving methods from the IsiXhosa and isiZulu cultures. This will cause embarrassment to parents as well as their children because the community will know that this child is no longer a virgin and they will not participate in such activities or ceremonies anymore. Those who remain virgins will be rewarded for taking care of themselves and not engaging in sexual activities.

**Participant 13 (LO teacher), Female, 40 years** mentioned that *'because in our culture for example the Zulu culture we were told that we must preserve the virginity until you are 21 years old, that doesn't automatically mean when you are 21 years you can have sex, but then it is preferred you must preserve it until you are 21 years old'*.



**Participant 21 (LO teacher), Female, 53 years** expressed that *'Culture plays a very special role, especially in some cultures they check this girl every time to see whether they have started the issue of sex'*.

**Participant 24 (LO teacher), Male, 26 years** mentioned that *'culture does play a role in teaching children to abstain as we do have a cultural practice called 'umkhosi womhlanga' which tells children to abstain till they reach 21 years of age without having started doing sex'*.

**Participant 23 (LO teacher), Female, 25 years** expressed that *'culture would prevent children from having sex while still being young and teaching the importance of such and with boys we also have a practice called 'Umkhosi weshwama' to prevent early sex but mostly the practice is maintained on the girl's side'*.

Participants suggested that both Venda and Tsonga cultures may adopt the Isizulu and isiXhosa cultures of checking virginity once a year. Those who will maintain and preserve their virginity must be rewarded as a way of motivating them from sexual intercourse. This will mitigate unhealthy sexual practices since no one will want to be embarrassed when you have joined this type of cultural activity.

**Participant 02 (SGB), Male, 33 years** emphasises that *'I think children must maintain their virginity and close their legs, once you continue abstain you will remain being good child and healthy'*.

**Participant 03 (SGB), Male, 33 years** supported the notion that *'I think parent must compliment their children for taking care of themselves until they are married, they must ensure they remain virgins'*.

**Participant 12 (SGB), Male, 50 years** said *'We can invite whoever to educate this kid, learners must know where they stand, and to play far away from sex, actually they must remain virgins all this sexual disease will not be hindering and causing problems.'*

Participants reported that cultural rewards for those who preserve virginity might mitigate the rate of infections and teen pregnancy because you will be embarrassed in front of your parent if they find that you are no longer a virgin.

**Participant 12 (SGB), Male, 50 years** mentioned that *'Aah was not using that culture like the Zulu to use virginity test that they already practicing sex or not'*.

**Participant 13 (SGB), Male, 53 years** said *'There must be something our Venda culture must do for this learner to remain a virgin until married. Maybe we name a price for learners who will sustain their virginity and preserve it'*.

**Participant 14(SGB), Male, 60 years** pointed out that *'I think we must have rewards like bursary for those who will pass matric being virgin, this will motivate and encourage learners to abstain from sexual activity, learners will preserve their virginity like the Xhosas'.*

**Participant 08 (SGB), Female, 52 years** added the notion that *'I feel like culture is destroying the youth. I feel like the culture is being destroyed, and we as a parent must strengthen our rules. We must sit down with our children and educate them about sexuality and a change in the body, so here you must protect yourself during sexual activity.'*

**Participant 09 (SGB), Male, 44 years** supported the notion that *'Our culture does not promote safe sex that much, though we still have parents, but our culture does not allow much of us to talk with children about these matters'.*

**Participant 12 (SGB), Male, 50 years expressed** that *'when it comes to cultural practices, I think these days even their parent speak with their learners about sexuality. Parents are open to telling their children about sexuality and prevention, things have changed, and there is no more taboo of sex talk between a child and the elderly'.*

**Participant 16 (SGB), Male, 40 years** added by expressing that *'so that's where the problem starts because we don't tell them the truth and then they go outside they experiment and then they come back pregnant, so I think we need to change it in our culture'.*

Participants reported that if the SGB and the community at large work together to establish healthy sexual practices programmes within schools and communities, the outcome will lower the phenomenon of HIV, STIs, and teen pregnancy. Parents who leave children alone at their homes must assign guardians to monitor their children, because boys take advantage and engage in sexual activities. Culturally, we must ensure that as parents regardless of not being biological parents, we are a parent to any child in the community.

**Participant 03 (SGB), Male, 41 years** emphasises that *'...from a school point of view we're not that much away open because mostly culturally is being done in their communities so here at school we are 80% based on on the Academy so every time we have to check if you have a cultural this can promote and the issue of STIs and the HIV...'*

**Participant 06 (SGB), Female, 50 years** said *'I think this one I cannot make any justifications. When it comes to HIV/AIDS and our African culture they normally think somebody has been witched by someone and they do not have proof'.*

Participants reported that cultural initiation school is no longer adding value to promoting healthy sexual practices. The issues of dignity and respect are no longer taught. In recent

years women and men were taught to maintain values and morals. When they are in the initiation school, as well as to promote safe sex, being a man, you must be responsible for taking care of the woman you impregnated.

**Participant 12 (SGB), Male, 50 years** thought that *'culture gives woman right to run after boys. It will give her the impression of running after boys or having multiple sexual partners. But we mustn't criticise culture let's take responsibility and make informed decisions while culture is there. Culture did not ruin anything but is how children conduct themselves regarding culture'*.

**Participant 11 (SGB), Female, 58 years** expressed that *'I think we have diverted into new South Africa, now we have this initiations school for ladies and boys and so on. Those things are no longer being practiced It its only that we just read from the pamphlet and we listen to the radio'*.

**Participant 07 (SGB), Male, 44 years** said *'So I think tradition is not contributing to the promotion of healthy sexual practices. Culture is fueling teenagers to be more vulnerable to teenage pregnancy and HIV'*.

**Participant 08 (SGB), Female, 52 years** reported that *'Regarding both initiation school for woman and men we also have a problem that if we don't tell them to prevent, these learners a very naughty and they are in the rural area where they are not exposed to many things so it is waste of time to say go and get advice, use condoms they don't do that'*.

#### **4.7 Theme 4: The roles of teachers and SGB in promoting healthy sexual practices**

Participants demonstrated their role in promoting healthy sexual practices and ensuring that the provision of contraceptives to learners is properly administered.

##### **4.7.1 Sub-theme 1: Conscientise learners about healthy sexual practices**

Participants revealed that since the establishment of life orientation in school, teenage pregnancy has been reduced when compared to previous years. It was further revealed that the implementation of Sex education programmes in schools has positive outcomes and learners are responding positively. Schools report fewer cases of teenage pregnancy and STIs.

**Participant 03 (LO teacher), Female, 31 years** reported *'According to my viewpoint I think it's important to help learners protect themselves and prevent sexually transmitted diseases, and pregnancies'*.

**Participant 07 (LO teacher), Female, 28 years** said, *'I think learners must be educated about sexual intercourse, yes and even to be taught when and how to do sexual intercourse'*.

**Participant 08 (LO teacher), Female, 55 years** emphasises that *'sex education is needed, so sex education is very important, and it is rely on needed'*.

**Participant 09 (LO teacher), Male, 48 years** emphasises the notion that *'I feel that sex education is not taught well, the curriculum is just here and there in the books, for example, there is only one chapter which talks about sex education'*.

Participants reported that they do discuss healthy sexual practices with learners as well as ensure educators teach sex education at school. This will enhance learners' knowledge and able to make informed decisions every time they engage in sexual intercourse.

**Participant 10 (SGB), Female, 45 years** mentioned that *'Learners must be taught about the sexual issue and the ways to prevent it'*.

**Participant 11 (SGB), Female, 58 years** expressed that *'Aaah usually I just gave guidance as far as sexual practices are concerned. More special they must look after themselves as they must safeguard themselves against pregnancy, more especially getting an unwanted pregnancy'*.

**Participant 12 (SGB), Male, 50 years** expressed that *'Our role is to work with parents to try to conscientise these learners and parents about sexual practices'*.

**Participant 16 (SGB), Male, 40 years** expressed that *'In the case where the issue goes far, we also advise this parent to advise their learners or children to use contraceptive measures like condoms or maybe to advise these learners to abstain'*.

Participants reported their opinions regarding healthy sexual practices, where they emphasised that learners should be taught to abstain from engaging in sexual intercourse, because, once they experience the desire for sexual intercourse, they will keep on doing it time and again.

**Participant 06 (SGB), Female, 50 years** expressed that *'...for learners to be taught about healthy sexual practices and abstaining'*.

**Participant 07 (SGB), Male, 44 years** mentioned that *'They must abstain from practicing sexual intercourse'*.

**Participant 14 (SGB), Male, 60 years** mentioned that *'We invite clinic staff to come and educate children, especially at grades 8 and 9 because it's them in most cases who usually lack knowledge in terms of sexual practice matters'*.

**Participant 13 (SGB), Male, 53 years** supported the notion that *'I think it is very important because as learners who come from the village, they do not have much awareness about sex or healthy sex, so they must get educated about a healthy sex practice, so they don't make mistakes because we have a high teenage pregnancy and diseases because of lack of awareness'*.

**Participant 02 (SGB), Male, 33 years:** expressed that *'I think it remains important that learner's number one be exposed to the knowledge that they should know, Number two you need to understand the environment from which they're coming from so that we have informed decisions on how to assist them going forward'*.

**Participant 03 (SGB), Male, 41 years** said *'What we do from the SGB point of view is that we organised activities from the NGO and were able to come and educate these learners and showed them the direction as to how to prevent teenage pregnancy and how to engage them in abstaining from sexual friendship when they isolate their younger stages'*.

#### **4.8 Theme 5: Challenge regarding the promotion of healthy sexual practices**

The findings revealed the challenges preventing learners from accessing health facilities for contraceptives, and contraceptives education. They revealed the harsh challenges from nurses and how they ignore the POPIA act as they disclose the status of their consultations to community members as well as colleagues to come and see the person consulting, our clinic is so embarrassing to youth seeking healthy sexual practices services.

##### **4.8.1 Sub-theme 1: Violation of POPIA Act at healthcare facilities**

Participants revealed that when they access health facilities for contraceptives so that they can practice healthy sexual intercourse, nurses will judge them based on their age group, they are rude and threaten to inform their parents about their consultation.

**Participant 08 (Learner), Female, 18 years** said *'They criticise us why should we use these contraceptives. That's the biggest problem I hate clinic'*.

**Participant 23 (Learner), Female, 15 years** said *'When I went to the clinic, they gave me 6 condoms instead of a pack. So, I decided not to go there anymore. They judge me, I could read the way they talk'*.

**Participant 21 (Learner), Male, 16 years** reported that *'I bought condoms at Shoprite and Link pharmacy they are cheap, and I trust it that they are 100% safer than the ones at the clinic. I hate nurses' attitude when I consult'.*

Participants revealed that when they want to consult about healthy sexual practices, nurses ensure that they must first undergo HIV Testing Services. They shout at young girls and they ruin the image of the learner consulting. So, learners no longer want to consult the PHC facilities because they are scared of being humiliated or harassed by the health nurses and community-based workers outside the clinic.

**Participant 12 (Learner), female, 16 years** reported that *'when I go to the clinic for contraceptives, they ask age, when I tell them that I'm 16 years, they start to be rude, swearing on me and asking people whom I am living with at home'.*

**Participant 23 (Learner), female, 15 years** said *'Nurses pursue to ask about my partner's age, so the clinic is annoying when we consult about contraceptives. And they will say did you start having sex. Others end up not assisting you regarding your consultations because of age'.*

Participants revealed that they are being threatened during consultation for healthy sexual practices at the local clinics. The clinic nurses further informed them that they would inform their parent that they started to engage in sexual practices with boys and also about the consultation.

**Participant 08 (Learner), Female, 18 years** reported intimidation *'I consulted about injection, they keep me waiting when I ask them, they started threatening me that I am young for injection and I can't take injection, she will tell my parent that I started dating and I was at the clinic'.*

**Participant 13 (Learner), Female, 16 years** reported that *'I hate the local clinic because of my neighbour she works there, she informs nurses that I must not receive an injection of my choice, I must go home else my parent will know about this matter of my consultation'.*

**Participant 11 (Learner), Female, 19 years** stated the notion that *'My right is infringement in that clinic, we consult because we do not have the option, nurses send the community-based worker to inform my mother about consultations I made regarding UID plant in my hand, I was bleeding and went to the clinic'.*

**Participant 07 (Learner), Female, 18 years** reported unprofessionalism that *'...health professionals are rude to us, they keep on swearing at us with threatening to inform our parents about consultations we made'*.

Participants revealed that the clinics are far away from where they live, and they require transport fees to take public transport to the clinic. Further, clinics have a shortage of staff which leads to long waiting periods and queues not moving which discourages learners from accessing clinics for contraceptives. The worst part they do not divide the queues based on the target groups like patients attending antenatal care, chronic patients, as well as learners consulting for contraceptives.

**Participant 15 (Learner), Male, 15 years** reported that *'Nurses do not help us, they will sit and have tea. The average waiting period is not normal in these clinics, and I hate consulting there'*.

**Participant 06 (Learner), Female, 19 years** reported that *'when you go to the health facility we stay longer and they do not attend you, they will pass you. You can arrive in the morning, and they treat you in the evening'*.

**Participant 01 (Learner), Male, 18 years** said that *'...sometimes you find clinic is being overcrowded and they sent you to another clinic which is far away from where I live which is a challenge to me, I don't have money to pay for transport'*.

**Participant 13 (Learner), Female, 16 years** reported that *'the disgusting things that nurses do is to take their friends and relatives who were not in the queues to be treated first while I was waiting for long period waiting for consultation. I hate local clinics because of that concern'*.

The findings revealed that learners obtain a permit from school to go to the clinic and consult for contraceptives, however, health professionals do not consider school permits during the consultation, and they want parent consent for learners under the age of 18 years. This frustrates learners during consultation because nurses should adhere to the POPIA act and prioritise the consultations as it is the right of learners to receive contraceptives as well as treatment based on NHI policy, regardless of age.

**Participant 26 (Learner), Male, 16 years** has the critical notion that *'I went to the clinic I was in a critical situation, I had swollen penis, I sleep out and I was discovered by the security guard, they reply that he does not have guardian there is nothing they can do'*.

#### **4.8.2 Sub-theme 2: Contraceptives are not 100% safe**

Participants reported their frustrations and concerns regarding contraceptives that they are ninety-nine percent not one hundred percent safe, you can get pregnant or contract sexual diseases while using them. Others further share their experiences of condom-bursting during sexual intercourse. Others emphasise the use of multiple condoms or dual condoms during sexual intercourse. While others reported that abstinence is not easy once you have tested sexual intercourse.

**Participant 03 (Learner), Male, 17 years** said *'at the clinic entrance there was a box where we used to collect condoms from. But now they don't load condoms there, I don't know why'.*

**Participant 17 (Learner), Female, 17 years** illustrated poor services of contraceptives that *'It will be back next month or after two months. It gives me a problem because it is possible for me to be pregnant even, though we are using condoms. After all, condoms are not 100% guaranteed'.*

**Participant 03 (Learner), Male, 17 years** reported that he was advised that *'they encourage me to use condoms and not to have a child at a young age because it will be a big burden. And it will ruin my future'.*

**Participant 07 (Learner), Female, 18 years** reported that appropriate information is needed *'They don't give us either forms or flyers that indicate whenever you do this is what happening regarding contraceptives. Even their consequences of prevention they do not give us that'.*

**Participant 22 (Learner), Female, 14 years** said that *'Sometimes contraceptives for prevention they will say that they experience stockout. You can inject and still be pregnant, I don't know what's happening in that regard'.*

**Participant 23 (Learner), Female, 15 years** reported *'I heard that condom could bust and you become pregnant, it is not safe to use it'.*

#### **4.6.3. Sub-theme 3: Lack of parental, family, and social support programme**

The findings revealed that healthy sexual practices education is not properly offered at school. Nurses should offer healthy sexual practices at school and these should be articulated in life orientation lessons. Social workers and stakeholders should motivate learners to promote healthy sexual practices whenever they engage in sexual intercourse. Participants reported that when they are at home, they rely on local clinics for healthy sexual practices information. Parents further rely on neighbours to speak with their children about healthy sexual practices



on their behalf. Furthermore, they rely on educators that they must discuss this sexuality with their children at school.

**Participant 10 (SGB), Female, 45 years** emphasises that *'Do you see a grade 8 learner when they reach grade 10 having a child that person is still young. That kind of learners did not receive sex education and their parent did not educate their children, that when they grow up and reach a certain stage and engage in sexual activity a child will be made.'*

**Participant 11 (SGB), Female, 58 years** expressed that *'As a private school we do communicate with parents regarding their children's affairs and dating at school, so that parents can further act in working with us, to guide their children about healthy sexual practices'.*

**Participant 12 (SGB), Male, 50 years** mentioned that *'...isn't unhealthy sexual practices that they are practicing because some of the problems come from home but if we can work hand and glove with this parent, we can resolve this problem'.*

Participants reported that learners at their school are from poverty-stricken families, so learners involve themselves in transitional sexual intercourse to help their parents to buy food. This causes learners to be susceptible to unhealthy sexual intercourse practices and the contraction of sexual diseases. Learners who are breadwinners at home turn to abusive substances.

**Participant 01(SGB), Male, 57 years** stated that *'Let's say people who are running the promotion come here with condoms, and say you can go home with the packet you can see those condoms spread all over the school, some are ashamed to take the packet hence they would like to go and do the issues of sexual relationships outside but they are afraid these are the challenges that we are experiencing in this school'.*

**Participant 07(SGB), Male, 44 years** said, *'Learner's drink alcohol because of home situation, they are after men because of the aim of making money for survival at home'.*

**Participant 10(SGB), Female, 44 years** mentioned that *'learners are living in an awkward position they become pregnant because of the grant aim, to fight poverty at home. This is a serious thing that affects learners' future'.*

#### **4.8.3 Sub-theme 4: Challenges in the provision of contraceptives, and contraceptives stock-out, clinics located far away from villages, waiting periods, and queues moving slowly at the healthcare facilities**

Participants revealed that nurses at the clinic do not follow their consultation privacy or respect the POPIA act in terms of not disclosing their consultations to other people, including nurses and community members visiting the clinic. Lack of contraceptives is one of the biggest challenges in the rural clinics, while distance and lack of clinics in other rural areas is the biggest challenge in accessing health facilities concerning contraceptives, mobile clinics do come to the villages that do not have clinics. However, mobile clinics visit the community without clinics during school hours and learners are unable to go and receive contraceptive services.

**Participant 20 (Learner), Male, 14 years** reported a strange attitude that *'nurses use to undermine us as if we are younger'*.

**Participant 26 (Learner), Male, 16 years** reported a bad attitude that *'Nurses are not ashamed to inform the patient about our consultations'*.

**Participant 13 (Learner), Female, 16 years** reported a similar attitude *'they shouted at me that I'm young for injection everyone looks at me as if I have killed someone. They further intimidate me to come home to inform my mother.'*

**Participant 22 (Learner), Female, 14 years** similar notion reported that *'nurses ask about my age, when I tell them, began swearing on me, stating that I'm young for injection. They say I am young I must not rush to sexual intercourse they refuse to inject me with contraceptives but in the end, she swears me they will inject me.'*

**Participant 23 (Learner), Female, 15 years** reported contrary views that *'I do not like the local clinic, it is always overcrowded and they work slowly'*.

Participants revealed that in the clinic they are faced with challenges of stock-out, health workers sometimes ask them to go and buy syringes at the pharmacy as the clinic has the contraceptive dose only. Another challenge is that there are inadequate contraceptives at the clinic and they are referred to the nearby village's local clinic for contraceptive consultations.

**Participant 18 (Learner), Female, 15 years** reported that *'I heard that the clinic is running out of condoms, so I decided not to go for contraceptives'*.

**Participant 07 (Learner), Female, 18 years** reported a notion that *'I was asked to go and buy syringe by matron of the clinic that where I will get the dose when I come back, clinic had runout of it'*.

**Participant 08 (Learner), female, 18 years** stated that *'when I go for contraceptives follow-up, I find that there is no dose that I normally use, and they choose to give me another one of their choices'*.

Participants revealed that the clinics are far away from where they live, and they require transport fees to take public transport to the clinic. Further, clinics have a shortage of staff which leads to long waiting periods and queues not moving which discourages learners from accessing clinics for contraceptives. The worst part they do not divide the queues based on the target groups like patients attending antenatal care, chronic patients, as well as learners consulting for contraceptives.

**Participant 15 (Learner), Male, 15 years** reported that *'Nurses do not help us, they will sit and have tea. The average waiting period is not normal in these clinics and I hate consulting there'*.

**Participant 06 (Learner), Female, 19 years** reported that *'when you go to the health facility we stay longer and they do not attend you, they will pass you. You can arrive in the morning and they treat you in the evening'*.

**Participant 1 (Learner), Male, 18 years** said *'...sometimes you find clinic is being overcrowded and they sent you to another clinic which is far away from where I live which is a challenge to me, I don't have money to pay for transport'*.

**Participant 13 (Learner), Female, 16 years** reported that *'the disgusting thing that nurses do is to take their friends and relative who were not in the queues to be treated first while I was waiting for long period waiting for consultation. I hate local clinics because of that concern'*.

#### **4.8.4 Sub-theme 5: Risky sexual behaviour amongst learners**

Participants reported that learners are sexually addicted; they cannot control their feelings, and even parents at home are the supporting structures of these unhealthy sexual practices. There is a case where a child of fifteen years impregnated one child and parents agree that those two must be married and live together. The girl is devastated now because the boy is cheating with girls without being pregnant.

**Participant 03 (SGB), Male, 41 years** expressed that *'indicate these learners who become pregnant are trying to resolve the issue of poverty because of child grant. Even if their parent*

*are educated and unemployed poverty strikes them and girls becomes vulnerable to change multiple partners. So, they seek help for themselves through transitional sex and they go for old people,*

#### **4.8.5 Sub-theme 6: Lack of awareness campaigns, support, and insufficient resources to teach learners at school**

Participants reported that educators are working tirelessly to ensure that healthy sexual practices education at school is provided. Sometimes they invite the Department of Health to visit the school and encourage learners to abstain from sexual intercourse. Parents should work with the school to ensure this important information is also taught at home.

**Participant 04 (SGB), Female, 55 years** said that *'...as an SGB member if there is a working together among SGB members the staff management we work together as a unit, it can help a lot. Because of everything that is happening here at school and in the community if we can work together as a unit, we can overcome this problem of unhealthy sexual practices.'*

Participants reported that their school has challenges because of limited resources and their schools rely mostly on textbooks. They depict that if the school can have resources on healthy sexual practices. it will assist in disseminating appropriate information better to equip learners to always protect themselves during sexual intercourse.

**Participant 10 (SGB), Female 45 years** said *'this one I can't lie. We don't do anything, we don't have resources to teach this, and teachers rely on the textbook, which is a limited resource. Then they just teach them no awareness'.*

**Participant 13 (SGB), Male, 53 years,** said *'the school was burned previously so we are running on limited resources, we just borrowed books from nearby schools, teaching proper healthy sexual practices won't be easy I don't want to lie to you and say we are doing better'.*

Participants reported that since they were elected to be part of the school, they had one campaign offered by the Department of Health. This campaign had a positive outcome, it reduced teen pregnancy for consecutive two years.

**Participant 09 (SGB), Male, 44 years** *'this one I can't lie. We don't do anything. We normally tell this health worker to offer all the programmes here at school concerning these sexual programmes. Then they just teach them no awareness'.*

## 4.9 Theme 6: Strategies regarding the promotion of healthy sexual practices

Participants revealed suggestions that could improve the promotion of healthy sexual practices in schools and these are reflected in the following sub-themes.

### 4.9.1 Sub-theme 1: Family system support

Learners further narrated that teachers should work hand and glove with parents. Parents should not be afraid to educate learners about healthy sexual practices as well as encourage their children to abstain from practicing sexual activities. Parents should deviate themselves from the issue of taboo when talking about healthy sexual practices with their children, no boundaries should be laid for learners to receive healthy sexual practices education at home.

**Participant 05 (Learner), Male, 17 years** affirmed that *'... teachers must invite health professionals from the clinics to come and educate us about the promotion of healthy sexual practices. This education should be offered for both the learners and parents in our school so that parents and be able to teach their children'*.

**Participant 26 (Learner), Male, 16 years** said that *'Parent or guardian, must not disown their children when they do the wrong thing because it leads to them having multiple partners and being vulnerable to HIV, STI, and teen pregnancy.'*

**Participant 15 (Learner), Male, 15 years** emphasises the establishment of working relationships as reported that *'Parents should work hand in hand with teachers to ensure children do not involve in the wrong action which will lead them to be more vulnerable.'*

Participants suggested that working together as one educator and parents will have positive results since educators will educate learners about healthy sexual practices at school. Parents will teach them at home to ensure that they do not engage in unhealthy sexual practices. And they must further abstain or use condoms as it is commonly known. The parent should play their role in promoting healthy sexual practices at home, while at school educators will be providing learners with adequate information to promote healthy sexual practices.

**Participant 03 (LO teacher), Female, 31 years** expresses that *'it can reduce especially having parents involved because parents spend most of the time with the student'*.

**Participant 05 (LO teacher), Female, 45 years** mentioned that *'parental involvement gives positive outcomes because percentage incidences of pregnancy decrease'*.

Participants reported that families and parents must take the initiative in discussing healthy sexual issues with their children, to depict that sexual intercourse is not a new thing in the world. This will assist in ensuring that learners or children do not practice or experiment with sexual activities at a tender age. In a new South Africa, talking about sex with a child is no longer a taboo we regard that as education.

**Participant 05 (SGB), Male, 32 years** supported the notion that *'we as parents take it as an insult. That's why we was afraid in teaching learners about this sexual activity they take it as an insult.'*

#### **4.9.2 Sub-theme 2: Health system support**

Participants stated that health professionals (Nurses) should be the ones to provide healthy sexual practices education in schools. Learners believe and trust health workers when they educate them more than their educators because they are used to them. They take the nurse's teaching seriously because nurses see this problem daily in the clinics and hospitals.

**Participant 17 (LO teacher), Female, 35 years** said, *'I think teaching them always to use condoms and go to doctors for preventative pills, and abstinence'.*

**Participant 19 (LO teacher), Female, 44 years** said *'I think we can open campaigns, that will educate on unprotected sex, focusing on the dangers accounting for unsafe sex thus children will know before indulging'.*

The findings revealed that participants are being conscientious about healthy sexual practices. Whenever educators are in class, they teach them how to take care of themselves and to practice healthy sexual activity. Others further indicated that the best method to take care of yourself is to abstain because contraceptives are not one hundred percent.

**Participant 10 (Learner), Male, 21 years** reported that *'we must not have sex before you are married. You will have sex after marriage infact we must abstain'.*

**Participant 16 (Learner), Male, 16 years** reported similarly that *'I think we must not have sexual intercourse at all because once we test, we will never mind to have it without condoms. Condomising is the best protection.'*

**Participant 18 (Learner), Female, 15 years** concurred with the above report and emphasised the negligence that *'they must be reminded that whenever they wanna have sexual intercourse they must wear condoms. They must be reminded to leave the issue of engaging themselves in quick sexual activities'.*

The findings narrate that accessibility and availability of clinics will increase knowledge through educating learners about contraceptives, and appropriate HIV Testing Services (HTS) which includes therapeutic counselling before issuing results. Regular clinic visits for healthy sexual practices will further assist learners in knowing whether they are pregnant or not before they choose termination from traditional healers.

**Participant 04 (Learner), Male, 20 years** alluded that *'firstly before you have sex make sure you wear condoms to protect yourself against sexual diseases. Every week and month you must visit clinic to test HIV and STI status'*.

**Participant 25 (Learner), Male, 14 years** reported that *'Health workers should teach us about sex, they provide relevant information'*.

The findings reveal relevant sources of appropriate organisations, and people to offer healthy sexual practices in school as well as at home. Learners refer to them because they are more knowledgeable regarding prevention and understanding of youth zones for the provision of contraceptives as well as deal with youth frustrations regarding healthy sexual practices.

**Participant 22 (Learner), female, 14 years** said *'We must sit down and talk with them, they must be educated about sexual prevention measures. The way they can prevent themselves when they want to engage in sexual activities is that they must use condoms. They must be taught as well how to wear condoms, and how to ensure that it must not bust so that they do not contract sexual disease and impregnate others'*.

**Participant 23 (Learner), Female, 15 years** emphasises that *'girls must be told to prevent, in the nearest clinic. And girls must also bath. They must keep on using condoms. Condoms must be the first choice to prevent STIs, HIV, and pregnancy.'*

#### **4.9.3 Sub-theme 3: NGO, NPO, and other stakeholders' system**

Participants suggested that the Department of Health, DOE, DSD, SAPS, and other stakeholders should jointly work together to promote healthy sexual practices to children or learners as well as to parents at home. These awareness campaigns must be for different target populations, this will enhance knowledge whether at home or schools for learners. Parents must play a role as well in ensuring they contribute to the provision of appropriate information for their children regarding healthy sexual practices.

**Participant 05 (SGB), Male, 32 years** stated that *'mm eh, we need to be aware of people who can help us to reduce this problem. To offer this campaign, those whom we are aware of is people from health facility, like nurses. If we have problems regarding teenage pregnancy,*

*we have that tendency of calling people from health. The only people we know will help us is the nurses'.*

**Participant 12 (SGB), Male, 50 years** alluded that *'...it can work because when we call these people sometimes these learners understand better when the issue is addressed by the department of health, and when bullying is administered by the department of safety and security. if you do bullying this will happen'.*

Participants suggested that during awareness campaigns, they must invite motivational speakers who have gone through the consequences of teenage pregnancy, and share their experiences. It was further stated that learners had challenges in not abstaining from sexual activities and in practicing protected sexual intercourse.

**Participant 06 (SGB), Female, 50 years** mentioned that *'normally like I said when those nurses are here, we even get ambassadors like learners who had been there in that situation, they go and present their personal experiences, unto learners. We regard that one as peer education'.*

**Participant 07 (SGB), Male, 44 years** emphasises that *'I think learners we must invite former learners to come and educate them, and to motivate them'.*

**Participant 11 (SGB), Female, 58 years** stated that *'usually our teacher call learners and try to educate them in everything, but still our today learners or children they don't listen. You guide them they will do the opposite. So, this means we must put more effort here at school or even at home.*

**Participant 13 (SGB), Male, 53 years** mentioned that *'yeah life orientations teachers can help time and again, number two usually we call people to motivate the learners for everything ah and another thing that we can do if we have time, we can invite health department people so that they can help including the life orientation teachers'.*

Participants revealed that the establishment of peer educators will disseminate and assist in sharing peer influences experienced by learners and the promotion of healthy sexual practices.

**Participant 11, Female, 19 years** reported that *'they must establish peer groups for both male and female learners which will be guided by the social workers.*

**Participant 09 (Learner), Male, 18 years** suggested *'I think we must have a meeting of all learners in this school, where they will tell us that whenever we want to have sex, we must*



*wear condoms or girls must prevent or we abstain from having sex. We form groups of peers to teach us.*

Participants revealed that in their communities condom distribution points must be increased as a mode of promoting healthy sexual practices. Every shop should have a box of condoms for youth to have access to condoms within the community. These will cater to villages that do not have clinics or villages where clinics are far away or the clinic is distance based and learners cannot afford to go there by walking or other transport.

**Participant 23 (Learner), Female, 15 years** said *'They must give us, original condoms that are 100%, not the ones from the clinics they are not 100%'*.

**Participant 17 (Learner), Female, 17 years** suggested that *'condoms must be distributed at school or at the gate we have a box where we can take condoms after school. They must be further warned of the consequences of not using contraceptives when they engage in sexual acts'*.

#### **4.9.4 Sub-theme 4: Education system support**

The findings revealed that learners should be taught to make informed decisions about sexual issues and they should be taught to negotiate the use of condoms whenever they engage in sexual intercourse.

**Participant 25 (Learner), Male, 14 years** reported that *'Health workers should teach us about sex, they provide relevant information'*.

**Participant 23 (Learner), Female, 15 years** said *'We must be taught how to force sex occurs and how to report it to SAPS and parent'*.

**Participant 17 (Learner), Female, 17 years** said *'We must be taught to make informed decisions regarding sexual harassment and to say no to sexual intercourse'*.

The findings further revealed that learners used to count menstrual cycle days to ensure they practice safe sexual intercourse when they are on ovulation. Another learner stated that it helps her to identify suitable days to visit her partner because she knows when are the days, she can be at risk of being pregnant.

**Participant 08 (Learner), Female, 18 years** supported the notion by stating that *'there is an app of menstrual cycle flow, you will know when are going for your date and when is your ovulation, so that you identify the time where you are not at risk of being pregnant, then if you*

*want to visit your boyfriend you will be knowing you are at what type of risk now so that app also assists too much because you will be able to identify which stage are you in now.*

**Participant 06 (Learner), Female, 19 years** added by stating that *‘mostly, when you change your cycle, you have to update the app. Like my cycle, if I finish today on the 6<sup>th</sup> from the 8<sup>th</sup> there is a danger of me being pregnant.*

Participants revealed that learners who have not been engaged in sexual activities should be provided with more information regarding abstinence. This will reduce the risk of being infected with sexual disease as well as the risk of unplanned pregnancy.

**Participant 18 (Learner), Female, 15 years** reported the notion that *‘I feel like we must be taught not to have sex at a young age. And how to reject older people from proposing to us’.*

**Participant 11 (Learner), Female, 19 years** reported that *‘for now I’m young to have a girlfriend when I am 21 years I can start engaging in sexual activities, my books come first’.*

**Participant 22 (Learner), Female, 14 years** stated that *‘When I am working, I can have a partner now I want to concentrate on education without any mistake of having a child at this age’.*

**Participant 23 (Learner), Female, 15 years’** contrary report state that *‘Visiting clinic for contraceptives is not a solution, you will be at risk of diseases the best way is to be stupid and not have sex until I am settled with education and secured work’.*

Participants revealed that school-based social workers should promote healthy sexual practices and should provide relevant information regarding the promotion of healthy sexual practices, and teach learners how to make informed decisions regarding sexual activities as well as the prevention measures.

**Participant 12 (Learner), Female, 16 years** reported that *‘...a school social worker helps us, to visit clinics as well as to stay away from relationships, they provide us with the consequence of having a child while you are at school’.*

**Participant 08 (Learner), Female, 18 years** reported that *‘When older people propose to me she advises me, she encourages me to abstain from boys or men. They will ruin my future and my family will be strived by poverty’.*

Participants revealed that educators should be trained to provide healthy sexual practices education without fear of cultural norms and values at schools. This will allow them to disclose

relevant information regarding protected sexual intercourse and disseminate information about healthy sexual practices in school.

**Participant 24 (Learner), Male, 15 years** said *'I think teachers are not properly trained especially the ones from colleges, because they hide information regarding healthy sexual practices'*.

**Participant 10 (Learner), Male, 21 years** said, *'I failed grade 11 last year, they will teach us one thing, they must be trained to have more information, in fact teachers must not come to class unprepared'*.

**Participant 04 (Learner), Male, 20 years** reported that *'when you ask teachers questions regarding contraceptives, they do not respond they do not have information, it is useless to be taught by them at least nurses they answer everything you wanna know'*.

Participants suggested that healthy sexual practices programmes must be initiated in General Education and Training (GET) from grades 6-7 since learners from lower grades transit to high school every year, and one or two learners are pregnant. Awareness campaigns must be offered for both Further Education and Training (FET) and GET, and health professionals must be notified or invited to offer healthy sexual practices in primary schools.

**Participant 08 (LO teacher), Female, 55 years** expressed that *'It was supposed to be done on the FET band. If it was done in the FET, it would give us more time so that we can be able to be with learners'*.

**Participant 15 (LO teacher), Male, 42 years** mentioned that *'I feel like it is not enough because it is only done in the lower level which is GET, However, we do look on that and we always find that aaaa whether you orientate them or you do not orientate them they normally respond much positive well to the peer pressure. Compared to the information given to them through a mentor or teacher'*.

**Participant 09 (LO teacher), Male, 48 years** said *'The school must also give us time together thus learners we go grade per grade 8 and 9 as well as grade 10-12 to teach them about this issues of sexuality'*.

Participants reported that educators must be given adequate support to educate the learner about healthy sexual practices. The Department of Education must provide necessary resources that will be used to unleash informed decisions and prevent them from contracting sexual diseases.

**Participant 08 (SGB), Female 44 years** expressed that *'aaah what they do they usually guide them to abstain, it just that learners are learners. They cannot abstain even when they are told.*

**Participant 12 (SGB), Male, 50 years** mentioned that *'They come and see learners in classes they distribute condoms to them, and they also tell them about the issue of HIV and also emphasises the issue of protecting themselves when they engaged in sexual activity'.*

**Participant 16 (SGB), Male, 40 years** mentioned that *'The issue of teenage pregnancy they usually come and educate our learners because our school is next to the clinic. They usually come here and speak to our learners.*

Participants suggested that teaching children about how to make informed decisions regarding healthy sexual practices will equip them with lifetime skills. They will not be controlled by any circumstances to engage in unhealthy sexual practices.

**Participant 12, (SGB) Male, 50 years** emphasises that *'when teachers teach, they have a slot, try to advise them how to take care of themselves and give them examples of other people outside who are also suffering who did not follow these so the strategy can work, every teacher in class when you attend, we talk about this. It will help.*

**Participant 10 (SGB), Female, 45 years** added that *'There are some learners who do not know how to make informed decisions and the person who had sexual intercourse with her might have used his force without say. So, if awareness to warn learners and teaching them about sex, I believe they won't be involving themselves to engaged to sex education'.*

**Participant 07 (SGB), Male, 44 years** elaborated that *'if they abstain it gives them an advantage to further their studies. Because if they do not do that, they allow themselves to be used by aaa older people you will find that they won't go anywhere, their future will be japertise, infect their future will be determined by the government they will rely on a social grant'.*

**Participant 16 (SGB), Male, 40 years** supported by elaborating that *'If they are regularly being taught those who will take it seriously will abstain and not engage in sexual intercourse. Those who will continually practice sex will know that unprotected sex has bad results in their future'.*

**Participant 01 (SGB), Male, 57 years** expressed that *'I said this comprehensive understanding of mind means sober minded people will understand and interpret things the way they are but not taking the school out of its destination sorry it could be misinterpreted*

*they missed the misconception now goes out to the people that they are doing this for the sake of this I think we need commanded people will implement what we need to plan correctly’.*

The findings revealed that most learners are in multiple sexual relationships which leads them to be exposed to the risk of sexual disease and they are involved in transitional sexual intercourse, where they do not make an informed decision regarding healthy sexual practices. Others are in exchange for alcohol and drugs.

**Participant 01 (Learner), Male, 18 years** said *‘Normal you must have sex with your partner, having multiple sexual partners must be prohibited’.*

**Participant 11 (Learner), Female, 19 years** reported that *‘we need to have good friends who do not influence others to be in multiple relationships and to use drugs’.*

**Participant 18 (Learner), Female, 15 years** has the conception that *‘I feel like life orientation further promotes youth to engaged in sexual activities, youth have many sexual partners and intimacy’.*

**Participant 21 (Learner), Male, 14 years** emphasises that *‘youth must stop going to taverns at a young age, because they sell their bodies to different rich men, they call sugar daddies’*

**Participant 21 (Learner), Male, 16 years** elaborated a serious notion that *‘these girls and boys must stop doing quick sex, because it makes them to be vulnerable to STI, HIV and pregnancy. They must not have sex at the bush, they must have sex at home. They must use condoms and further check their expired dates, because if it is expired it is easy to bust and put both partners at risk of contracting STI, HIV, and unplanned pregnancy.’*

**Participant 24 (Learner), Male, 15 years** said *‘I think you must use injection as a prevention method as a lady. When you wanna have sex, you must ensure you use condoms. Never have skin-to-skin sex until you are married. By so doing, you must not be infected by diseases and you won’t be pregnant.’*

**Participant 23 (Learner), Female, 15 years** said *‘There should be campaigns where youth are being told and encouraged on what should be done to reduce these sexual issues’*

**Participant 18 (Learner), Female, 18 years** similar view reported that *‘It can be reduced but we cannot get a complete deal with it. These campaigns may assist in addressing STI, HIV, teen pregnancies’*

**Participant 14 (Learner), Male, 15 years** reported a contrary view that *'When others are taught about sex education they want to practice. Which results in unhealthy sexual practices. I feel like life orientation further promotes youth to engage in sexual activities'*.

**Participant 17 (Learner), Female, 17 years** stated that *'They must be taught about sexual intercourse that they will start having sexual intercourse at the age of 19 years'*.

Other findings emphasise that healthy sexual practices education must be continuous and provided weekly to remind learners to always wear condoms when they engage in sexual intercourse.

**Participant 18 (Learner), Female, 15 years** stated that *'They must be reminded that whenever they want to have sexual intercourse they must wear condoms. They must be reminded to leave the issue of engaging themselves in sexual activities'*.

**Participant 16 (Learner), Male, 17 years** affirmed that *'I think we must not have sexual intercourse at all because once we test, we will never mind having it without condoms'*.

**Participant 6 (Learner), Female, 19 years** emphasises the issue of proper content *'At school we have life orientation and we must be taught about sexual issues not to hide information'*

*'Teachers must create a programme that will teach or educate youth about STI, HIV, and unwanted pregnancy'* reported **Participant 08 (Learner), Male, 18 years**.

**Participant 25 (Learner), Male, 15 years** concurred with the above view that *'Teachers must come up with ideas that how are they going to educate us about STI, HIV and teens pregnancy'*

Teachers must not hide information regarding the promotion of healthy sexual practices, they are qualified personnel, and they are trained to disseminate relevant context to learners. Learners must be provided with appropriate information that will lead them to make an informed decision regarding healthy sexual practices and in their entire lives.

**Participant 02 (Learner), Female, 19 years** elaborated that *'Teachers, they do teach us about contraceptives and sex education. However, they do not state it directly they hide content, and we just assume what they are trying to say. At some point, we do understand but we do not take it seriously'*.

**Participant 03 (Learner), Male, 17 years** concurred that *'yeah, it's not lying let me say in life orientation. They might say sexual behaviour they will not tell us how it is being done and how it goes. They can say all of it but hidden'*.

**Participant 24 (Learner), Male, 15 years** has contrary views that *‘No, life orientation does not help us because when they are teaching us, they hide details or information. They do not teach us about sex’.*

Participants revealed that healthy sexual practices are not properly taught at school. Schools require more context and resources to ensure that they equip learners with the necessary skills regarding healthy sexual practices. Furthermore, participants reported that healthy sexual practices education might lessen the phenomenon of STIs, HIV, and teen pregnancy. The provision of healthy sexual education reduces teenage pregnancy in schools.

**Participant 01 (LO teacher), Male, 25 years** said that *‘I think it is right that we teach learners about sex so that they look out for themselves, and practice safe sex at their age’.*

**Participant 13 (LO teacher), Female, 40 years** supported the notion that *‘healthy sexual education is good for learners because it assists them with the prevention of pregnancies while being young, just for them to focus in school and have better academic performance. So that they must not have children at a young age.’*

**Participant 02 (LO teacher), Male, 52 years** elaborated that *‘I think it’s a good idea because we teach learners how to protect themselves, basically it’s a good thing that they know what to do if they indulge in sexual intercourse without proper protection’.*

**Participant 25 (LO teacher), Female, 28 years** similarly reported that *‘I think more teaching, we must inform them, give them more education to the learners and don’t hide anything’.*

**Participant 05 (LO teacher), Female, 51 years** said *‘Ehh eh infect I can say as a life orientation educator we normally teach healthy sexual relationships under one topic that is called Development of self in a society’.*

**Participant 06 (LO teacher), Female, 51 years** indicated that *‘sexual practices are causing a lot of problems, especially to the young learners in high schools. Because they want to experience something that they had never seen and by so doing. They find themselves caught by teenage pregnancy and school drop-outs’*

#### **4.10 Field notes reports**

The researcher had taken field notes which are very necessary and were recorded in a diary which noted bias, specifically with participants and their own biases. These diary notes were also coded in addition to the interview data. However, the researcher enlisted common field notes since the interviews were FGD it was difficult to match the interviews and participants

reactions. Diary notes contain a record of experiences, ideas, fears, confusion, breakthroughs, change of facial expressions, shaking of head, laughing, rude, swearing, and problems that occurred during fieldwork, in addition to the biases noted on the diary book.

#### **4.11 Stage 2 Phase 2 Quantitative method Presentation and Interpretation of findings**

The principal objectives of the quantitative stage were to provide information and demonstrate the results on how participants can be involved in the promotion of healthy sexual practices in the Vhembe district. The findings of this stage are presented using tables and charts; after that the narrative of the findings is presented. The findings of this study are considered based on the information that developed from the quantitative data analysis of the self-administered questionnaires with the participants.

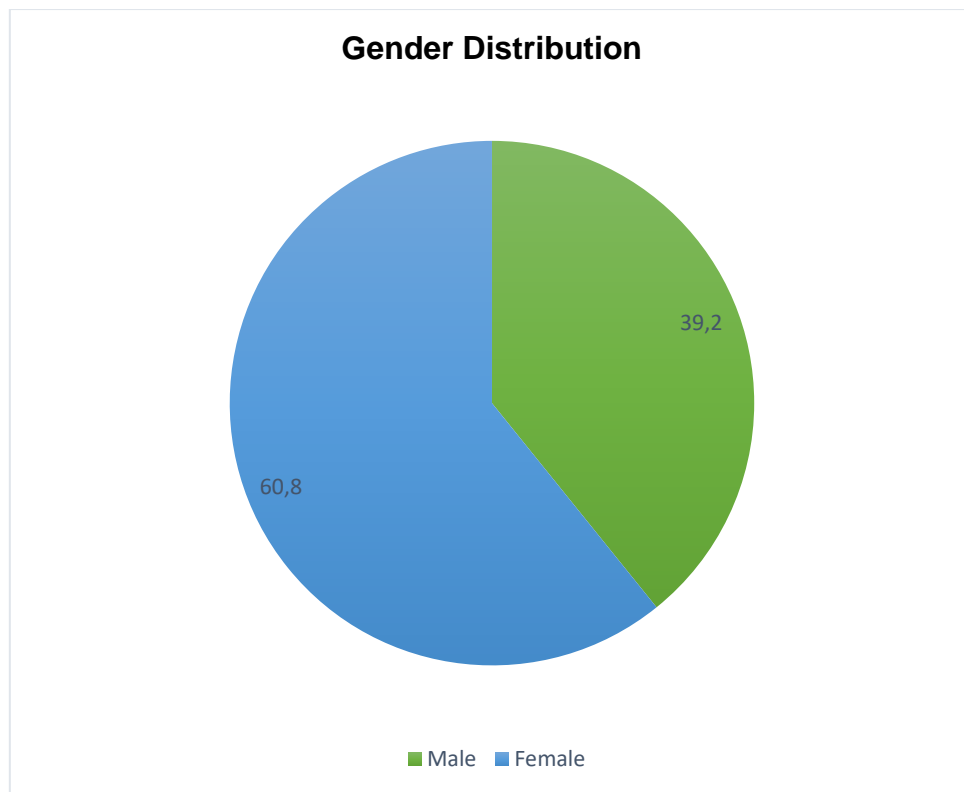
##### ***4.11.1 Demographic information***

The demographic information contains the characteristics of the respondents which include age, gender, religion, marital status and people living with the respondents.

##### ***4.11.1.1 Gender distribution of the respondents***

The findings of the study revealed that the majority of respondents 323 (60.8%) were females' learners, 208 (39.2%) were male learners. The summary of all the descriptions given above is as shown in Figure 6.

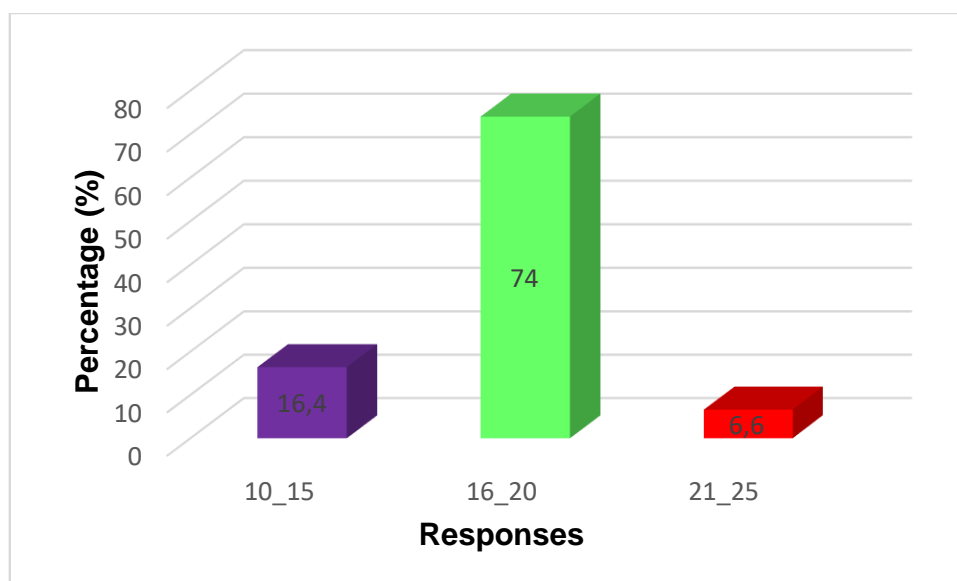




***Figure 6: Gender distribution of the respondents (N=531).***

#### ***4.11.1.2 Age distribution of the respondents***

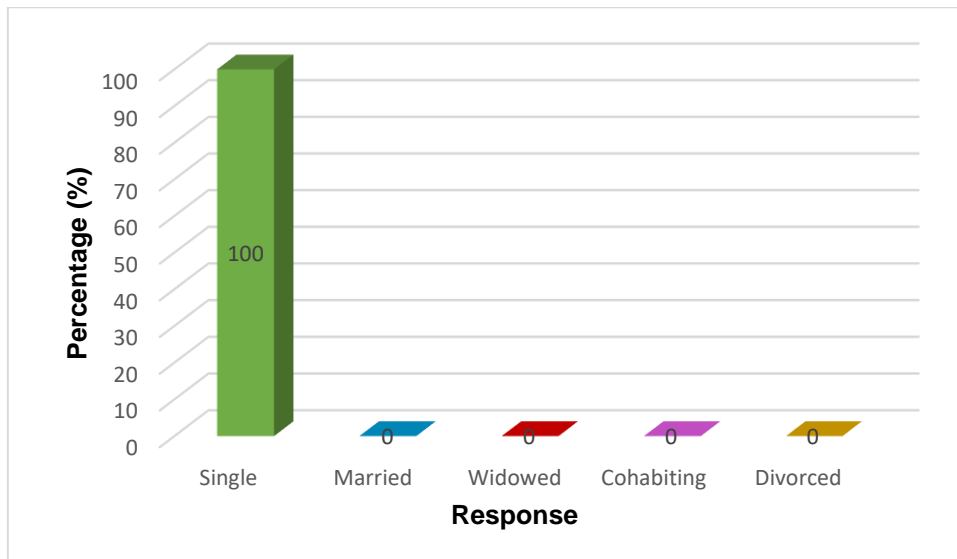
The findings of the study revealed that the majority of respondents 393 (74.0%) were in the age bracket of 16-20 years, 87 (16.4%) were in the age bracket of 10-15 years, 51 (9.6%) in the age bracket of 21-25 years. The summary of all the descriptions given above is as shown in Figure 7 below.



**Figure 7: Age distribution of the respondents (n=531).**

#### **4.11.1.3 Marital status**

The study findings show that 531 (100%) of respondents were single while Married, Widow, Cohabiting and Divorced rated zero percent response. It appears that all the respondents are single. The summary of all the descriptions given above is as shown in Figure 8.

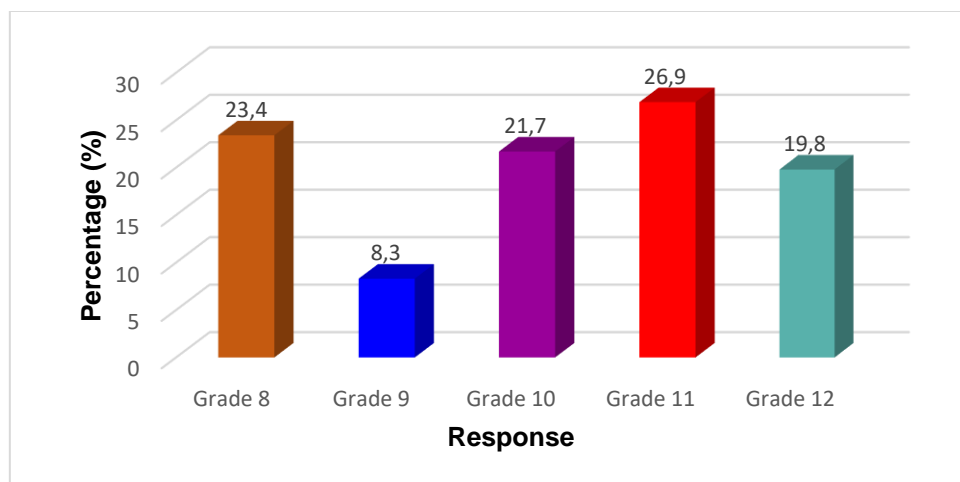


**Figure 8: Marital Status (n=531).**

#### **4.11.1.4 Learners per grade**

The study findings indicate that 143 (26.9%) of the study respondents were learners from grade 11 while 124 (23.4%) of the respondents were learners from grade 8. Furthermore, 115 (21.7%) of the respondents were learners from grade 10, while 105 (19.8%) of the

respondents were learners from grade 12 and 44 (8.3%) were respondents from grade 9. The summary is as shown in figure 9.



**Figure 9: Learners per grade (n=531).**

#### **4.11.1.5 People living with the respondents**

The findings indicated that 179 (33.7%) of the respondents lives with both parents while 175 (33.0%) of the respondents lives with their mothers. In addition, the findings revealed that 82 (15.4%) of the respondents are living with their grandmothers, 50 (9%) are living with others. The findings further showed that 20 (3.8%) are living with their fathers, 15 (2.8%) are living with their brothers, 10 (1.9%) are living with their sisters. The summary of all the descriptions given above is shown in Table 11.

**Table 11: People living with the respondents (n=531).**

Items	Frequency	Percentage (%)
Both Parents	179	33,7%
Mother	175	33,0%
Grandmother	82	15,4%
Other	20	9,0%
Father	20	3,8%
Brother	15	2,8%
Sister	10	1,9%
<b>Total</b>	<b>531</b>	<b>100%</b>

#### **4.11.1.6 Responses regarding children**

The findings showed that the majority of respondents 395 (74.4%) do not have children while 136 (25.6%) of the respondents have children. The findings further showed that 177 (22%) of the respondents have one child while 19 (3.6%) of the respondents have two children and 0

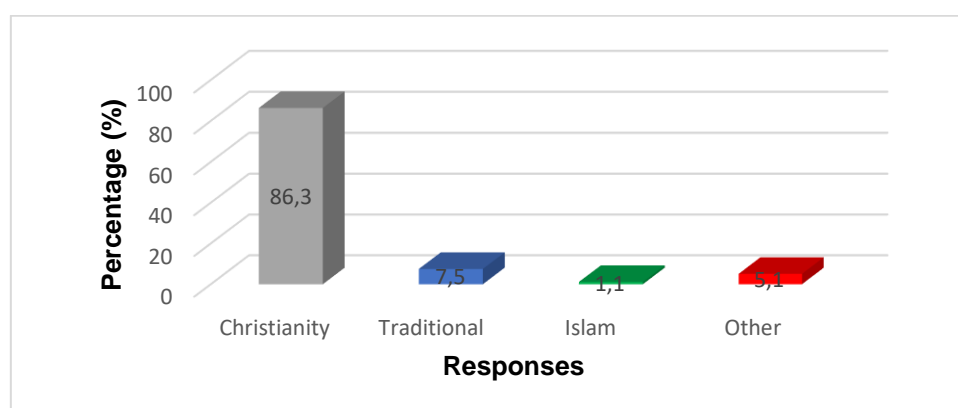
(0.0%) have more than two children. There were some non-responses of 295 (74.4%) to the question posed in relation to children because they do not have child/children. The summary of all the descriptions given above is shown in Table 12.

**Table 12: Responses regarding children (n=136).**

Respondents with children	Frequency	Percentage (%)
Yes	136	25,6%
No	395	74,4%
<b>Total</b>	<b>531</b>	<b>100,0%</b>
Number of Children	Frequency	Percentage (%)
One	117	22,0%
Two	19	3,6%
Three and above	0	0,0%
<b>Total</b>	<b>136</b>	<b>25,6%</b>

#### **4.11.1.7 Religion of respondents**

The findings revealed that 458 (86.3%) of the respondents were Christians while 40 (7.5%) of the respondents revealed that they belong to traditional religions. The findings further showed that 27 (5.1%) belong to other religions, 6 (1.1%) belong to the Islamic religion. Figure 10 shows the descriptive of religions.



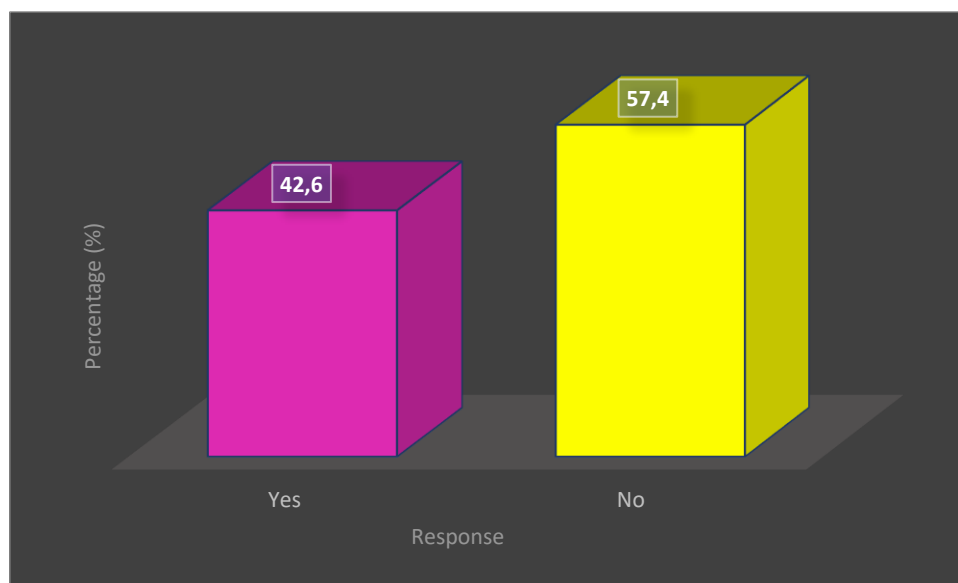
**Figure 10: Shows the respondents regarding religion (n=531).**

#### **4.11.2 Knowledge of youth about the promotion of healthy sexual practices**

This presents the study findings regarding the knowledge of the youth about the promotion of healthy sexual practices.

##### **4.11.2.1 Do you discuss with your boyfriend about the choice of contraceptive?**

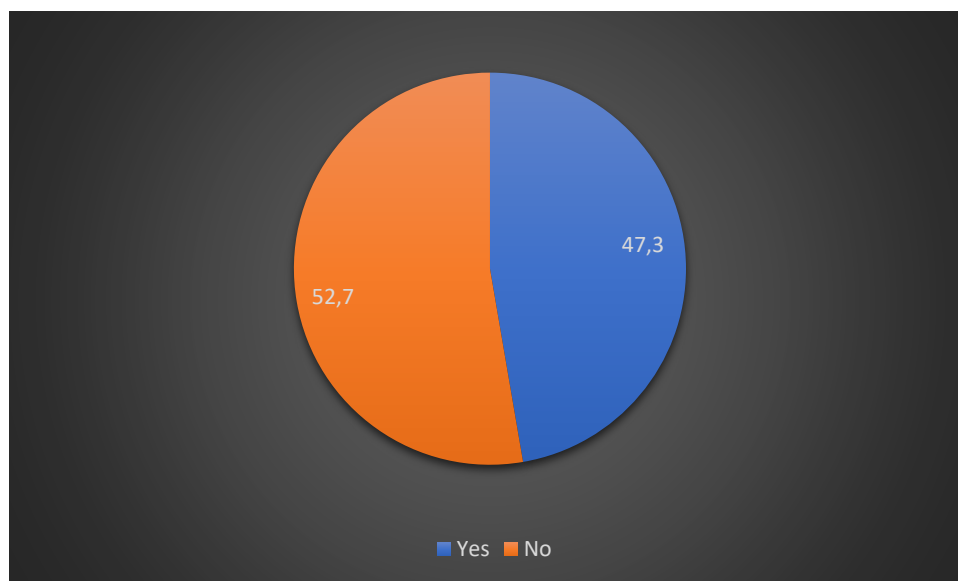
The findings showed that 305 (57.4%) of the respondents revealed that they do not discuss with their boyfriend about the choice of contraceptive while 226 (42.6%) of the respondents revealed that they discuss with their boyfriend about the choice of contraceptive. The summary is as shown in Figure 11.



**Figure 11: Choices of contraceptives with boyfriend (n=531).**

##### **4.11.2.2 Are you in favour of a workshop about contraceptives for women and men together?**

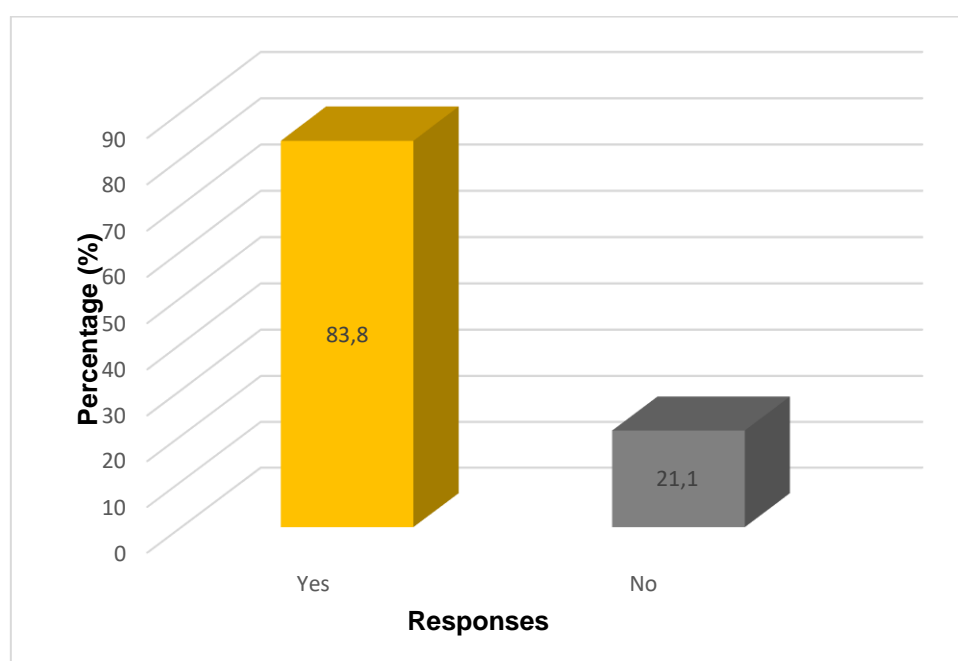
The findings showed that 280 (52.7%) of the respondents are not in favour of a workshop about contraceptives for woman and men together while 251 (47.3%) of the respondents are in favour of a workshop about contraceptives for woman and men together. The summary is as shown in Figure 12.



**Figure 12: Favour of a workshop about contraceptives for woman and men together (n=531).**

#### ***4.11.2.3 Abstaining from sexual activities would help to prevent unplanned pregnancy***

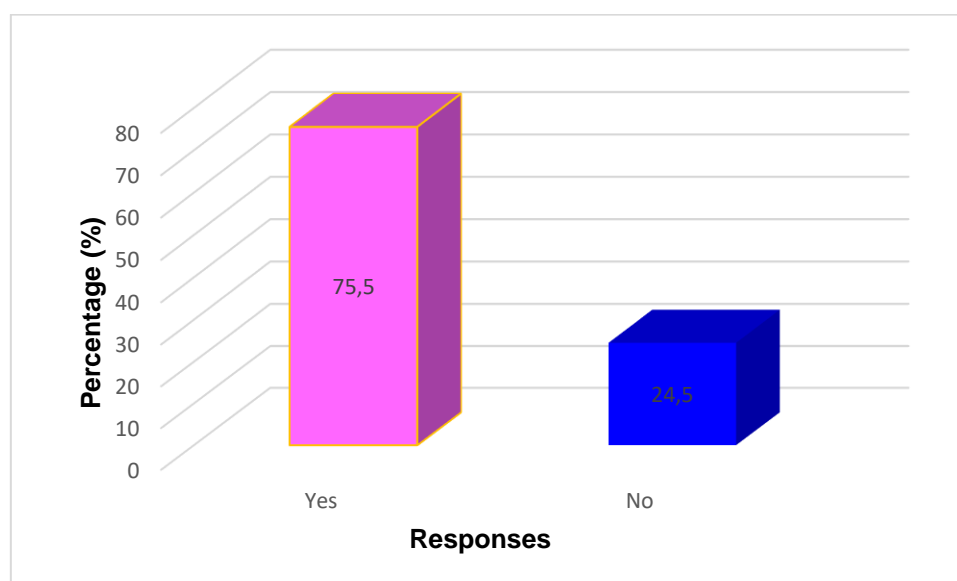
The findings showed that 445 (83.8%) of the respondents indicated that abstaining from sexual activities would help to prevent unplanned pregnancy while 86 (16.2%) of the respondents indicated that abstain from sexual activities would not help to prevent unplanned pregnancy. The summary of the descriptions given above is as shown in Figure 13.



**Figure 13: Abstaining from sexual activities to prevent unplanned pregnancy (n=531)**

***4.11.2.4 The introduction and teaching of sex education would help to prevent unplanned pregnancy***

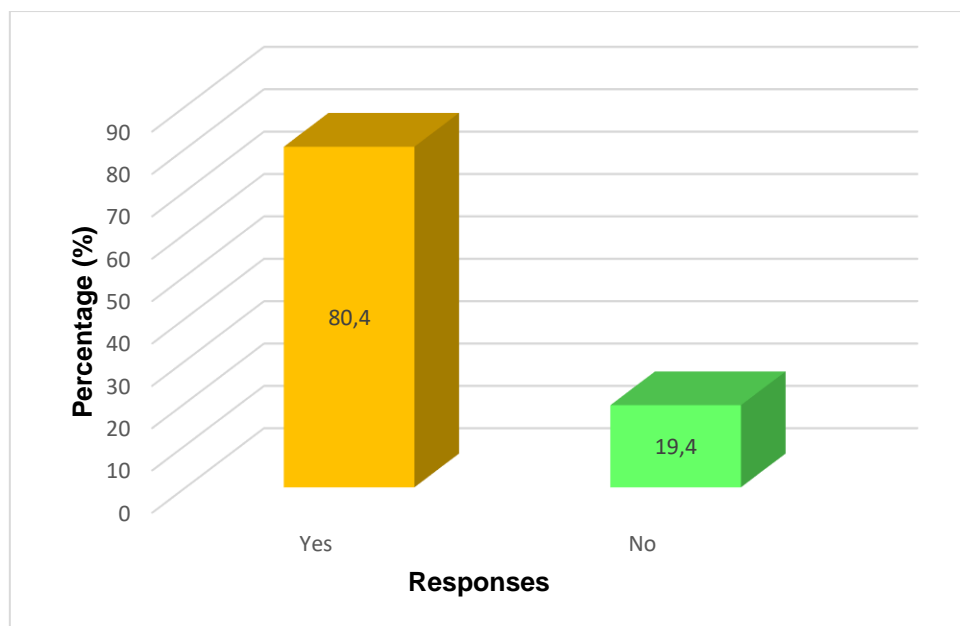
The findings showed that 401 (75.5%) of the respondents indicated that the introduction and teaching of sex education would help to prevent unplanned pregnancy while 130 (24.5%) of the respondents indicated that the introduction and teaching of sex education would not help to prevent unplanned pregnancy. The summary is as shown in Figure 14.



**Figure 14: Introduction and teaching of sex education to prevent unplanned pregnancy (n=531)**

***4.11.2.5 Unplanned pregnancy can be prevented by supplying contraceptives programmes at clinics and schools***

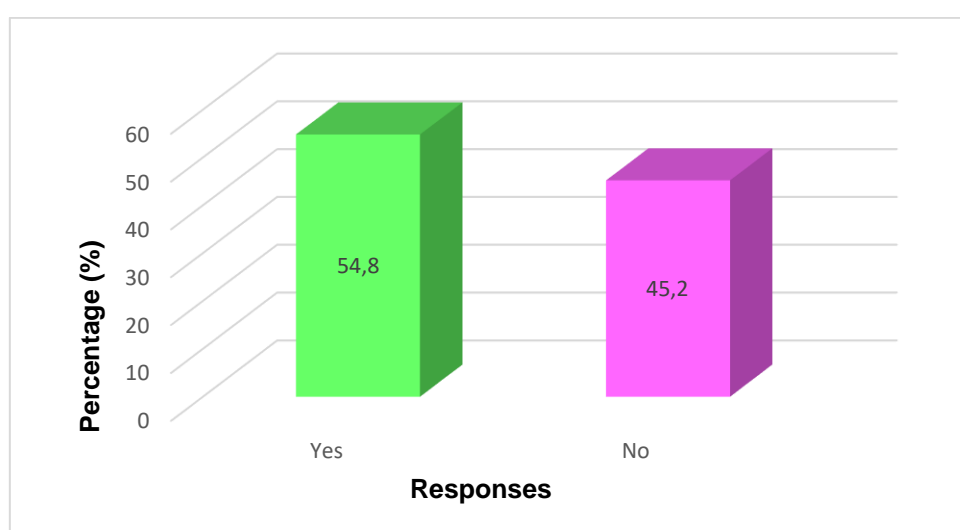
The findings showed that 428 (80.6%) of the respondents indicated that unplanned pregnancy can be prevented by supplying contraceptives programmes at clinics and schools while 103 (19.4%) of the respondents indicated that unplanned pregnancy cannot be prevented by supplying contraceptives programmes at clinics and schools. The summary is as shown in Figure 15.



**Figure 15: Unplanned pregnancy can be prevented by supplying contraceptives programmes at clinics and schools (n=531).**

#### ***4.11.2.6 Teaching religious and moral values into adolescents would help to prevent unplanned pregnancy***

The findings showed that 291 (54.8%) of the respondents revealed that teaching religious and moral values to adolescents would help to prevent unplanned pregnancy while 240 (45.2%) of the respondents indicated that teaching religious and moral values to adolescents would not help to prevent unplanned planned pregnancy. The summary of the descriptions given above is as shown in Figure 16.

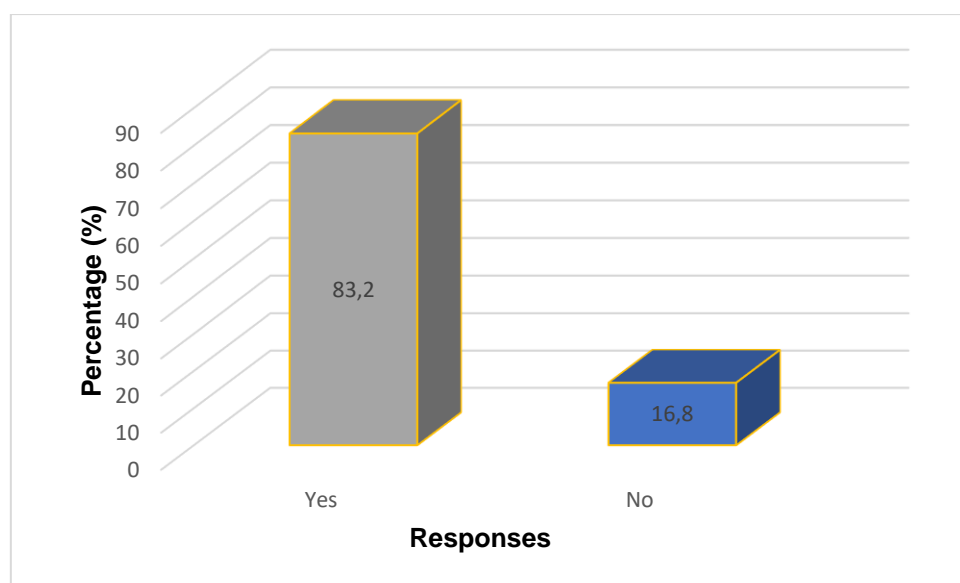




**Figure 16: Teaching religious and moral values to adolescents would help to prevent unplanned pregnancy (n=531)**

#### ***4.11.2.7 Programmes linked with contraceptive services to prevent unplanned pregnancy***

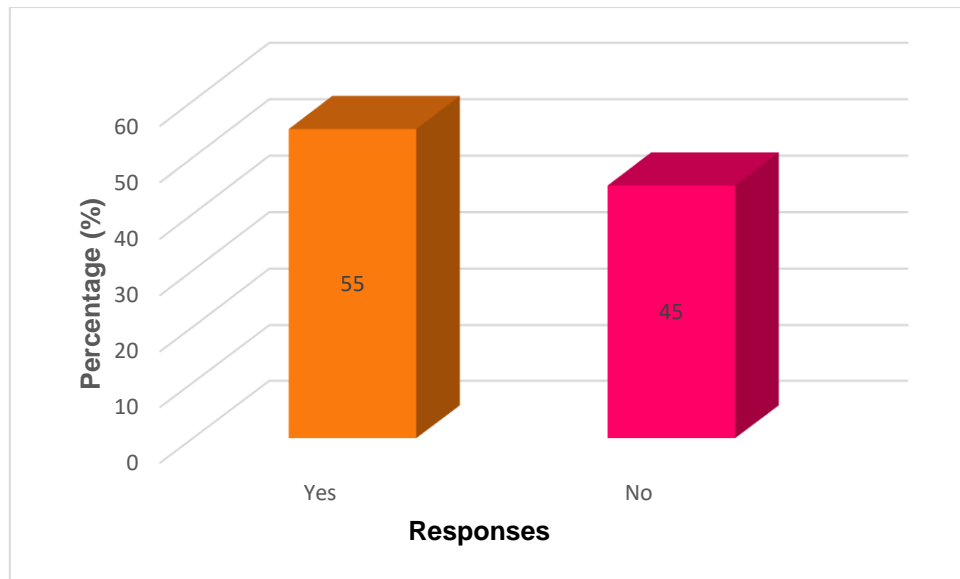
The findings showed that 442 (83.2%) of the respondents revealed that programmes linked with contraceptive services can help prevent unplanned pregnancy while 89 (16.8%) of the respondents indicated that programmes linked with contraceptive services cannot help preventing unplanned pregnancy. The summary is as shown in Figure 17.



**Figure 17: Shows programmes linked with contraceptives services (n=531)**

#### ***4.11.2.8 Parental education support can help prevent unplanned pregnancy***

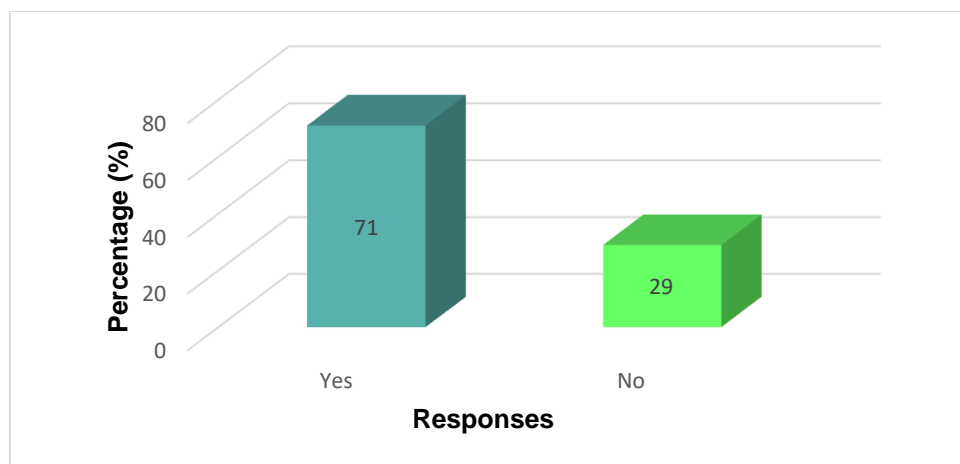
The findings showed that 424 (79.8%) of the respondents revealed that parental education support can help prevent unplanned pregnancy while 107 (20.2%) of the respondents indicated that parental education support cannot help prevent unplanned pregnancy. The summary of the descriptions given above is as shown in Figure 18.



**Figure 18: Parental education support can help prevent unplanned pregnancy (n=531)**

#### ***4.11.2.9 Social support and parenting can help prevent unplanned pregnancy***

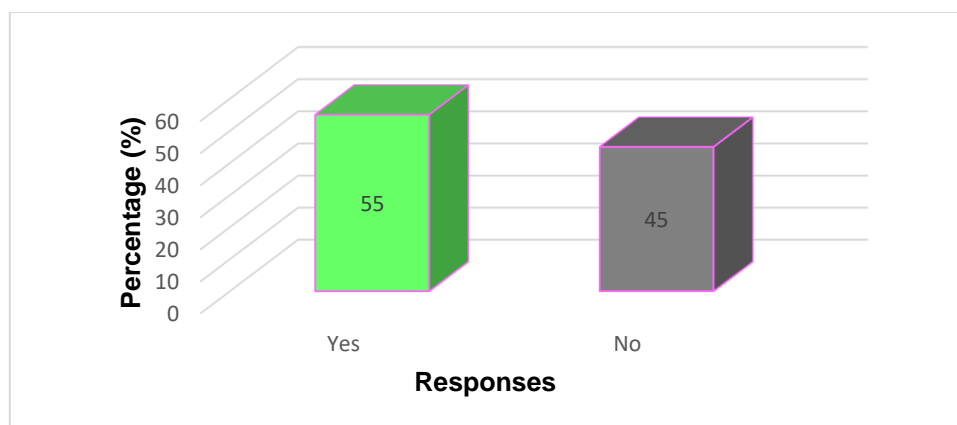
The findings showed that 377 (71.0%) of the respondents revealed that social support and parenting can help prevent unplanned pregnancy while 154 (29%) of the respondent indicated that social support and parenting cannot help to prevent unplanned pregnancy. The summary of the descriptions given above is as shown in Figure 19.



**Figure 19: Social support and parenting can help prevent unplanned pregnancy (n=531).**

#### 4.11.2.10 *Have you ever used any type of contraceptive?*

The findings showed that 198 (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. The summary is as shown in Figure 20.



**Figure 20: Have you ever used any type of contraceptive? (n=292)**

#### 4.11.2.11 *If yes, which method did you use?*

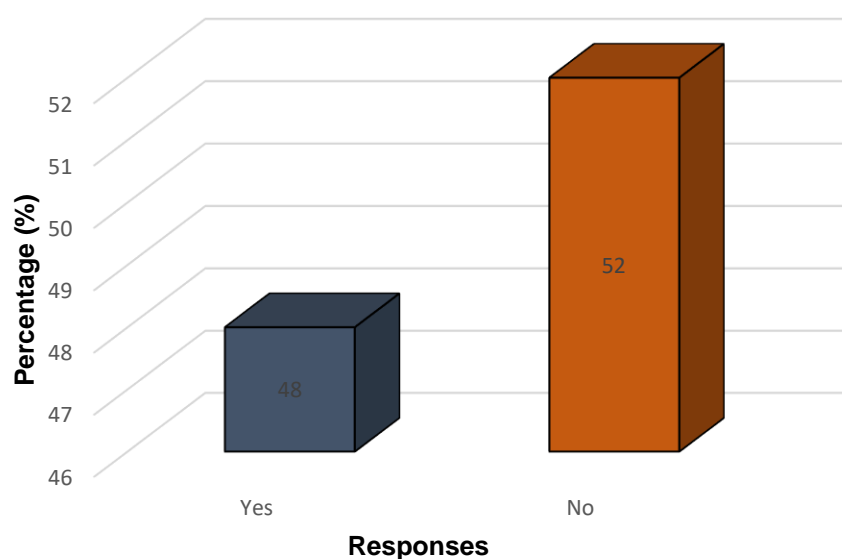
The findings showed that 100 (18.8%) of the respondents revealed that they use condoms as methods of contraception while 93 (17.9%) of the respondents revealed that they abstain as methods of contraception. The findings further showed that 21 (3.9%) of the respondents revealed that they use standard days methods of contraception, 20 (3.7%) of the respondents revealed that they use pills as methods of contraception while 20 (3.7%) of the respondents revealed that they use natural method as methods of contraception and 13 (2.4%) of the respondents revealed that they use injectables as a method of contraception. Furthermore, the findings showed that 5 (1.7%) of the respondents revealed that they use progestogen only contraceptives, 5 (1.7%) of the respondents revealed that they use emergency contraceptives as methods of contraception while 4 (0.7%) of the respondents revealed that they use implants as methods of contraception and 4 (0.7%) of the respondents revealed that they use male sterilisation as the method of contraception. Three (0.5%) of the respondents revealed that they use combined hormone contraceptives as methods of contraceptives while two (0.4%) of the respondents revealed that they use intra-uterine contraceptive device (IUD) as methods of contraceptives and two (0.4%) of the respondents revealed that they use female sterilisation as the method of contraception. There were non-responses of 239 (44%) to the question posed in relation to which method did you use, if yes. The summary is shown in Table 13.

**Table 13: If yes, which method did you use (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%
<b>Total</b>	<b>531</b>	<b>100%</b>

**4.11.2.12      *On the method selected, do you comply with the instruction on the usage of that contraceptive method?***

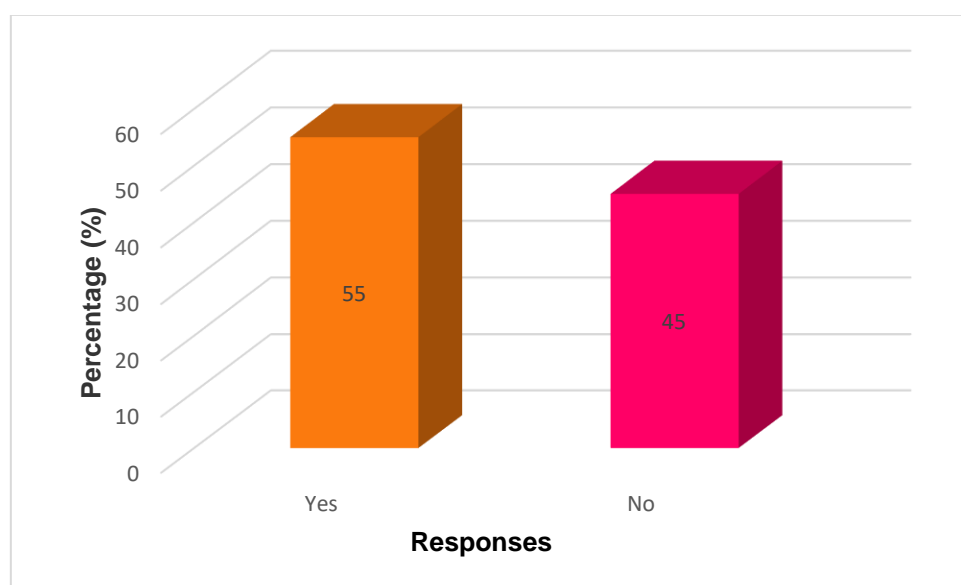
The findings showed that 152 (52%) of the respondents revealed that they do not comply with the instruction on the usage of the contraceptives methods while 140 (48%) of the respondents revealed that they comply with the instruction on the usage of the contraceptives methods. It appears that the majority of the study respondents do not comply with the instruction on the usage of the contraceptive methods. The summary of the descriptions given above is as shown in Figure 21.



**Figure 21: Instruction on the usage of the contraceptive method (n=292)**

**4.11.2.13      *Do you think there is a need for more information on contraceptive methods and their use?***

The findings showed that 293 (55%) of the respondents indicated that there is a need for more information on contraceptives and their usage while 238 (45%) of the respondents indicated that there is no need for more information on contraceptives and their usage. The summary of the descriptions given above is as shown in Figure 22.



**Figure 22: The need for more information on contraceptives methods and their use (n=531)**

**4.11.2.14      *If yes, where do you think you will get your contraceptive information?***

The findings showed that 120 (22.5%) of the respondents indicated that they will get information about contraceptives from healthcare facilities/workers, while 40 (7.5%) of the respondents indicated that they will get information about contraceptives from the social media, 40 (7.5%) of the respondents indicated that they will get information about contraceptives from the internet. The findings further showed that 20 (3.8%) of the respondents indicated that they would get information about contraceptives from the family while 20 (3.8%) of the respondents indicated that they would get information about contraceptives from the school (Life Orientation teachers) and 14 (2.6%) of the respondents will get information from the Radio/Newspaper/Television. The findings further showed that 11 (2.0%) of the respondents indicated that they will get information about contraceptives from

the church while 10 (1.9%) of the respondents indicated that they will get information about contraceptives from the school peer education. The findings further showed that nine (1.7%) of the respondents indicated that they would get information about contraceptives from the sugar daddy while five (0.9%) of the respondents indicated that they will get information about contraceptives from the school sugar mama and two (0.4%) of the respondents will get information from the girlfriend while two (0.4%) of the respondents will get information from the boyfriend. There were non-responses at 238 (45%) of the respondents to the question posed in relation to where do you think you will get your contraceptive information. The summary of the descriptions given above is shown in Table 14.

**Table 14: If yes, where will you get your contraceptive information (n=293)**

Source of information about contraceptives	Frequency	Percentage (%)
Health care facilities/ workers	120	22,5%
Social Media	40	7,5%
Internet	40	7,5%
Family	20	3,8%
School (Life orientation Teachers)	20	3,8%
Radio/ Newspaper/ Television / Posters	14	2,6%
Church	11	2,0%
Peer Education	10	1,9%
Sugar daddy	9	1,7%
Sugar mama	5	0,9%
Girlfriend	2	0,4%
Boyfriend	2	0,4%
Non-response	238	45%
<b>Total</b>	<b>531</b>	<b>100%</b>

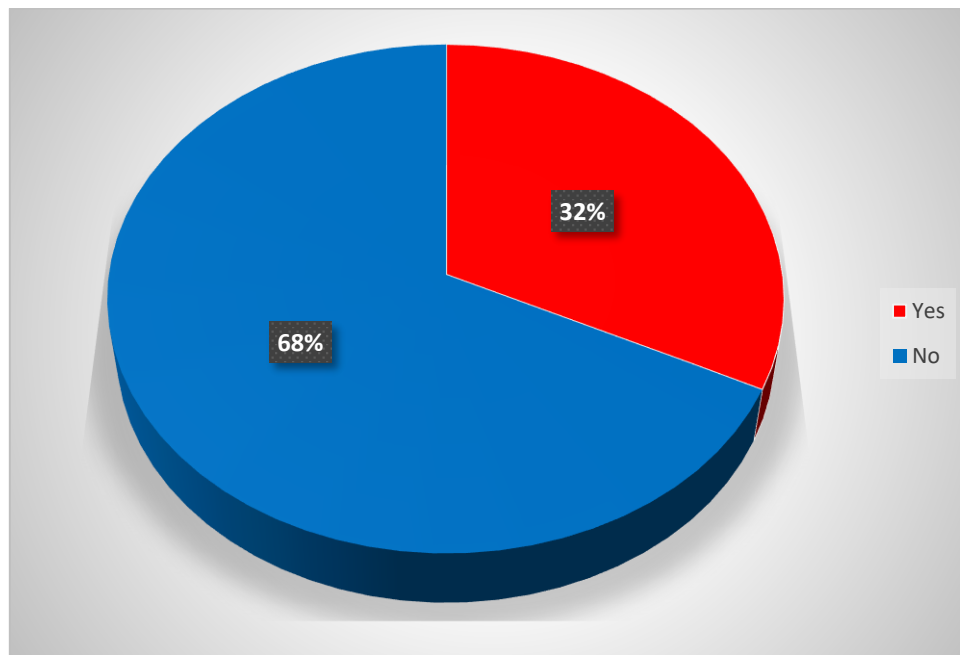
#### ***4.11.3 Factors and risky sexual behaviours that influence the promotion of healthy sexual practices***

This presents the study findings regarding factors and risky sexual behaviours that influence the promotion of healthy sexual practices. Further, the decision that makes youth to have sexual intercourse for the first time, their opinion regarding sexual intercourse without a condom.

##### ***4.11.3.1 Are you having unprotected sexual intercourse (skin to skin) sex currently***

The findings showed that 360 (68%) of the respondents revealed that they are not having unprotected sexual intercourse (skin to skin) sex currently while 171 (32%) of the respondents revealed that they are having unprotected sexual intercourse (skin to skin) sex currently. It

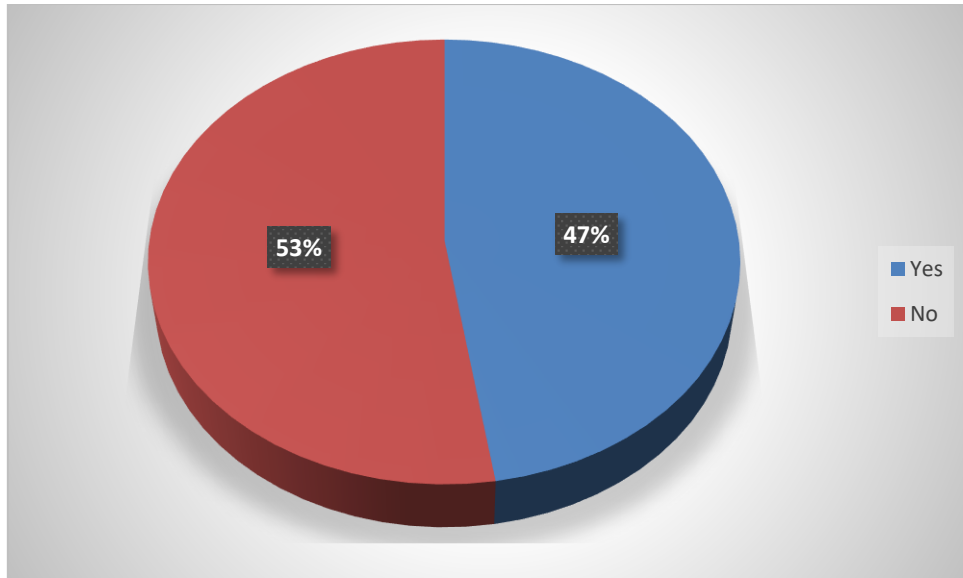
appears that the majority of the study respondents are not having unprotected sexual intercourse (skin to skin) sex currently. The summary of the descriptions given above is as shown in Figure 23.



**Figure 23: Are you having unprotected sexual intercourse (skin to skin) sex currently (n=531)**

#### ***4.11.3.2 I had unprotected sexual intercourse to make me feel very good***

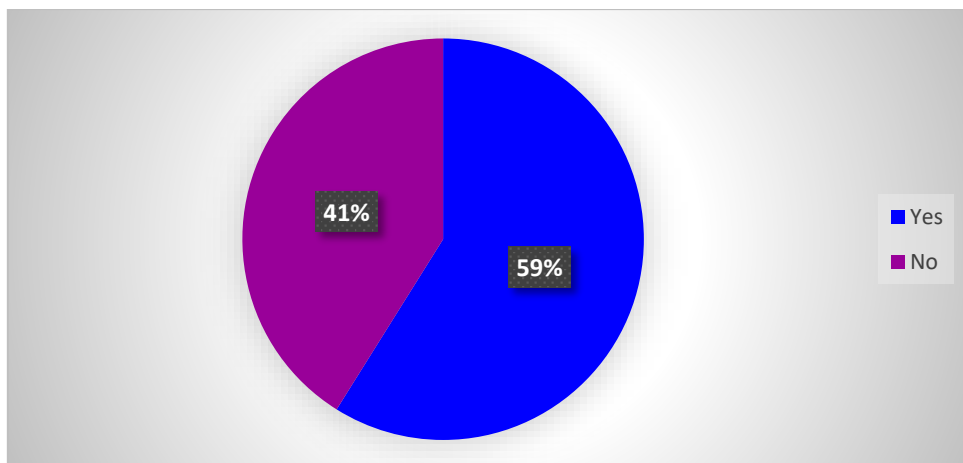
The findings showed that 279 (53%) of the respondents revealed that they are not having unprotected sexual intercourse to make themselves feel very good while 252 (47%) of the respondents revealed that they had unprotected sexual intercourse to make themselves feel very good. It appears that the majority of the study respondents do not have sexual intercourse to make themselves feels very good. The summary of the descriptions given above is as shown in Figure 24.



**Figure 24: Unprotected sexual intercourse to makes me feel very good (n=531)**

#### ***4.11.3.3 I had unprotected sexual intercourse to satisfy my own sexual needs better***

The findings showed that 313 (59%) of the respondents revealed that they had unprotected sexual intercourse to satisfy their own sexual needs better while 218 (41%) of the respondents revealed that they are not having unprotected sexual intercourse to satisfy their own sexual needs better. It appears that the majority of the study respondents had unprotected sexual intercourse to satisfy their own sexual needs better. The summary of the descriptions given above is as shown in Figure 25.

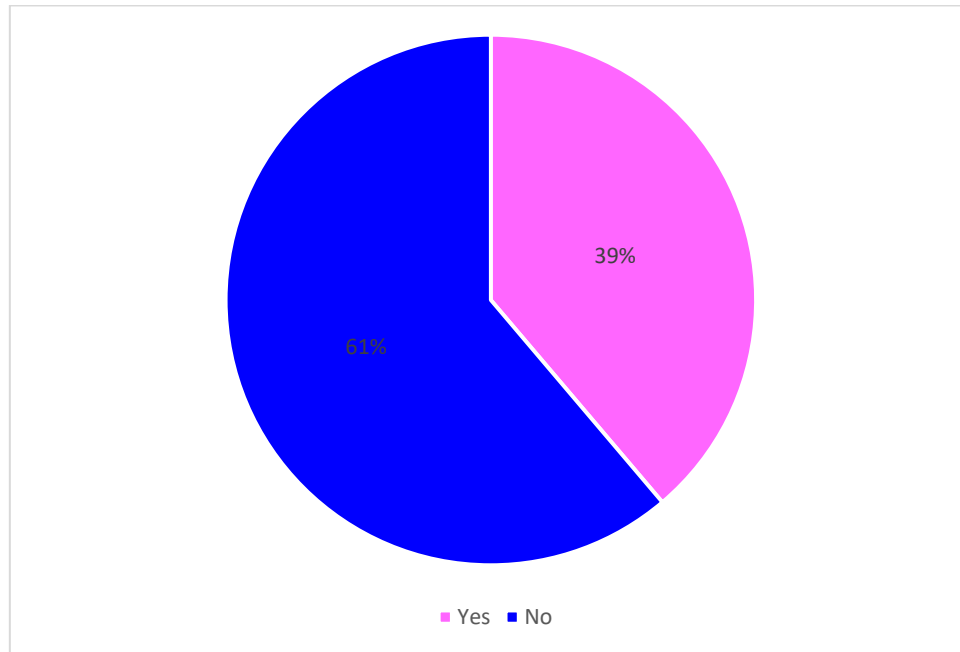


**Figure 25: Unprotected sexual intercourse to satisfy my own sexual needs better (n=531)**



#### ***4.11.3.4 I had unprotected sexual intercourse to please my partner and that's the reason I had sex without condom***

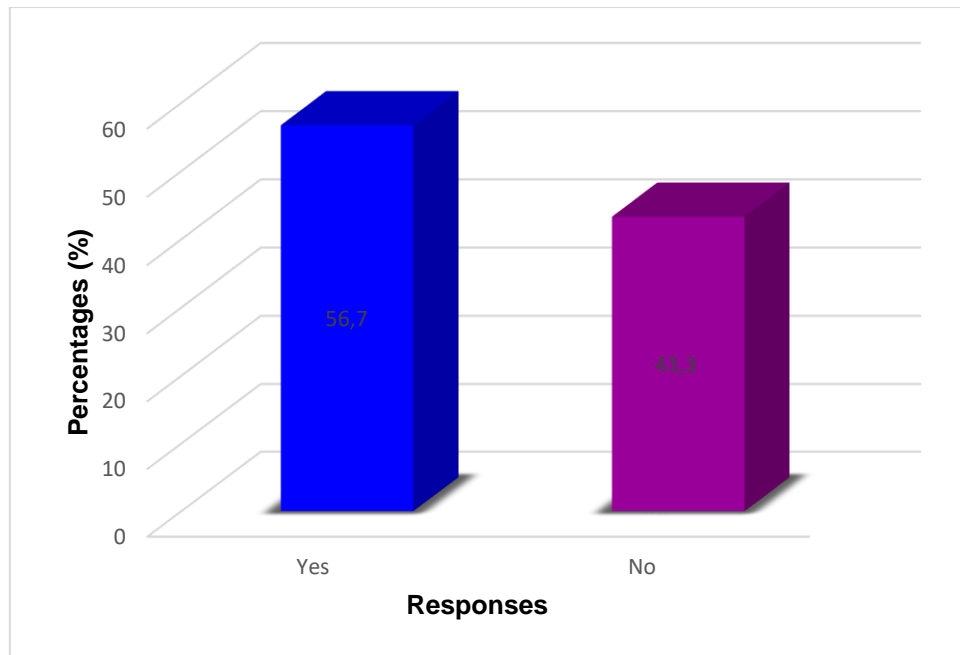
The findings showed that 325 (61%) of the respondents revealed that they are not having unprotected sexual intercourse to please their partner and that is the reason they are not having sex without a condom while 206 (39%) of the respondents revealed that they had unprotected sexual intercourse to please their partner and that is the reason they had sex without a condom. The summary of the descriptions given above is as shown in Figure 26.



**Figure 26: Unprotected sexual intercourse to please my partner and that's the reason I had sex without condom (n=531)**

#### ***4.11.3.5 I had unprotected sexual intercourse because condoms are not 100% safe anyway***

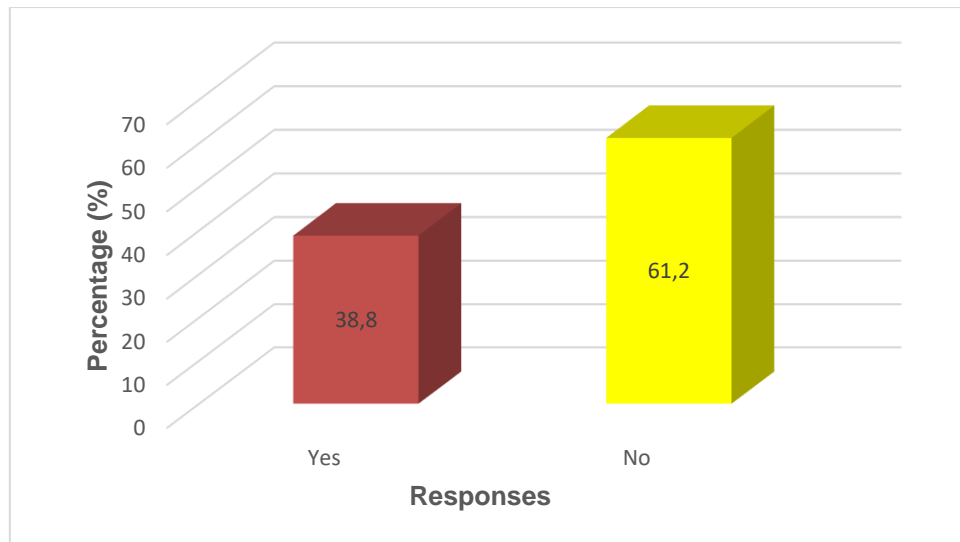
The findings showed that 301 (56.7%) of the respondents revealed that they had unprotected sexual intercourse because condoms are not 100% safe anyway while 230 (43.3%) of the respondents revealed that they are not having unprotected sexual intercourse because condoms are 100% safe anyway. The summary of the descriptions given above is as shown in Figure 27.



**Figure 27: Unprotected sexual intercourse due to condoms are not 100% safe anyway (n=531)**

***4.11.3.6 They had unprotected sexual intercourse make them feels like a real man/woman***

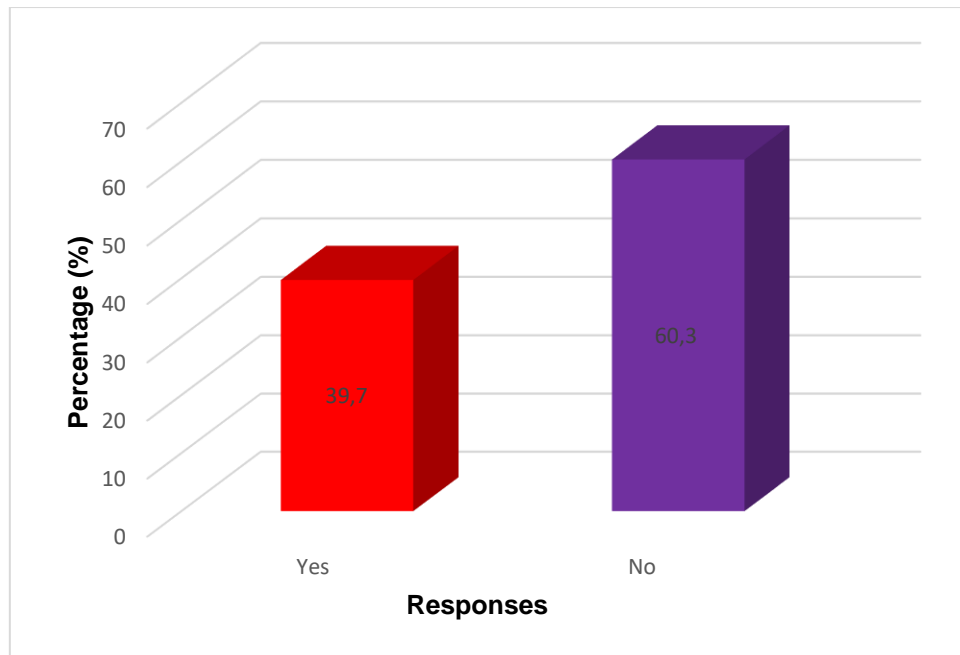
The findings showed that 325 (61.2%) of the respondents revealed that they are not having unprotected sexual intercourse to make themselves feels like a real man/woman while 206 (38.8%) of the respondents revealed that they had unprotected sexual intercourse to make themselves feels like a real man/woman. The summary of the descriptions given above is as shown in Figure 28.



**Figure 28: Unprotected sexual intercourse makes me feels like a real man/woman (n=531)**

***4.11.3.7 I had unprotected sexual intercourse because we were in a long and steady relationship so there was no need for condoms***

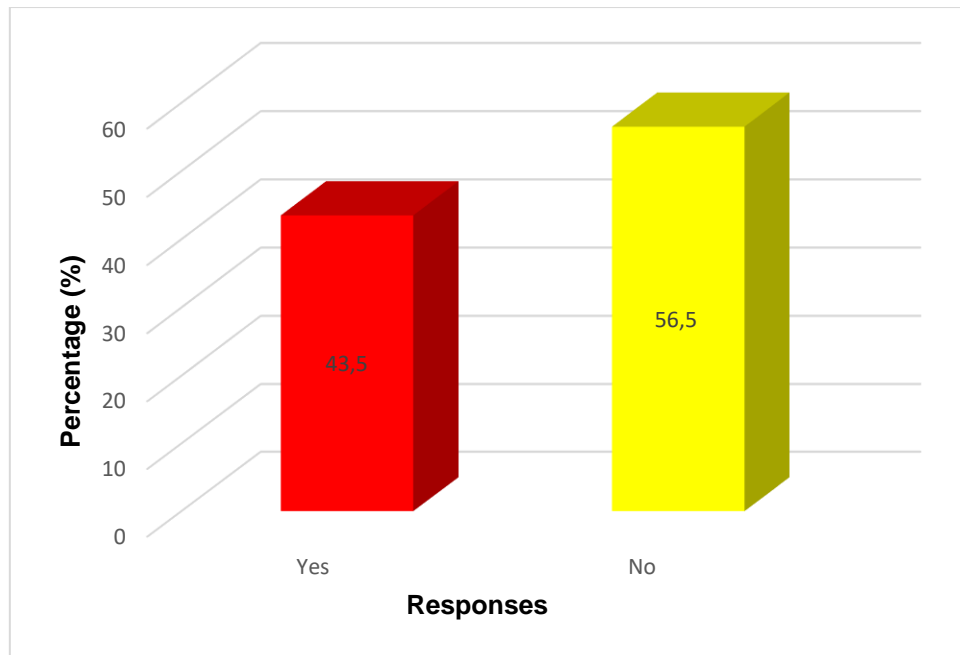
The findings showed that 320 (60.3%) of the respondents revealed that they are not having unprotected sexual intercourse because they were in a long and steady relationship, there was a need for condoms while 211 (39.7%) of the respondents revealed that they had unprotected sexual intercourse because they were in a long and steady relationship, there was no need for condoms. The summary of the descriptions given above is as shown in Figure 29.



**Figure 29:Unprotected sexual intercourse because we were in a long and steady relationship so the was no need for condoms (n=531)**

***4.11.3.8 I had unprotected sexual intercourse because my partner refuses to use a condom and I do not want to lose him/her***

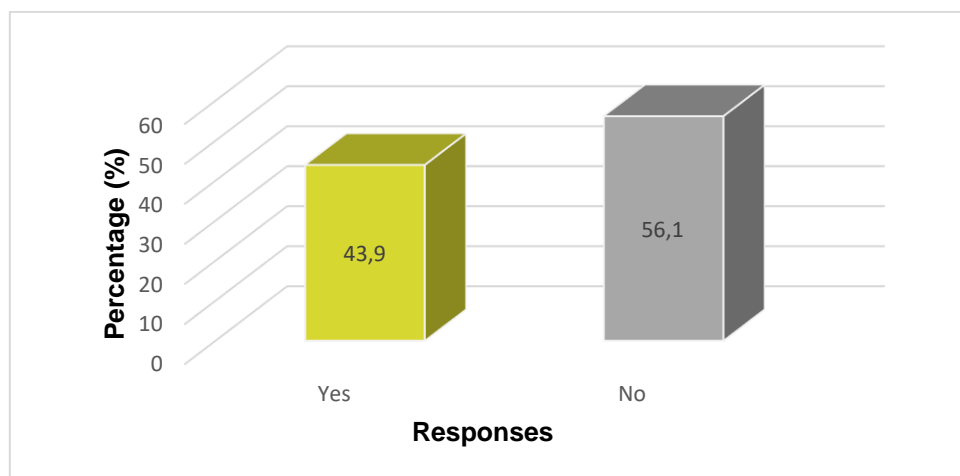
The findings showed that 300 (56.5%) of the respondents revealed that they are not having unprotected sexual intercourse because their partner refuses to use a condom and they are not afraid to lose him/her while 231 (43.5%) of the respondents revealed that they had unprotected sexual intercourse because their partner refuses to use a condom and they do not want to lose him/her. The summary of the descriptions given above is as shown in Figure 30.



**Figure 30: Unprotected sexual intercourse because my partner refuses to use a condom and I do not want to lose him/her (n=531)**

***4.11.3.9 I had unprotected sexual intercourse because there was no condom available at the time sex was not planned***

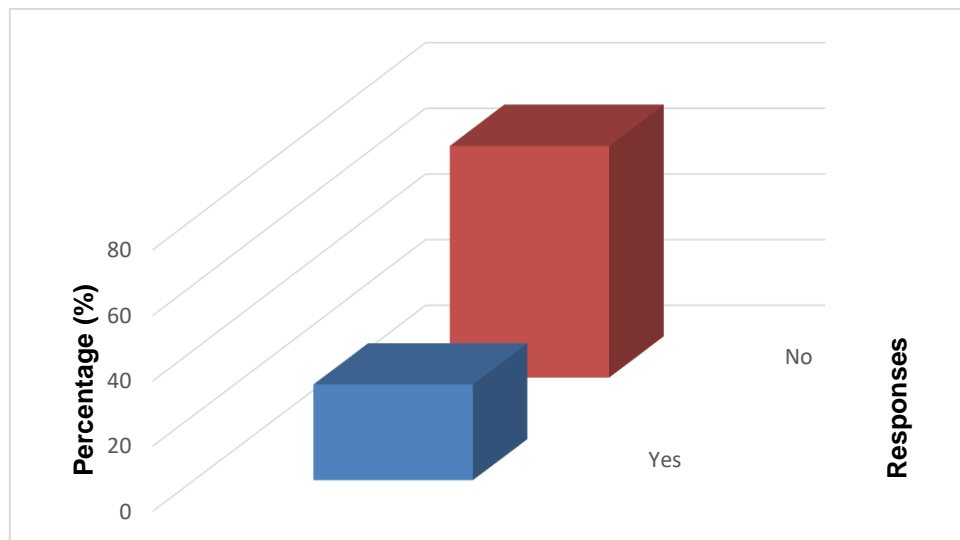
The findings showed that 298 (56.1%) of the respondents revealed that they are not having unprotected sexual intercourse because there was no condom available at the time, sex was not planned while 233 (43.9%) of the respondents revealed that they had unprotected sexual intercourse because there was no condom available at the time, sex was not planned. The summary of the descriptions given above is as shown in Figure 31.



**Figure 31: Unprotected sexual intercourse to because there was no condom available at the time sex was not planned (n=531)**

#### **4.11.3.10      *I had unprotected sexual intercourse because I was offered money***

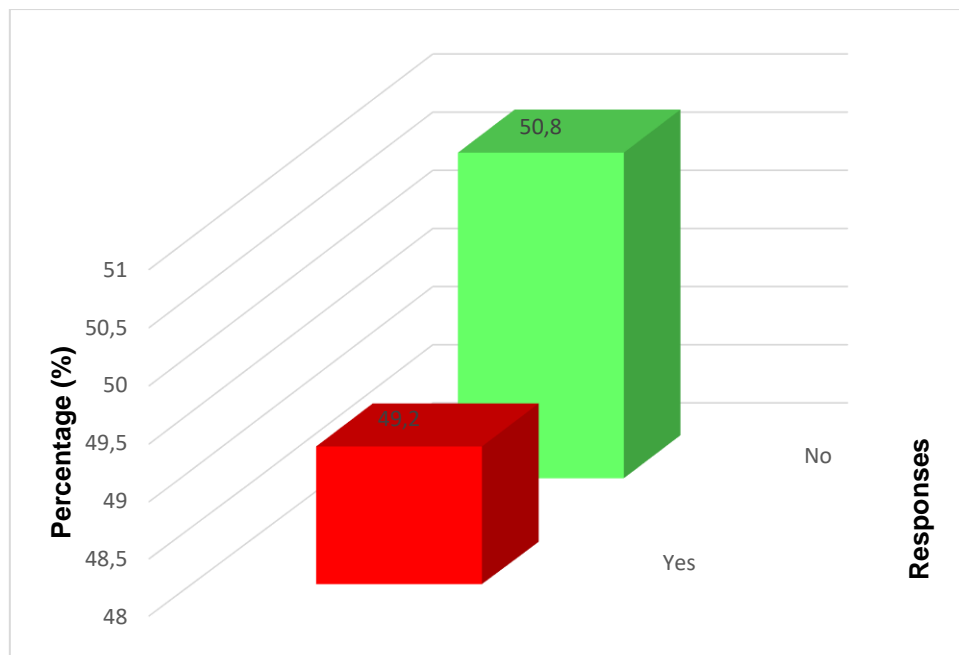
The findings showed that 375 (70.6%) of the respondents revealed that they are not having unprotected sexual intercourse because they were not offered money while 156 (29.4%) of the respondents revealed that they had unprotected sexual intercourse because they were offered money. The summary of the descriptions given above is as shown in Figure 32.



**Figure 32: Unprotected sexual intercourse because I was offered money (n=531)**

#### **4.11.3.11      *I had unprotected sexual intercourse because it is more enjoyable***

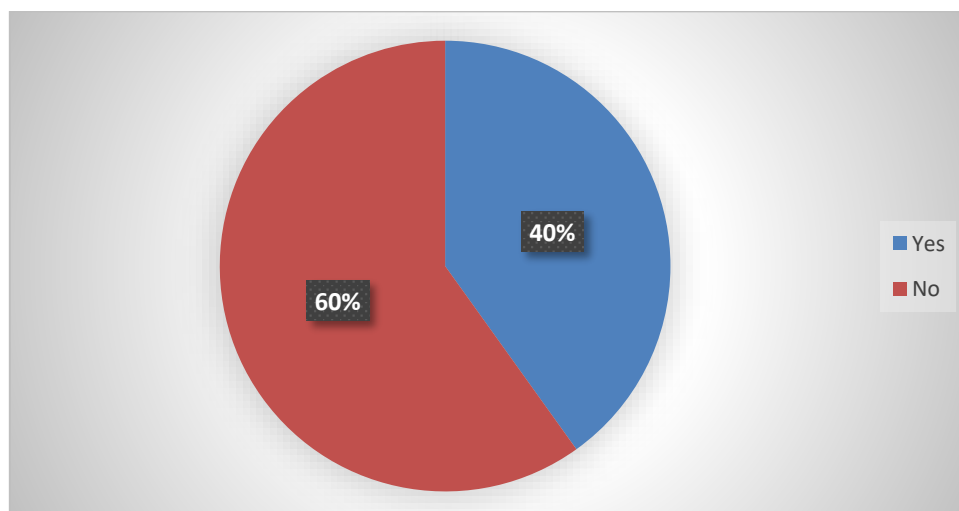
The findings showed that 270 (50.8%) of the respondents revealed that are not having unprotected sexual intercourse because it is not enjoyable while 261 (49.2%) of the respondents revealed that they had unprotected sexual intercourse because it is more enjoyable. The summary of the descriptions given above is as shown in Figure 33.



**Figure 33: Unprotected sexual intercourse t because it is more enjoyable (n=531)**

#### **4.11.3.12 *I had unprotected sexual intercourse because my partner is faithful and does not cheat on me***

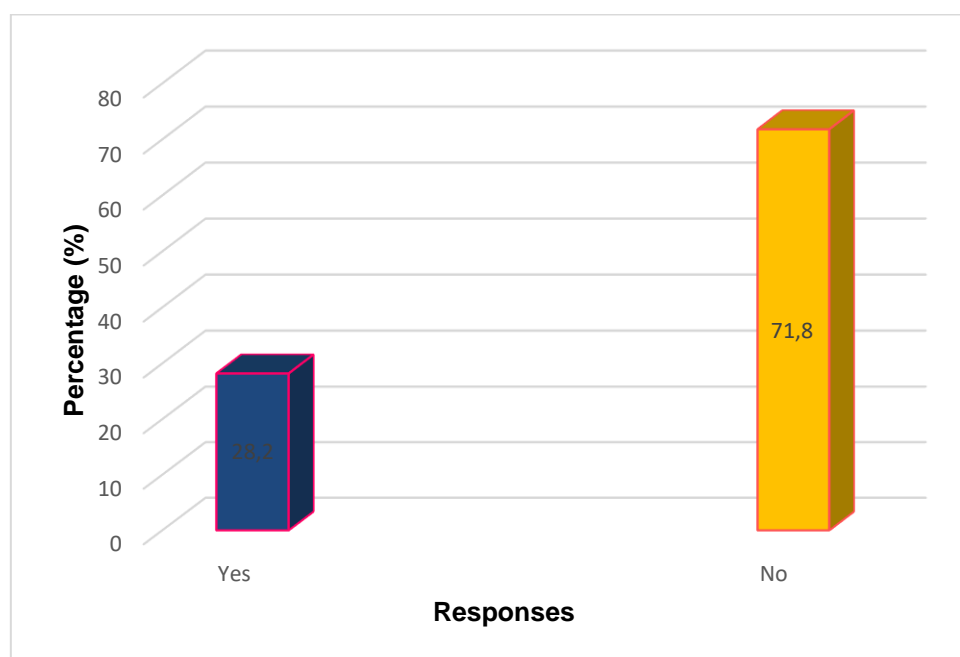
The findings showed that 318 (60%) of the respondents revealed that they had unprotected sexual intercourse because their partners are faithful and do not cheat on them while 213 (40%) of the respondents revealed that they had unprotected sexual intercourse because their partner is not faithful and cheats on them. The summary of the descriptions given above is as shown in Figure 34.



**Figure 34: Unprotected sexual intercourse because my partner is faithful and do not cheat on me (n=531)**

#### **4.11.3.13      *I had unprotected sexual intercourse because I wanted pregnancy/ impregnant***

The findings showed that 381 (71.8%) of the respondents revealed that they are not having unprotected sexual intercourse because they do not want pregnancy/ impregnant while 150 (28.2%) of the respondents revealed that they had unprotected sexual intercourse because they wanted pregnancy/ impregnant. The summary of the descriptions given above is as shown in Figure 35.

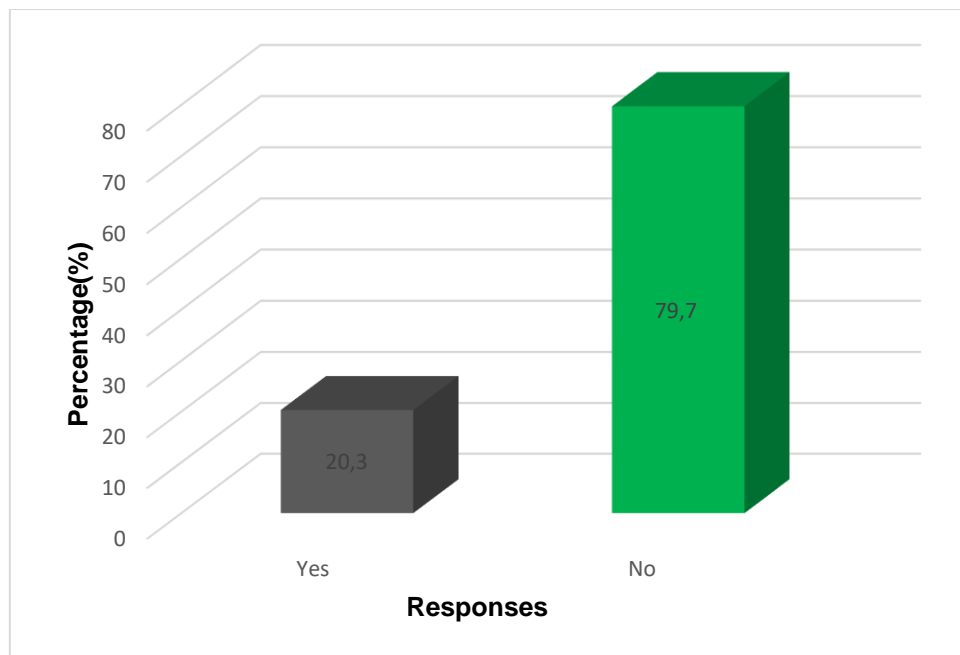


**Figure 35: Unprotected sexual intercourse because I wanted pregnancy/ impregnant (n=531)**

#### **4.11.3.14      *I had unprotected sexual intercourse because I was under the influence of alcohol and drugs***

The findings showed that 423 (79.7%) of the respondents revealed that they are not having unprotected sexual intercourse because they were not under the influence of alcohol and drugs while 108 (20.3%) of the respondents revealed that they had unprotected sexual intercourse because they were under the influence of alcohol and drugs. The summary of the descriptions given above is as shown in Figure 36.

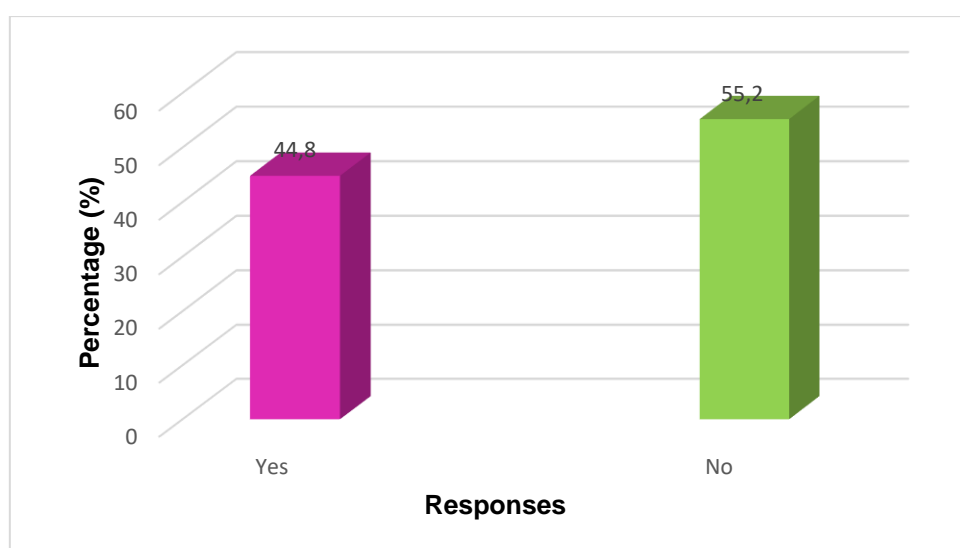




**Figure 36:Unprotected sexual intercourse because I was under the influence of alcohol and drugs (n=531)**

#### **4.11.3.15 *I had sexual intercourse for the first time because I wanted to experiment (curiosity)***

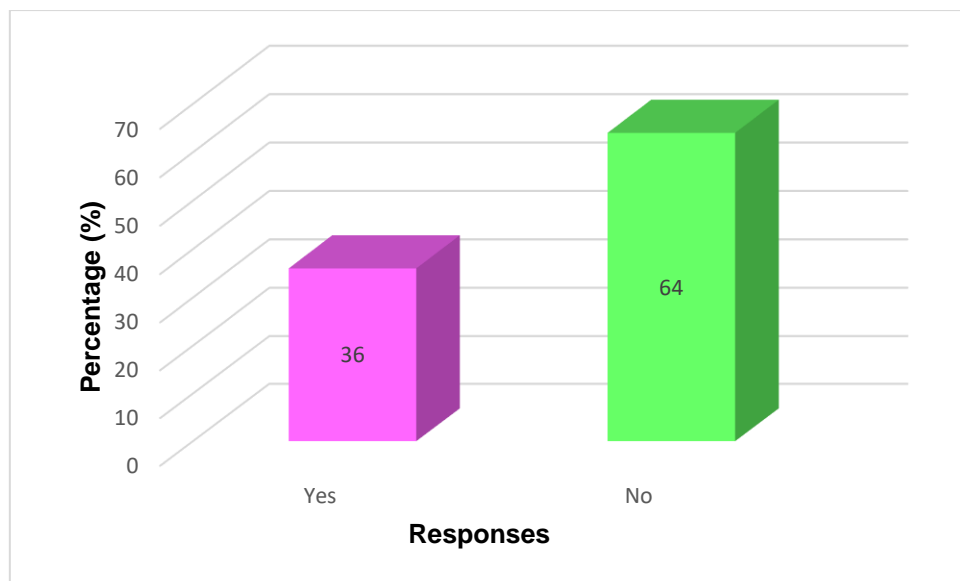
The findings showed that 293 (55.2%) of the respondents revealed that they are not having sexual intercourse for the first time, because they do not want to experiment (curiosity) while 238 (44.8%) of the respondents revealed that they had sexual intercourse for the first time because they wanted to experiment (curiosity). The summary of the descriptions given above is as shown in Figure 37.



**Figure 37: To experiment (curiosity) first time sexual intercourse (n=531)**

#### **4.11.3.16      *I had sexual intercourse for the first time because I was encouraged by my friends***

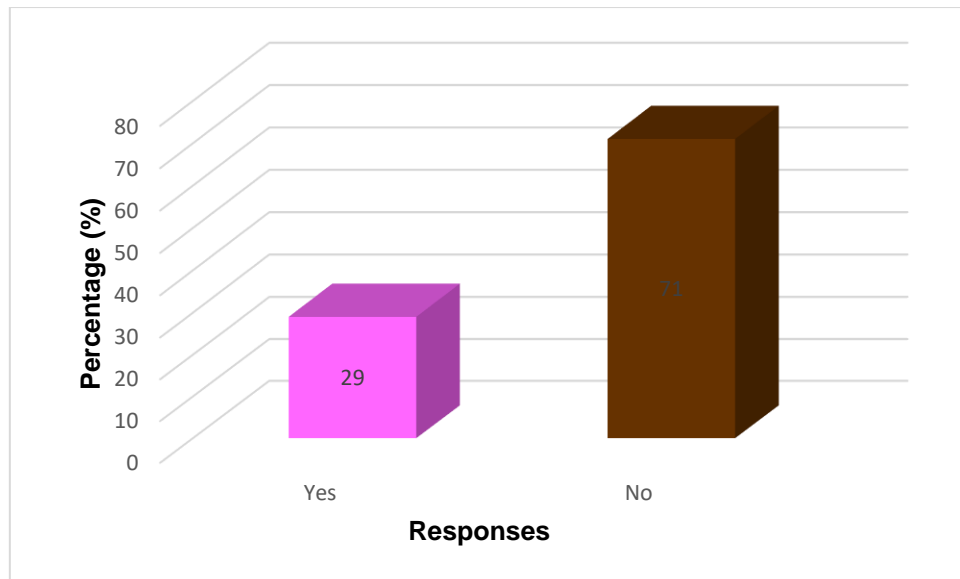
The findings showed that 340 (64%) of the respondents revealed that they do not have sexual intercourse for the first time because they were not encouraged by their friends while 191 (36%) of the respondents revealed that they had sexual intercourse for the first time because they were encouraged by their friends. The summary of the descriptions given above is as shown in Figure 38.



**Figure 38 Encouraged by their friends to have sexual intercourse for the first time (n=531)**

#### **4.11.3.17      *I had sexual intercourse for the first time because my boyfriend/girlfriend persuaded me***

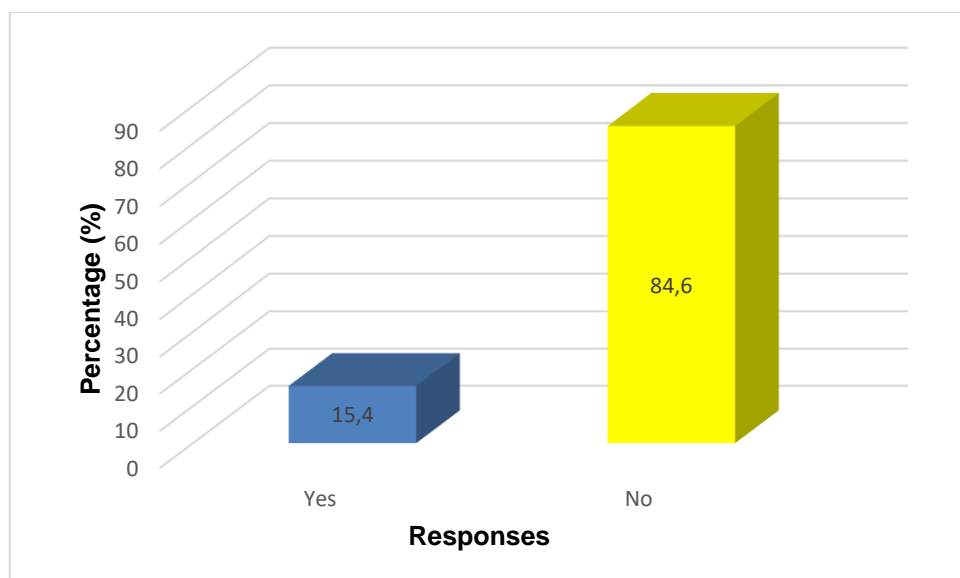
The findings showed that 377 (71%) of the respondents revealed that they do not had sexual intercourse for the first time because their boyfriend/girlfriend did not persuaded them while 154 (29%) of the respondents revealed that they had sexual intercourse for the first time because their boyfriend/girlfriend persuaded them. The summary of the descriptions given above is as shown in Figure 39.



**Figure 39: Their boyfriend pursued them to have sexual intercourse for the first time (n=531)**

#### **4.11.3.18 *I had sexual intercourse for the first time because I was raped/forced***

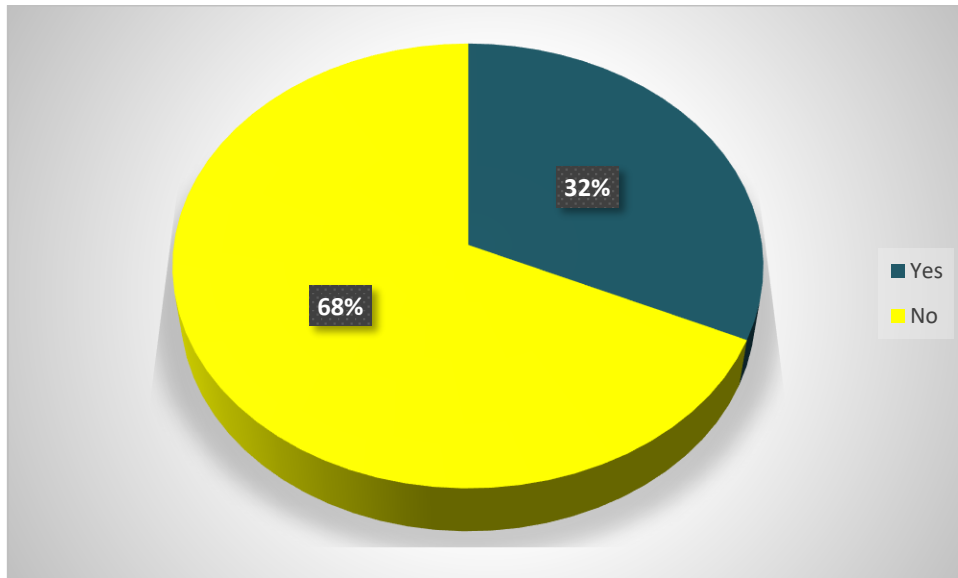
The findings showed that 449 (84.6%) of the respondents revealed that they did not have sexual intercourse for the first time because they were not raped/forced. while 81 (15.3%) of the respondents revealed that they had sexual intercourse for the first time because they were raped/forced. The summary of the descriptions given above is as shown in Figure 40.



**Figure 40: I was raped/forced to have sexual intercourse for the first time (n=531)**

#### **4.11.3.19      *I had sexual intercourse for the first time because culture expects me to have sex at my age***

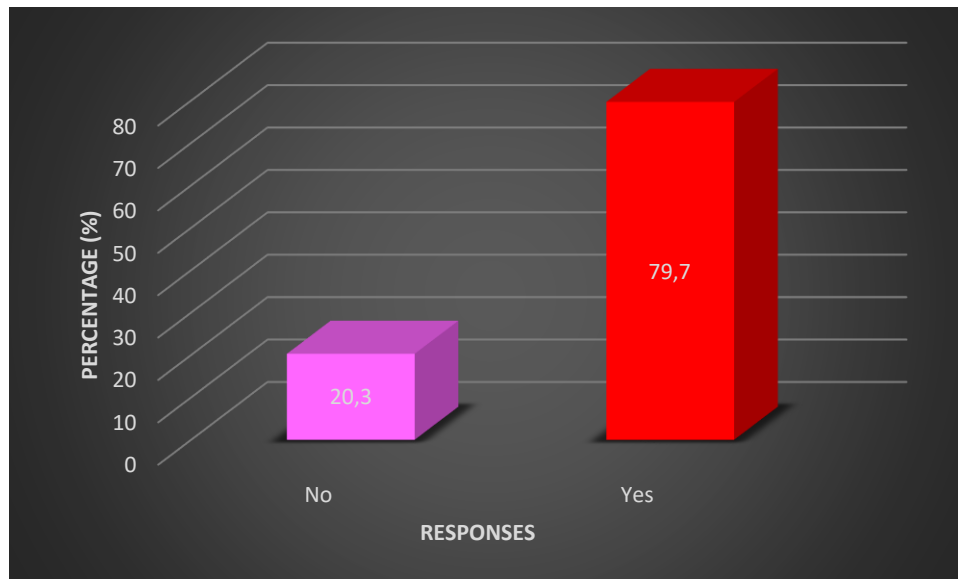
The findings showed that 362 (68.2%) of the respondents revealed that they are not having sexual intercourse for the first time because culture expects them not to have sex at their age while 169 (31%) of the respondents revealed that they had sexual intercourse for the first time because culture expects them to have sex at their age. The summary of the descriptions given above is as shown in Figure 41.



**Figure 41: Culture expect me to have sex at my age (n=531)**

#### **4.11.3.20      *I had sexual intercourse for the first time because I was under the influence of alcohol (drugs)***

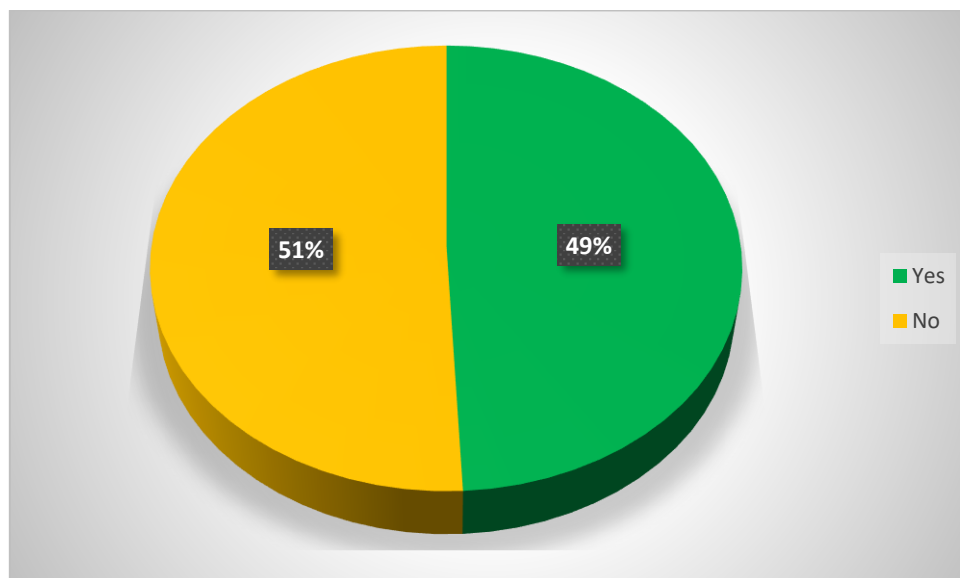
The findings showed that 423 (79.7%) of the respondents revealed that they had sexual intercourse for the first time because they were under the influence of alcohol (drugs) while 108 (20.3%) of the respondents revealed that they are not having sexual intercourse for the first time because they were not under the influence of alcohol (drugs). The summary of the descriptions given above is as shown in Figure 42.



**Figure 42: Had sexual intercourse for the first time because I was under the influence of alcohol (drugs) (n=531)**

#### **4.11.3.21 *I had sexual intercourse without a condom because it is more enjoyable***

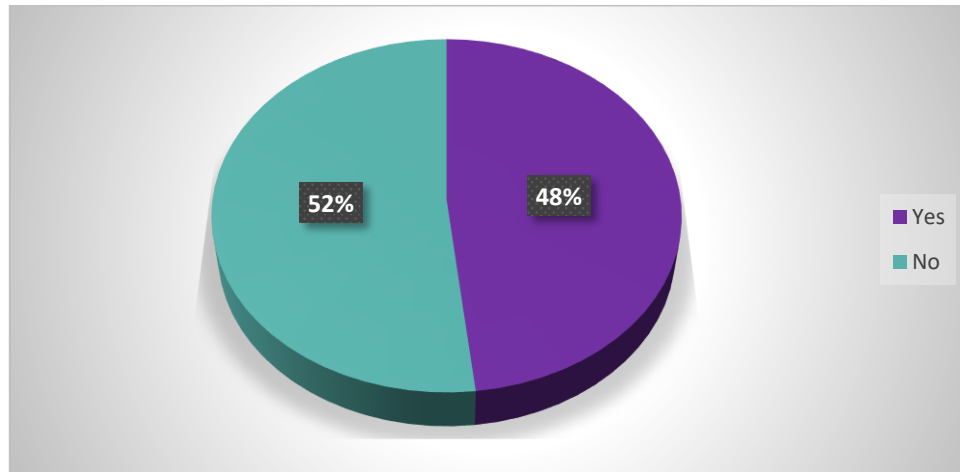
The findings showed that 270 (51%) of the respondents revealed that they are not having sexual intercourse without a condom because it is not enjoyable, while 261 (49%) of the respondents revealed that they had sexual intercourse without a condom because it is more enjoyable. The summary of the descriptions given above is as shown in Figure 43.



**Figure 43: I had sexual intercourse without a condom because it is more enjoyable**

#### **4.11.3.22      *I had sexual intercourse without a condom because I was encouraged to take a risk***

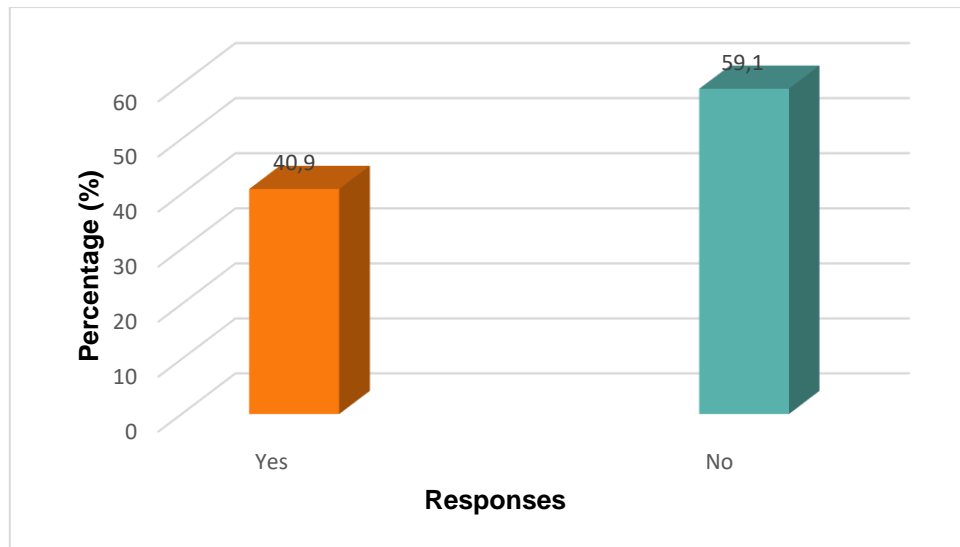
The findings showed that 275 (52%) of the respondents revealed that they had sexual intercourse without a condom because they were encouraged to take a risk while 256 (48%) of the respondents revealed that they are not having sexual intercourse without a condom because they were not encouraged to take a risk. The summary of the descriptions given above is as shown in Figure 44.



**Figure 44: I had sexual intercourse without a condom because I was encouraged to take a risk (n=531)**

#### **4.11.3.23      *I had sexual intercourse without a condom because I was discouraged by my partner***

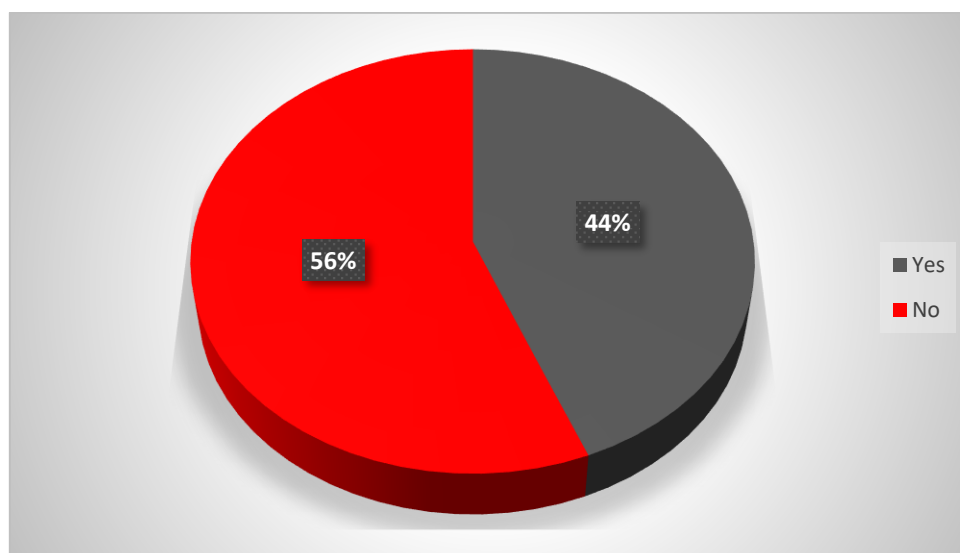
The findings showed that 314 (59.1%) of the respondents revealed that they are not having sexual intercourse without a condom because they were discouraged by their partner while 217 (40.9%) of the respondents revealed that they had sexual intercourse without a condom because they were not discouraged by their partner. The summary of the descriptions given above is as shown in Figure 45.



**Figure 45: I had sexual intercourse without a condom because I was discouraged by my partner (n=531)**

#### **4.11.3.24 *I had sexual intercourse without a condom because I need money to buy something***

The findings showed that 298 (56%) of the respondents revealed that they are not having sexual intercourse without a condom because they do not need money to buy something while 233 (44%) of the respondents revealed that they had sexual intercourse without a condom because they need money to buy something. The summary of the descriptions given above is as shown in Figure 46.



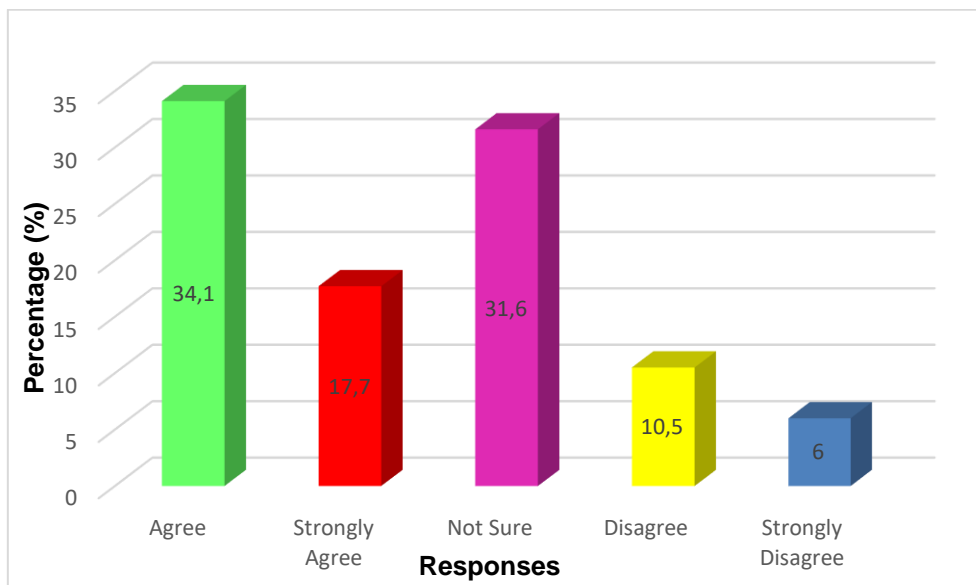
**Figure 46: I had sexual intercourse without condom because I need money to buy something (n=531)**

#### **4.11.4 Section D Health System to promote healthy sexual practices**

This section present attitude, actions and behaviour of health care professionals regarding the provision of contraceptives among youth.

##### **4.11.4.1 Health care staff do not respect patients during consultation**

The findings showed that 275 (51.8%) of the respondents agreed while 88 (16.5%) of the respondents disagree that health care staff do not respect patients during consultation. However, 168 (31.6%) of the respondents were not sure whether health care staff do not respect patients during consultation. Figure 47 shows the descriptive pattern above.

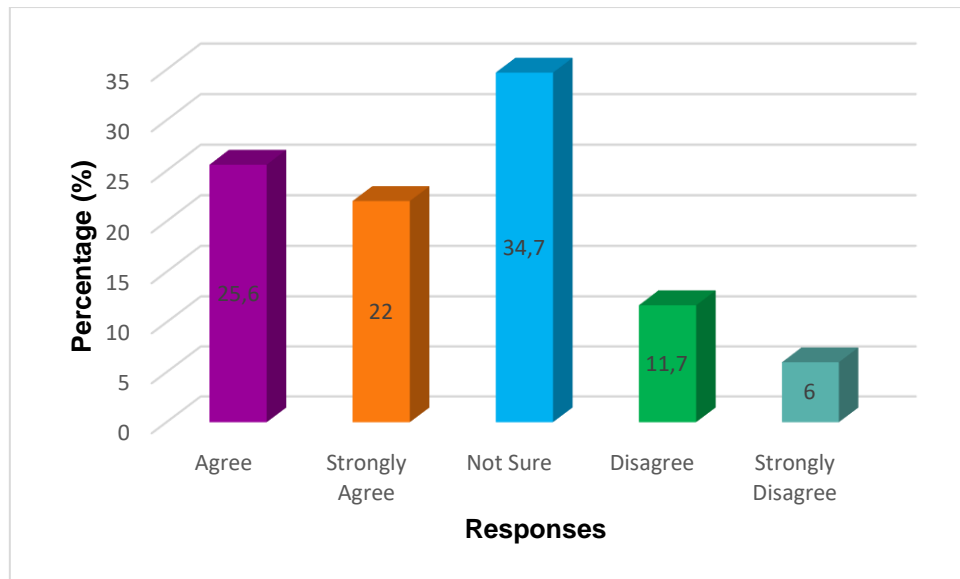


**Figure 47: Health care staff do not respect patients during consultation (n=531)**

##### **4.11.4.2 Health practitioners do not keep confidentiality of adolescent accessing health facility/ contraceptives**

The findings showed that 253 (47.6%) of the respondents agreed while 94 (17.7%) of the respondents disagreed that health practitioners do not keep confidentiality of adolescent accessing health facility/ contraceptives. However, 35 (10.3%) of the respondents were not sure whether health practitioners do not keep confidentiality of adolescent accessing health facility/ contraceptives. Figure 48 shows the descriptive pattern above.

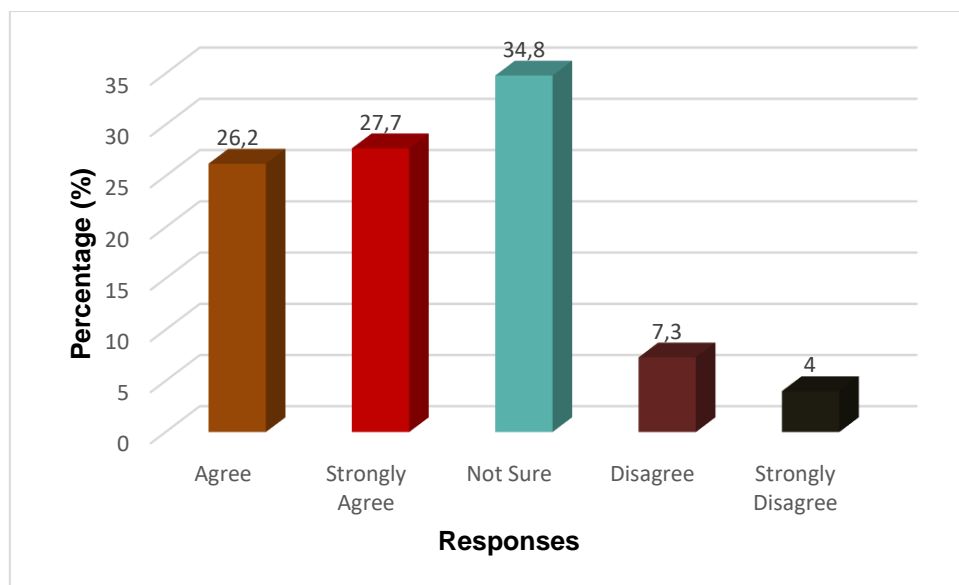




**Figure 48: Health practitioners do not keep confidentiality of adolescent accessing health facility/ contraceptives (n=531)**

#### ***4.11.4.3 Language barrier used to give instruction by health care staff associated with contraceptives***

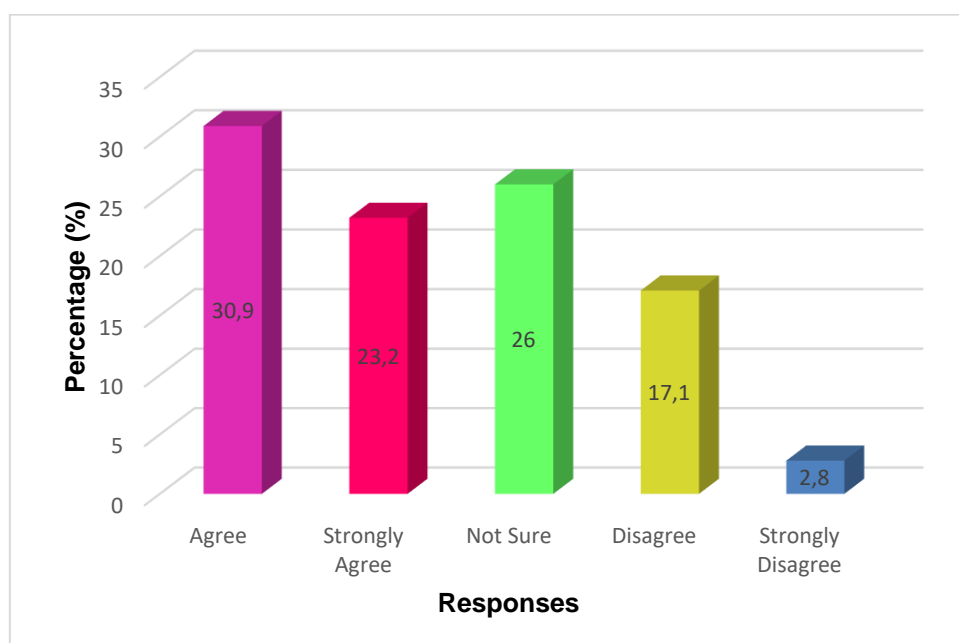
The findings showed that 286 (53.9%) of the respondents agreed while 60 (11.3%) of the respondents disagreed that language barrier used to give instruction by health care staff associated with contraceptives. However, 185 (34.8%) of the respondents were not sure whether language barrier was used to give instruction by health care staff associated with contraceptives. Figure 49 shows the descriptive pattern above.



**Figure 49: Language barrier used to give instruction by health care staff associated with contraceptives (n=531)**

#### ***4.11.4.4 Health care staff are swearing at me***

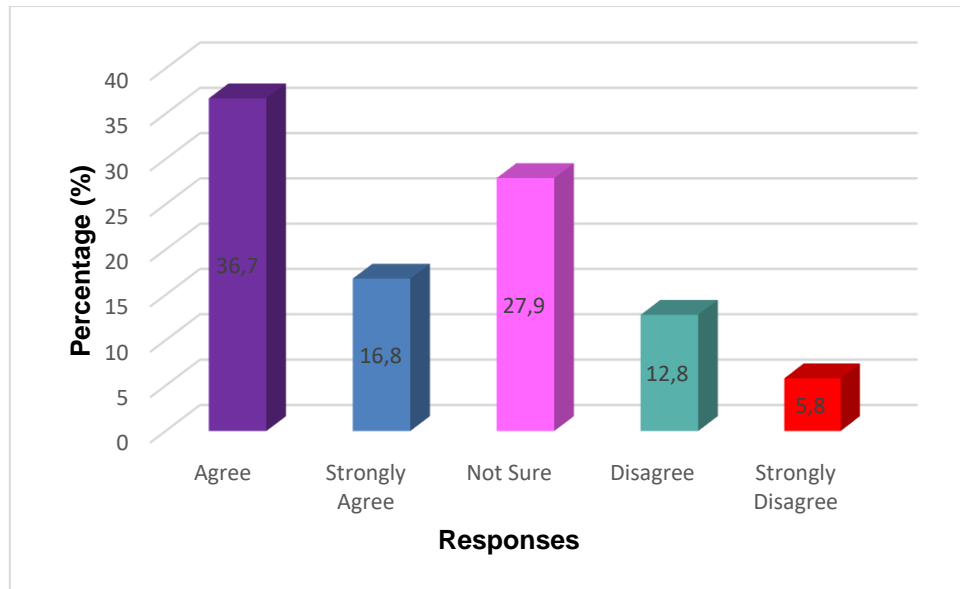
The findings showed that 287 (54.1%) of the respondents agreed while 106 (19.9%) of the respondents disagreed that health care staff are swearing at them. However, 138 (26.0%) of the respondents were not sure whether health care staff are swearing at them. Figure 50 shows the descriptive pattern above.



**Figure 50: Health care staff are swearing at them (n=531).**

#### ***4.11.4.5 Health care staff provide their relatives with contraceptives***

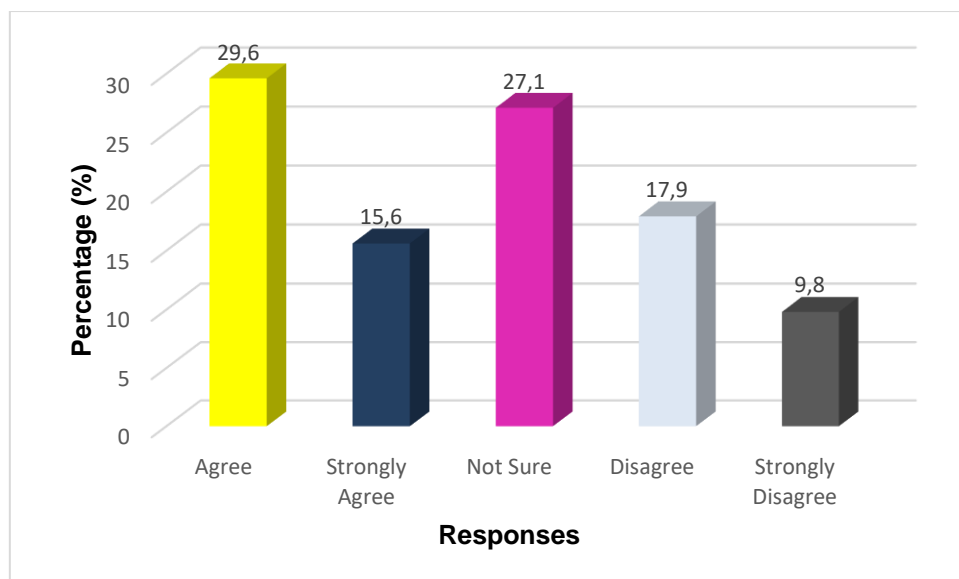
The findings showed that 284 (53.5%) of the respondents agreed while 107(31.4%) of the respondents disagreed that health care staff provide their relatives with contraceptives. However, 148 (27.9%) of the respondents were not sure whether health care staff provide their relatives with contraceptives. Figure 51 shows the descriptive pattern above.



**Figure 51: Health care staff provide their relatives with contraceptives (n=531)**

#### ***4.11.4.6 Health practitioners wanted consent from my parents to take contraceptives or family planning***

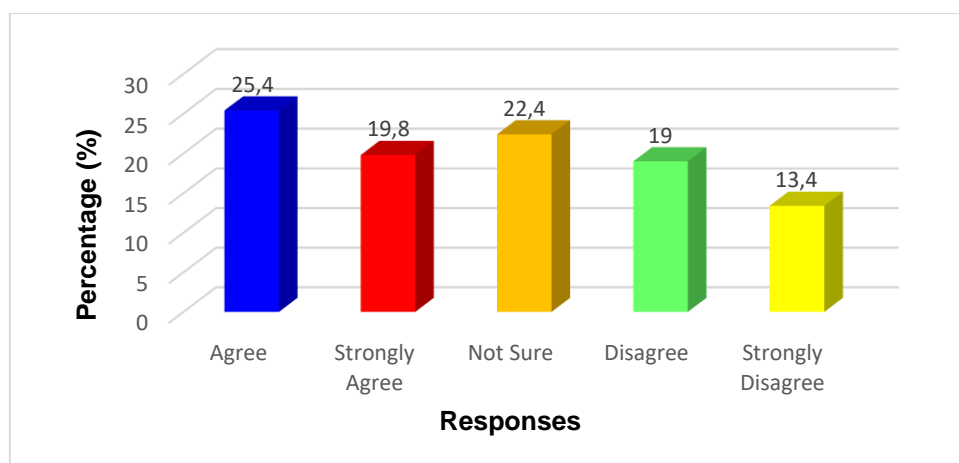
The findings showed that 240 (45.2%) of the respondents agreed while 144 (27.7%) of the respondents agreed that health practitioners wanted consent from their parents before they took contraceptives or family planning. However, 144 (27.1%) of the respondents were not sure whether health practitioners wanted consent from their parents to take contraceptives or family planning. Figure 52 shows the descriptive pattern above.



**Figure 52: Health practitioners wanted consent from my parents before taking contraceptives or family planning (n=531)**

#### ***4.11.4.7 Health practitioner informed my parent about the consultation I made regarding contraceptives***

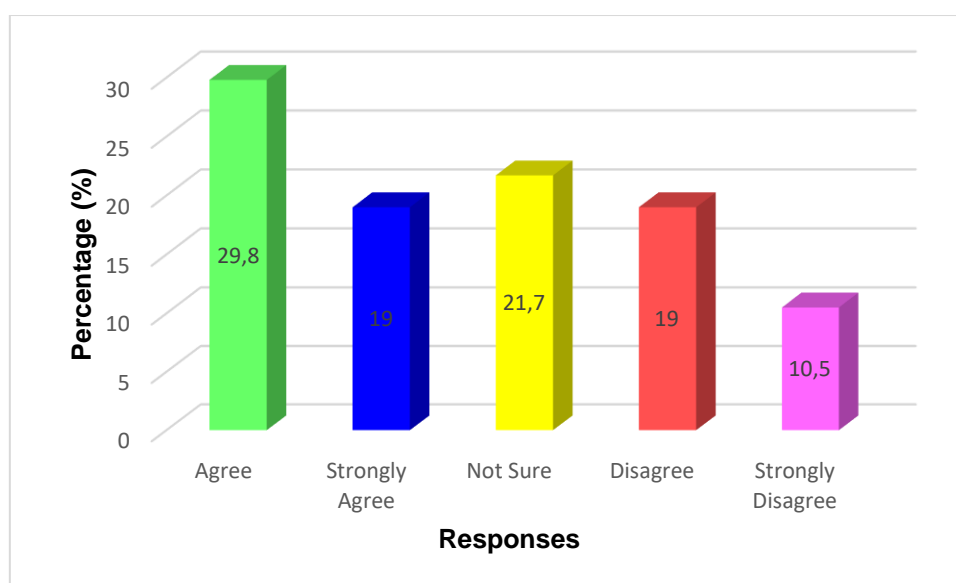
The findings showed that 240 (45.2%) of the respondents agreed while 172 (32.4%) of the respondents disagreed that the health practitioner informed their parent about the consultation they made regarding contraceptives. However, 119 (22.4%) of the respondents were not sure whether the health practitioner informed their parent about the consultation they made regarding contraceptives. Figure 53 shows the descriptive pattern above.



**Figure 53: Health practitioner informed their parent about the consultation they made regarding contraceptives (n=531)**

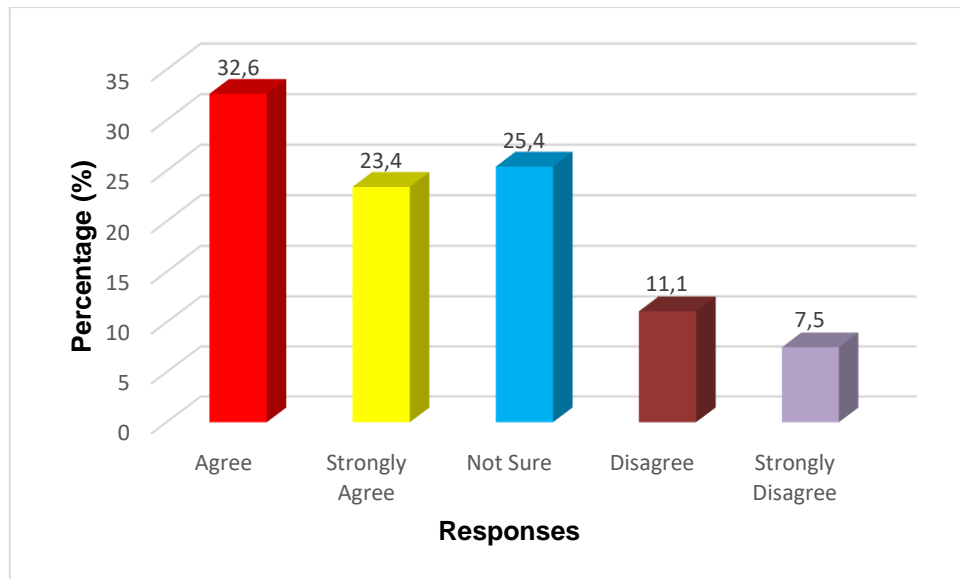
#### **4.11.4.8 Lack of contraceptives made me not visit health facility**

The findings showed that 259 (48.8%) of the respondents agreed while 157 (29.5%) of the respondents agreed that lack of contraceptives made them not visit the health facility. However, 115 (21.7%) of the respondents were not sure whether lack of contraceptives made them not visit the health facility. Figure 54 shows the descriptive pattern above.



#### **4.11.4.9 Figure 54: Lack of contraceptives made them not visit the health facility (n=531) The average waiting period at the public health facility is very long**

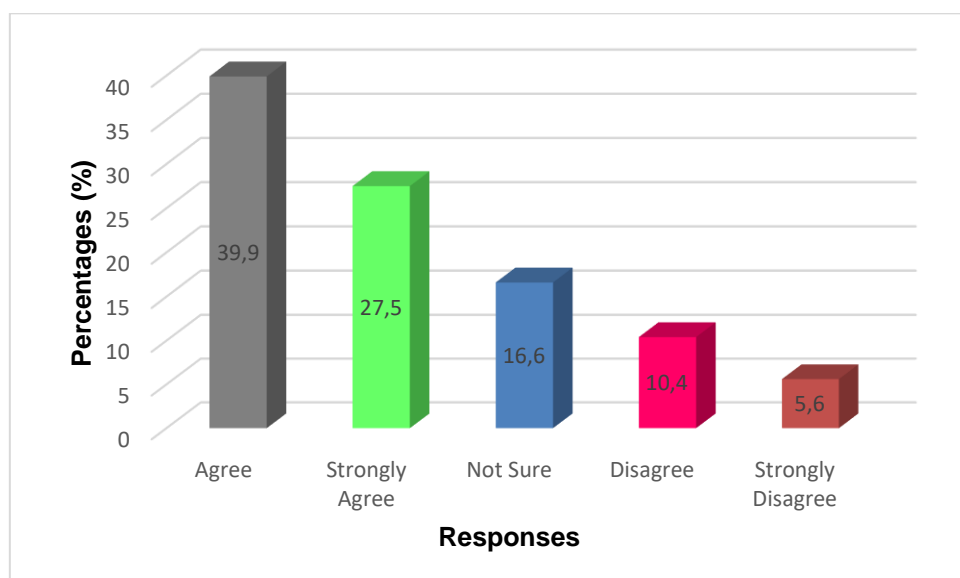
The findings showed that 297 (56%) of the respondents agreed, while 99 (18.6%) of the respondents disagreed that the average waiting period at the public health facility is very long. However, 135 (25.4%) of the respondents were not sure whether the average waiting period at the public health facility is very long. Figure 55 shows the descriptive pattern above.



**Figure 55: The average waiting period at the public health facility is very long (n=531)**

**4.11.4.10 *I feel more comfortable visiting a private health facility than a public health facility***

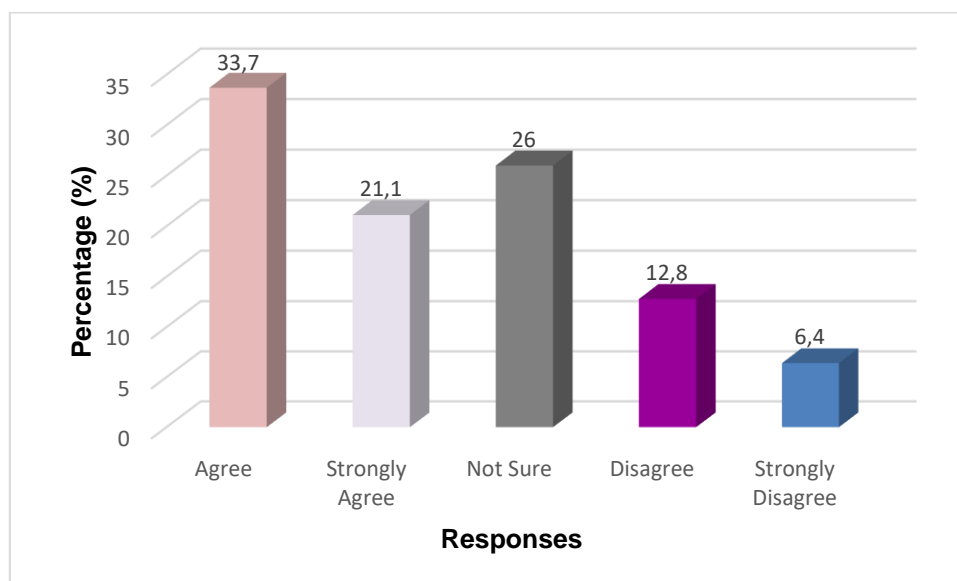
The findings showed that 358 (67.3%) of the respondents agreed while 85 (16%) of the respondents disagreed that they feel more comfortable visiting a private health facility than a public health facility. However, 88 (16.6%) of the respondents were not sure whether they feel more comfortable visiting a private health facility than a public health facility. Figure 56 shows the descriptive pattern above.



**Figure 56: They feel more comfortable visiting a private health facility than a public health facility (n=531)**

#### **4.11.4.11      *The queue to see a health worker at a public facility is often long and moves at a slow pace***

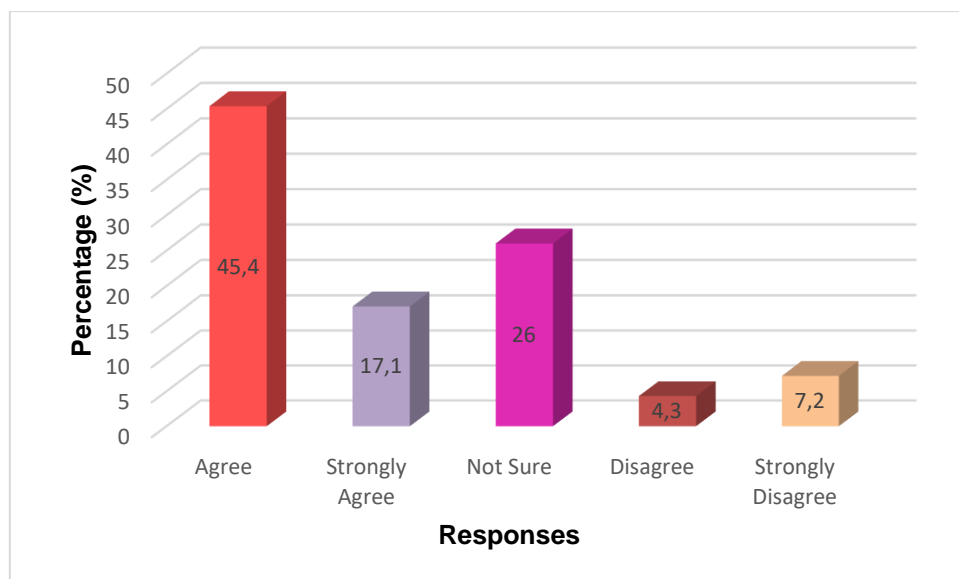
The findings showed that 291 (54.8%) of the respondents agreed while 102 (19.2%) of the respondents disagreed that the queue to see a health worker at a public facility is often long and moves at a slow pace. However, 138 (26.0%) of the respondents were not sure whether the queue to see a health worker at a public facility is often long and moves at a slow pace. Figure 57 shows the descriptive pattern above.



**Figure 57: The queue to see a health worker at public facility is often long and moves at slow pace (n=531)**

#### **4.11.4.12      *Health care should provide contraceptives education in the health facility***

The findings showed that 332 (62.5%) of the respondents agreed while 61 (11.5%) of the respondents disagreed that health care staff should provide contraceptives education in the health facility. However, 138 (26.0%) of the respondents were not sure whether health care staff should provide contraceptives education in the health facility. Figure 58 shows the descriptive pattern above.



**Figure 58: Health care should provide contraceptives education in the health facility (n=531)**

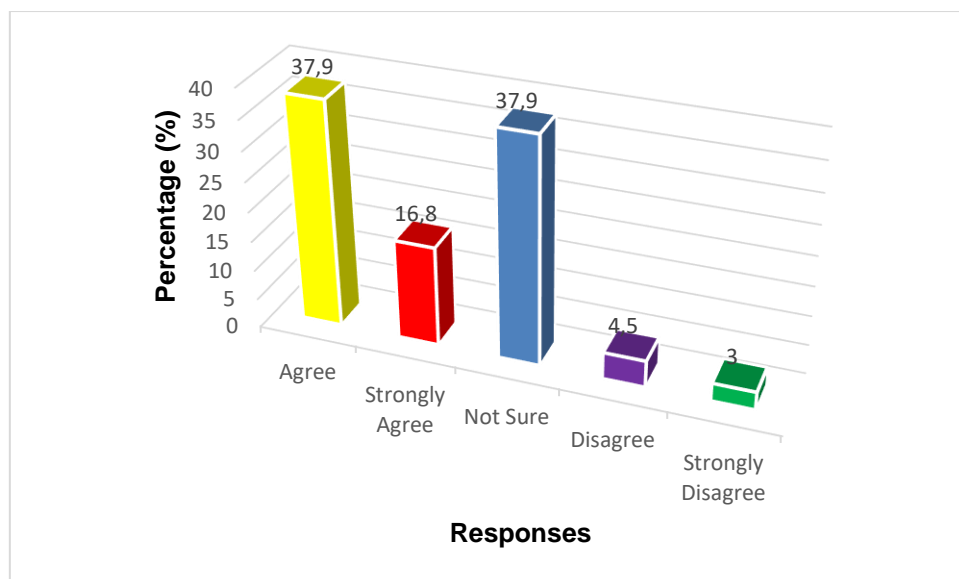
#### ***4.11.5 Section E: Measures to consider in increasing the use of contraceptives among the youth***

This section presents an increased provision strategies to dispense contraceptives among the youth in the primary health care facilities.

##### ***4.11.5.1 Informed choice of contraceptives***

The findings showed that 290 (53.7%) of the respondents agreed while 40 (7.5%) of the respondents disagreed that they were informed about the choice of contraceptives. However, 201 (37.9%) of the respondents were not sure whether they were informed about the choice of contraceptives. Figure 59 shows the descriptive pattern above.

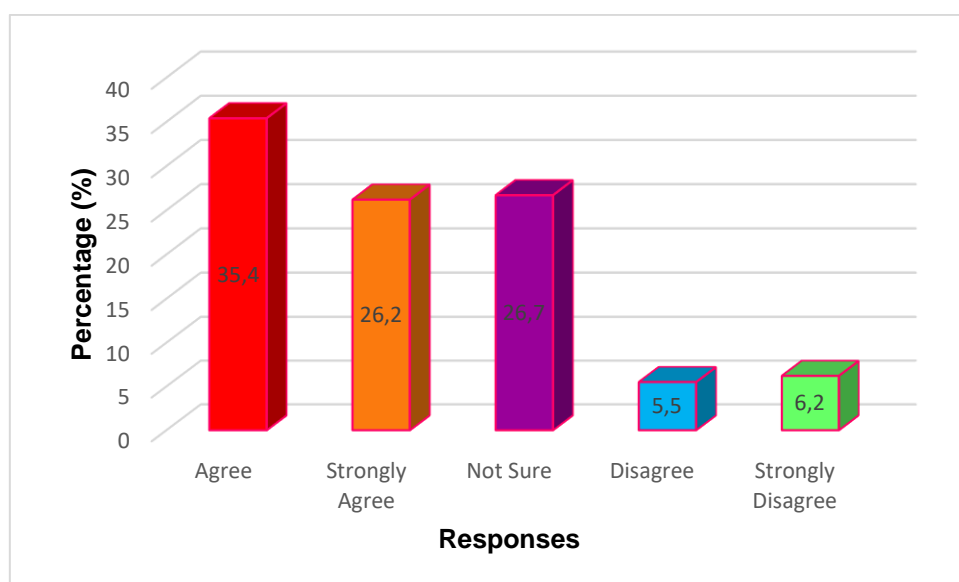




**Figure 59: Informed choice of contraceptives (n=531)**

#### ***4.11.5.2 Elements of quality of care is poor in health facilities***

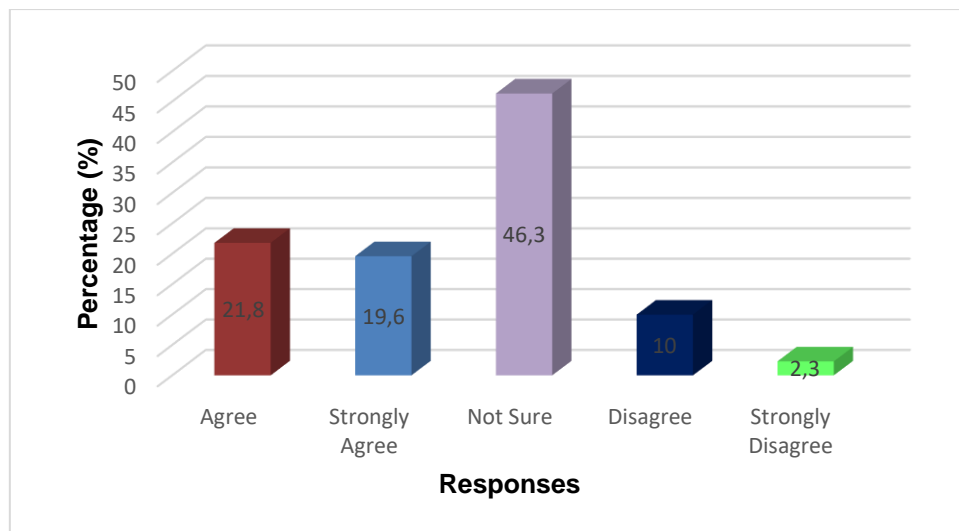
The findings showed that 327 (61.6%) of the respondents agreed while 62 (11.7%) of the respondents disagreed that the elements of quality of care is poor in public health facilities. However, 142 (26.7%) of the respondents were not sure whether the elements of quality of care is poor in public health facilities. Figure 60 shows the descriptive pattern above.



**Figure 60: Elements of quality of care is poor in public health facilities (n=531)**

#### ***4.11.5.3 Essential screening procedures for administering the contraceptive method in the primary health care facility***

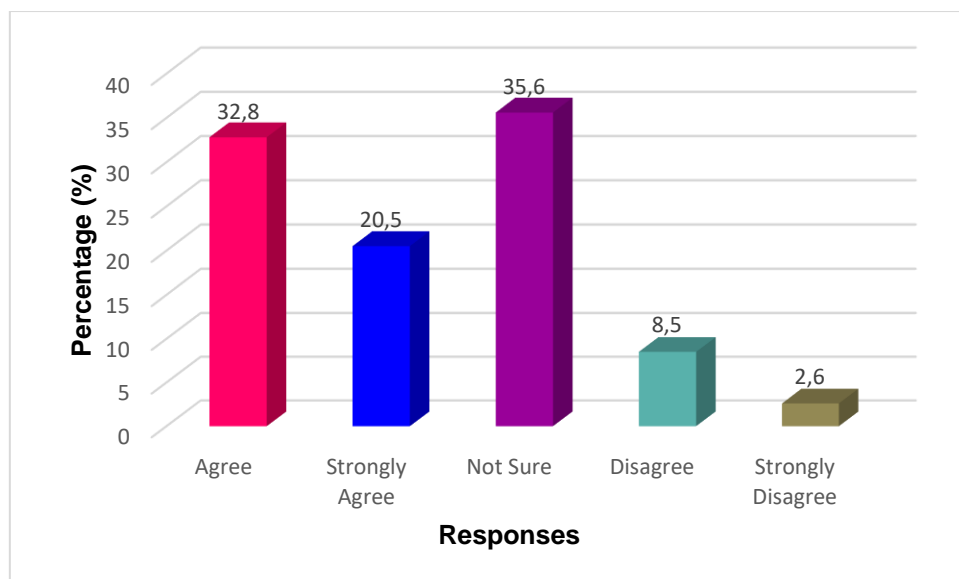
The findings showed that 246 (46.3%) of the respondents were not sure what the essential screening procedures were for administering the contraceptive method in the primary health care facility. However, 220 (41.4%) of the respondents disagreed while 65 (12.3%) of the respondents agreed that the essential screening procedures for administering the contraceptive method in the primary health care facility took place. Figure 61 shows the descriptive pattern above.



**Figure 61: Essential screening procedures for administering the contraceptive method in the primary health care facility (n=531)**

#### ***4.11.5.4 Health care referral and follow-up for contraceptive usage as appropriate***

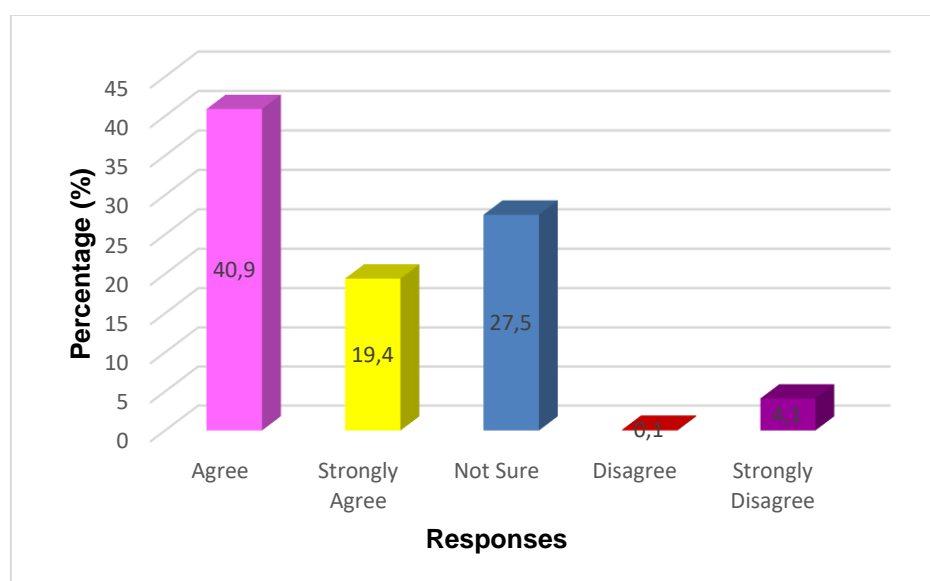
The findings showed that 283 (53.3%) of the respondents agreed while 59 (11.1%) of the respondents disagreed that health care referral and follow-up for contraceptive usage was appropriate. However, 189 (35.6%) of the respondents were not sure whether health care referral and follow-up for contraceptive usage was appropriate. Figure 62 shows the descriptive pattern above.



**Figure 62: Health care referral and follow-up for contraceptive usage as appropriate**

***4.11.5.5 Health care should ensure that adolescents visiting health facility for contraceptives must test for HIV/AIDS and pregnancy***

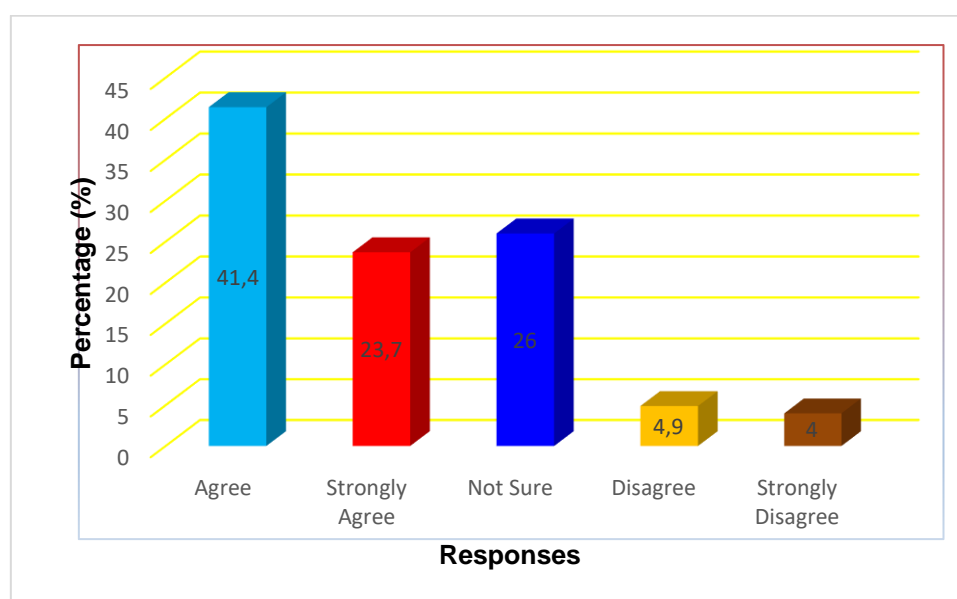
The findings showed that 320 (60.3%) of the respondents agreed while 65 (12.2%) of the respondents disagreed that the health care should ensure that adolescents visiting the health facility for contraceptives must test for HIV/AIDS and pregnancy. However, 146 (27.5%) of the respondents were not sure whether health care should ensure that adolescents visiting the health facility for contraceptives must test for HIV/AIDS and pregnancy. Figure 63 shows the descriptive pattern above.



**Figure 63: Health care should ensure that adolescents visiting health facility for contraceptives must test for HIV/AIDS and pregnancy (n=531)**

#### ***4.11.5.6 Health care should refer adolescents for counselling before taking contraceptives***

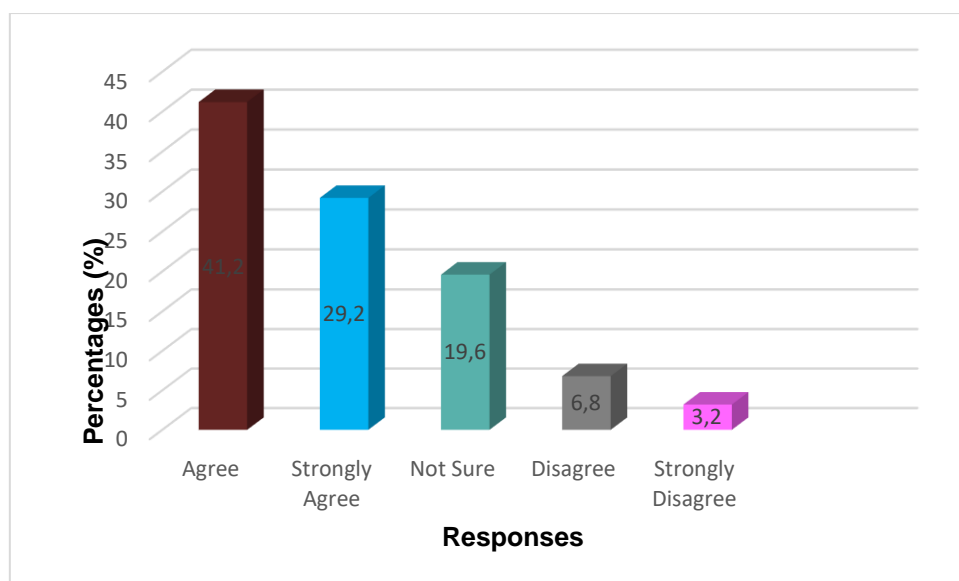
The findings showed that 346 (65.1%) of the respondents agreed while 47 (8.9%) of the respondents disagreed that health care should refer adolescents for counselling before taking contraceptives. However, 126 (23.7%) of the respondents were not sure whether the health care should refer adolescents for counselling before taking contraceptives. Figure 64 shows the descriptive pattern above.



**Figure 64: Health care should refer adolescents for counselling before taking contraceptives (n=531)**

#### ***4.11.5.7 The health care must use the language that I understand during my visit to the health facility***

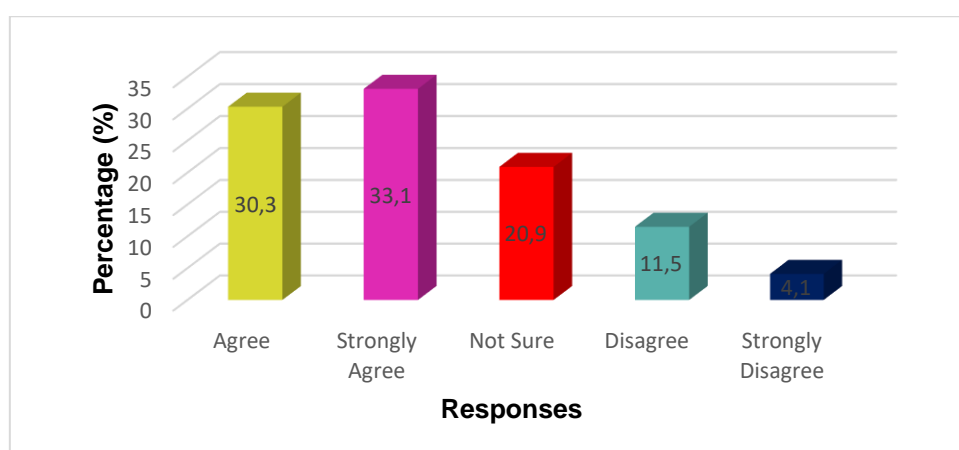
The findings showed that 374 (70.4%) of the respondents agreed while 53 (10%) of the respondents disagreed that health care staff must use the language that they understand during a visit in the health facility. However, 104 (19.6%) of the respondents were not sure whether health care staff must use the language that they understand during a visit in the health facility. Figure 65 shows the descriptive pattern above.



**Figure 65: Health care must use the language that I understand during my visit in the health facility (n=531)**

#### ***4.11.5.8 The health care must provide explanation on the use of contraceptive opted by adolescent using the local language of adolescent***

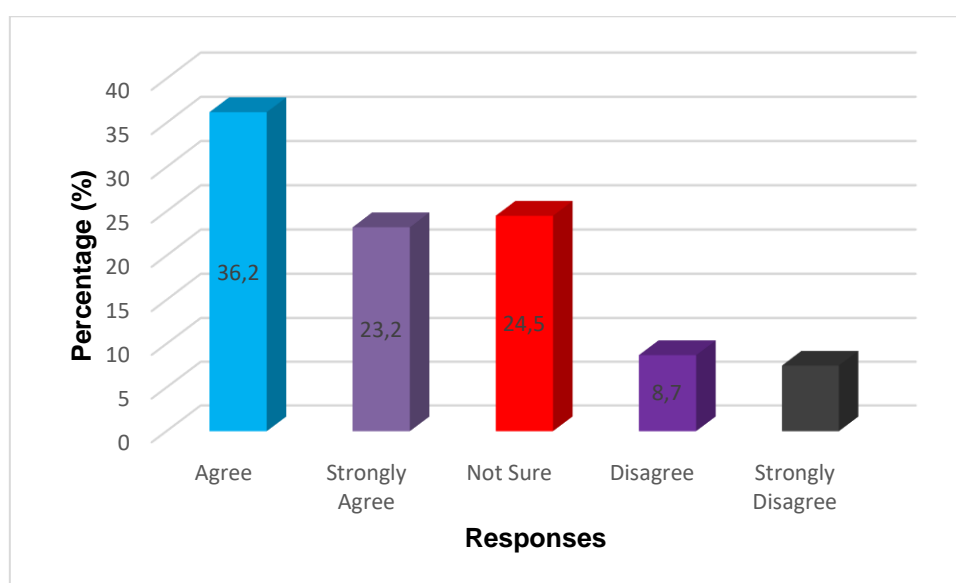
The findings showed that 337 (63.4%) of the respondents agreed while 83 (15.6%) of the respondents disagreed that the health care staff must provide explanations on the use of the contraceptive opted for by the adolescent using the local language of adolescents. However, 111 (20.9%) of the respondents were not sure whether the health care staff must provide an explanation on the use of contraceptives opted for by the adolescents using the local language of adolescents. Figure 66 shows the descriptive pattern above.



**Figure 66: The health care must provide explanation on the use of contraceptive opted by adolescent using the local language of adolescent (n=531)**

#### **4.11.5.9 Health care should explain the side effects of the contraceptive opted by adolescents**

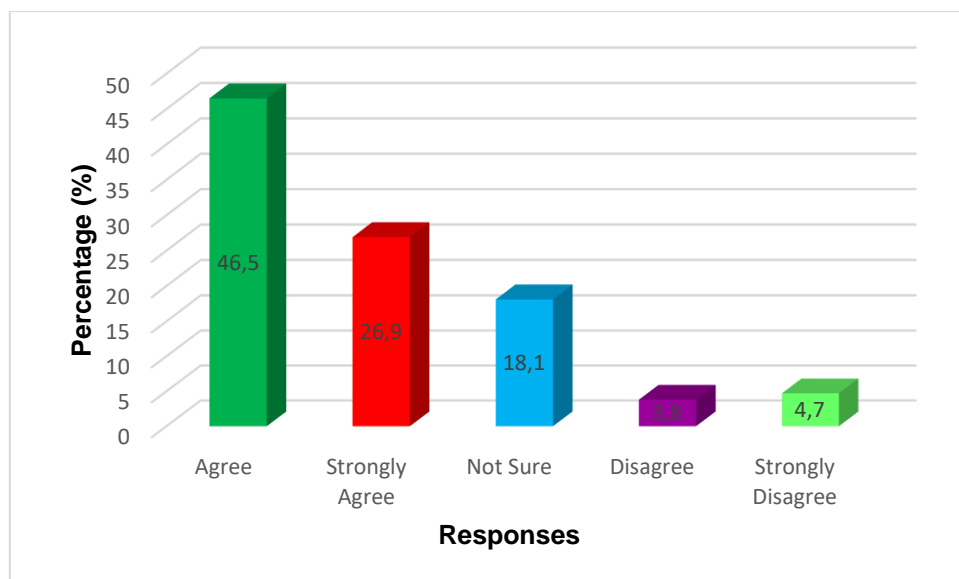
The findings showed that 315 (59.4%) of the respondents agreed while 86 (16.2%) of the respondents disagreed that the health care staff should explain the side effects of the contraceptive opted for by the adolescent. However, 130 (24.5%) of the respondents were not sure whether the health care staff should explain the side effects of the contraceptive opted for by the adolescent. Figure 67 shows the descriptive pattern above.



**Figure 67: Health care should explain the side effects of the contraceptive opted by adolescent (n=531)**

#### **4.11.5.10 Health cares should explain what to do in terms of missed dose of the contraceptive**

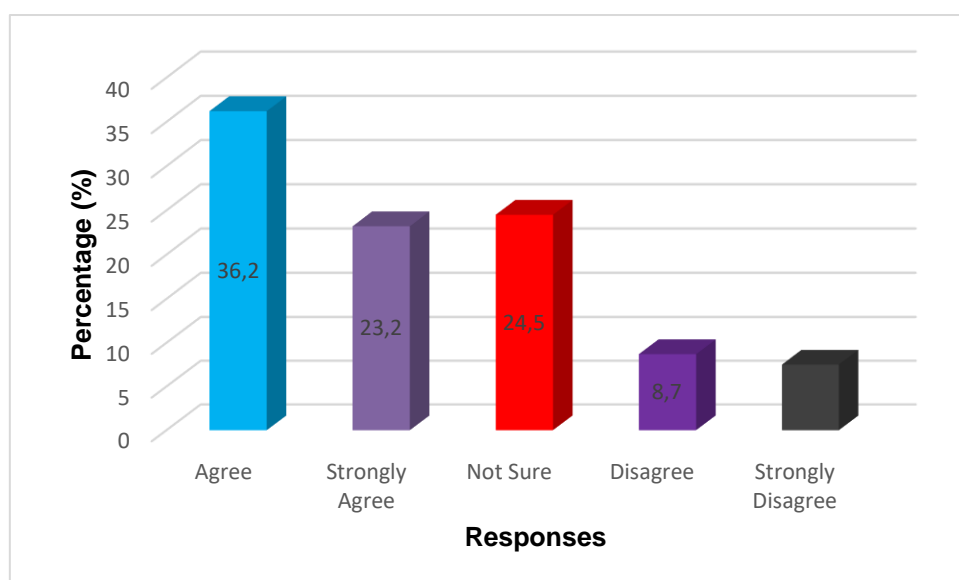
The findings showed that 390 (73.4%) of the respondents agreed while 45 (8.5%) of the respondents disagreed that the health care staff should explain what to do in terms of a missed dose of the contraceptive. However, 96 (18.1%) of the respondents were not sure whether the health care staff should explain what to do in terms of a missed dose of the contraceptive. Figure 68 shows the descriptive pattern above.



**Figure 68: Health care staff should explain what to do in terms of missed dose of the contraceptive (n=531)**

#### **4.11.5.11 Health care workers are rude when youth are consulting**

The findings showed that 315 (59.4%) of the respondents agreed while 86 (16.2%) of the respondents disagreed that the health care workers are rude when youth are consulting for contraceptives at the health facilities. However, 130 (24.5%) of the respondents were not sure whether the health care workers are rude when youth are consulting for contraceptives at the health facilities. Figure 69 shows the descriptive pattern above.



**Figure 69: Health care workers are rude when youth are consulting for contraceptives in the health facilities (n=531)**

#### **4.11.6 Association between study variables**

Cross tabulation in the study was used in order to establish associations between some of the variables. This involved the application of the Chi-square/Pearson Exact Test of Associations. In this study, a 5% level ( $p=0.05$ ) of significance was used as the scale for stating whether an association was statistically significant or not.

##### **4.11.6.1 Association between demographic information and choice of contraceptives**

Table 15 shows the association between demographic information and the choice of contraceptive with the sexual partner. A cross-tabulation was performed on a pair of variables (for instance, association between age group and the choice of contraceptive with the sexual partner). From the table, the Pearson Chi-square test of independence indicated that there was statistically a significant difference in the age group and do you discuss the choice of contraceptive with your sexual partner  $\chi^2 (2), (n=531) = 11.223^a, p=0.004^*$ . It, therefore, indicates that age groups were linked with the respondents in the choice of contraceptive with the sexual partner. Therefore, 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 (for instance, association between gender and the choice of contraceptive with the sexual partner) was done. From the table, the Pearson Chi-square Test of Independence indicated that there were statistically significant differences between gender and the choice of contraceptive with the sexual partner,  $\chi^2 (1), (n=531) = 2.901^a, p=0.089$ . This indicates that gender was linked to the choice of contraceptive with the sexual partner. Therefore, the alternative hypothesis is accepted which stated that there is statistically a difference between gender and the choice of contraceptive with the sexual partner.

A cross-tabulation of a pair of variables (for instance, association between school grade and the choice of contraceptive with the sexual partner). From the table, the Pearson Chi-square Test of Independence indicated that there were statistically significant differences between the school grade and the choice of contraceptive with the sexual partner,  $\chi^2 (4), (n=531) = 28.259^a, p=0.001^*$ . This indicates that school grades were linked to the choice of contraceptive with the sexual partner. Therefore, the null hypothesis was rejected which stated that there is no statistical difference between school grades and the choice of contraceptive with the sexual partner.

A cross-tabulation was made of the association between religion and the choice of contraceptive with the sexual partner. From the table, the Pearson Chi-square test of



independence indicated that there was no statistically significant difference in religion and the choice of contraceptive with the sexual partner,  $\chi^2 (4), (n=531) = 0.783^a, p=0.864$ . This indicates there is a association between respondents' religion and the choice of contraceptive with the sexual partner. Therefore, the alternative hypothesis is accepted which stated that there is a statistical difference between religion and the choice of contraceptive with the sexual partner.

**Table 15: The association between the demographic information and ignoring the use of contraceptives (n=531)**

Demographic information item		Yes	No	Total	Pearson Chi-square	D F	Asymptotic significance (2-Sided)
Demographic information*Choice of contraceptives							
Age	10_15	23	64	87	11.223 <sup>a</sup>	2	0.004*
	16_20	18	21	39			
	21_25	22	29	51			
	<b>Total</b>	<b>226</b>	<b>305</b>	<b>531</b>			
Gender	Male	98	110	208	2.901 <sup>a</sup>	1	0.089
	Female	128	195	323			
	<b>Total</b>	<b>226</b>	<b>305</b>	<b>531</b>			
School Grade	Grade 8	39	85	124	28.259 <sup>a</sup>	4	0.001*
	Grade 9	18	26	44			
	Grade 10	37	78	115			
	Grade 11	85	58	143			
	Grade 12	47	58	105			
	<b>Total</b>	<b>226</b>	<b>305</b>	<b>531</b>			
Religion	Christianity	198	260	458	0.738 <sup>a</sup>	3	0.864
	Traditional	16	24	40			
	Islam	2	4	6			

	Other religion	10	17	27			
<b>Total</b>		<b>226</b>	<b>305</b>	<b>531</b>			

#### **4.11.6.2 Association between the age group and health care providers wanted consent from their parent to take contraceptives**

Table 16 shows the association between age group and health care providers who wanted consent from their parents to take contraceptives. A cross-tabulation was performed on a pair of variables (for instance, association between age group and health care providers wanted consent from their parent to take contraceptives). From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the age group and health care providers who wanted consent from their parent to take contraceptives.  $\chi^2$  (8), (n=531) =24.602<sup>a</sup>,  $p=0.001^*$ . It therefore, indicates that age groups were linked with the respondents' health care providers who wanted consent from their parent to take contraceptives. Therefore, the null hypothesis was rejected, which stated that there is no statistical difference between age groups and health care providers who wanted consent from their parent to take contraceptives.

**Table 16: The association between the age group and health care providers who wanted consent from their parent to take contraceptives (N=531)**

Item	Agree	Strongly Agree	Not Sure	Disagree	Strongly Disagree	Total	Pearson Chi-square	Df	Asymptotic (2-Sided)
<b>Health care providers wanted consent from my parent to take contraceptives</b>									
A G E	10 _1 5	33	7	34	11	2	24,602a	8	<b>0.002*</b>
	16 _2 0	112	67	91	77	46			
	21 _2 5	12	9	19	7	4			
<b>Total</b>	<b>157</b>	<b>83</b>	<b>144</b>	<b>95</b>	<b>52</b>	<b>531</b>			

#### **4.11.6.3 Association between the age group and lack of contraceptives made them not visit health facility**

Table 17 shows the association between age group and lack of contraceptives that made them not visit the health facility. A cross-tabulation was performed on a pair of variables (for

instance, association between age group and lack of contraceptives made them not to visit health facility). From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the age group and lack of contraceptives that made them not to visit health facility.  $\chi^2 (8), (n=531) = 45.783^a, p=0.001^*$ . It, therefore, indicates that age groups were linked with the respondents' lack of contraceptives that made them not visit health facility. Therefore, the null hypothesis was rejected, which stated that there is no statistical difference between age groups and lack of contraceptives that made them not visit the health facility.

**Table 17: The association between the age group and lack of contraceptives made them not visit health facility (N=531)**

**4.11.6.4 Association between there is a need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy**

Item		Agree	Strongly Agree	Not Sure	Disagree	Strongly Disagree	Total	Pearson Chi-square	Df	Asymptotic (2-Sided)
<b>lack of contraceptives made me not to visit health facility</b>										
AGE	10_15	27	2	26	28	4	87	45.783a	8	0.001*
	16_20	123	91	72	59	48	393			
	21_25	8	8	17	14	4	51			
<b>Total</b>		<b>158</b>	<b>101</b>	<b>115</b>	<b>101</b>	<b>56</b>	<b>531</b>			

Table 18 shows the association between there is a need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy. A cross-tabulation was performed on a pair of variables (for instance, association between there is a need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy. From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the question there is a need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy.  $\chi^2 (8), (n=531) = 24.602^a, p=0.001^*$ . It, therefore, indicates that there is a need for more information on contraceptive methods and their use was linked with the respondents' parental education support to help prevent STIs, HIV/AIDS and pregnancy. Therefore, the null hypothesis was rejected, which stated that there is no statistical difference between there is a need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy.

**Table 18: Association between the need for more information on contraceptive methods and their use and parental education support to help prevent STIs, HIV/AIDS and pregnancy (N=531)**

Item	Yes	No	Total	Pearson-Chi-square	Df	Asymptotic (2-sided)
<b>parental education support help prevent STI's, HIV/AIDS and pregnancy</b>						
Need for more information on contraceptives methods and their uses	Yes	346	73	419	9.189a	1
	No	78	34	112		
Total	424	107	531			

#### **4.11.6.5 Association between the choice of contraceptive with their partner and health care staff do not respect patients during consultation**

Table 19 shows the association between choice of contraceptive with their partner and the health care staff do not respect patients during consultation. A cross-tabulation was performed on a pair of variables (for instance, association between the choice of contraceptive with their partner and health care staff do not respect patients during consultation). From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the choice of contraceptive with their partner and health care staff do not respect patients during consultation.  $\chi^2 (8), (n=531) = 24.602^a, p=0.001^*$ . It, therefore, indicates that choice of contraceptive with their partner was linked with the respondents that health care staff do not respect patients during consultation, the null hypothesis was rejected, which stated that there is no statistical difference between the choice of contraceptive with their partner and the health care staff do not respect patients during consultation.

**Table 19: The association between the choice of contraceptive with their partner and health care staff do not respect patients during consultation (N=531)**

Item	Agree	Strongly Agree	Not Sure	Disagree	Strongly Disagree	Total	Pearson Chi-square	Df	Asymptotic (2-Sided)
<b>Health care staff do not respect patient</b>									
Choice of contraceptives with your sexual partner	Yes	107	28	58	16	17	226	38,949a	4

	N o	74	66	110	46	12	3 0 5			
Total		18 1	94	168	56	32	5 3 1			

#### ***4.11.6.6 Association between the choice of contraceptive with their partner and language barrier used to give instruction by health care staff associated with contraceptives***

Table 20 shows the association between the choice of contraceptive with their partner and the language barrier used to give instruction by health care staff associated with contraceptives. A cross-tabulation was performed on a pair of variables (for instance, association the choice of contraceptive with their partner and the language barrier used to give instruction by health care staff associated with contraceptives. From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the choice of contraceptive with their partner and the language barrier used to give instruction by health care staff associated with contraceptives.  $\chi^2 (8), (n=531) = 24.602^a, p=0.001^*$ . It, therefore, indicates that the choice of contraceptive with their partner was linked with the respondents that there was a language barrier used to give instruction by health care staff associated with contraceptives. Therefore, the null hypothesis was rejected, which stated that there is no statistical difference between the choice of contraceptive with their partner and the language barrier used to give instruction by health care staff associated with contraceptives.

**Table 20: The association between the choice of contraceptive with their partner and the language barrier used to give instruction by health care staff associated with contraceptives (N=531)**

Item		Agree	Strongly Agree	Not Sure	Disagree	Strongly Disagree	Total	Pearson Chi-square	df	Asymptotic (2-Sided)
language barriers use to give instruction by health care associated to with contraceptives										
Choice of contraceptives with your sexual partner	Yes	76	71	47	24	8	226	38.515a	4	<b>0.001*</b>
	No	63	76	138	15	13	305			
Total		139	147	186	39	21	531			

#### ***4.11.6.7 Association between the choice of contraceptive with their partner and health care are swearing at them***

Table 21 shows the association between the choice of contraceptive with their partner and health care are swearing at them. A cross-tabulation was performed on a pair of variables (for instance, association between the choice of contraceptive with their partner and health care are swearing at them). From the table, the Pearson Chi-square test of independence indicated that there was a statistically significant difference in the choice of contraceptive with their partner and health care are swearing at them.  $\chi^2(8), (n=531) = 24.602^a, p=0.001^*$ . It, therefore, indicates that the choice of contraceptive with their partner were linked with the respondents health care are swearing at them. Therefore, the null hypothesis was rejected, which stated that there is no statistical difference between the choice of contraceptive with their partner and health care are swearing at them.

**Table 21: The choice of contraceptive with their partner and health care are swearing at them (N=531)**

Item		Agree	Strongly Agree	Not Sure	Disagree	Strongly Disagree	Total	Pearson Chi-square	df	Asymptotic (2-Sided)
Health care staff swearing at me										
Choice of contraceptives with your sexual partner	Yes	90	63	33	32	8	226	36,328a	4	0.002*
	No	74	60	105	59	7	305			
Total		164	123	138	91	15	531			

## 4.12 Merging of qualitative and quantitative findings

In this study, a convergent parallel mixed method was employed where there is a merging of study results obtained from both Stage 1 qualitative and stage 2 quantitative approaches. In this study, the design allows the merging of results from both qualitative and quantitative data and is accomplished to convey a stronger understanding.

Therefore, the most important of the merging was completed using a comparison technique where qualitative and quantitative outcome were merged together to determine the degree which the two data affirmed, were contrary, or expanded. In this study, a mixed method was used to combine and present the integration or the merging of study outcomes within a single study (Maree, 2016).

Mostly, the main purpose of the visual merged method was to represent the integration of the study results or outcome. It thus, enabled readers to follow the study with ease. The display presents both the convergent and divergent findings. The following are the description of merged data for the identified degree from the two sets of results that converge, diverge, and are associated with each other.

### ***4.12.1 The findings reveal the lack of knowledge of learners about STIs, HIV/AIDS and pregnancy***

The findings of the theme lack of knowledge of learners about STIs, HIV/AIDS and pregnancy were supported by 55% of the respondents, indicating that there is a need for more information

on contraceptive methods and their uses, while 3.8% of the respondents indicated that family is their source of information.

#### ***4.12.2 The findings' view and perceptions of learners, teachers and SGB regarding the promotion of healthy sexual practices was supported by the following sub-themes***

The findings that suggest teachers should discuss risky sexual behaviour in life orientation was supported by 3.75% of the respondents, and indicated that teachers are their source of information regarding healthy sexual practices.

The findings of sexual harassment by educators in school was supported by 1.7% of the respondents indicated that the 'sugar daddy' is their source of information regarding healthy sexual practices, while 44% of the respondents indicated that they agree to have unprotected sexual intercourse because they were in need of money to buy something.

The findings on substance abuse by learners was supported by 20.3% of the respondents that they were under the influence of alcohol and drugs when they had unprotected sex for the first time while 44% of the respondents indicated that they have sexual intercourse without a condom because they were in need of money to buy something they really liked.

The findings about the risk of forced sexual activity by sexual partners and older people was supported by 15.3% of the respondent who indicated that they had sexual intercourse for the first time because they were forced/raped while 29% of the respondents indicated that they had sexual intercourse for the first time because their boyfriend/girlfriend persuaded them.

The findings about the early initiation of sexual intercourse were supported by 36% of the respondents and indicated that they were encouraged by their friends to have sexual intercourse for the first time. They also indicated that 28.2% had sexual intercourse for the first time because they wanted to be pregnant/ to be impregnated.

The findings concerning peer influence, curiosity and experimentation were supported by 44.8% of the respondents who indicated that they had sexual intercourse because they wanted to experiment out of curiosity, while 52% of the respondents indicated that they had sexual intercourse without a condom because they were encouraged to take a risk. Furthermore, 38.8% of respondents indicated that they had unprotected sexual intercourse to make themselves feel like a real man/woman.

The additional findings about the peer influence on the sexual behaviour act such as kissing, hugging, improper wearing of uniform (seducing educators) and curiosity and experiences by learners at the school premises was supported by 53% of respondents, who indicated that



they have sexual intercourse to make themselves feel very good while 49% of the respondents indicated they have sexual intercourse for the first time because they wanted to experiment (curiosity).

***4.12.3 Theme 3: Culture, beliefs, norms and values regarding the promotion of healthy sexual practices was supported by the following sub-themes***

The findings that early marriage (arranged marriage) and forced marriage was supported by 31% of the respondents, indicated that cultures expect them to have sex at their age.

The findings that the cultural environment, belief norms and values regarding healthy sexual practices was supported by 31% of the respondents and indicated that culture expect them to have sex at their age, 52.7% of the respondents indicated that they are in favour of a workshop about contraceptives for women and men together, 54.8% of the respondents indicated that teaching religious and moral values to adolescents help to prevent STIs, HIV/AIDS and pregnancy, 83.8% of the respondents indicated that abstaining from sexual activities will help to prevent STIs, HIV/AIDS and Pregnancy while 75.5% of respondents indicated that introduction to and teaching sex education help to prevent STIs, HIV/AIDS and pregnancy.

The findings that culture promotes the preservation of virginity until marriage was supported by 54.8% of the respondents, and indicated that teaching religious and moral values to adolescents help to prevent STIs, HIV/AIDS and pregnancy, 79.8% of the respondents indicated that parental education support help prevent STIs, HIV/AIDS and pregnancy, while 83.8% of the respondents indicated that abstaining from sexual activities will help to prevent STIs, HIV/AIDS and pregnancy.

***4.12.4 Theme 4: The roles of teachers and SGB in promoting healthy sexual practices was supported by the following sub-themes***

The findings to conscientise learners about healthy sexual practices was supported by 75.5% of respondents, and indicated that an introduction and teaching sex education help to prevent STIs, HIV/AIDS and pregnancy; 53.7% of the respondents indicated the informed choice of contraceptives/ choice of contraceptive was discussed with their sexual partner, 55.5% of the respondents indicated that their sexual partner liked using contraceptives, 55% of the respondents indicated that there is a need for more information on contraceptive methods and their uses while 52% of the respondents indicated that they comply with the instruction on the usage of that contraceptive method. 80.6% of the respondents indicated that STIs, HIV/AIDS and pregnancy could be prevented by supplying a contraceptives programme at

clinics and school, 83.2% indicated that programmes linked to contraceptive services e.g. in life orientation, help prevent STIs, HIV/AIDS and pregnancy, while 79.8% of the respondents indicated that parental education support help prevent STIs, HIV/AIDS and pregnancy, while 71.0% of the respondents indicated that social support and parenting help prevent STIs, HIV/AIDS and pregnancy. 55% of the respondents indicated that there is a need for more information on contraceptive methods and their uses, 83.8% of the respondents indicated that abstaining from sexual activities will help to prevent STIs, HIV/AIDS and pregnancy, 22.5% of the respondents indicated that they obtain abstinence education from health care facilities and workers while 62.5% of respondents indicated that the health care staff should provide contraceptives education in the health facility.

#### ***4.12.5 Theme 5: Challenge regarding the promotion of healthy sexual practices was supported by the following sub-themes***

The findings of violation of the POPIA act at healthcare facilities was supported by 54.1% of respondents who indicated that health care workers swear at them, 51% of respondents indicated that the health care staff do not respect patients during consultation, 45.2% of respondents indicated that health practitioners wanted consent from their parent to take contraceptives or family planning, 45.2% of respondents indicated that health practitioner informed their parent about the consultation they made regarding contraceptives while 47.6% of respondents indicated that health practitioner do not keep the confidentiality of adolescents accessing health facility/ contraceptives.

The findings that contraceptives are not 100% safe was supported by 48.8% of respondents indicated that lack of contraceptives made them reluctant to visit health facility. The following contraceptives were indicated to be not 100% safe by respondents 3.7% Pills, 2.4% Injectable, 0.7% Implants, 0.37% Intra-uterine Contraceptive Device (IUD), 3.71% Natural method, 0.3% Female sterilisation, 0.7% Male sterilisation, 1.7% Emergency Contraceptives, 3.90% Standard days method, 0.50% Combined hormonal contraceptives, 1.7% Progestogen- only contraceptives, while 56.7% felt that condoms are not 100% safe anyway.

The findings concerning the challenges on the provision of contraceptives and side effects by health care nurses were merged with contraceptives stock-out, clinic located far away from villages, long waiting period, queues move slowly at the clinic and were supported by 52% of the respondents, who indicated that they comply with the instruction on the usage of that contraceptive method, 53.5% of respondents indicated that there was the language barrier used to give instruction by health care associated with contraceptives, 48.8% of respondents indicated that lack of contraceptives made them not to visit health facility, 56% of respondents

indicated that the average waiting period at the public health facility is very long, 54.8% of respondents indicated that the queue to see a health worker at a public facility is often long and moves at a slow pace, 59.4% of respondents indicated that health care staff should explain the side effects of the contraceptive opted for by the adolescent, while 73.4% of respondents indicated that health care staff should explain what to do in terms of missed dose of the contraceptive.

The findings around poverty influences, lack of parental, family and social support programmes was supported by 44% of respondents and indicated that they needed money for school or to buy something they really liked, made them agree/accept to have unsafe/unprotected, 29.4% of respondents indicated that they were offered money for unsafe/unprotected (skin to skin sex), while 29% of respondents indicated that their boyfriend/girlfriend persuaded them.

The findings about sexual behaviour amongst learners was not supported by any variables from the statistical analysis. The findings concerning insufficient resources to teach learners were not supported by any variables from the statistical analysis. The findings about lack of awareness campaigns at school was not supported by any variables from the statistical analysis.

#### ***4.12.6 Theme 6: Strategies regarding the promotion of healthy sexual practices was supported by the following sub-themes***

The findings about the family system support was supported by 44% of respondents who indicated that they needed money for school or to buy something they really liked, made them agree/accept having unsafe/unprotected, 29.4% of respondents indicated that they were offered money for unsafe/unprotected (skin to skin sex), 79.8% of the respondents indicated that parental education support help prevent STIs, HIV/AIDS and pregnancy, while 71.0% of the respondents indicated that social support and parenting help prevent STIs, HIV/AIDS and pregnancy. 54.8% of the respondents indicated that teaching religious and moral values to adolescents help to prevent STIs, HIV/AIDS and pregnancy. 3.8% of respondents indicated that family is their source of information, while 79.8% of the respondents indicated that parental education support help prevent STIs, HIV/AIDS and pregnancy.

The findings of the education system support were supported by 36% of the respondents and indicated that they were encouraged to have sexual intercourse for the first time by their friends while 31% of the respondents indicated that they had sexual intercourse for the first time because their culture expect them to have sexual intercourse at a young age. 79.8% of the respondents indicated that parental education support helped prevent STIs, HIV/AIDS and

pregnancy while 71.0% of the respondents indicated that social support and parenting help prevent STIs, HIV/AIDS and Pregnancy. 40% of the respondents indicated that they had sex for the first time because the partner is faithful and will not cheat on them while 43,5% indicated that they had sex for the first time because their partner refused to use condoms and they did not want to use them. Furthermore, 43,9% of the respondents indicated that they had unprotected sexual intercourse because there was no condom available at the time, they had sex and sex was not planned. 83.2% indicated that programmes linked to contraceptive services e.g., in life orientation, help prevent STIs, HIV/AIDS and pregnancy, while respondents indicated their source of information regarding provision of healthy sexual practices, 3.75% school (Life orientation Teachers), 3.8% family, 2.1% church and 22.5% health care facilities/workers. 0.3% of respondents indicated that they use natural methods as their contraceptive methods. 53.7% of the respondents indicated the informed choice of contraceptives/ choice of contraceptive with their sexual partner while 62.5% of respondents indicated that the health care should provide contraceptives education in the health facility. 17.9% of the respondents revealed that they abstain as methods of contraception while 83.8% of the respondents indicated that abstaining from sexual activities will help to prevent STIs, HIV/AIDS and pregnancy. 52.7% of the respondents indicated that they favour a workshop about contraceptives for women and men together. 53.7% of the respondents indicated the informed choice of contraceptives/ choice of contraceptive with their sexual partner, 55.5% of the respondents indicated that their sexual partner like using contraceptives, 55% of the respondents indicated that there is a need for more information on contraceptive methods and their uses while 52% of the respondents indicated that they comply with the instruction on the usage of that contraceptive method.

The findings concerning the health system support was supported by 53.3% of the respondents who indicated that the use of health care referral and follow-up for contraceptive usage as appropriate, 46.3% of the respondents indicated that the essential screening procedures for administering the contraceptive method were used, 65.1% of the respondents indicated that the health care staff should refer adolescents for counselling before taking contraceptives, 60.3% of respondents indicated that health care staff should ensure that adolescents who visited the health facility for contraceptives must be checked for HIV/AIDS and pregnancy, while 63.4% of the respondents indicated that health care staff must provide an explanation on the use of the contraceptive opted for by adolescents using the local language of the adolescent. 80.6% of the respondents indicated that STIs, HIV/AIDS and pregnancy could be prevented by supplying a contraceptives programme at clinics and school, 83.2% indicated that programmes linked to contraceptive services e.g. in life orientation, help prevent STIs, HIV/AIDS and pregnancy, while respondents indicated their source of

information regarding provision of healthy sexual practices, 3.75% school (Life orientation teachers), 3.8% family, 2.1 % church and 22.5% health care facilities/workers.

The findings of NGO, NPO and other stakeholders' system support was supported by 80.6% of the respondents who indicated that STIs, HIV/AIDS and pregnancy could be prevented by supplying contraceptives programmes at clinics and schools. 62.5% of respondents indicated that the health care staff should provide contraceptives education in the health facility. 1.9% of the respondents indicated that peer educators are their source of healthy sexual practices information. 80.6% of the respondents indicated that STIs, HIV/AIDS and pregnancy could be prevented by supplying contraceptives programmes at clinics and schools.

#### **4.13 Diverge data**

Sub-themes that diverge with variables in the statistical analysis, vice versa.

The findings about school based auxiliary social workers was not supported by any variables from the statistical analysis. The findings about the misconception regarding healthy sexual practices such as STIs, HIV/AIDS and pregnancy had no variables from the statistical analysis. The findings about primary school, healthy sexual practices programme should be included was not supported by any variables from the statistical analysis. The findings about school educators' support were not supported by any variables from the statistical analysis. The findings about an experienced motivational speaker to share experiences on the exposure to teenage pregnancy, STIs and HIV was not supported by any variables from the statistical analysis. The findings about community/ neighbourhood support were not supported by any variables from the statistical analysis. The findings about the narratives that healthy sexual practices education should be taught to learners was not supported by any variables from the statistical analysis. The findings about auxiliary-based social workers needed in schools was not supported by any variables from the statistical analysis. The findings about establishment of sexual education structures at school was not supported by any variables from the statistical analysis. The findings about rewards for preserving virginity was not supported by any variables from the statistical analysis. The findings about an organisation to provide awareness programmes about the promotion of healthy sexual practices was not supported by any variables from the statistical analysis. The findings about sexual education at initiation schools was not supported by any variables from the statistical analysis.

The following variables tested statistically was not supported by themes and sub-themes: having unsafe/unprotected (skin to skin) sex currently; satisfying their own sexual needs better: a long and steady relationship, so there is no need for condoms; their partner refuses to use a condom and they do not want to lose her/him; they were discouraged from using

condoms/contraceptives; they feel more comfortable visiting a private health facility than a public health facility; health care staff provide their relatives with contraceptives; elements of quality of care and the health care staff must use the language that I understand during my visit in the health facility. Sources of information that were not supported by themes and sub-themes include social media, boyfriend, girl friend, internet, sugar mama and radio/newspaper/television/posters.

#### **4.14 Conclusion**

This chapter presented the results of the data analysis and interpretation, with the use of frequencies tables, pie and bar charts, as well as themes and sub-themes. It appears that most of the respondents have knowledge regarding contraceptives. It appears that participants are faced with challenges regarding the promotion of healthy sexual practices. Further, the cultural environment, beliefs, norms, and values regarding the promotion of healthy sexual practices had been identified as the gap between learners, teachers, and parents (SGB). Most of the respondents do not have children while a minority of the respondents have children. The statistical tests across different variables were performed to test the association among variables or to test whether there was a link between the variables. The chi-square tests were used to compare categorical variables and the statistical significance level, which were  $p < 0.05$ . The discussion presented above showed the significance of variables that were associated with healthy sexual practices, while other variables were not significantly associated with unplanned pregnancy. In addition, the variables were compared to determine whether there was an association between respondents' ages and other variables. These variables were compared using chi-square tests to determine the association among variables regarding the promotion of healthy sexual practices. Also, the merging and diverging data, as well as field notes reports was discussed.

## **Chapter 5: Discussion of merged findings**

### **5.1 Introduction**

The findings presented narratively in this chapter are the results of merging the qualitative and quantitative findings. The findings demonstrated some comparisons in the themes, constructs, and some differences. The discussion in this section focuses on similar findings from both the qualitative and quantitative results. The results are discussed in line with the themes that merged with the qualitative findings and were statistically supported or differed from the quantitative findings.

### **5.2 Lack of Knowledge to learners about STIs, HIV/AIDS and pregnancy**

For the purpose of this study, *knowledge* refers to the awareness of the youth regarding STIs, HIV/AIDS, and pregnancy. This is categorised into lack of knowledge, knowledge about the accessibility and affordability of contraceptives, knowledge of teenagers about contraceptives, and types of contraceptives.

The findings of the theme revealed a lack of knowledge among learners about STIs, HIV/AIDS, and pregnancy. The concurrent findings revealed that most of the youth do not have information about STIs, HIV/AIDS, pregnancy, or contraceptives (Mahlangu, Nzaumvila, Ramochele-Ngwenya & Mabuza, 2021). Contrary findings alluded to the fact that if this knowledge could be passed to them, the problem of STIs, HIV/AIDS, and pregnancy would be reduced because they would be aware of the different methods of contraception (Kgarose, Mashiane & Machaka, 2023). Similar findings were reported by Chauke (2019), who found that 26% of youth acquire sexual education. In this study, information from the health facilities was associated with the reduction of STIs, HIV/AIDS, and pregnancy cases. On the contrary, some revealed that they were concerned that the information they received from their family, school, and church might be misunderstood information that could cause the problems of STIs, HIV/AIDS, and pregnancy (Rice, 2018).

A study by Kgarose et al. (2023) found that for those who received information from the media, the problem with these messages is that they are brief and usually do not expand more on pertinent issues surrounding healthy sexual practices. Similar views revealed that there is also a lack of interaction with populations and communities, so if youth fail to understand what has been said, they do not have the opportunity to ask questions. This will lead to them using contraceptives incorrectly and inconsistently, resulting in STIs, HIV/AIDS infections, and pregnancy.

Khosa (2019) concurred with the findings that 88% of youth receive information about healthy sexual practices from the radio, while 30% of these youth receive information from television programmes. These findings were supported by Neal, Channon, Chandra-Mouli, and Madise (2020), who reveal the importance of television advertisements run by healthcare workers because they would receive queries and questions on air, but seeing that media is expensive, this platform cannot be sustained. The media is also cited in Ramathuba, Khoza, and Netshikweta (2012) as the preferred means of information for youth.

Chola, Hlongwana, and Ginindza (2020) view this by saying that most of the youth derive different information on family planning and contraceptive use from different people, especially their peers, rather than health professionals, which is inadequate and could lead them to be infected with STIs and HIV/AIDS, as well as to conceive unplanned pregnancies.

In this study, the use of any type of contraceptive was significantly associated with the reduction of STIs, HIV/AIDS, and unplanned pregnancy. These contrary findings were revealed by Alukagberie, Elmusharaf, Ibrahim, and Poix (2023), who stated that though the use of contraceptives among youth was found to have a positive effect, only a small proportion of them were using modern methods, and their supply, quality, and availability was low. Hence, community health workers are given condoms to distribute throughout the community.

Further, it was reported that access to contraceptive services is very important because when they are lacking, the risks of unplanned pregnancy, STIs, and HIV/AIDS infections increase (Neal et al., 2020). Additionally, the findings coincide with the study that found that the responses here varied because the distance could be a barrier, as some respondents live far from the health facilities that are in place, so they could not obtain healthy sexual practices services from the health facilities. The findings further indicated that most youth lack information on the use of contraceptives. Many health facilities do not offer education on healthy sexual practices to the youth who visit them. If the knowledge could be passed to them, then the problems of STIs, HIV/AIDS, and pregnancy would be lowered (Ahinkorah, Kang, Perry, Brooks & Hayen, 2021).

In this study, compliance with instructions on the use of contraceptive methods was not significantly associated with STIs, HIV/AIDS, or pregnancy. These findings support individual preferences on the method of contraception according to their choice (Alukagberie et al., 2023). Similar study findings indicate that most of the respondents thought condoms, pills, and injections were the best because they required little knowledge of how to use them. Ahinkorah et al. (2021) state the contrary finding that the natural method and condom use could be the



best alternative because others like pills, injections, IUCD, and implants are more complicated and need much supervision, and they may have negative results like irregular menstrual flow when using injections and weight loss or weight gain, especially when using pills and other methods.

In this study, abstaining from sexual intercourse could help prevent STIs, HIV/AIDS, and pregnancy. Similar study findings reported by Ajayi, Ushie, Mwoka, Igonya, Ouedraogo, Juma, and Aboderin (2019) stated that abstinence from sexual intercourse is the only form of STI prevention, HIV/AIDS prevention, and pregnancy prevention that is almost 100 percent effective. A study conducted in Ghana by Phiri, Kasonde, Moyo, Sikaluzwe, and Simona (2023) argues that every method of contraception has a risk of failure, however small, but a youth who practices abstinence will not become pregnant or infected by STIs, HIV/AIDS, or pregnancy.

Therefore, ignoring the use of contraceptives is associated with the burden of STIs, HIV/AIDS, and pregnancy. The result shows similar findings by Amoadu, Ansah, Assopiah, Acquah, Ansah, Berchie, Hagan, and Amoah (2022), who reported that the majority of female youth do not use any contraceptives and can easily be infected with HIV and AIDS and other related diseases. Mezmur, Assefa, and Alemayehu (2021) argued that female learners who are sexually active are more likely to use no contraceptives, which puts them at a high risk of unplanned pregnancy. Some are influenced by their boyfriends regarding birth control, or they forget to use contraceptives. Achiaa (2023), in a study conducted in Ghana, found that ignorance also leads to myths such as the belief that the use of contraceptives may cause infertility and will make them gain too much weight.

### **5.3 Views and perceptions of learners, teachers, and SGB regarding the promotion of healthy sexual practices**

The findings reveal the views and perceptions of learners, teachers and SGB regarding the promotion of healthy sexual practices. Fasakin (2017) contended that the annual outcome survey of schools in South Africa found that almost fifteen thousand learners fell pregnant during the academic year. Similar findings were conveyed that the increased proportion of pregnancies at schools has become a main social challenge not only for the DoE but also significant for national development (Mukwevho, Maputle & Ramathuba, 2023). In addition, Fasakin (2017) reported contrary reasons for participating in illegal abortion, such as humiliation, financial resources, fear of parents, punishment, and limitations to reproductive health and advice. Contrary findings revealed punishment as a conduct of violence or sexual

coercion that young boys act against young girls to have unprotected sexual intercourse (Worku, Tessema, Teshale, Tesema, & Yeshaw, 2021).

The HRSC (2016) supported the findings by attesting that youth between the ages of 15 and 24 are living with HIV, which constitutes 7.1%. Galappaththi-Arachchige, Zulu, and Kleppa (2018) supported the idea that youth is characterised by sexuality and risky behaviours; these behaviours become a main concern for parents, schools, healthcare professionals, and researchers. It was revealed that the number of youth involved in risky sexual behaviour rises every day, exposing more of them to the risks of sexually transmitted diseases and unplanned pregnancies (Mathewos & Mekuria, 2017). Yogi and Neupane (2018) suggest that influencing factors, such as peers, the media, and the environment could be due in part to misconceptions about sexual intercourse, as well as parental attitudes and insufficient information about healthy sexual practices. Mabasa (2018) reveals that risky behaviours in which youth are involved, such as alcohol intake, drug use, smoking, dating violence, and even other emerging addictions, such as gaming and the Internet, jointly contribute to early sexual intercourse among young age groups.

The findings reveal teachers should disclose sexually risky behaviour as any conduct that increases the possibility of negative consequences linked with sexual interaction, such as STIs, HIV/AIDS, and termination of an unplanned pregnancy, whether illegal or legal (WHO, 2018). Furthermore, similar findings reveal that these behaviours also include issues like having multiple sexual partners, having risky casual or unfamiliar sexual partners, initiating early sexual intercourse, and failing to have sexual intercourse discussions prior to intercourse. WHO (2018) affirms the failure to take responsible action related to sexual activities, such as the use of condoms and birth control (WHO, 2018).

Similar findings reveal that the risky sexual behaviours that youth engage in can lead to STIs, HIV/AIDS, and unplanned health challenges. According to the 2015 Youth Risk Behavior Survey in the USA, 41% of high school learners reported that they had sex, while 30% had sex three months earlier before the survey, and 43% had not worn a condom the last time they had sex (Nang-bayi, Wie, Siepaal, Kuufira, & Der, 2021). The CDC (2016) reported contrary findings, which state that 21% of sexual intercourse learners were under the influence of alcohol and drugs before their last sexual intercourse, while only 10% of sexually active learners tested positive for HIV.

The coinciding youth behaviours are influenced by the following elements, including individual, peer, family, school, community, and societal levels (Yakubu, Garmaroudi, Sadeghi,

Yekaninejad, & Yidana, 2019). The contrary findings reveal efforts by the Social Welfare Department to teach the youth about health, safety, and well-being. There is a basic need for a collaborative effort that engages multiple partners, such as the DoE, DSD, and DOH, as well as the Department of Sport, Art, and Culture (DSAC). These combined efforts can also help in the promotion, accessibility, availability, and affordability of a more comprehensive approach to addressing youth's healthy sexual practices (Fasakin, 2017).

Youths are confronted with healthy sexual practices and risks stemming from unsafe or unplanned sexual intercourse. A study conducted by Kassa, Arowojolu, and Odukogbe (2019) concurred that the key underlying risk factors include a lack of accessibility, availability, affordability, and proper, healthy sexual practices. WHO (2018) asserted that, in the absence of intensive investigative support, the development of evidence-based interventions to improve healthy sexual practices globally, it was revealed that youth must wait until past the age of maturity to engage in sex or sexual activities. However, a study conducted by Maharaj and Haffejee (2021) confirmed that about half of high school learners stated that they had had sexual interaction. Ahinkorah et al. (2019) reveal the prediction related to the links: three in ten influential young girls will become pregnant at an early age and before turning 20 years old.

In accordance with the findings revealed by a study conducted in Spain, 4,653 young boys and 4,687 young girls with a mean age of 15 years indicated that 38.7% of learners had sexual relationships at least once, indicating that 82.3% of young boys and 63.0% of young girls interact in sexual risk behaviours (Cunha-Oliveira, Camarneiro, Gómez-Cantarino, Cipriano-Crespo, Queirós, Cardoso, Santos, & Ugarte-Gurrutxaga, 2021). Similar findings reported that the incidence of sexual interactions and risk behaviours was mostly elevated in boys compared to girls (Mejia, Estares, Rondon, Beltran, Sulca, Hilario, Cochachi, & Huamanchumo, 2021). Mejia et al. (2021) attested that young boys were statistically significant with a P-value of 0.001, that they have more than one sexual partner, and that they used condoms as a contraceptive technique. In comparison to young girls, it was similar, with a P-value less than 0.05.

The study conducted in Canada and the United States (US) revealed that youth between the ages of 15 and 19 had sexual intercourse at least once (Ewunetie et al., 2022). In addition, similar findings were reported in studies conducted in two countries, Canada and the US, respectively, that reported that 23.9% and 45.5% of young girls had two or more sexual promiscuities in the past year. In Canada, supported findings reveal that 32.1% of young males in the very same age group (15–17) had two or more partners, While similar findings reveal

that 50.8% were reported in the US (Meherali, Louie-Poon, Idrees, Kauser, Scott, Salami, Valliantos, Meherali, Patel, Suthar, Akbarzada, Marcus, Khangura & Mangat, 2022). A contrary study carried out in the United Nations that focuses on youth sexual health indicates extensive concerns about youth sexually explicit photographs sent through smartphones or the internet, commonly known as 'sexting', which appear to be primarily based on exaggerated reports. A concurred finding reported by a national survey conducted among 1,560 underage people between 10 and 17 years stated that almost 7% had obtained 'almost nude' snapshots or movies, and most effectively, about 2% had appeared in or created such snapshots. It was coincidental that women had been much more likely to create or appear in such images, and over half of such pictures have been generated between senders and recipients as a part of romantic dating (Alekhya, Parida, Giri, Begum, Patra, & Sahu, 2023).

A study conducted in the Republic of Tanzania reported that 50% of primary school children of both genders, aged 12 years and over, who had or 'ever had sex' said their initial act was vaginal sexual intercourse, 10% anal sex, and 40% oral sex (WHO, 2018). A National Survey of Family Growth in the US indicates that 54% of 15–19-year-old females and 55% of boys had oral sex and 10% had anal sex (Mpimbi et al., 2022). These contrary actions tended to follow rather than lead (Alekhya et al., 2021).

A number of studies have additionally highlighted continual patterns of sexual harassment, manipulation, and coercion of male and (extra normally) female learners by way of teachers as well as by using different learners (WHO, 2020; Nmadu, 2017). For instance, similar reports in Tanzania indicate that 50% of primary school girls were sexually active at the age of 12 years, while 3% of sexually active boys convey that they were forced to have sexual intercourse by the teacher (Abdul, Gerritsen, Mwangome & Geubbels, 2018). Additionally, the findings concurred that 36% of sexually active girls and 14% of sexually active boys stated that they were forced to have sexual intercourse by their peers (Lince-Deroche, Berry, Hendrickson, Sineke, Kgowedi & Mulongo, 2019). A longitudinal study conducted in Nigeria that focuses on youth groups reported similar findings: girls usually engage in sexual intercourse at an early age of 11–13 years when compared to boys at 14–15 years. A survey conducted in the Caribbean reported similar findings: approximately 40% of male learners between the ages of 10 and 18 and 9% were under the age of 12 when they first engaged in sexual intercourse (Nmadu, 2017).

A Tanzanian study that yielded data on unmarried youth reported that approximately 32% of youth revealed that they are sexually active, and the elevated rate was higher for males than females (Mpimbi, Mmbaga, El-Khatib, Boltena, & Tukay, 2022). In addition, the only sexual

practices inquired about and reported include vaginal sex, masturbation, oral sex, and anal sex. However, contrary findings reveal that 15% of sexually active youth stated that they have multiple sexual promiscuities (Nkata, Teixeira, & Barros, 2019). A study conducted in SA in Kwazulu-Natal province reported that 14% of girls who first engaged in sexual interaction at the age of 14 used a pregnancy prevention technique during their first sexual intercourse, and 10% of the technique was for STI/HIV prevention (Mgwaba & Maharaj, 2021). The use of such techniques rose by single years of age to 48% and 46%, respectively, for girls who first had sexual intercourse when they were aged 19 (Mgwaba & Maharaj, 2021). A Demographic Health Survey (DHS) tabulation of sexually active unmarried 15–19-year-olds in 12 sub-Saharan African countries shows 50% of boys using a condom at their first sexual intercourse and 61% at their most current sexual intercourse, compared with 28% of girls at their first sexual intercourse and 50% at their most recent sexual intercourse (WHO, 2018a).

Both youths are slightly more likely to report that they practiced safe sex during sexual intercourse. A study conducted in Ghana, represented by a sample between the ages of 12 and 14, reported that 25% of sexually active boys and 6% of girls who were recently under the age of 12 and 14 had used condoms during their initial sexual intercourse when compared with 15% and 24% of comparable age groups (15–19 years) at most current sexual intercourse, one-fifth of younger boys and girls and one-third of the older cohort used condom protection (Kumi-Kyereme, 2021).

Additionally, a study conducted in Tanzania's Dar es Salaam reported that 304 youth between the ages of 18 and 25 attended an STI clinic. 93% of male youth stated that they had more than one sexual lifetime companion, compared to 63% of female youth (Nicholas & Kavana, 2021). The contrary findings affirm that approximately 50% of males, compared to 43% of females, always use condoms, and 8.3% of females use other contraceptive methods or family planning methods. In addition, contrary findings show that 60% of abortions were induced, while 42.0% of female youth reported that they received gifts or money in exchange for sexual favours or sex (Pakhomova, Dietrich, Closson, Smit, Hornschuh, Smith, Beksinska, Ndung'u, Brockman, Gray, & Kaida, 2021). The HIV incidence was 15.3% and 7.5% for both female and male youth, respectively. Furthermore, youth who use alcohol or illicit drugs are linked with an increased risk of HIV infection (Mgopa, Ross, Lukumay, Mushy, Mkony, Massae, Mwakawanga, Leshabari, Mohamed, Trent, Wadley, Bonilla, & Rosser, 2021).

In addition, a study conducted at Mada Walabu University in Ethiopia revealed the risky behaviour of students as it was identified in a theme of sexual reproductive health problems that dominated the university community. The risk behaviours include substance use, multiple

sexual partners, early sexual initiation, low knowledge, STIs or HIV infection, unplanned pregnancy or abortion, and gender-based violence or sexual harassment (Mezmur, Assefa, & Alemayehu, 2021). Further, contrary findings revealed by the study conducted among high school youth in Ethiopia reported that 260 (38.1%) of learners stated that they have confidence that it is normal and acceptable to have sexual feelings during youth, while 607 (88.2%) believe that sexual intercourse should be delayed until marriage (Mezmur et al., 2021). Yet, similar findings were reported: 118 (17.2%) of the participants had premarital sexual intercourse, and they engaged in sexual intercourse aiming for earlier marriage, as stated by 87 (25.4%) male participants compared to 31 (9%) female participants. The mean age of sexual commencement was  $15.2 \pm 3$  SD, and the median was 16 years old (Central Statistical Agency (CSA), 2017).

A study conducted by Birhanu, Tushune, and Jebena (2018) in Addis Ababa, Ethiopia, reported that 10.6% of youth were involved in sexually risky behaviour in the past 12 months, while 79.4% of sexually active youth reported that they were sexually active in the 12 months preceding the survey, 45.6% reported having sexual intercourse with more than one partner, 55.6% did not use condoms consistently, and 20.6% reported having sexual intercourse in exchange for money or a gift (Birhanu et al., 2018).

According to the study conducted at Jimma Zone in Ethiopia, students were randomly selected, and it was reported that 42.1% of students had sexual risk behaviours; 30.8% of students stated they had more than two sexual promiscuities in their lives. 11.2% of students reported that they always use condoms. 37% of students reported that they consumed alcohol. Furthermore, an elevated probability of sexually risky behaviour is significantly related to higher levels of alcohol consumption and a low rate of religious activity (Nicholas & Kavana, 2021).

An Ethiopian study conducted in Ambo High School among youth shows that among active sexual participants, 29 (16.5%) of male learners' state that they had experience or involvement with female commercial workers or sex workers (Ewunetie, Alemayehu, Endalew, Abiye, Gedif, & Simieneh, 2022). In addition, 8 (27.6%) asserted that they consistently use condoms (Ewunetie et al., 2022). A contrary study conducted by the Central Statistical Agency (CSA) (2017) reported that 18.6% of female students reported that they started sexual relationships under the age of 15 years, while a total of 167 sexually active female participants reported that they had a history of consistently using condoms.

The magnitude to which youth abuse substances is motivated by the necessity of relieving stress, the prerequisite to permitting time to socialise, enhance confidence, and stimulate themselves sexually, resulting in school drop-outs, binge drinking, and addiction (WHO, 2018). Coinciding findings revealed that substance abuse in rural settlements is also linked with school drop-out, unplanned sexual interaction, and the spread of sexually transmitted infections (Tshitangano & Tosin, 2016). The findings concurred that youth that engage in substance abuse are likely to have numerous sexual partners and engage in sexual intercourse at an early age, which puts them at greater risk of unplanned pregnancies, HIV/AIDS, and STIs (Mabasa, 2018). Similar findings revealed that both male and female youth who abuse substances have elevated levels of risky sexual behaviours such as having multiple partners and participating in unprotected sexual intercourse (Lince-Deroche et al., 2019). As a result of substance abuse among learners, they are vulnerable to HIV infections, as well as sexually transmitted infections and poor performance at school (Mabasa, 2018). The National Strategic Plan for HIV, TB, and STIs (2017–2022) underlines that substance abuse is one of the social drivers of HIV and AIDS (Mashaphu, Wyatt, Zhang, & Liu, 2022).

The findings were supported by a multitude of sexual promiscuities that are simultaneously mutual among youth girls in most sub-Saharan African regions, especially in South Africa. A communication programme conducted in Zambia enlightens simultaneously sexual partnerships as sexual affairs that appear at the same time and concurrently with more than one sexual partner at a time and then continue to engage in sexual intercourse where one sexual partner starts the engagement before the other partners come to an end (Ntshiga, Musekiwa, & Mlotshwa, 2018).

Mmusi-Phetoe, Thupayagale-Tshweneagae, and Akpor (2019) contended that sexual promiscuity is related to the elevated number of teenage pregnancies. However, many studies showed that young girls are faced with economic needs; hence, they are involved in multiple promiscuous and simultaneous sexual affairs, and as a result, they allow vulnerability into their lives (Hoffman, Levasseur, Mantell, Beksinska, Mabude, Ngoloyi, Kelvin, Exner, Leu, Pillay, & Smit, 2017). The study conducted by Maxwell, Radzilani-Makatu, and Takalani (2020) concurred with the findings by revealing that young girls are mostly inclined to have transactional sexual intercourse in exchange for gifts, money, or cosmetics. The study conducted by Hoffman et al. (2017) concurred with the findings that having more than one sexual partner at once has resulted in unstable relationships, where inconsistent and incorrect use of condoms was outlined as a key element. Therefore, contrary findings on negative practices in sexual intercourse convey that there is a high-risk factor for STIs, HIV/AIDS, and teenage pregnancy. Furthermore, the findings stated that young girls in this situation are

deprived of the right to negotiate for protected sex or safe practices of sexual intercourse (Mmusi-Phetoe et al., 2019).

#### **5.4 Culture, beliefs, norms, and values regarding the promotion of healthy sexual practices**

In this study, the introduction of healthy sexual practices education was significantly associated with cultural expectations that youth should have sex at a young age. Compulsory education on healthy sexual practices can help revive the culture, beliefs, norms, and values regarding the promotion of healthy sexual practices. A study conducted by Kalioyu (2018) concurred that education on healthy sexual practices can empower parents and teachers to disseminate accurate information to learners regarding protected sexual intercourse and the consequences of unprotected sexual intercourse in the future. The contrary findings reveal that the most effective strategy to prepare learners for early marriage, planned and delayed pregnancy, and better motherhood is through cultural values (Mbachu, Agu, Eze, Agu, Ezenwaka, Ezumah & Onwujekwe, 2020).

In this study, teaching religious and moral values was significantly associated with the cultural environment, beliefs, norms, and values regarding the promotion of healthy sexual practices. A coinciding finding revealed that youth who are more religious hold more traditional views regarding sexual intercourse (Thin Zaw et al., 2021). However, attitudes and expectations are typically only moderately predictive of future behaviour. Khosa (2019) confirms that youth pregnancy, STIs, and HIV/AIDS infections are the outcomes of a combination of things, such as the ignorance of the church, school, parents, teachers, and community. The reason why teachers, parents, and pastors avoid breaking the silence is that they do not want to engage with the challenges of unplanned pregnancy, STIs, and HIV/AIDS infections (Modise, 2019).

In this study, it was found that programmes linked with contraceptive services were significantly associated with the lessening of STIs, HIV/AIDS infections, and unplanned pregnancies. According to a White Paper on Basic Education in South Africa, the life orientation communication programme in schools should include healthy sexual practices education as early as primary school (Venketsamy, & Kinear, 2020). What is not clear is what information should be given to learners and to what extent, in terms of the depth, as cited by Ramathuba, Khoza, and Netshikweta (2012).

The findings of the study by Mavhandu-Mudzusi and Mhongo (2021) revealed that teachers, parents, and health professionals must be involved in the design of the school curriculum on healthy sexual practices education and in teaching learners about reproductive health in



schools and homes. The findings of the study by Leung, Shek, Leung and Shek (2019) revealed that the involvement of teachers, parents, and health professionals in the school curriculum should have more depth and clarity so that learners could be persuaded to use contraceptives to curb the high rate of STIs, HIV/AIDS, and unplanned pregnancy among youth.

In this study, parental education and support were significantly associated with the cultural environment, beliefs, norms, and values regarding the promotion of healthy sexual practices. The findings revealed that they expressed the opinion that contraceptives should be made available freely and without parental knowledge or consent (Wood & Hendricks, 2017). It seemed that parents hesitated to make healthy sexual practices, education, and contraceptives available to their children out of fear that youth would interpret this as permission to engage in sexual intercourse (WHO, 2020). Similar findings revealed that parents and teachers are against healthy sexual practices education at school (Klein et al., 2018). A study conducted by Klu, Agordoh, Azagba, Acquah, Doegah, Ofori and Gyapong (2022) concurred with the findings that revealed parents do not want their children to be taught life-orientation subjects at school because they fear that learners will experiment with what they learn at school. Rose et al. (2019), on the contrary, reported that parents thought it improper to discuss healthy sexual practices issues with their children because it was against their culture and beliefs. In the study by Bjork and Bjork (2019), similar findings revealed by youth revealed that at home, they were not receiving healthy sexual practices education from their parents and pastors. The feelings of youth were that parents, pastors, and cultural believers wished their children to complete their school education before engaging in sexual intercourse. *"My mother told me to finish school first and not rush to do things meant for adults; my time will also come, and I must not play with boys because they will destroy my future"* (Righi et al., 2021).

In this study, rebelling against parental and religious limits was significantly associated with the cultural environment, beliefs, norms, and values regarding the promotion of healthy sexual practices. Furthermore, ignorance about the physiological aspects of conception led them to believe that first-time sexual intercourse or irregular sexual intercourse could not cause pregnancy, infections with STIs, or HIV/AIDS (Santa Maria, Rafferty, Lau, Guilamo-Ramos, Tebb, Chadi & Marcell, 2018). Youth are reluctant to take contraceptive precautions for fear of complications and parental detection. In a study conducted in Uganda, it was found that some youth believed that not having sexual intercourse regularly would cause them not to become pregnant and infected by STIs and HIV/AIDS (Mutabazi, Esaete, & Kansimev, 2023).

Boateng, Baah, Boakye-Ansah, and Aboagye (2022) asserted that the young girls quoted by those young boys contended about not getting adequate pleasure while using condoms during sexual intercourse. Youth, girls, and boys need to prove their fertility as required by their cultural norms. This ideology resulted in STI infections and other encounters during teen pregnancies (CDC, 2021). A cultural norm is for young girls to give birth at an early age as a way of proving fertility and transitioning to adulthood (Ahinkorah et al., 2021; Ministry of Health, 2017). Further, none of the young girls used any family planning; it was illustrated that culture encouraged them to trust their partners, which resulted in unprotected sexual intercourse and a risky increase in the spread of STIs, HIV/AIDS, and unplanned pregnancy (Nabisubi, Kanyerezi, Kebirungi, & Mboowa, 2021).

In this study, pregnancy to test fertility was not found to be significantly linked with unplanned pregnancy. A similar study conducted by Neal et al. (2020) in sub-Saharan Africa reported that there is also a perception that one needs to prove one's fertility through pregnancy. Also, it was reported that youth who were previously ostracised because of an unplanned pregnancy may today be proud of their motherhood and receive social support and acceptance (Oluwole, Oyekanmi, Ogunyemi, & Osanyin, 2020). The findings indicate that traditionally it was not acceptable to fall pregnant before marriage, but cultural norms have shifted, and having an unplanned pregnancy now is not seen as so immoral (Alukagberie et al., 2023).

The study by Zhang and Chung (2021) outlined different factors that prevent youth from accessing contraceptives in PHC facilities, such as age, cultural views regarding early marriage, the cultural restriction or prohibition of contraceptive use, inadequate knowledge about the risks of unprotected sexual intercourse, and a lack of life skills needed to practice protected sexual behaviours. These factors could affect the health of the young population. Restricted access to healthy sexual practices services complemented by poor service provision and the ignorance of unmarried and young women are common contributing factors to youth healthy sexual practices complications in most low and middle-income countries (UNICEF, 2021; Zhang & Chung, 2021). Studies attested that youth healthy sexual practices service operation was perceived to be low among the youth that is still at school (Kayondo et al., 2020; Righi et al., 2021). A study conducted in Ethiopia revealed that only 33.8% of adolescents testified to the use of healthy sexual practices (Kassie et al., 2020). Similarly, another study conducted in Ethiopia contended that less than one-third of the youth were found to use youth healthy sexual practices services (Mulugeta, Girma, Kejela, Meskel, Andarge & Zerihun, 2019).

## **5.5 The roles of teachers and SGB in promoting healthy sexual practices**

In this study, favouring workshops about contraceptives for men and women together was significantly associated with the roles of teachers and SGBs in promoting healthy sexual practices. Similar findings were reported by Mekonen, Dagnew, Yimam, and Reta (2018), who found that the involvement of teachers and SGBs in healthy sexual practices education improved their attitudes and increased the chances of their children or learners using contraceptives.

However, the primary concern is that SGBs are often excluded from these workshops, and yet they are reported not to be in favour of contraception (Zulu, Zulu, Svanemyr, Michelo, Mutale, & Sandøy, 2022). It is possible that teachers and SGBs do not know the benefits of using contraceptives or have misconceptions about the perceived disadvantages of using contraceptives (Klu et al., 2022). A study conducted in Nigeria by O'Mara and Duncanson (2021) reported that if teachers and SGBs were included in workshops about contraceptives, they would be ready to face the challenges of parenting children and plan when their children would start their own families.

In this study, social support and parenting were significantly associated with the promotion of healthy sexual practices. A study conducted by Kalioyu (2018) concurs with the study findings that social and parental education could play a significant role in developing self-confidence, increasing the age of first sexual intercourse, and delaying marriage among learners.

In this study, a lack of self-confidence in decisions about sexual intercourse was significantly associated with the promotion of healthy sexual practices. Righi, Bogen, Kuo, and Orchowski (2021) found that in the United States, a lack of self-confidence was not significantly associated with healthy sexual practices. The study conducted by Olmstead (2020) revealed that youth who engaged in sexual intercourse and had more liberal attitudes toward premarital sex had greater self-confidence than those who engaged in sex and had more conservative attitudes. A contrary study revealed that the commencement of menarche in most countries has largely decreased and seems to have stabilised at an average of 13 years with 0.5-year variations between countries (Klein, Becker, & Štulhofer, 2018). Similar findings from the study conducted by Rose, Boyce, Crittenden Murray, Lesesne, Szucs, Rasberry, Parker, and Roberts (2019) indicate that the age of menarche is decreasing in both urban and rural black females.

Daagu, Madugu, Uwalaka, Egahi, and Daagu (2021) reported that early sexual intercourse is defined as having had sexual intercourse before 15 years of age and can be associated with early menarche. Early sexual initiation could have negative effects on young girls' health owing to their inability to deal with the consequences of such sexual intercourse (Munyai, Makhado, Ramathuba, & Lebese, 2023). Research studies have shown that sexual intercourse at a young age is related to reduced use of contraceptive methods and an increase in sexually transmitted diseases and unplanned pregnancies (Oluwole et al., 2020).

In this study, the notion that teachers and SGBs should conscientise learners to promote healthy sexual practices was significant associated with lowering power imbalances in sexual relationships between males and females, which is associated with the promotion of healthy sexual practices. The research revealed that the social construction of gender has been an important focus of related studies (Munyai et al., 2023; Daagu et al., 2021; Zhang & Chung, 2021).

The findings of other studies suggest that although female youth view themselves as having equal responsibility as males to engage in protected sexual intercourse behaviour, gender inequality is prolonged by delicate power processes (Zhang & Chung, 2021). Similar findings were reported by Kayondo, Byamugisha and Ntuyo (2020) that youth who have greater sexual relationship power will get their way in terms of condom use, and young men seem to have greater sexual relationship power than young girls. Furthermore, decision-making power is not as important as sexual relationship power in determining condom use among the youth, because the degree of decision-making power is supported by the degree of sexual relationship power (Kassie, Gudayu, & Araya, 2020; Wood & Hendricks, 2017). Further, it was revealed that youth were involved in an asymmetrical sexual relationship power structure, and females have great difficulty taking control over decision-making in condom use negotiations (Tilahun & Mamo, 2020).

STIs, HIV/AIDS, and teenage pregnancies could be contested by accessing and using condoms. A study conducted in Ghana revealed that the majority of sexually active youth do not use any contraceptives: among those who are sexually active, 31% of those were 12–18 years old (Boah et al., 2019). In addition, in their last sexual encounter, they were not using any contraceptives or family planning methods. The majority of youth pregnancies are unplanned (Nigussie & Yosef, 2020). Yet, this raises the question of why youth are not protecting themselves during sexual intercourse (Nihan, 2020). It was reported that young girls had inadequate knowledge regarding their menstrual cycle and used it as a measure to prevent pregnancy (Nabugoomu, 2019). In addition, youth girls are confident that they can

use their menstrual cycle to prevent pregnancy, which results in unplanned pregnancy as well as being infected by HIV/AIDS (Boah et al., 2019).

A study conducted in Ghana by Krugu, Mevissen, Münkkel, and Ruiter (2017) reported that youth girls stress that condom usage is the responsibility of boys. Some had used condoms before. However, the utilisation of condoms was irregular, resulting in the spread of STIs, HIV/AIDS, and others who had become pregnant (Nguyen, Luong, Le, Hobbs, Andridge, Casterline & Gallo, 2022). Furthermore, numerous reasons for the lack of condom utilisation were drawn from a study conducted in Senegal showing that 61% of young girls and boys had inconsistent use of condoms, including unavailability of condoms at the point of need, incorrect use of condoms, lack of self-confidence at the point of sexual intercourse, being unable to negotiate condom use during sexual intercourse, and being unaware that boys were not using condoms during sex encounters (Chau, Seck, Chandra-Mouli, & Svanemyr 2016).

A study conducted in SSA alluded to the fact that young girls have limited use of contraceptive methods because of several factors, such as violent and coercive sexual relationships, lack of knowledge, limited access to contraceptive methods, lack of control over contraception decisions, low distribution of condoms, and concerns over the perceived side effects of family planning methods (CDC, 2021).

## **5.6 Challenges regarding the promotion of healthy sexual practices**

The findings reveal challenges regarding the promotion of healthy sexual practices, supported by the violation of the POPIA Act by healthcare workers at the healthcare facilities. A study conducted in Botswana supported the findings by revealing that it has been reported that healthcare providers refuse to give youth contraceptives because they require parental consent. In a study on youths and contraceptive utilisation, Kanda and Mash (2018) found that youths reported that nurses would not give them contraceptives prior to asking about their sexual awareness and lecturing them on being too young to have sexual intercourse. According to Kola (2018), contrary findings revealed that intimidation by healthcare staff resulted in the under-utilisation of clinics by youths.

Mehta and Seeley (2020) emphasise how positive attitudes are an important component of any programme to improve the quality of healthcare services, especially for healthy sexual practices. Effective staff attitudes are crucial for improving the quality of care rendered to youth. Furthermore, awareness about contraceptives and youths' reproductive rights initiates

the substructure on which contraceptive service providers should reveal efficacy (Thongmixay, Essink, Greeuw, Vongxay, Sychareun & Broerse, 2019).

The attitudes of healthcare providers toward youths receiving services for healthy sexual practices are paramount. This is because their attitudes can influence youth to access services that enable them to safely manage their healthy sexual practices and make informed decisions concerning their sexual issues (International Planned Parenthood Federation (IPPF), 2022). Naezer, Rommes and Jansen (2017) further stated that providing healthy sexual practices services to youths is a sensitive issue and that confidentiality, privacy, and respect must be maintained all the time. Qolesa (2017) pointed out that youths feel embarrassed about being seen at the clinics and fear that their privacy and confidentiality will be compromised by the healthcare workers, as well as being judged during the consultations.

In this study, bad attitudes towards contraceptive use were associated with disrespect and swearing among youth by nurses during consultations. Similar findings were reported by the United Nations (2018), which encouraged youth to develop positive attitudes towards contraceptive use and the desire to avoid STIs, HIV/AIDS, unplanned pregnancy, and childbearing. The findings by Ndlazi and Masango (2022) reported that youth were encouraged to develop negative attitudes toward contraceptive use, but this was because of misconceptions and a lack of knowledge regarding the side effects of the use of contraceptives.

Furthermore, the wrong information held by youth was that girls who use contraceptives experience childbirth problems. Thus, for the respondents, contraceptives were meant for married or single adults who already had children. Young men thought that contraceptives had permanent side effects, such as infertility, and they tended to avoid them (Logie, Lys, Fujioka, MacNeill, Kayley Mackay & Yasseen, 2019). These findings are consistent with other previous studies in Malawi and Uganda (Samati, 2021; Kaphagawani & Kalipeni, 2017). Pregnant youth that experience school interruption brings shame and disgrace to their families (Chilambe, Mulubwa, Zulu, & Chavula, 2023). These youth are forced into early marriage when they become pregnant, thereby negatively affecting their lives as they struggle to raise the children since they are mostly financially dependent (Sunarsih, Astuti, Ari Shanti & Ambarwati, 2020).

Failure to get accurate information regarding sexual intercourse from their peers was significantly associated with STIs, HIV/AIDS, and unplanned pregnancy. A study conducted in South Africa by Mahlangu et al. (2021) found that another possible reason for youth unplanned pregnancy is that sex regularly takes place because youth perceive that people of

their age (peers) are sexually active. Similar findings in a study conducted in Ghana by Klu et al. (2022) revealed that the peer group plays an important role during youth, and young girls often feel pressure from their peers to engage in sexual activities as a means to gain peer group respect. Books, magazines, films, videos, and the Internet with explicit descriptions or scenes concerning sex are freely available (Ninsiima et al., 2021).

In this study, ignoring the consequences of sexual activities was not significantly associated with unplanned pregnancy. Similar findings by Roth, Bukoye, Kunnuji, Schaub, Kanaahe, Atukunda, Esiet, and Izugbara (2022) show that young girls acted submissively and agreed to have unprotected sexual intercourse even though they knew the consequences. In the study conducted by Mekie, Taklual and Tesfaw (2022), it was found that most youth perceived falling pregnant as a negative event with consequences, such as unemployment, loss of boyfriends, blame from friends and family members, feeling guilty, difficulty at school, complications during pregnancy or delivery, risk of HIV, secondary infertility if abortions are done, and not being prepared for motherhood.

In this study, fear of visiting the clinic was significantly associated with an unplanned pregnancy. Similar findings by Mulugeta et al. (2019) found that 79.2% of youth were reluctant to visit clinics for contraceptives. The findings of the study conducted by Mekie et al. (2020) further revealed that the youth's concern is that they cannot go to a family planning clinic because they may come across their relatives, who might inform their parents that they were at the clinic.

According to Janighorban, Boroumandfar, Pourkazemi, and Mostafavi (2022), youth are often too shy to visit an adult family planning clinic. Often contraceptives are provided, while education about healthy sexual practices is neglected, because of the heavy workload of health care professionals. According to McCalman, Heyeres, Campbell, Bainbridge, Chamberlain, Strobel, and Ruben (2017), youth are afraid to make use of family planning services, are dissatisfied with the quality of communication at clinics, and perceive the staff as being unapproachable. They want healthcare providers to be approachable, friendly, and caring.

The study conducted by Sunarsih et al. (2020) revealed that there was a significant link between these two variables with a P-score of 0.001. A study in Botswana by Kanda and Mash (2018) revealed that a positive relationship between youth and healthcare providers is often associated with increased utilisation of contraceptives or family planning services. Further, youth prefer to receive advice regarding contraceptives from service providers whom they

deem relatable and up-to-date with current norms (Gausman, Othman, Al-Qotob, Shaheen, Sabbah, Aldiqs, Hamad, Dabobe & Langer, 2021). In addition, the conditions at the clinic, the long queues, waiting times, and negative staff attitudes prevented youth from visiting the clinic. Also, youth describe clinic staff members as being rude and unsympathetic about the long lines and poor clinic conditions that they experienced. Furthermore, a study by Najafi-Sharjabad and Haghighatjoo (2019) revealed that there were also youth who presented to the clinic early but were turned away by the booking staff and told to return at a later date without assessment or explanation.

## **5.7 Strategies regarding the promotion of healthy sexual practices**

Sexuality is an important component since it is present throughout our lives. It is an interaction of physiological, psychological, social, political, economic, cultural, legal, ethical, historical, religious, and spiritual dimensions (UNESCO, 2018). According to WHO, effective healthy sexual practices education is a right for youths, on top of different sexual rights like freedom, privacy, equity, coexistence, and equality, and without any variety of discrimination (United Nations Children's Fund (UNICEF), 2021).

In this study, abstaining from sexual intercourse could help promote healthy sexual practices, and it is significantly associated with abstinence from sexual intercourse until marriage. Similar study findings reported by Thin Zaw, McNeil, Liabsuetrakul, and Htay (2021) stated that abstinence from sexual intercourse is the only form of STI, HIV/AIDS, and pregnancy prevention that is almost 100 percent effective. A study conducted in Tanzania by Rodgers, Tarimo, McGuire, and Diversi (2018) argues that every method of contraception has a risk of failure, however small, but youth who practice abstinence will not become pregnant and infected by STIs and HIV/AIDS.

The findings reveal that strategies to promote healthy sexual practices were associated with healthy sexual practices education. The contrary report stated that a lack of healthy sexual practices education in schools exposes learners to experiment with sexual intercourse, which results in the spread of STIs, HIV/AIDS, and pregnancy (Wilkins, Rasberry, Liddon, Szucs, Johns, Leonard, Goss, & Oglesby, 2022). The supporting findings reveal that inadequate education on healthy sexual practices could destroy the development and well-being of youth (Smith, 2020). A study conducted in Spain and Portugal attested to significant content misinformation of data, beliefs, prejudices, cultural and social norms, and practices that create a state of affairs of vulnerability to problems like physiological state, family relationships and



fatherhood in youth, sexual violence, HIV, and STIs (Cunha-Oliveira, Camarneiro, Gómez-Cantarino, Cipriano-Crespo, Queirós, Cardoso, Santos, & Ugarte-Gurrutxaga, 2021).

In Spain, it was reported that the highest prevalence rates of HIV cases were found in 15–29-year-old youth (Ballester-Arnal, Gil-Llario, Ruiz-Palomino, & Giménez-Garca, 2017), and abortion occurs more commonly in young girls at the age of 20–24 years (Cunha-Oliveira et al., 2021). Considering this condition, there are effective interventions to reduce these risks, such as healthy sexual practices education, which is a sexual right of youth recognised by international organisations (Cunha-Oliveira et al., 2021). There is strong evidence to support school-based healthy sexual practices education programmes that can delay unprotected sexual intercourse for the first time and increase the use of condoms and other contraceptive methods, which could result in decreasing STIs, HIV/AIDS, and unplanned pregnancies (Ballester-Arnal et al., 2017).

According to UNESCO (2018), both boys and girls improved their knowledge, attitudes, and skills in sexually healthy practices. Yet, the coinciding intervention clusters faced a considerably larger increase in knowledge and skills (Corcoran, Susan Davies, Candace, Knight, Lanzi, Peng Li, & Ladores, 2020). This was conjointly effective on sexual behaviour: reduced sexual interaction with penetration, with statistical significance in young girls, and greater utilisation of condoms initially in sexual intercourse in each sexual practice once the intervention began (Nihan, 2020). Therefore, it was affirmed that within the medium term, youth girls conjointly declared greater usage of condoms in their most recent sexual interaction. At a similar time, the intervention had no impact on attitudes: variables advanced completely, but there were no variations between the groups (Johnson & Jackson, 2021). These findings were similar to the results obtained by different sex education programmes (García-Vázquez, Quintó, & Agulló-Tomás, 2019). These results are consistent with those found in other Spanish studies, which reported improvements in knowledge and skills and sometimes in sexual risk behaviour (García-Vázquez et al., 2019).

In addition, Estonia executed a school-based sexuality education programme that was associated with youth-friendly sexual and reproductive health services and an environmental policy (UNICEF, 2021). The proportion of abortions and births among youths between the ages of 15 and 19 was substantially reduced (UNICEF, 2021).

In Ethiopia, the Ministry of Health accomplished outstanding improvements in the utilisation of modern contraceptives among youths from less than 10% in 2011 to approximately 25% in 2021 through the National Health Programme (HEP), which necessitated the issue of

recruiting, training, and deploying all female workforces to provide health information and services at the local level (WHO, 2020; UNICEF, 2021).

In this study, education system support was associated with the promotion of healthy sexual practices. In South Africa, the DoE adopted sex education in schools. Comprehensive sexuality education (CSE) is currently delivered through the Life Orientation curriculum and work schedule. The CSE was reviewed by experts in the field of public health before it was established in 2013, but their review recommends the need for a healthy sexual practices education programme to effectively expand knowledge and attitude and to challenge gender relations, cultural norms, beliefs, and values (Khamisa, Mokgobi, & Basera, 2020).

Additionally, the CSE classes should address several issues that are associated with equality and young girls' power, including negotiation and communication skills; healthy, happy relationships; sexual rights; gendered roles and norms; sexual pleasure; and alternative sexualities, such as lesbian, gay, bisexual, and transgender people (Leung et al., 2019). The Youth Risk Behaviour Survey (YRBS) alluded to the fact that sexual educational programmes could improve when they specifically address situations where sex occurs, such as forced sexual intercourse and sexual intercourse under the influence of substance abuse, such as drugs and alcohol (Mavhandu-Mudzusi, & Mhongo, 2021).

The literature and our interviews all repeatedly indicate that the acceptability, accessibility, and appropriateness of contraceptives for youth, health workers, and health facilities distributing contraceptives, as well as each SRH or healthy sexual practice service area, are critically necessary (Mbachu et al., 2020). The study findings critically address factors that have developed to assist with increasing acceptability and appropriateness in SA (Khuzwayo, Taylor, & Connolly, 2020).

The evidence shows that enabling young girls to take self-control of their relationships is far more powerful than simply handing out condoms or hormonal injections (Ram, Andajani, & Mohammadnezhad, 2020). Furthermore, supporting youth to improve all their relationships (with friends, parents, siblings, and partners) should mean that their relationship with a boyfriend or girlfriend should be better (Venketsamy & Kinear, 2020). It should be more equal, based on trust, love, and respect, and flowing from safer sexual relationships (HSRC, 2016). Khuzwayo et al. (2020) reported that comprehensive sex education is an opportunity to support youths in developing and enhancing their relationship skills, as well as the promotion of healthy sexual practices in SA.

In addition, the NDoH has established several techniques and programmes to improve youth sexual health practices in various elements of health policy and programming (DoH, 2019). This establishment includes health policy and programming:

- Youth and Youth Friendly Services (AYFS), which is a standards-determined method to improve the quality of care for youth,
- An Integrated School Health Programme, initiated by the NDoH, concentrates on addressing both the immediate health problems of learners, including barriers to teaching and learning, as well as implementing interventions that can promote their health and well-being during childhood and beyond.
- Ideal clinics are defined as clinics with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and adequate bulk supplies. It uses appropriate clinical policies, protocols, and guidelines, and it uses partner and stakeholder support.
- B-Wise is a young person's interactive cell phone health platform to empower youth to make the right choices, based on accurate information. The primary target is young people between the ages of 10 and 24, both in and out of school. Secondary targets include healthcare providers, parents, teachers, and other partners.
- She Conquers Campaign: A youth-led campaign that will run for three years, collaborating with government, NGOs, businesses, and civil society to address the major issues that young girls and young women face in South Africa today. With almost 2000 youth girls and young women (aged 15 to 24 years) becoming infected with HIV every week, we can only effect large-scale change if we work closely with young people and collaborate with partners providing relevant services to mobilise and share resources and improve health provision and support.

The SA government works tirelessly to Implement one-service point-of-delivery models for merging HIV and sexual procreative health services (Venketsamy & Kinear, 2020). Wherever this is not possible, strengthened referral systems and guaranteed easy accessibility for youths and youths to connected services should be standard (African Union Commission, 2016). Youth and youth-friendly clinic areas should aim to satisfy the sensible and psychosocial needs of their target users, as well as operational hours that accommodate learners' timetables, uphold privacy, and use non-judgemental employees (DoH, 2017).

Evidence suggests that this intervention is vital for HIV prevention among young ladies and young girls (Benharrousse, 2020). A guarantee of access to money and care programmes for young ladies and young girls whose monetary and social circumstances render them

particularly liable to transactional sexual exploitation: orphans, those in illness-affected families, and people with a history of abuse (DoH, 2017).

Additionally, in SA, the Integrated School Health Policy reviews and revises school-based programmes to actively promote healthy sexual practices through evidence-based programming (DoH, 2017). The programme should embody accessible and practical information regarding HIV/AIDS and psychological state, sexual and reproductive health, nutrition and healthy weight, drug abuse, and violence prevention (Modise, 2019). A similar suggestion revealed that interactive behavioural skills (such as role-plays) and non-judgemental, non-moralising styles of engagement and education are very important for effective and inclusive health communications with youth (DoH, 2017).

In this study, NGO, NPO and other stakeholders' support system was significant associated with the promotion of healthy sexual practices. In South Africa, the distribution of condoms was amended in Act 38 of 2005 to allow youth to have access to contraceptives or condoms. In addition, condoms were made free and available in the community (Aventin, Gordon, Laurenzi, Rabie, Tomlinson, Lohan & Skeen, 2021). In South Africa, condoms are available in two forms that cater to both genders (Male and Female), and the utilisation of condoms for both partners could result in dual protection for STIs, HIV/AIDS, and unplanned pregnancy (Mullis, Kastrinos, Wollney, Taylor, & Bylund, 2021).

As a result, consistent or correct condom use by both males and females is known to be 70%–90% effective in preventing pregnancy, as well as HIV/AIDS (Mullis et al., 2021). In South Africa, studies conducted illustrated that young girls from economically underprivileged backgrounds had a greater risk and were more vulnerable to HIV/AIDS, STIs, and pregnancy. It was hard for them to allude to the use of a condom (NDoH, 2016). Contrary findings reveal that perceptions that reducing condom use reduces sexual pleasure are caused by young girls risking themselves by having unprotected sexual intercourse (Mavhandu-Mudzusi & Mhongo, 2021). In a similar African situation, because of inequalities between the genders, most young girls socialise and grow up with the impression that men are in control and desire to be sexually happy and satisfied (Gedif & Simienneh, 2022). Therefore, the majority would rather risk and have unprotected sexual intercourse; hence, the youth girls' power to negotiate protected sexual intercourse is obstructed (Mekonen et al., 2018).

Family system support and interaction can influence children's knowledge about the youth healthy sexual practices services available because the family is one of the main sources of healthy sexual practices information (Olmstead, 2020). The concurred findings reveal that the

existence of such family support in the lives of children has a positive impact on their knowledge of and access to healthy sexual practices (Rose et al., 2019). Another aspect that must be considered when developing educational programmes for parents is the dimension that contributes to the effectiveness of parenting programmes in schools in general (O'Mara & Duncanson, 2021).

In this study, it was found that parents had restricted knowledge about healthy sexual practices and hardly discussed them with their children (Ewunetie et al., 2022). Most parents in research provide cautions to preserve virginity and avoid pregnancy (Leung et al., 2019). The outcome of the study coincides with the necessity of improving parenting skills through the construction of interventions directed at parent-teen communication about healthy sexual practices (O'Mara & Duncanson, 2021). Such interventions can form the foundation for strengthening healthy sexual practices programmes for youth (O'Mara & Duncanson, 2021). Further research needs to consider that the possibility of communication is associated with youth, parental education, and parental type (Munyai et al., 2023). From the results of the study, it can be understood that there is an urgent need to provide a concerned group of parents who have at least basic knowledge and skills in healthy sexual practices in order to be able to provide knowledge and skills to their children (Munyai et al., 2023).

The contrary findings reveal that the role of parents does not directly affect healthy sexual practice behaviour but must be further supported by health promotion for parents (Klu et al., 2022). Youth are expected to increase their participation in counseling activities, increasing access to information about healthy sexual practices (Klein et al., 2019). Schools are expected to be able to intensify their institutional role through an organised counselling plan, the provision of materials, and the provision of guidelines and modules for teenagers, teachers, and parents (Leung et al., 2019).

It was revealed that young girls, whether married or not, face significant difficulties in accessing contraception (Zulu et al., 2022). Without access to evidence-based information in the PHC facilities and services about healthy sexual practices, these youth are at higher risk of unplanned pregnancies and an elevated risk of contracting sexually transmitted infections (STIs), including HIV and HPV (Oluwole et al., 2020). Youth are the only age group in which death because of HIV/AIDS is increasing on a daily basis, with young girls being the most affected (Oluwole et al., 2020).

In this study, health system support was associated with the promotion of healthy sexual practices. The Ethiopian Ministry of Health has established youth healthy sexual practices

strategies to reveal youth healthy sexual practices problems (Kassa et al., 2019). Despite efforts made by the health ministry to improve access and ensure the availability of youth healthy sexual practices services, the use of the service is still low, and the youth population, particularly females, is highly affected by healthy sexual practices problems (Mekonen et al., 2018). Dissimilar studies were conducted in Ethiopia about the utilisation of youth healthy sexual services, which is associated with factors (Mezmur et al., 2021). However, there is limited evidence about youth healthy sexual practices problems, service preferences, and associated factors in Ethiopia (SADC, 2018; Corcoran et al., 2020; Wilkins et al., 2022).

Counselling sessions on healthy sexual practices in youth are very important in supporting youth to gain more knowledge, awareness, attitudes, and behaviours for a healthy and responsible life (Rwabukwali, Atekyereza, & Achen, 2020). Knowledge is one of the factors driving behaviour and attitude change (Saad & Alsubaie, 2020). The findings reveal that youth's knowledge about healthy sexual practices can influence how they behave and make informed decisions in their lives (Nabisubi et al., 2021). Counselling is not restricted to changing youth behaviour but to increasing interaction between stakeholders so that they are able to optimise their accessibility and availability of information so that they are able to improve youth's healthy sexual practices (Nguyen et al., 2022). Healthy sexual practices education programmes have been associated with increased knowledge and behaviour regarding healthy sexual practices (Modise, 2019).

## **5.8 Conclusion**

This chapter provides a discussion of the findings from the merged findings in the previous chapter; the discussion was generalised, based on the themes regarding healthy sexual practices. This was supported by literature from international, African, and local sources. This literature supported the findings and established a scientific argument to close the identified gap.

## **Chapter 6: The conceptualisation of the study findings in the theoretical framework**

### **6.1 Introduction**

This chapter provides a description of an intervention to promote healthy sexual practices in the Vhembe district. The previous chapter covered the discussion of the merged data. This showed that a robust effort is needed in order to promote healthy sexual practices in the Vhembe district.

### **6.2 The conceptualisation of the theoretical framework**

The programme development was guided, based on the empirical phase (convergent parallel mixed methods) findings of phase two (2), which involved life orientation teachers, school governing body members, and learners in the Vhembe district. After data analysis, consultations with supervisors, and intensive searching for evidence of literature from international, national, and local sources, the researcher made an appointment with the Heads of the schools, circuit managers, and curriculum advisors of life orientation in the Vhembe district. The researcher arranged a workshop with the Vhembe district Department of Education and different stakeholders in order to disseminate the findings of Phase 2. Three workshops were conducted in different circuits of Vhembe districts, where participants alluded to the interventions and materials or flyers to inform the development of the programme to address and mitigate the identified challenges, which map out the first step of needs assessment or community diagnosis. Therefore, Bartholomew's intervention mapping was used to develop an intervention programme to promote healthy sexual practices, guided by the health promotion model.

The health promotion model was used to develop the intervention programme to reduce the problem (unhealthy sexual practices) based on the study findings from phase 2 of the study (Pender, 2011). The steps followed were guided by the three major concepts of Pender's model: the collection of information, the development of the programme, analysis, and the establishment of the commitment to action. Pender's concepts include individual characteristics and experiences, behaviour-specific, cognitive, and affective behaviours, and behavioural outcomes or health-promoting behaviours; these will drive the programme to the commitment of an action plan and a healthy change of behaviour amongst youth (Pender, 2011). The following discussion concentrates on the improved model that originated from Pender's health promotion model.

### **6.3 A brief explanation of Pender's improved model is associated with the results**

The revised Pender's HPM guided the researcher in the procedure of developing an intervention programme to promote healthy sexual practices, as supported by relevant literature for the study. The results of the study were incorporated with the HPM to form the foundation of the study, which aided the researcher in the development of an intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province. With the use of the three major concepts of Pender's model guide, information was collected, analysed, and the findings established.

Pender's first concept was individual characteristics which matched with the themes of lack of knowledge, and perception regarding healthy sexual practices and misconception regarding healthy sexual practices, for instance STIs, HIV/AIDS, and pregnancy (Health Promotion), personal factors (personal and psychosocial factors), early marriage (arranged marriage) and forced marriage, poverty influences peer norms and involvement, lack of knowledge, and perception regarding healthy sexual practices, for instance, about STIs, HIV/AIDS, and pregnancy, risk of forced sexual activity by sexual partners and older people, sexual harassment by educators in school, curiosity and experimentation, perceived control of risky sexual behaviour. The second concepts were behaviour-specific cognitive and affective matching with sexual infectious disease, unplanned pregnancy (situational influence), concerns about negative side effects of contraceptives, violations of the POPIA Act at healthcare facilities, challenges in the provision of contraceptives, and side effects not mentioned by health care nurses; contraceptives stock-outs; clinics located far away from villages; long waiting periods; queues moving slowly at the clinic (interpersonal influence); perceived barriers; contraceptives not 100% safe; insufficient resources to teach learners; lack of parental, family, and social support programmes. Pender's third concept match with the findings was behavioural outcome matched with the theme plan of action (to develop an intervention programme for the promotion of healthy sexual practices) and information dissemination. Therefore, Bartholomew's intervention mapping was used to develop an intervention programme that may reduce the rate of non-adherence to contraceptives and follow-up of contraceptives, train learners, pastors, parents, and life orientation teachers, and revive the cultural environment, belief norms, and values regarding healthy sexual practices. Figure 70 show Khosa's Model for promoting healthy sexual practices among youth, adopted from Pender's health promotion model.



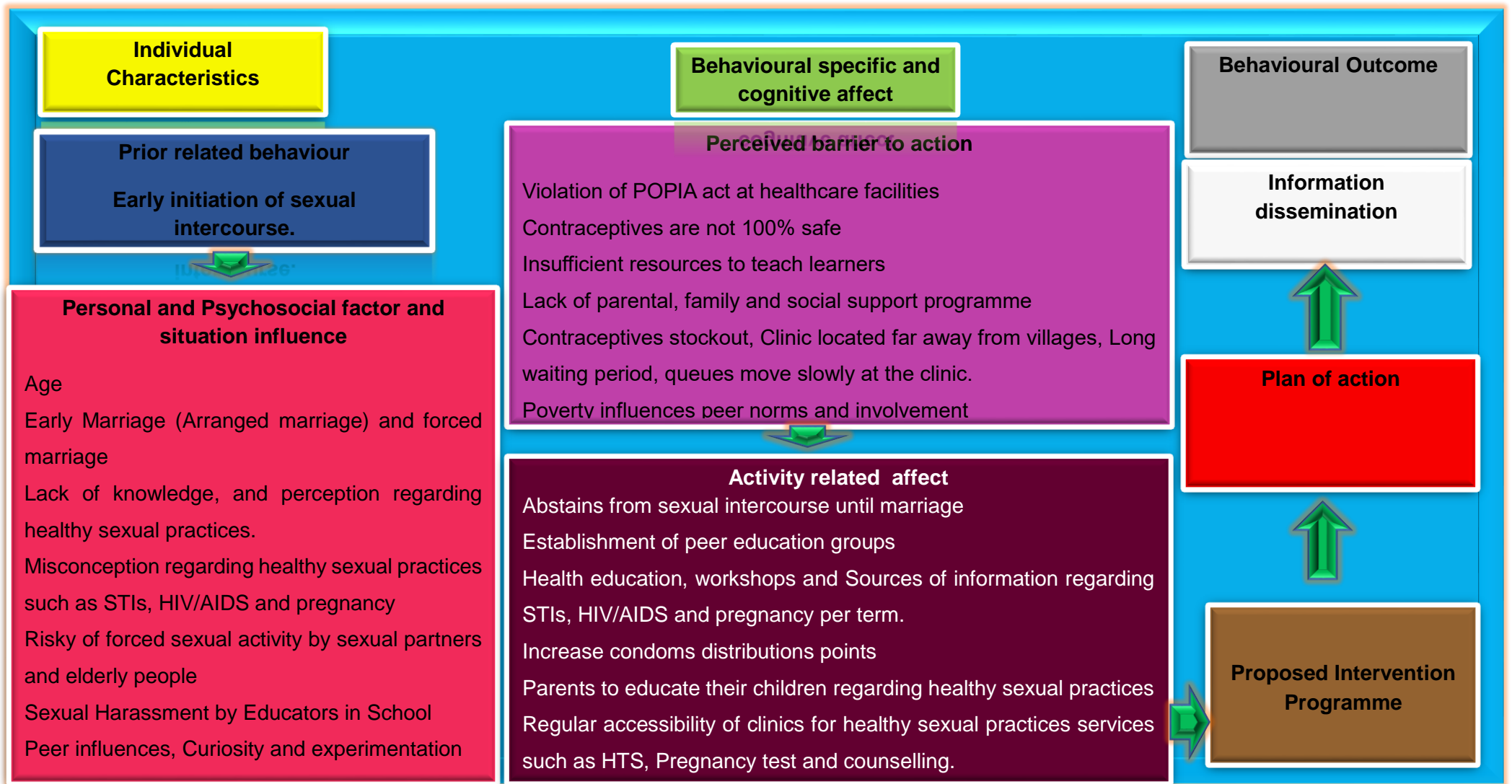


Figure 70: Khosa's Model for promoting healthy sexual practices among youth, adopted from Pander's health promotion model.

The themes are associated with Pender's HMP and the three major concepts are discussed.

### **6.3.1 *Individual characteristics and experiences***

Pender's first major concepts in the individual characteristics and experiences classification are prior related behaviour and personal factors (biological, psychological, and socio-cultural). Prior-related behaviours are defined as those ancient or baseline behaviours that correlate to a particular feature of health being studied. Personal factors are defined as those differentiated features that may influence behaviour. In this study, personal factors are categorised as Biological (age), Psychological (self-esteem and self-motivation), and socio-cultural (ethnicity, religion and culture, education, and poverty).

The researcher relates prior related behaviour to challenges experienced by learners during the provision of life orientation subjects, and this leads to learners experiencing early initiation of sexual intercourse practices at a young age that result in STIs, HIV/AIDS infections, and unplanned pregnancy. Personal and psychosocial factors are associated with early marriage (arranged marriage) and forced marriage; early sexual doubt; poverty influences peer norms and involvement; lack of knowledge and perception regarding healthy sexual practices; misconceptions regarding healthy sexual practices, for instance STIs, HIV/AIDS, and pregnancy; the risk of forced sexual activity by sexual partners and older people; sexual harassment by educators in school; peer influences sexual behaviour act; curiosity; and experimentation. Individual characteristics are shown by participants who reported that STIs, HIV/AIDS, and unplanned pregnancies occurred at a younger age among learners enrolled at schools. Participants further had negative experiences, such as embarrassment and withdrawal from society, peer isolation, and discrimination, fear of visiting local clinics, mental problems in the early postpartum period of the unplanned pregnancy, as well as complications from illegal abortions. However, youth need time to transition to adulthood. Participants reported that parents disown their children when they discover that they are pregnant. By forcing early marriage, they took the girl to the boy, who is responsible for impregnating her, and gave her to the boy's family. They are further forced by the school code of conduct to come and stay at school to guard their child until she gives birth to the baby. As a result of this union, the following year she was forced to change schools since she had a fear of being judged and humiliated by fellow peers and teachers if she decided to return to the original school. Parents should learn that healthy sexual practice education is not taboo, and parents should learn to establish healthy sexual practice education or discussion with their children. Parents should further support the life orientation curriculum and teachers, as it helps children at school learn about the consequences of sexual intercourse. Parents should support school-based sexual education programmes, which are believed to be the intervention that could

primarily change the behaviour and attitude of learners regarding unprotected sexual intercourse (Mugewandala & Hagedorn, 2017). Mavhandu, Adekola, Kutame, and Mavhandu-Mudzusi (2022) concur that education in healthy sexual practices could guide youth to evade risky sexual behaviours and the issues of quick sexual intercourse that put them at risk. The Youth Risk Behaviour Survey (YRBS) alluded to the fact that healthy sexual educational programmes would improve when they specifically addressed situations that transpire in sexual intercourse, such as forced sexual intercourse, early marriage, engaging in sexual intercourse under the influence of substance abuse, such as drugs or alcohol, and cultural environment, belief norms, and values regarding healthy sexual practices (Jonas, 2016).

### **6.3.2 Behaviour-specific and cognitive affect**

Pender's major concepts in the behaviour-specific cognition and affect types are perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational influences. Perceived barriers to action are defined as tangible or affected perceptions concerning the unavailability or difficulty of a particular action.

Perceived self-efficacy is defined as the judgement of the personal ability to manage and accomplish a particular course of action. The activity-related effect is defined as the subjective feeling states that occur prior to, during, and following an activity. Interpersonal influences are defined as perceptions pertaining to the behaviours, beliefs, or attitudes of others. Situational influences are defined as those perceptions of options available, necessity characteristics, and aesthetic features of the environment in which a given behaviour is proposed to take place.

Behaviour-specific cognitions and affect state an expected positive outcome that comes from health behaviours. In this study, outcomes are regarded as key encouragements and reflected as the cornerstone of the intervention. Subsequently, these are the most confirmable factors that will change behaviour through health professionals (nurses) and social workers' intervention. The outlined themes used in this study were perceived barriers to action, which are related to a perceived barrier to a lack of PHC facilities and healthy sexual practices services, violation of the POPIA Act, cultural environment, belief norms and values regarding healthy sexual practices, embarrassment and withdrawal from society, peer isolation and discrimination, fear of pain in labour, mental problems in the early postpartum period, as well as complications of illegal abortion. In this study, using Pender's point of view, these are referred to as situational and interpersonal influences, perceived benefits of action, barriers to action, and perceived self-efficacy.

The perceived benefits in this study were demonstrated by both learners and life orientation teachers, and the school governing body attested that youth-friendly services offered to youth should be available and be enough in all communities. For communities that have no clinic, the Integrated School Health Programme (ISHP) must be provided for schools situated in that area, as must a mobile clinic that will offer youth-friendly services or reproductive health, targeting youth since they are the victims of an unplanned pregnancy at a young age (DoH, 2017). Khuzwayo et al. (2020) reported that Comprehensive Sexuality Education (CSE) is an opportunity to support youth in developing and enhancing their relationship skills, as well as the promotion of healthy sexual practices in SA.

Participants alluded to the possibility that youth may form their own peer group in order to maintain free discussion of healthy sexual practices under the supervision of school-based auxiliary social workers and related issues like contraceptive accessibility and adherence, abstinence, and encouraging advice. They further alluded to the fact that having suitable special services for youth to use for their health promotion and also awareness campaigns at school can combat the challenges that learners face on a daily basis (Health System Trust, 2015). This could encourage youth to access and attend healthy sexual practice services without fear of being judged by health workers and adults. Barriers to action were illustrated when participants stated that the majority of youth conceived unplanned pregnancies as a result of unprotected sexual intercourse and sexual disorientation at a younger age, which results in school drop-out, while others revealed the attitudes of parents, peers, and teachers as well as the entire community. Learners also feared health practitioners' attitudes when accessing health services for sexual practices, as well as HIV testing services (HTS) (DoH, 2017).

### **6.3.3 Behavioural Outcome**

Pender's last major concept is the behavioural outcome classified through the commitment of an action plan, instant demands, and preferences for the promotion of healthy sexual practices. Commitment to an action plan is defined as the start of a behaviour event. Instant demands and preferences are defined as other behaviours that affect curriculum action immediately prior to the planned instant occurrence of promoting healthy sexual practices. Healthy sexual practices are defined as behaviours that eventually focus on positive health outcomes for the participants (Pender, 2011).

In this study, health promotion behaviour refers to the developmental reasoning point or outcome of the decision-making towards the promotion of healthy sexual practices and preparation of action (Pender 2011). Further, it refers to the encouragement given by learners,

LO teachers, and SGBs on ways in which they might assist in establishing change in learner behaviours. A committed action plan was used as a theme related to Pender's healthy sexual practice behaviour outcome. In this study, learners were motivated and guaranteed access to healthy sexual practice services, mobile clinics offering healthy sexual practices in their respective communities that do not have primary health care facilities, and integrated school health programmes (ISHP) are offered in the whole of the district. These will provisionally provide a better understanding of their needs.

Mavhandu et al. (2022) stated that information related to healthy sexual practices and contraceptives should be improved through the collective dissemination of information for both girls and boys in a workshop. Further, the learners will receive productive information associated with the promotion of healthy sexual practices, education, and contraceptives. Teachers, parents, pastors, nurses, social workers, peer educators, and the community at large should also be encouraged to teach healthy sexual practice education to their children (Mugewandala & Hagedorn, 2017). Mavhandu et al. (2022) alludes to key elements to be merged into the training of teachers, social workers, nurses, and peer educators to enhance their competence, confidence, and comfort in facilitating all features of the Sexuality Education curriculum in the classroom. These elements include training educators on content knowledge and challenges related to interacting with different contextual factors and stakeholders while offering healthy sexuality practices education in a life orientation subject to the learners (Mugewandala & Hagedorn, 2017).

This integrated innovation was outlined by Pender's model and the application of the concepts in the provision of sexual health services. The provision of health sexual practices services was based on the magnitude of the individual characteristics and experiences, as referred to in Pender's model, as registered nurses experience challenges during the provision of healthy sexual practices services to learners when receiving sexual reproductive health services. Challenges associated with the provision of sexual reproductive health include a lack of PHC facilities, inadequate contraceptives, inadequate sexual health education, a lack of incentive to travel to the nearest PHC facility, failure to adhere to the POPIA Act in the PHC facility, the attitude of health workers, and the judgement of patients when they consult for contraceptives (registered medical practitioners).

The researcher believed that non-judgemental services by the health workers, the availability of resources, including mobile clinics, and the employment of younger nurses and social workers who will understand the youth better may change the attitudes of both registered nurses and the youth themselves to improve the health and wellbeing of youth, together with

the involvement of the government and other stakeholders. The government should establish a youth zone that will provide health care services for youth.

In addition, learners encounter challenges while accessing PHC facilities and receiving contraceptives; these were applicable on the level of behaviour-specific and cognitive effects, which are characterised by personal factors and perceived barriers to action, while interpersonal influence and perceived self-efficacy also played a role. Concerning self-efficacy, the researcher trusts that personal encouragement from an individual deep inside himself or herself will encourage the youth to make an informed decision regarding healthy sexual practices and that they will not commit themselves to risky sexual behaviours, which is the leading factor for youth concerning STIs, HIV/AIDS, and unplanned pregnancy. This internal encouragement is important as it will signal to him or her and the world that they are ready to be scholars, complete their studies, and pursue a variety of careers they intended to study and be professionals in.

The researcher also believes it is vital and necessary that youth need unconditional and loving support from parents, families, teachers, pastors, and community members to encourage them to promote and practice healthy sexual intercourse. In relation to interpersonal influence, the establishment of healthy sexual practices education for parents, families, pastors, and the community as a way of empowering them with knowledge and information about the importance of supporting youth associated with reproductive health, is of further significance. Children could be taught healthy sexual practices at a young age by their parents, school nurses, and life orientation teachers; the curriculum should be established, and it must include healthy sexual practices at primary school. The informative education that will be provided for learners at this level should be age-appropriate in detail. The researcher trusts that the involvement of school nurses, teachers, and social workers would establish relationships or collaboration with parents and other stakeholders to establish a working relationship towards the promotion of healthy sexual practices and also to concur about the allocation of the child support grant to the parent when the mother of the child is still an on-going school learner.

In this study, participants reported that youth are reluctant to access and utilise the available services in the PHC facility or local clinics. It was further reported that youth and learners do not visit the clinics, even under certain circumstances. In the case of unplanned pregnancy, participants reported that they only visit the PHC facility when complications arise, such as bleeding or being tested HIV positive; some never return for follow-up and adherence to medications.

Recent research also gives confidence that an action plan will be prepared to mitigate the situation. The action plan was allocated based on behavioural outcomes. This level is characterised by an action plan for the benefit of healthcare practices and providers, youth, parents, and educators. The researcher trusts that school nurses, educators, and social workers would initiate programmes in which families, communities, managers, and other stakeholders who respect human rights and will collaborate to disseminate information, through awareness campaigns, workshops, and health education among youths related to their legal rights, to identify and report or visit the health facility for any form of sexual abuse to prevent and protect youth from becoming victims of child abuse, negligence, and mistreatment. In the case where a girl child becomes pregnant, the school nurses should provide health promotion and report her uncertainties during counselling and testing, as well as HIV/AIDS, as a way of preventing illegal abortions that have negative complications in the lives and futures of youth.

## **6.4 Conclusion**

HPM guided the conceptualisation of the study, through the possible plans and solution to resolve the identified gap. Both study findings were integrated with the common goal of developing an intervention to promote healthy sexual practices among learners. The identified stakeholder must disseminate appropriate information about healthy sexual practices in order to prevent the consequences of unhealthy sexual practices.

## **Chapter 7: Development of an intervention programme to promote healthy sexual practices**

### **7.1 Introduction**

This chapter presents the development of an intervention programme integrated with the conceptualisation approach from the previous chapter. The programme is guided by Bartholomew et al. (2016) intervention mapping, which outlines six steps to be followed. Further, different interventions and programmes are discussed as a strategy to combat STIs, HIV/AIDS, and unplanned pregnancy as a way of promoting healthy sexual practices among youth in the Vhembe district of Limpopo Province. The overall aim of the study is to develop an intervention programme to promote healthy sexual practices among youth in the Vhembe district of Limpopo Province.

### **7.2 Development of an intervention programme**

The programme was developed based on the study findings of a mixed method (qualitative and quantitative) approach using convergent parallel mixed methods from phases one and two, which involve learners, SGBs, and teachers within the schools. Subsequently, through analysis of the data, consultations with the circuit managers, heads of school (principals), and an intensive search of the literature, the researcher established need assessments, based on the study findings.

The Department of Education in the Vhembe district releases the requested individuals from their respective institutions. The researcher presented the findings of phase 2 convergent parallel mixed methods. Three workshops were conducted, and the researcher discussed with the attendees the impediment findings in the study. The Department of Education representative concurred with the findings and further shared their impediment to adding to the researcher's findings. Therefore, participants alluded to the interventions and materials to enlighten the development of the programme to report the identified impediment undertaken in IM (needs assessments) as the first step. Pender's (2011) HPM was used to develop a logical framework for the problems, based on the findings from phase 2 of the study. The analysis revealed various impediments to the promotion of healthy sexual practices in the Vhembe district of Limpopo Province, including personal factors, school/community/family/church challenges, and health system challenges. The following steps were then followed to develop the programme: matrices of change objectives, the selected theory-based methods of intervention, the development of an educational programme, and a plan of implementation.



### **7.2.1 *Personal issues***

Lack of knowledge regarding healthy sexual practices among youth has resulted in teenage marriages, sexual harassment, misconceptions about STIs, HIV/AIDS, teenage pregnancy, and early sexual debuts, which have demonstrated a negative impact on the provision of healthy sexual practices. Most youths spend time at school seven days a week, making it difficult for them to visit PHC facilities or clinics for services related to healthy sexual practices. Further, the findings revealed that youth have challenges when they want to access healthy sexual practices services and education because the clinic is far from the village where they live, others revealed that long waiting periods and long queues have a negative impact on youth who need healthy sexual practices services in the local clinics.

### **7.2.2 *School/Community/ Family/Church***

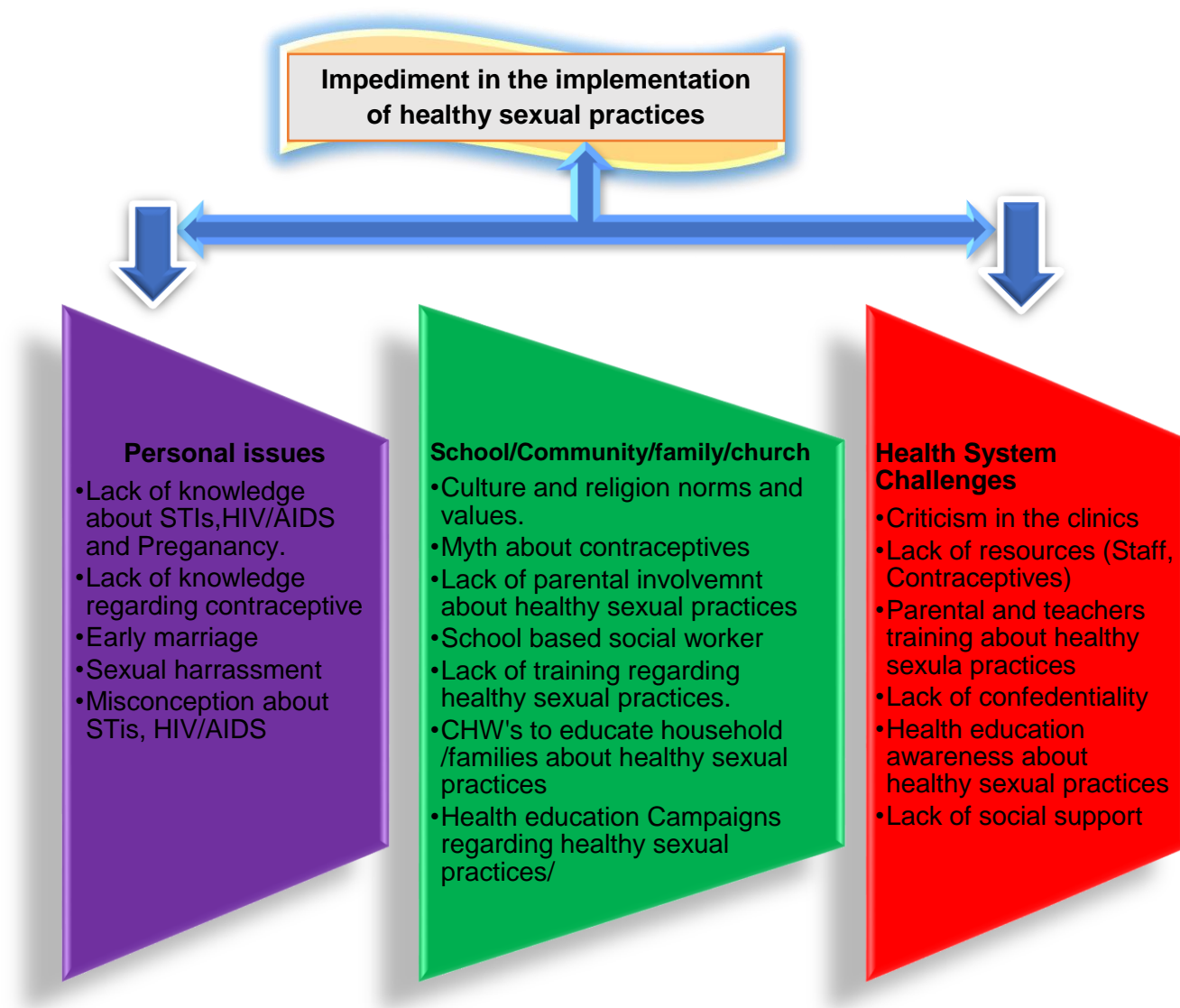
After the study's findings, the analysed data revealed that life orientation teachers have negative attitudes toward healthy sexual practices education. Others revealed that cultural stereotypes do not allow them to teach healthy sexual practices or communicate with children about issues related to sexual intercourse. These infringe on the right of learners to learn about healthy sexual practices so that they are equipped with life skills and make informed decisions regarding unhealthy sexual practices. Parents' failure to teach learners about healthy sexual practices has a negative impact on the lives of their children. Culture plays a significant role in influencing parents not to play their role in sharing experiences about healthy sexual practices with their children. Learners' belief in myths regarding healthy sexual practices results in them not accessing health facilities or using proper contraceptives. The lack of parental support from families, the community, and the school is mainly significant since there is inadequate support from the DSD and DoH that offer awareness campaigns at school.

### **7.2.3 *Health system challenges***

The health system challenges include a shortage of health workers (staff), and nurses' workload when the facility is overcrowded to support healthy sexual practices education during the provision of contraceptives among youth. The attitude and behaviour of health professionals when offering healthy sexual practices services have a negative impact on youth because they criticise and judge them, as well as not adhering to the POPIA Act by disclosing the status and confidentiality of consultations with youth.

### 7.3 Matrices of Change Objectives

A matrix of change objectives is the basic tool of Bartholomew et al. (2016) and details what change objectives need to be attained to accomplish performance objectives that will empower changes in behaviour or environmental circumstances that will, in turn, improve the health and quality programme goal identified in the need assessment. This is shown in Figure 71.



**Figure 71: Logical framework for programme development**

Based on the identified impediment, this has benchmarked the matrices of change objectives, which were executed as a determined result through the intervention of content and methods. The matrices of change objectives were grounded in establishing health education, empowerment, motivation, and support. The objective of the programme will be achieved by using these elements.

### **7.3.1 Motivation**

Motivation refers to behaviour driven by both intrinsic and extrinsic motivation with the aim of changing the behaviour of an individual toward health care through lifestyle change (Vinoy & Kumar, 2019). Motivation for healthy sexual practices among learners may come from LO teachers, parents at home, and health professionals (school, family, community, church, and health professionals). Health professionals can involve the CHWs to emphasise the use of contraceptives when engaging in sexual intercourse among youth within the community. Healthcare workers can further encourage parents, and educators to ensure that the utilisation of contraceptives by youth is appropriate and that enough information is provided. The motive can be in the form of a reward for good behaviour.

### **7.3.2 Advocacy**

Advocacy in health starts with the health determinants to establish a change in attitude and behaviour and reduce health inequalities. This element may be done on request, it may also be carried out without the intended recipient or recipients asking for it, with the agent failing to provide a change in behaviours (Hubinette, Dobson, Scott & Sherbino, 2017). These might come as counselling for a change in behaviour through empowering the individual's self-confidence to ensure that he or she makes an informed or better decision about issues that affect their health. Healthcare access necessarily raises principles of fairness, the distribution of resources, systems-based practices, and public policy. This is in line with youth policy, which advocates for a jointly supportive community or environment, including schools and families, that will enable sustainable, healthy sexual practices.

### **7.3.3 Education**

Healthy sexual practices education and support should be encouraged in schools, communities, and families. Parents and teachers should be trained to offer these lessons or discussions without any fear, disseminating appropriate information will enhance the knowledge of youth regarding the myths they have concerning healthy sexual practices. Healthcare professionals, with the assistance of Community health Workers (CHWs), should promote and encourage youth to visit clinics for contraceptives. CHWs must further assist in health education by teaching parents that sex education or talking at home is not taboo. They must not be afraid to share their knowledge, experiences, and consequences of engaging in sexual intercourse at a young age while they are still in school.

The study findings can be attained through health education campaigns, community outreach programmes, and CHW's door-to-door campaigns. Every day at school, health education can

be offered in the morning during assembly congregations. CHWs and health professionals should establish a schedule of healthy sexual practices education programmes targeting parents (families and communities) about cultural stereotypes regarding healthy sexual practices education, or that parents should not have discussions about sex with children.

Regular health education and counselling within the community, family, and school can reduce the misunderstandings, myths, and frustrations of youth regarding healthy sexual practices. Health care professionals and CHWs should conduct healthy sexual practices educational sessions in which youth or learners can participate, including sessions on the prevention measures of sexual intercourse, the transmission of sexual disease, and appropriate information related to the termination of pregnancy, so that learners can pursue education without the burden of a child or the stress of being infected by a chronic disease, such as HIV.

The development of healthy sexual practices intervention flyers with relevant, comprehensive information could cover and improve the accessibility of contraceptives as well as provide relevant information to youth, parents, and teachers. These include programmes to improve healthy sexual practices and the benefits of intervention in healthy sexual practices.

#### **7.3.4 Empowerment**

An extra effort needs to be made to increase youth, parents, life orientation teachers, and pastors' confidence in their ability to inform learners about engaging in healthy sexual practices. This empowerment comprises restricted elimination, and the impact will control perceptions and behaviours toward healthy sexual practices and education. Repeatedly understanding unintended obstacles to healthy sexual practices with the health system and community must be alluded to.

There should be access to both formal and informal opportunities for healthy sexual practices, education, and training skills. For instance, peer educators learn from more experienced healthcare professionals and LO teachers about the variety of ways of teaching healthy sexual practices and the youth zone policies for the provision of healthy sexual practices services.

Healthy sexual practices training should be done by all educators and final-year students. The goal of the programmes is that the effective execution of the identified elements will result in the empowerment of health care professionals, youth at school, churches, and families to be able to deliver positive prevention when engaging in protected sexual intercourse and better choices regarding healthy sexual practices.

### **7.3.5 Support**

Youth need counselling regarding the results of unprotected sexual intercourse. Parents, teachers, and pastors need emotional support through healthy sexual practices. Emotional support during pregnancy, labour, and the postnatal period is closely associated with unhealthy sexual practices that result in unplanned pregnancies. These are the main stressors among school-going youth. The establishment of emotional support during pregnancy affects both elements, the promotion of healthy sexual practices and education can curb teen pregnancies, STIs, and HIV/AIDS issues, as well as build self-confidence regarding abstinence and making an informed decision in the future.

A lack of confidence and doubt amongst parents, teachers, and pastors in churches' competence are common factors in healthy sexual practices and education termination as a result of cultural norms and values. CHWs can conduct household visits to offer healthy sexual practices education as well as support parents, youth, and other stakeholders in ensuring that there is no emotional stress regarding sexual issues. Peer education structures can be established within the community, churches, and schools to encourage youth to regularly visit clinics for contraceptive services for the prevention of STIs, HIV, and teen pregnancy. These structures can be monitored by healthcare professionals and CHWs in the community.

LO teachers, parents, and pastors should establish support groups in the community that can encourage youth to engage in protected sexual intercourse to mitigate STIs, HIV/AIDS, and teen pregnancies. It is families, schools, and the community at large that are responsible to support and encourage youth to access services for healthy sexual practices before they engage in sexual intercourse. Families should encourage their children to visit PHC facilities when they observe that their children are sexually active for healthy sexual practices. Health care professionals, CHWs, and school-based social workers should encourage and support abstinence as well as access to contraceptives at the clinics among school-going youth.

Social workers should provide counselling services to parents who disown their children as a result of an unplanned pregnancy. Parents should be supportive to ensure their children do not develop any emotional stressors and are encouraged to continue with school after the delivery of the infant or child. CHWs and social workers must facilitate and support parental discussion regarding contraceptives, abstinence, and sharing their experiences and consequences of unprotected sexual intercourse with their sexually active children. Furthermore, they must facilitate, support, and encourage the negotiation of protected sexual intercourse among young people and ideas on how to make an informed decision regarding contraceptives and forced sexual intercourse or rape. Lastly, youth must be provided with the

necessary support to acquire the relevant skills for the correct use of contraceptives, as well as follow-ups on the contraceptives chosen. This will reduce missed dose effects if they are using injections and pills as their prevention measures.

#### **7.4 Selecting theory-based intervention methods and practical application**

An HPM aims to describe the factors underlying motivation to engage in health promotion behaviours and it appropriately focuses on people's interactions with their physical and interpersonal environment during initiation to improve health (Pender, 2011). The HPM alluded to the fact that there is a free similitude to models of health protection using the three concepts of the HPM, namely: Individual characteristics and experiences, Behaviour specific cognitions and affect, and behaviour outcome (Pender, 2011). The establishment of communication channels within the community, schools, and churches about innovations for healthy sexual practices education is paramount among youth.

In this study, the researcher collected and analysed both qualitative and quantitative data from learners, LO teachers, and SGBs. Interviews were used to stimulate communication or opinion regarding healthy sexual practices, as well as innovations in social support. The findings of the study were used to identify needs assessments and obstacles to the implementation of healthy sexual practices, for disseminating the study findings and validating the programme.

**Table 22: Proposed educational intervention programme to promote healthy sexual practices**

<b>Target Group</b>	<b>Identified Problem</b>	<b>Programme objectives</b>	<b>Activities</b>	<b>Responsibility</b>	<b>Expected Outcome</b>	<b>Time and place</b>
Health care professionals	Lack of resources (long waiting period, stockout, contraceptives). Violation of POPIA Act at healthcare facilities.	Provision of healthy sexual practices services.	1. Conduct awareness campaigns at school, and in the community about healthy sexual practices.  2. Conduct workshops for teachers about healthy sexual practices.	1. Nurses 2. CHWs	1. To promote healthy sexual practices knowledge and strategies  2. Knowledge of the consequences of unhealthy sexual practices  3. To increase contraceptives usage and accessibility of PHC facilities. 4. Benefits of using contraceptives.	1. Educational programme twice a year at school.  2. Educational programme per quarter in the community and churches  3. Educational programme once a year during royal councils' meetings

Target Group	Identified Problem	Programme objectives	Activities	Responsibility	Expected Outcome	Time and place
Learners	Lack of knowledge, lack of resources at school, ignorance of the use of contraceptives, misconception, and myth regarding contraceptives.	To improve healthy sexual practices	<p>1.Distribution of flyers about healthy sexual practices information at school.</p> <p>2.Provision of ongoing healthy sexual practices education.</p> <p>3.Provide social support education to learners with pregnancy</p>	<p>1.Health care professionals</p> <p>2.Teachers</p> <p>3.Social workers</p>	<p>1.Reduced stresses and worries that lead to fear of accessing clinics.</p> <p>2.Reduces emotional support to learners who are pregnant through rape and unplanned pregnancies.</p> <p>3. Provide accurate information to correct misconception and myths about contraceptives</p>	<p>1.In schools twice a year.</p> <p>2.Community per quarter.</p> <p>3. On-going process</p>



Target Group	Identified Problem	Programme objectives	Activities	Responsibility	Expected Outcome	Time and place
LO Teachers	Lack of resources, lack of confidence, Cultural norms and values, religion and beliefs	To improve knowledge of healthy sexual practices	1.Health education during life orientation 2.Encourage learners to abstain/ visit PHC facilities for contraceptives.	1.Health care professionals 2.Social workers	Motivated and supported learners at school	During Life orientation lesson at school.
Families/ Community/ Church	Cultural norms and values, religion and beliefs	To prevent the barriers to healthy sexual practices	1.Conduct Health education workshops to the community and church regarding the benefits of healthy sexual practices.  2.Conduct door-to-door campaigns to give counselling	1.Health care professionals.  2.Social workers.  3.CHWs	1. Identify Barriers and provide strategies to promote healthy sexual practices. 2. Community empowerment with knowledge and skills on the benefits of healthy sexual practices. 3.Community, churches	1.Tribal authorities twice a year  2.Church per quarter

Target Group	Identified Problem	Programme objectives	Activities	Responsibility	Expected Outcome	Time and place
			<p>and health education regarding healthy sexual practices.</p> <p>3.Distribute flyers with healthy sexual practice information and distribute to the families, church, community during gatherings.</p> <p>4.Distribute condoms in the communities.</p>		<p>empowered with knowledge and skills on the benefits of healthy sexual practices.</p> <p>4.Increased condoms distribution within the community.</p>	

Target Group	Identified Problem	Programme objectives	Activities	Responsibility	Expected Outcome	Time and place
			5.Capacity building of stakeholders 6.Involvement of stakeholders like pastors.			

Healthcare professionals rely on compromising resources for services because of a shortage of staff to render healthy sexual practices services. This results in overcrowding in the PHC facilities, long waiting periods, and long queues, which health workers are unable to manage, especially the healthy sexual practices services, such as health education, before providing contraceptives to youth. Health professionals experience a workload that hinders their services and a shortage of resources, which is a challenge to the provision of healthy sexual practices. Another issue is the violation of the POPIA Act at healthcare facilities, which discourages youth from visiting the PHC facilities for contraceptives and advice regarding sexual issues.

Learners are in a critical situation that requires the co-operation of healthcare professionals, LO educators, families, churches, and the community to strengthen their support by promoting healthy sexual practices. This will underpin the cultural norms and values that play a role in the lack of communication among elders and children about sex issues. PHC facilities must establish a youth zone that will be privately accessed by youth only, will only deal with youth issues, and will adhere to the POPIA Act. Awareness campaigns regarding the promotion of healthy sexual practices should be encouraged and enforced by the Department of Education and Health. This department must establish peer educators in schools who will be trained to disseminate appropriate information regarding healthy sexual practices within the school and be under the supervision of school-based auxiliary social workers.

Teachers, communities, churches, and families: the establishment of training will endorse skills and more knowledge regarding healthy sexual practices among these stakeholders. Training these stakeholders will capacitate them for effective, sustainable community-based behaviour, attitude, and knowledge, which are key to promoting healthy sexual practices. Attitude and behavioural change are the vehicles for empowering the youth to engage in protected sexual intercourse since relevant stakeholders in the community will advise, while others provide contraceptive condoms or increase condom distribution in the community. The issue of cultural stereotypes will be revived as a way of assisting youth not to face the consequences of unprotected sexual intercourse. Counselling programmes will be offered to stakeholders who have special cases regarding sex education. Furthermore, they must establish care and supporting structures that will empower stakeholders to use healthy sexual practices programmes within the community, schools, and churches, which will be under the guidance of healthcare professionals as well as CHWs. Urgent approaches for attitude and

behavioural change are needed within communities, churches, and other stakeholders regarding healthy sexual practices.

The community-based intervention involves all the stakeholders in establishing support groups, such as teen pregnancy support groups, and supporting each other in the community. Teen mothers should establish support for newly pregnant teens, whether at schools or homes, not to drop out of school, they must be encouraged to return and pursue education. As a line of intervention, the community level needs to change its attitude and behaviour and be equipped with the knowledge to do so. There should be discussion of specific interventions and the integration of community-based healthy sexual practices initiatives with preventive and PHC services. These intervention measures include teamwork, where the healthcare facilities work with the established care community structures to measure the rate of healthy sexual practices, thus, reducing the burden of sexual issues.

Conducting workshops and training in the community will increase the ability for active and sustainable community-based attitude, behaviour, and knowledge change. Collaboration with the DoE, DSD, DoH, churches, and traditional healers to clarify the value, beliefs, and practices of healthy sexual practices to their followers can introduce the concept to stakeholders. The significant others should be equipped with information about flyers (Intimate friendships and chronic diseases). They should then meet the stakeholders for feedback, and arrange awareness campaigns and empowerment dates, since society is ready for the information at hand. For instance, the study findings reveal a lack of knowledge about healthy sexual practices and the beliefs and myths that make youth susceptible to sexual diseases. Improved services for healthy sexual practices should occur if youth perceive them as beneficial, feasible, and socially acceptable.

Improving and promoting healthy sexual practices requires changes in attitude, behaviour, and knowledge that lead to changes in cultural norms and values, including both individual and community approaches. Youth alone must typically make an informed decision regarding healthy sexual practices. For instance, healthcare workers may train and teach the benefits of contraceptives and the practice of healthy sexual intercourse at PHC facilities. However, youth feed myths regarding contraceptives, which reduces their chances of accessing healthcare facilities and receiving services. As a result, they end up being pregnant or contracting sexual diseases at a young age.

Attitude, behaviour, knowledge change, and community-based strategies are useful to empower people in a sustainable way. The HPM (Behavioural-specific cognitive and affective) is a suitable tool for observational processes of attitude, behaviour, and knowledge change. In this model, the individual moves from an individual characteristic through recommended practices to awareness, behavioural-specific cognitive and affective processes, and lastly, a behavioural outcome review of trying the new practices.

**Table 23: The stages of change**

<b>Stages of Change</b>	<b>Level of attitude and knowledge towards new practices</b>	<b>Purpose of appropriate communication intervention to move individual to next stage</b>
1.Perceived benefits of action	Has not heard of the benefits of using contraceptives, consequences of sexual intercourse	Provide appropriate information. Life changing opportunity
2.Perceived barriers of action	Heard of lack of resources, and phc facilities	Provide empowerment and encouragements
3.Perceived self-efficacy	Heard of quick sexual intercourse	Provide more information and begin to focus on persuasion
4.Perceived related affect	Heard of Peer influences	Continue to strengthen and support practices including praise influential
5.Interpersonal influences	Reinforce social support to new practices	Provide more information and begin to focus on persuasion
6.Situation influences	Intend to eliminate poverty by having transitional sexual intercourse, lack of negotiation to protected sexual intercourse	Focus on appreciating benefits and overcoming poverty obstacles; introduce negotiation of trying new practices; home visits are appropriate

<b>Stages of Change</b>	<b>Level of attitude and knowledge towards new practices</b>	<b>Purpose of appropriate communication intervention to move individual to next stage</b>
7.Commitment to action	To make informed decision regarding protected sexual intercourse and the use of contraceptives	Believe in new practices and informed others
8.Health promotion behaviour	Believes in protected sexual intercourse and wants to tell their partners. Establishment of family support, peer educators, accessibility of clinics for contraceptives	Provide opportunities for practitioners to communicate messages to families, schools and community to make informed decision on prevention measures

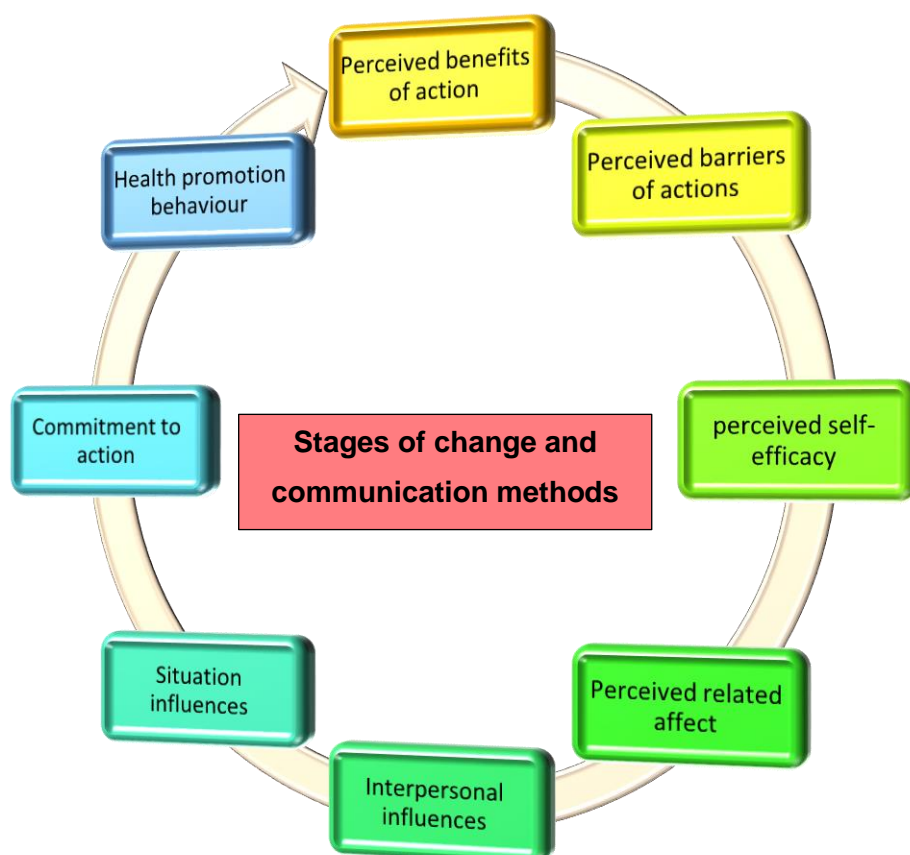
The HPM model enables the implementers to first identify the stage of change for the target audience and then structure interventions to move individuals along the process of change. The stages of change (table 23) revealed a lack of knowledge regarding healthy sexual practices. Youth might have knowledge about practicing protected sexual intercourse, but during engagement in sexual intercourse, they do not wear condoms or do not implement the informed decision. If the health care professionals ask youth to always condomise during awareness campaigns, health education at the PHC facilities, and family training, parents should try to share their sexual experiences with their children at home, and they should try these new practices such as condomising when engaging in sexual intercourse, knowing their HIV status, and making an informed decision before engaging in sexual intercourse. The family will immediately see for themselves the advantages and disadvantages of healthy sexual practices and may convince their children to adopt them; thus, they will not hide condoms within the family, and there will be family discussion regarding the consequences of unhealthy sexual practices. The individual is persuaded through negotiation to move along the change process from knowledge to trial, increasing the chances of adoption.

## **7.5 Stages of change and communication method**

The execution from one stage of changes to another requires a combination of appropriate approach, communication, and training intervention, from the resulting categories:

Community groups, family and individual counselling, peer educators support groups, LO teachers support and regular family visit from CHWs. These approaches help change individual behaviours and cultural beliefs, norms and values and are directed to LO teachers, parents as well as family members, community leaders, churches, and other social and political influences.

Pender's (2011) HPM is suitable for exploring how innovative ideas are introduced and adopted in a community, schools and families. Innovations are more easily implemented when they have certain appearances, such as the case of adoption, comparison to current practices and the benefits that outweigh the disadvantages. When an innovation is introduced to a community by early adopters, others observe the outcomes and gradually adopt the practice themselves. Long-term change of a community norm occurs when a critical mass of community members has tried the innovation and begun to perceive its benefits, per Pender (2011) the process of HPM innovations has eight steps (figure 72).





**Figure 72: Process of HPM innovations**

❖ **Step 1: Perceived benefits of action**

Healthy sexual practices are essential for maintaining a healthy lifestyle. There are numerous benefits of action in healthy sexual practices, including physical, emotional, and psychological benefits.

❖ **Step 2: Perceived barriers of action**

Sexual health is an essential aspect of overall well-being, yet many individuals face perceived barriers to engaging in healthy sexual practices. These physical, psychological, or social barriers can prevent individuals from accessing the resources and information necessary for maintaining good sexual health.

❖ **Step 3: Perceived self-efficacy**

Perceived self-efficacy is a crucial factor in healthy sexual practices. It refers to an individual's belief in their ability to perform a specific behaviour or task successfully. In the context of sexual health, perceived self-efficacy can influence an individual's decision-making process and their ability to negotiate safe sex practices.

❖ **Step 4: Perceived related affect**

Perceived related affect in healthy sexual practices refers to the emotional connection between partners during sexual activity. This connection is crucial in maintaining a healthy and satisfying sexual relationship. The perception of related effects can be influenced by various factors, such as communication, trust, and intimacy.

❖ **Step 5: Interpersonal influences**

Interpersonal influences play a crucial role in shaping healthy sexual practices. The way we communicate, interact, and relate to our partners can significantly impact our sexual health. Positive interpersonal relationships can foster open communication, trust, and mutual respect, leading to healthier sexual practices.

❖ **Step 6: Situation influences**

Healthy sexual practices are essential for maintaining good physical and mental health. However, the situation in which sexual intercourse occurs can have a significant influence on whether or not these practices are followed. Factors such as location, partner choice, and

communication, all play a role in determining the level of safety and satisfaction experienced during sexual encounters.

#### ❖ **Step 7: Commitment to action plan**

Commitment to an action plan for healthy sexual practices is an essential aspect of promoting sexual health and preventing the spread of sexually transmitted infections (STIs). The commitment to action plan involves taking proactive steps toward ensuring that individuals engage in safe sexual practices that protect their health and that of their partners. Another critical aspect of the commitment to the action plan is access to healthcare services. Individuals need access to affordable healthcare services where they can receive testing, treatment, and counseling for STIs and HIV. This includes access to contraception options, such as condoms and birth control pills.

#### ❖ **Step 8: Health promoting behaviour**

Health promoting behaviour plan in healthy sexual practices is an essential aspect of maintaining a healthy lifestyle. Sexual health is not only about avoiding sexually transmitted infections but also encompasses physical, emotional, and social well-being. Therefore, it is crucial to adopt healthy sexual practices that promote overall health and well-being. The first step towards developing a health-promoting behaviour plan in healthy sexual practices is to educate oneself on the risks associated with unprotected sex. This includes understanding the importance of using condoms during sexual intercourse and getting tested regularly for sexually transmitted infections.

## **7.6 Intervention programme**

The developed programme is aimed at promoting healthy sexual practices for four terms in school and life with appropriate balancing contraceptive services in the clinics for a lifetime. These behaviours are promoted during awareness campaigns at schools, life orientation lessons at schools and churches, and community and family advice at homes. Healthy sexual practices must be monitored at the clinics and promoted in the clinics, as well as at school, especially to the newly employed life orientation teachers and grade 8 learners each year. Early initiation of a workshop is needed to train these stakeholders regularly within the school and community levels.

The development of the programme uses educational strategies, counselling, and group activities to change individual behaviour and attitude, while at the same time educating and engaging parents and teachers to influence the notion that healthy sexual practices are taboo as a choice. Continued monitoring of healthy sexual practices at home, in schools, and in the community, as well as counselling during consultation in the PHC facility for contraceptives, provides opportunities for health professionals to negotiate for contraceptive intake follow-ups and to adhere to the practices. The programme is designed to address these issues and educate youth to make informed decisions about protected sexual intercourse to curb the spread of sexual diseases as well as teen pregnancies. Cultural stereotype: to be resuscitated, talking about sex is taboo.

## **7.7 Programme components and materials**

The developed intervention aims to promote healthy sexual practices by addressing multifactorial determinates of healthy sexual practices identified in need assessments. An intervention focused on parents, teachers, churches, families, learners and communities was developed, consisting of a series of health discussions and the promotion of healthy sexual practices (Appendix 24). The developed flyers for youth, pastors, teachers, and communities (Appendix 25) will be given to stakeholders during training and health campaigns and after health discussions. The developed programme consists of three components that are important to achieving the purpose of the intervention. The components include the training of CHWs, parents, teachers, families, the church, and the community.

The first component focused on training parents, and life orientation teachers on implementing the intervention using health discussions. This training will be conducted by health professionals and CHWs. It includes a group discussion session and lecture regarding healthy sexual practices, highlighting the benefits and consequences of healthy sexual practices, and adapting the wrong ideas and influences from cultural norms and values, which is an impediment to healthy sexual practices education. A 30-minute discussion of healthy sexual practices per term at schools and the sharing of experienced teachers and parents, as well as health professionals for successful healthy sexual practices education and experience will take place.

The health care professionals and CHWs will assist the youth, school, families, church, and community with attaining the expected outcome of the intervention programme which includes themes suggested by the programme adopters during the workshops.

The second component focused on teaching youth about the myths surrounding using contraceptives. Health discussions (Health talk 2a) were developed as a guide for healthy sexual practices education content to be taught to youth, parents, teachers, family, community, and church by the CHWs. The health discussions include the benefits of contraceptives, myths regarding contraceptives, and how to use both male and female condoms. This can be attained by using demonstrations and group discussions.

The third component focuses on family, community, and church. After training. CHWs will conduct household campaigns: community, family, and church will be taught about cultural norms and values that will be resuscitated to allow sexual discussion or talk at home (Health talk 1b), and the appropriate time to initiate the discussion of healthy sexual practices, especially when they observe that their children are sexually active. Health discussions and information flyers consist of the following themes:

**Table 24: Information flyers**

<b>1. How to express healthy sexual practices</b>
<b>2. Cultural environment, belief norms and values regarding healthy sexual practices</b>
<b>3. Myths about contraceptives</b>
<b>4. The benefits of healthy sexual practices</b>
<b>5. Consequences of unhealthy sexual practices</b>

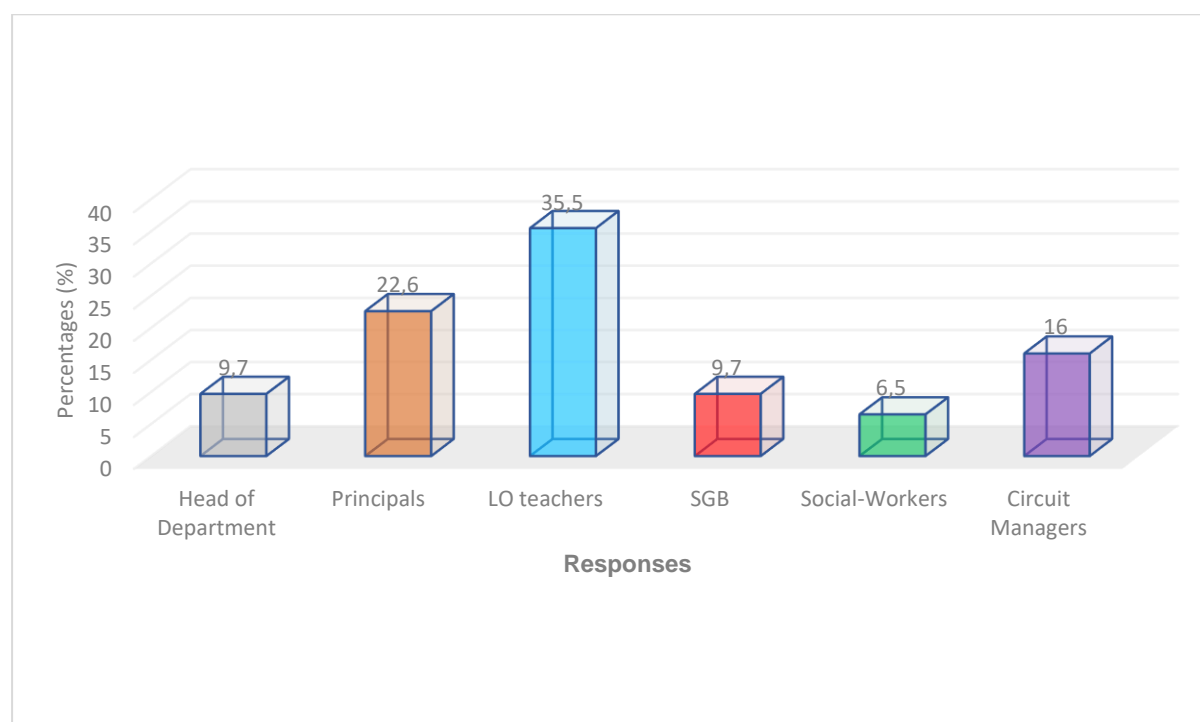
## **7.8 Validation of the developed intervention programme**

Validation is the method that endorses programme beneficiaries receiving relevant and accurate information and services and that the programme yields the expected results. It is vital to validate the programme with the end users (Circuit managers, Heads of Schools, LO teachers, social workers, and SGBs). Thereafter, it can be implemented to determine practicability and significance.

An intervention programme was validated by visiting schools where data was collected from participants, in each selected circuit, two meetings were held with LO teachers and SGBs, as well as managers of the circuits, heads of the school, and curriculum advisors. After the researcher presented the findings, participants were asked to complete the validation questionnaires. The questionnaire consists of level score ratings and Likert scale questions.

Participants had to reveal how they agree or disagree and also the level of relevance to the statements.

Thirty-one respondents validated the developed intervention programme to promote healthy sexual practices among youth. The respondents include the Heads of Department 3 (9.7%), School principals 7 (22.6%), Life Orientation teachers 11 (35.5%), School governing bodies 3 (9.7%), Social Workers 2 (6.5%) and Circuit Managers 5 (16%). Figure 73 provides details.



**Figure 73: Distribution of respondents by their roles**

Validation aimed to measure the intervention programme's quality, relative advantage, compatibility, and flexibility. The following were the goals for determining and validating the programme: Verify the principles employed in the intervention programme's accuracy and viability and consider whether or not they should be adopted by the institution's procedures.

The respondents' responses indicated a positive acceptance of the programme. The validation of results is summarised in percentages of the Likert scale and is combined. Summaries are provided in Table 25.

**Table 25: Results on validation of the programme.**

Descriptions of Items	Agree	Strongly Agree	Disagree	Strongly Disagree
1. Is the developed intervention programme relevant to school learners?	15(48.4%)	13(41.9%)	3(9.7%)	0.0%
2. Should the intervention be offered as a separate subject in schools?	19(61.3%)	7(22.6%)	5(16.1%)	0.0%
3. Is the subject matter comprehensive?	19(61.3%)	11(35.5%)	1(3.2%)	0.0%
4. Are stipulate periods per week sufficient?	14(45.2%)	7(22.6%)	8(25.8%)	2(6.5%)
5. Is the programme achievable?	22(71.0%)	9(29.0%)	0.0%	0.0%
6. Do you concur with the selection procedures of life orientation educators and other stakeholders?	11(35.5%)	15(48.4%)	2(6.5%)	3(9.7%)
7. Do you agree with teachers' training procedures?	15(48.4%)	12(38.7%)	4(12.9%)	0.0%
8. Are the roles of educators in life orientation lessens clear?	19(61.3%)	7(22.6%)	3(9.7%)	2(6.5%)
9. Are the role of nurses in the promotion of healthy sexual practices clear?	14(45.2%)	12(38.7%)	2(6.5%)	3(9.7%)
10. Are the role of social workers in the promotion of healthy sexual practices clear?	14(45.2%)	11(35.3%)	5(16.1%)	1(3.2%)
11. Are the role of SGBs/parents clear in the promotion of healthy sexual practices?	13(41.9%)	6(19.4%)	9(29.0%)	3(9.7%)
12. Are teaching tactics too clear?	18(58.1%)	7(22.6%)	6(19.4%)	0.0%
13. Are learner assessment strategies relevant to life orientation?	26(83.9%)	3(9.7%)	1(3.2%)	1(3.2%)
14. Is the execution setting conducive?	19(61.3%)	12(38.7%)	0.0%	0.0%

The findings show that the developed intervention programme was relevant to school learners. The results further indicated the role played by LO teachers, nurses, social workers, and SGBs were clearly stated, making the programme easy and simple to implement.

The results revealed that respondents felt that there are similarities between the practices variables. This reveal that the programme emphasises the practical aspects of the solution to the problem being solved. Teachers must be trained to offer life orientation lessons, while the

teaching tactics is clear and adoptable for disseminating appropriate information, as well as sufficient periods per week would be in line with the context of life orientation. The programme is achievable, and the assessment strategies are relevant with the life orientation context. Programme's accessibility to implementers was also confirmed, positively indicating that it was easy to interpret and to act on by teachers and parents interested in solving the existing problems. Conclusively, there was common confirmation of the importance of the intervention among 90.3% of validators. These findings show that the intervention programme met the minimum expectations of the validators in clarity, simplicity, implementation ability, and accessibility, in general.

The findings in Table 26 depict the validation quality of the developed programme. The quality validation was based on three indicators, namely, Very Important, Neutral, and Not Important. The interpretations are based on the very important indicators, which had a high opinion of respondents. 61.3% reveal that the developed intervention programme is relevant to the school. 64.5% concurred that the intervention can be offered in a separate subject in school. 64.5% reveal that the subject is comprehensive. 74.2% concurred that the programme is achievable to yield positive results. 54.8% concurred with the selection of teachers to facilitate life orientation and to receive training before they facilitate LO.

The results further indicated the role played by LO teachers, nurses, social workers, and SGBs adds value in promoting healthy sexual practices. 48.4% reveal that the teaching tactics are too clear. 93.5% reported that assessment strategies are relevant to life orientation. 58.1% reveal that the execution setting is conducive to offering healthy sexual practices.

The indicator was very important, showing that the overall quality of the programme based on the given rate, was rated as very important from 48.4% to 93.5% by the respondents. 93.5% of respondents were eager to recommend the use of the programme in the district.

All the validation stakeholders revealed that the programme is adaptable and can be practised. The programme can reduce the challenges of unhealthy sexual practices with which schools are faced. This programme also provides the opportunity to close the gap between parents, and teachers, because parents do not attend school meetings when they are requested. This programme addressed a variety of ways that can bring parents and teachers on board, to work together.

Further, the findings implied that the stakeholders concurred with the developed programme that it can promote healthy sexual practices in Vhembe District in Limpopo Province. Additionally, the validation of the programme generally indicates the success of a developed intervention programme in this study.

**Table 26: The validation quality of the developed programme**

Descriptions of Items	Very Important	Neutral	Not Important
1. Is the developed intervention programme relevant to school learners?	19(61.3%)	8(25.8%)	4(2.9%)
2. Should the intervention be offered as a separate subject in schools?	20(64.5%)	7(22.6%)	4(12.9%)
3. Is the subject matter comprehensive?	20(64.5%)	11(35.5%)	0.0%
4. Are stipulate periods per week sufficient?	15(48.4%)	9(29.0%)	7(22.6%)
5. Is the programme achievable?	23(74.2%)	8(25.8%)	0.0%
6. Do you concur with the selection procedures of life orientation educators and other stakeholders?	17(54.8%)	14(45.2%)	0.0%
7. Do you agree with teachers' training procedures?	17(54.8%)	10(32.3%)	4(12.9%)
8. Are the roles of educators in life orientation lessens clear?	21(67.7%)	7(22.6%)	3(9.7%)
9. Are the role of nurses in the promotion of healthy sexual practices clear?	15(48.4%)	15(48.4%)	1(3.2%)
10. Are the role of social workers in the promotion of healthy sexual practices clear?	16(51.6%)	12(38.7%)	3(9.7%)
11. Are the role of SGBs/parents clear in the promotion of healthy sexual practices?	15(4.4%)	6(19.4%)	10(32.3%)
12. Are teaching tactics too clear?	15(4.4%)	10(32.3%)	6(19.4%)
13. Are learner assessment strategies relevant to life orientation?	29(93.5%)	2(6.5%)	0.0%
14. Is the execution setting conducive?	18(58.1%)	13(41.9%)	0.0%



Open-ended space for comments or opinion regarding an intervention programme was provided. The following are the findings of the data analysis.

- Participants revealed that the intervention programme should be initiated at primary and intermediate schools, as well as rural clinics.
- Life orientation teachers alluded that per week at least one hour period should be offered by health professionals or social workers. Based on the feasibility of the lessons, periods should be increased to three times a week, which was effected.
- It was recommended that once a month ISHPs and mobile clinics should visit rural schools to promote healthy sexual practices and sexual reproductive health services. However, the DoH was consulted and it was stated that it would not be feasible to provide ISHPs and mobile clinics throughout the district because of the shortage of mobile clinics, shortage of staff, health care staff at the health facilities are overloaded and shortage of resources.
- It was further suggested that the DOH must increase its operating hours in PHC facilities to cater for learners who finished school late and seek healthy sexual practices services.
- It was further recommended that the DSD should provide each school with a full-time social worker. The DSD reported that they have constraints with the budget; they are running the department with limited budget. However, they will engage with universities to provide schools with student social workers, as well as a youth development specialist.
- The DOE, DSD, DoH and other stakeholders suggested that an intervention programme to promote healthy sexual practices should also be implemented in primary, intermediate schools, NGOs and NPOs; this has been recommended for further studies.

## **7.9 Plan for implementation of the intervention programme**

This is the IM's fifth step. In essence, it involves using IM to schedule how the programme will be implemented. The programme's development and validation involve identifying and involving potential adopters and implementers, including LO teachers, SGBs/parents, social workers, head of department, heads of schools, and circuit managers. Before the programme is launched in the district, adopters and implementers will also be involved in its piloting. Before it could be adopted, the programme needed to be tested in the real world because the pilot's

goal is to determine whether or not the programme is effective. Two chosen circuits will be used for the piloting.

### **7.10 Evaluation Plan of the developed Intervention Programme**

The process of evaluating how a programme is implemented and how far it has reached the target audience is the last phase in IM (Bartholomew et al., 2016). After the pilot, the evaluation process will be carried out. The execution, which is outside the scope of the study, will determine the effect and impact.

### **7.11 Conclusion**

An intervention programme was developed using collected data. IM was used to guide the development of the programme. HPM was used to guide the stages of the change. Healthcare professionals, Teachers, parents, pastors and community health workers were the key informants to initiate change through health talks. The programme was validated and it was accepted that it might yield change about the promotion of healthy sexual practices.

## **Chapter 8: Summary, Strengths, Limitations, Conclusion and Recommendations**

### **8.1 Introduction**

This chapter presents the summary, limitations, conclusion, and recommendations of the study findings. These summaries were constructed on the results of the study and the limitations of the study were grounded on the challenges uncouneted during the study project. The conclusions of the study were built on the results of the study.

### **8.2 Summary of the study**

The purpose of the study was to develop an intervention programme to promote healthy sexual practices among youth in Vhembe district, Limpopo Province, South Africa. To achieve this, four phases were posed which include:

#### ***8.2.1 Phase 1: Systematic Review***

- ❖ Review the impact of the intervention programme on promoting healthy sexual practices.
- ❖ Describe the intervention programme used to promote healthy sexual practices.

#### ***8.2.2 Phase 2: Empirical study***

- ❖ To assess the knowledge of youth about the promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences the promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influence the increased use of contraceptives or family planning to promote healthy sexual practices among youth.

#### ***8.2.3 Phase 3: Develop the intervention programme***

- ❖ To develop the intervention programme to promote healthy sexual practices among youth.

#### ***8.2.4 Phase 4: Validate intervention programme***

- ❖ To validate the developed intervention programme on the promotion of healthy sexual practices among youth.

The study was a mixed methods approach that utilised both qualitative and quantitative methods using a convergent parallel mixed method. Data were collected simultaneously since

it is the parallel convergent mixed methods principle. For the qualitative strand, the data collection tool was used to guide the researcher during the FGD interviews for both participants (learners 26, LO teachers 25, and SGBs members 16). The sample size was 67 who were purposively sampled and interviewed from different schools in the Vhembe district in selected circuits. Trustworthiness was ensured through the study that includes credibility, transferability, dependability, and confirmability. Thematic principles were used to generate themes and sub-themes and thematic analysis was used to analyse data. For the quantitative strand, the instrument for data collection was the structured self-administrated questionnaire. Validity and reliability issues were considered in the study to ensure the consistency of the work.

The sample size was 531 learners registered for the 2023 academic year in selected high schools and circuits who were purposively recruited to form part of the study. The data was analysed using SPSS version 28.0 and results were presented using bar charts, frequency tables, and the chi-square statistical test was used to compare variables. The significance levels of the variables were tested at 0.005. At the end of qualitative and quantitative data analysis, data was merged. To determine whether to converge data or diverge data, converged data was discussed in Chapter 5.

## **8.3 Strengths and Limitations of the Study**

### ***8.3.1 Strengths of the Study***

The strength of the study rests on the fact that most of the youth who participated in the study age range between 14-19 years and were keen participants in the study. These participants were easily accessible, and they were able to honour appointments for data collection during weekends as they attend school. This displays the commitment to contributing to the change of behaviours and living a healthy lifestyle. For the quantitative strand, the response rate of 75.8% percent in this study was excellent and can, thus, be recorded and make the findings reliable. Learners, SGBs and LO teachers who participated in this study were very co-operative during the entire procedures of data collection and validation of the programme. This added further credibility to this study, while the qualitative strand response rate of 74.4% percent in this study was also excellent. The findings of the study among the youth in the Vhembe district regarding healthy sexual practices can be reported as valuable and significant.

### **8.3.2 *Limitations of the Study***

The results of the study cannot be generalised to the whole of the Limpopo province because the study only focused on one district municipality, other districts municipalities in Limpopo province were excluded from the study. However, the programme can be adopted in all districts of Limpopo province as well as the other provinces in South Africa can use it to promote healthy sexual practices. Even though youth constraints might be experiencing different challenges than the identified ones in this study, an intervention programme can be employed to equip youth in addressing different challenges regarding healthy sexual practices in different provinces than Limpopo province.

The study was liable to bias since some professional teachers refuse to form part of the study, by not honouring appointments due to commitments, and lack of time, while others did not want to hear anything about the research, they further did not want to hear the purpose of the study. In addition, some teachers did not want to sign consent forms and audio recording consent forms which resulted in the discarding of their participation in this study.

## **8.4 Conclusion**

The purpose of the study was to develop an intervention programme to promote healthy sexual practices among youth in Vhembe district, Limpopo province. To accomplish this purpose, decisive research was conducted and a robust methodology that consists of mixed methods, both qualitative and quantitative approaches, using convergent paralleled mixed methods. Data were simultaneously collected, analysed and integrated the results for both qualitative and quantitative approaches. Lastly, data were merged in a single study.

The study was guided by the Health Promotion Model. The analysis revealed several impediments that include lack of knowledge, and perception regarding healthy sexual practices and misconception regarding healthy sexual practices such as STIs, HIV/AIDS and pregnancy, early marriage (arranged marriage) and forced marriage, early sexual doubt, poverty influences on peer norms and involvement, lack of knowledge, and perception regarding healthy sexual practices, risk of forced sexual activity by sexual partners and older people, sexual harassment by educators in school and peer influences, curiosity and experimentation, perceived control of risky sexual behaviour, violation of POPIA act at clinics, challenges on the provision of contraceptives and side effects by health care nurses, contraceptives stockout, clinic located far from villages, long waiting periods, queues move slowly at the clinic and cultural environment, belief norms and values regarding healthy sexual

practices embarrassment in Vhembe district. The HPM was used to develop the intervention programme by integrating it into the Intervention mapping process.

Validation of the programme was done to determine accuracy on whether the programme would work or not. The indicator was very important, showing that the overall quality of the programme, based on the given rate, was rated as very important from 48.4% to 93.5% by the respondents. 93.5% of respondents were eager to recommend the use of the programme in the district.

All the validation stakeholders revealed that the programme is adoptable and can be practised. The programme can reduce the challenges of unhealthy sexual practices with which schools are faced. This programme also provides the opportunity to close the gap between parents, and teachers, because parents do not attend school meetings when they are requested. This programme has addressed a variety of ways that can bring parents and teachers on board, to work together.

## **8.5 Recommendations.**

Based on the research findings and conclusions of the study, the researcher would like to suggest the following recommendations:

### **8.5.1 Recommendations for Learners**

- ❖ By promoting responsible behaviour and delivering accurate information, we can empower youth to make an informed decision regarding their healthy sexual practices.
- ❖ Consent should always be enthusiastic, on-going, and spontaneously given by all parties involved or sexual partners. Educating learners about consent helps adopt a culture of respect and ensures that everyone's boundaries are respected. It will reduce forced and rape sexual intercourse.
- ❖ Learners should be encouraged to use contraceptive methods, such as condoms, consistently and correctly when they engaged in sexual intercourse. Further, regular testing for STIs, HIV and teen pregnancy should be promoted as part of a comprehensive approach to promoting healthy sexual practices.
- ❖ Learners should be encouraged to have open communication with partners, which is key to maintaining healthy sexual practices' relationships. Encouraging learners to discuss their desires, boundaries, and concerns with their partners promotes trust and mutual understanding, as well as practicing protected sexual intercourse.

- ❖ Learners should be provided with healthy sexual practices and educated about the importance of regular follow-ups with healthcare professionals specialising in healthy sexual practices services. These professionals can provide guidance on contraception options, and STI prevention strategies, and answer any questions or concerns learners may have.

### **8.5.2 Recommendations for Teachers**

- ❖ Teachers should be equipped with knowledge regarding healthy sexual practices. Teachers should be provided with training regarding healthy sexual practices' education.
- ❖ Teachers should be provided with adequate resources in order to teach accurate information about healthy sexual practices.
- ❖ Teachers should be provided with counselling that healthy sexual practice education is not a taboo; it must be taught at school.

### **8.5.3 Recommendations for SGBs / parents**

- ❖ Parents should receive the Sassa child grant on behalf of school-going youth. This will reduce unplanned pregnancies with the aim of receiving grant money. It will also reduce cases of school-going youth having two children before completing school.
- ❖ Parents should provide their children with guidance on healthy sexual practices. By doing so, parents can help their children grow positive and responsible attitudes toward healthy sexual practices.
- ❖ Parents should make an environment where their children feel comfortable discussing themes related to healthy sexual practices. This includes answering questions honestly and age-appropriately, without judgement or embarrassment. By fostering open dialogue, parents can ensure that their children receive accurate information regarding healthy sexual practices and relationships.
- ❖ Parents should highlight the importance of consent and respect in sexual relationships. Teaching children about boundaries and consent from an early age helps them understand the significance of mutual agreement in any sexual intercourse. This knowledge will empower them to make informed decisions about their own bodies and to respect their bodies.
- ❖ Parents should educate their children about contraception methods, abstinence and healthy sexual practices. It is important for youth to be aware of the various

contraceptive options available to them to prevent unplanned pregnancies or sexually transmitted infections (STIs). Parents can also encourage consistent visits to healthcare professionals for comprehensive healthy sexual practices' services follow-ups.

#### **8.5.4 Recommendations for churches**

- ❖ Churches must emphasise the significance of abstinence before marriage. This teaching encourages youth to develop self-control and respect for themselves and their future partners. By abstaining from sexual activity until marriage, couples can build a foundation of trust and commitment when promoting healthy sexual practices.
- ❖ Churches advocate for faithfulness within marriage, thus promoting commitment that encourages stability in relationships and protects against sexually transmitted infections (STIs). They should encourage open communication between spouses about sexual desires and boundaries that also enhances intimacy. This encourages parents to promote healthy sexual practices.
- ❖ Churches should emphasise the importance of consent in sexual relationships. Consent should ensure that both partners freely agree to engage in any sexual intercourse without coercion or manipulation. This principle promotes mutual respect and dignity between sexual partners.

#### **8.5.5 Recommendations for the Policy Makers (Department of Education)**

- ❖ Policy makers should terminate Sassa child grant support from school-going youth, they should ensure that parents receive grants on behalf of their children. This will reduce unplanned pregnancies with the aim of getting a child grant.
- ❖ Policymakers should prioritise the youth zone, which will offer healthy sexual services for youth consultation.
- ❖ Policy makers should prioritise comprehensive healthy sexual practices education in schools. This includes teaching the youth about consent, contraception methods, sexually transmitted infections (STIs), and the importance of healthy relationships. By equipping learners with this knowledge early on, they are more likely to make informed decisions about their sexual health.
- ❖ Policymakers should focus on increasing access to affordable and reliable contraception methods. This can be achieved by subsidising contraceptives or making them available free of charge through PHC facilities services. By doing so, youth will



have greater control over their healthy sexual practices' choices and reduce the risk of unplanned pregnancies and contracting STIs and HIV.

- ❖ Policymakers should address the stigma surrounding STIs by promoting regular testing and treatment. They can establish initiatives that provide confidential testing services at no cost or low cost to encourage youth to seek medical help without fear of judgement or discrimination or violation of the POPIA act.

## **8.6 Recommendations for future research**

It is recommended that further studies should be done in other districts municipalities and schools using other research designs, including other variables that have a significant influence on the promotion of healthy sexual practices, and other groups, such as learners in primary schools from grade 6 and 7 to be included in future research. The following research topics can be researched in the future: The development of guidelines to promote healthy sexual practices among learners in the Vhembe district, Limpopo province; Intervention strategies to promote healthy sexual practices among primary school learners in Vhembe district municipality, Limpopo province, South Africa; Investigation of healthy sexual practices among learners in Vhembe district municipality, Limpopo province, South Africa: with a public health intervention, and Evaluation of an intervention programme to promote healthy sexual practices among youth in Vhembe district, Limpopo Provinces.

## **8.7 Conclusion**

This study was designed to develop an intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province. This purpose was achieved through formative research that was conducted and a robust methodology of mixed methods using a convergent parallel mixed method where qualitative and quantitative data were intergrated. This ensured a comprehensive enquiry spanning the length and breadth of the research topic, guided by both the HPM, and IM to develop an intervention programme.

The results were compared with an intensive literature review to identify a gap in the study. Cultural environment, beliefs, norms and values were the identified gap in this study. This depicts the difficulty between teachers and parents to have health talk with learners at school and at home. This difficulty potentially leads learners to be vulnerable to the consequences of unhealthy sexual practices. Teachers, parents, pastors, healthcare professionals, social workers and community health workers are the key informants to initiate changes of attitude, knowledge and behaviour among learners at home and schools.

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# Appendix 1: Approval from University of Venda Ethical Committee

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION  
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:  
**Mr NV Khosa**

STUDENT NO:  
**11625895**

PROJECT TITLE: **An intervention programme to promote healthy sexual practices among Youth in Vhembe District, Limpopo Province.**

ETHICAL CLEARANCE NO: **FHS/22/PH/22/0303**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr AG Mudau	UNIVEN, Public Health	Supervisor
Prof L Makhado	UNIVEN, Public Health	Co - Supervisor
Mr NV Khosa	UNIVEN, Public Health	Investigator - Student

Type: **Doctoral Research**

Risk: **Minimal risk to humans, animals, or environment (Category 2)**  
Approval Period: **March 2023 – March 2024**

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

**General Conditions**

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principal investigator) must report in the prescribed format to the REC:
  - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project.
  - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
  - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date; a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
  - Request access to any information or data at any time during the course or after completion of the project,
  - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
  - withdraw or postpone approval if:
    - Any unethical principles or practices of the project are revealed or suspected.
    - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
    - The required annual report and reporting of adverse events was not done timely and accurately.
  - New institutional rules, national legislation or international conventions deem it necessary.

ISSUED BY:  
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE  
Date Considered: February 2023

Name of the HCTREC Chairperson of the Committee: Prof MS Maputle

Signature

*MS Maputle*

<b>UNIVERSITY OF VENDA</b> OFFICE OF THE DIRECTOR RESEARCH AND INNOVATION  <b>2023 -03- 06</b>  Private Bag X5050 Thohoyandou 0950
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UNIVERSITY OF VENDA  
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA  
TELEPHONE: (018) 862 8048/311 FAX: (018) 862 8066  
"A quality driven financially sustainable, rural-based Comprehensive University"

## Appendix 2: Letter to Office of the Premier Limpopo Province



P.O. Box 1249  
Malamulele  
0982

Office of The Premier  
Private Bag X9489  
Polokwane  
0700

Dear Sir/ Madam

### **REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR PROVINCIAL DoE.**

I, the undersigned, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Vhembe District Municipality, the proposed topic of my research is: ***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.*** The study objectives are:

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influences the increased use of contraceptives or family planning to promote sexual healthy practices among youth.

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Contact details: 072 858 8418/ 078 113 9522 Email. [khosavn@gmail.com](mailto:khosavn@gmail.com) Your permission to conduct this study will be greatly appreciated.

Kind regards,

Mr. N.V. Khosa Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix 3: Approval from Office of the Premier Limpopo Province

CONFIDENTIAL

 **LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

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OFFICE OF THE PREMIER

**TO: DR MC MAKOLA**  
**FROM: PROF I SWARTS**  
**CHAIRPERSON: LIMPOPO PROVINCIAL RESEARCH ETHICS COMMITTEE (LPREC)**  
**REVIEW DATE: 04 MAY 2023**  
**SUBJECT: AN INTERVENTION PROGRAMME TO PROMOTE HEALTHY SEXUAL PRACTICES AMONG YOUTH IN VHEMBE DISTRICT**  
**RESEARCHER: KHOSA NV**

Dear Colleague

The above researcher's research proposal served at the Limpopo Provincial Research Ethics Committee (LPREC). The committee is satisfied with the methodological ethical soundness of the proposal.

**Decision: The research proposal is granted approval**

Regards

Chairperson: Prof I Swarts



Secretariat: Ms MJ Mokgokong



Date: 19/05/2023

CONFIDENTIAL



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

**OFFICE OF THE PREMIER**

Office of the Premier

Research and Development Directorate

Private Bag X9483, Polokwane, 0700, South Africa

Tel: (015) 230 9910, Email: mokoblj@premier.limpopo.gov.za

**LIMPOPO PROVINCIAL RESEARCH ETHICS  
COMMITTEE CLEARANCE CERTIFICATE**

**Review Date: 04 May 2023**

**Project Number: LPREC/86/2022: PG**

**Subject: An Intervention Programme to Promote Healthy Sexual Practices among Youth  
in Vhembe District, Limpopo Province**

**Researcher: Khosa NV**

**Chairperson: Prof I Swarts**

Chairperson: Limpopo Provincial Research Ethics Committee

The Limpopo Provincial Research Ethics Committee (LPREC) is registered with National Health Research Council (NHREC) Registration Number REC-111513-038.

**Note:**

- i. This study is categorized as a Low Risk Level in accordance with risk level descriptors as enshrined in LPREC Standard Operating Procedures (SOPs)
- ii. Should there be any amendment to the approved research proposal; the researcher(s) must re-submit the proposal to the ethics committee for review prior data collection.
- iii. The researcher(s) must provide annual reporting to the committee as well as the relevant department and also provide the department with the final report/thesis.
- iv. The ethical clearance certificate is valid for 12 months. Should the need to extend the period for data collection arise then the researcher should renew the certificate through LPREC secretariat. PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRIES.

## Appendix 4: Letter to Provincial Department of Education Limpopo Province



P.O. Box  
1249  
Malamulele  
0982

The Department of Education  
Private Bag X9489  
Polokwane  
0700  
Dear Sir/ Madam

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SCHOOL

I, the undersigned, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Vhembe District Municipality; the proposed topic of my research is:

***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.*** The study objectives are:

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influence the increased use of contraceptives or family planning to promote sexual healthy practices among youth.
- ❖ To develop the intervention program to promote healthy sexual practices among youth

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Contact details: 072 858 8418/ 078 113 9522 Email. khosavn@gmail.com  
Your permission to conduct this study will be greatly appreciated.

Kind regards,  
Mr. N.V Khosa  
Signature: \_\_\_\_\_



## Appendix 5: Approval from Provincial Department of Education Limpopo Province

Confidential Information - This is for official consumption



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF  
**EDUCATION**  
CONFIDENTIAL

Ref: 2/2/2      Enq: Makola MC      Tel No: 015 290 9448      E-mail: [MakolaMC@edu.limpopo.gov.za](mailto:MakolaMC@edu.limpopo.gov.za)

**Khosa NV**

P.O. Box 582,  
Malamulele  
0982

**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: **"AN INTERVENTION PROGRAMME TO PROMOTE HEALTHY SEXUAL PRACTICES AMONG YOUTH IN VHEMBE DISTRICT, 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 School concerned.
  - 3.3 The conduct of research should not in 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).
  - 3.6 Upon completion of research study, the researcher shall share the final product of the research with the Department.

REQUEST FOR PERMISSION TO CONDUCT RESEARCH : KHOSA NV Page 1

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Cnr 113 Biccard & 24 Excelsior Street, POLOKWANE, 0700, Private Bag X 9489, Polokwane, 0700  
Tel: 015 290 7600/ 7702 Fax 086 218 0560

***The heartland of Southern Africa-development is about people***



## Appendix 6: Letter to Schools in Vhembe District



P.O. Box  
1249  
Malamulele  
0982

Dear Sir/ Madam

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SCHOOL

I, the undersigned, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Vhembe District Municipality, the proposed topic of my research is: ***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.*** The study objectives are:

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influence the increased use of contraceptives or family planning to promote sexual healthy practices among youth.
- ❖ To develop the intervention program to promote healthy sexual practices among youth

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Contact details: 072 858 8418/ 078 113 9522 Email. khosavn@gmail.com your permission to conduct this study will be greatly appreciated.

Kind regards,

Mr. N.V Khosa

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix 7: Letter to Circuits in Vhembe District



P.O. Box 1249  
Malamulele  
0982

Dear Sir/ Madam

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR CIRCUIT

(Malamulele West Circuit, Malamulele Central Circuit, Malamulele South Circuit, Vurhonga One Circuit, and Vurhonga Two).

I, the undersigned, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Vhembe District Municipality, the proposed topic of my research is: ***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.*** The study objectives are:

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influence the increased use of contraceptives or family planning to promote sexual healthy practices among youth.
- ❖ To develop the intervention program to promote healthy sexual practices among youth

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Contact details: 072 858 8418/ 078 113 9522 Email. [khosavn@gmail.com](mailto:khosavn@gmail.com) your permission to conduct this study will be greatly appreciated.

Kind regards,

Mr. N.V Khosa

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix 8: Approval from Malamulele West Circuit



LIMPOPO  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF  
**EDUCATION**  
VHEMBE EAST DISTRICT  
**MALAMULELE WEST CIRCUIT**

Ref: 13/3/2/11

Enq: Chauke K.C

Cell: 084 470 7377

Email: khazamulacollinschauke@gmail.com

**CONFIDENTIAL**

**PRINCIPALS OF SCHOOLS  
SCHOOL GOVERNING BODIES**

**PERMISSION TO CONDUCT RESEARCH IN MALAMULELE WEST CIRCUIT**

1. The above matter refers.
2. Permission is hereby granted to Khosa Ntiyiso Vinny, a registered PhD student in the Department of Public Health at the University of Venda. The main focus of the research will be: **AN INTERVENTION PROGRAMME TO PROMOTE HEALTHY SEXUAL PRACTICES AMONG YOUTH IN VHEMBE DISTRICT, LIMPOPO PROVINCE.**
3. The following conditions are to be considered:
  - 3.1 The research do not have any financial implication for the Limpopo Department of Education.
  - 3.2 The research should not in any how disrupt the academic programs at the schools.
  - 3.3 The research should not be conducted during the time of Examinations especially the fourth term.
  - 3.3 During the study, applicable research ethics should be adhered to; in particular the principle of voluntary participation (the people involved should be respected).
  - 3.4 Upon completion of research study, the researcher shall share the final product of the research with the Department.
4. This letter is expected to be produced by the researcher at school where he intend to conduct research as an evidence that he is permitted to conduct the research.
5. Hope you find this in order.

  
7 **CIRCUIT MANAGER**  
**MALAMULELE WEST CIRCUIT**

18.04.2023  
**DATE**

Malamulele West Circuit Building opposite Shitthelani Clinic, Private Bag X 9133, Malamulele, 0982  
Tel: (015) 851 7919, 7920, 7921 Fax: 086 516 2264

**The heartland of southern Africa - development is about people!**

## Appendix 9: Approval from Malamulele South Circuit



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF  
**EDUCATION**

**VHEMBE EAST DISTRICT  
MALAMULELE SOUTH CIRCUIT**

Ref: 13/3/2/11

Enq: Chauke K.C

Cell: 084 470 7377

Email: khazamulacollinschauke@gmail.com

**CONFIDENTIAL**

**PRINCIPALS OF SCHOOLS  
SCHOOL GOVERNING BODIES**

**PERMISSION TO CONDUCT RESEARCH IN MALAMULELE SOUTH CIRCUIT**

1. The above matter refers.
2. Permission is hereby granted to Khosa Ntiyiso Vinny, a registered PhD student in the Department of Public Health at the University of Venda. The main focus of the research will be: **AN INTERVENTION PROGRAMME TO PROMOTE HEALTHY SEXUAL PRACTICES AMONG YOUTH IN VHEMBE DISTRICT, LIMPOPO PROVINCE.**
3. The following conditions are to be considered:
  - 3.1 The research does not have any financial implication for the Limpopo Department of Education.
  - 3.2 The research should not in any way disrupt the academic programs at the schools.
  - 3.3 The research should not be conducted during the time of Examinations especially the fourth term.
  - 3.3 During the study, applicable research ethics should be adhered to; in particular the principle of voluntary participation (the people involved should be respected).
  - 3.4 Upon completion of research study, the researcher shall share the final product of the research with the Department.
4. This letter is expected to be produced by the researcher at school where he intend to conduct research as an evidence that he is permitted to conduct the research.
5. Hope you find this in order.

  
7 **CIRCUIT MANAGER  
MALAMULELE SOUTH CIRCUIT**

18. 04. 2023.  
**DATE**

Malamulele South Circuit Building opposite Shitshelani Clinic, Private Bag X 9133, Malamulele, 0982  
Tel: (015) 851 7919, 7920, 7921 Fax: 086 516 2264

**The heartland of southern Africa - development is about people!**



## Appendix 10: Approval from Malamulele Central Circuit



**LIMPOPO**  
PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF  
**EDUCATION**  
**VHEMBE DISTRICT**  
**MALAMULELE CENTRAL CIRCUIT**

**CONFIDENTIAL**

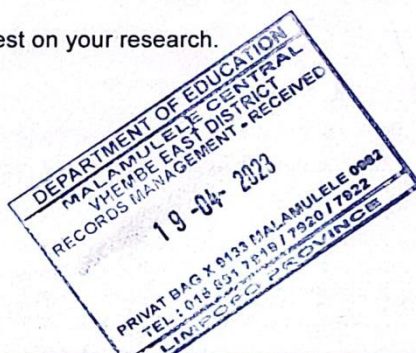
Ref: 2/2/1/1 Enq: Mnisi R.T. Cell: 0640640000/0660660000

Mr Khosa N.V.  
P.O. Box 1249  
MALAMULELE  
0982

**REQUEST FOR A PERMISSION TO CONDUCT RESEARCH AT MALAMULELE CENTRAL CIRCUIT: YOURSELF**

1. The above matter refers.
2. Your request for a permission to conduct research at Malamulele Central Circuit schools has been approved on the following condition that:
  - 2.1. Schools will not be disturbed for effective teaching and learning.
  - 2.2. Research must be done after 14h30.
  - 2.3. You will be at your school till after 14h30 for your research.
  - 2.4. The research will not be conducted during the time of examinations, especially the fourth term.
3. You are further requested to make prior arrangements with the school principals of the schools concerned.
4. Wishing you all the best on your research.

CIRCUIT MANAGER



18/04/2023  
DATE

Malamulele Central Circuit Building Opposite Shitshelani Clinic, Private Bag X 9133, Malamulele, 0982

Tel: (015) 851 7919, 7920, 7921 Fax: 086 537 3059

**The heartland of southern Africa - development is about people!**

## Appendix 11: Approval from Vhuronga One circuit



**LIMPOPO**

PROVINCIAL GOVERNMENT  
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF  
**EDUCATION**

**VHURONGA ONE CIRCUIT**

Enq: Mafune ID  
Cell: 071 676 4372

10 May 2023

DEPARTMENT OF EDUCATION
VHURONGA ONE CIRCUIT
VHEMBE EAST DISTRICT
RECORD MANAGEMENT - RECEIVED
10 MAY 2023
PRIVATE BAG X 1248 VUWANI 0952
TEL: 015 961 5417
LIMPOPO PROVINCE

**Principals of Schools**

1. The above matter bears reference.
2. Kindly be informed that Khosa N.V has been granted permission to conduct research in Vhuronga 1 Circuit.
3. Your co-operation shall be highly appreciated.

Vhuronga 1 Circuit Office  
Mafune I.D

10/05/2023

Date

Vhuronga One Circuit, P/Bag X 1248, Vuwani 0952

Tel: 015 961 5417, e-mail: mafuneid@gmail.com

THE HEARTLAND OF SOUTHERN AFRICA: DEVELOPMENT IS ABOUT PEOPLE



## Appendix 12: Approval from Vhuronga Two Circuit



*Limpopo Province*  
Department of Education  
**VHURONGA TWO CIRCUIT**

P/Bag X1248  
VUWANI  
0952  
Tel: (015) 961 5417  
Fax: 0159615417

Enq : Thivhafuni TJ  
Tel : 015 961 5417  
Cell : 082 094 4500

08 May 2023

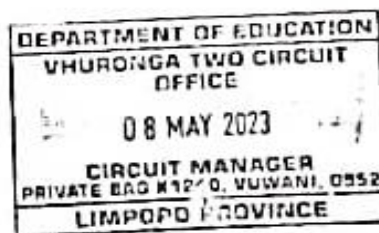
To: Khosa NV

**RE: PERMISSION TO CONDUCT RESEARCH IN VHURONGA 2 CIRCUIT.**

1. The above matter refers.
2. Vhuronga 2 Circuit Office would like to inform you that permission to conduct research is granted on condition that you adhere to research ethics.
3. Furthermore, you are requested to make arrangements with principals of schools where data will be conducted on time.
4. All the best with your research study.

*Thivhafuni TJ*  
Circuit Manager

*08/05/2023*  
Date



---

Vuwani Magistrate Buildings, Vuwani 0952.  
Tel/Fax 015 961 5417 Cell No: 082 094 4500

**The heartland of Southern Africa- development is about people**

## Appendix 13: Letter to The head of the schools



P.O. Box 1249  
Malamulele  
0982

To the head of the school (principal).

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN YOUR SCHOOL

I, the undersigned, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda. I am hereby requesting permission to conduct a study on schools under Vhembe District Municipality, the proposed topic of my research is: ***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.*** The study objectives are:

- ❖ To assess knowledge of youth about promotion of healthy sexual practices.
- ❖ To explore factors and the sexual risk behaviours that influences promotion of healthy sexual practices.
- ❖ To explore and describe measures that could influences the increased use of contraceptives or family planning to promote sexual healthy practices among youth.
- ❖ To develop the intervention program to promote healthy sexual practices among youth

Should you require any further information, please do not hesitate to contact me or my supervisor. Upon completion of the study, I undertake to provide you with a bound copy of the dissertation. Contact details: 072 858 8418/ 078 113 9522 Email. khosavn@gmail.com Your permission to conduct this study will be greatly appreciated.

Kind regards,

Mr. N.V Khosa

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Appendix 14: Participants information letter



### Introduction

I, Khosa Ntiyiso Vinny, am a registered PhD student in the Department of Public Health at the University of Venda conducting research on a study under the topic: '***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.***' I am hereby requesting permission from you to participate in the study by giving information concerning the promotion of healthy sexual practices.

### How will you participate in the study?

In case you voluntarily participate in this study, you will be required to complete consent form on the study. An interview guide will be used to probe opinions associated with promotion of sexual health practices. It will take almost 45 minutes per interview. Your answers will not be assessed as wrong or right since people have different opinions, your opinion will be helpful on the healthy sexual practices.

### What are your rights as research respondents?

When you have opted your choice to participate in the study, participation is voluntarily there is no reward. You are free to reject or to accept to be part of the study. You are also allowed to withdraw at any time when you wish not to continue with the study. You are allowed to withdraw at any time when you wish not to continue with the study, without being asked or to explain the reason.

### How will your personal privacy and confidentiality be protected?

All your answers will be strictly kept in a confidential manner. Furthermore, you will not be requested to write your name or id number on the questionnaire. Information collected will not be associated with any name in the report of the study and information collected will only be accessed by the researcher. Nobody will access the information except the researcher.

---

Researcher Signature

---

Date

For further information, please do not hesitate to contact me at 0728588418/0781139522. Khosavn@gmail.com in order for clarity.

## Appendix 15: Consent Forms

### RESEARCH ETHICS COMMITTEE

#### UNIVEN Informed Consent

##### Appendix 1

### LETTER OF INFORMATION

**Title of the Research Study : AN INTERVENTION PROGRAMME TO PROMOTE HEALTHY SEXUAL PRACTICES AMONG ADOLESCENT IN LIMPOPO PROVINCE**

**Principal Investigator/s/ researcher : (Mr. KHOSA N. V, BSc (RLP), PGDM and MPH).**

**Co-Investigator/s/supervisor/s : (Dr. A.G Mudau, B Cur, MPH, and PhD)**

**: (Prof. L. MAKHADO, BA Cur, MSc, and PhD).**

### **Brief Introduction and Purpose of the Study:**

Globally, 21 million adolescent girls between the age of 15 to 19 years and two million adolescent girls under the age of 15 years become pregnant in developing countries (WHO, 2018). In addition, 16 million adolescent girls between the age of 15 to 19 years and 2.5 million adolescent girls under the age of 16 years give birth in developing countries (WHO, 2015). Each year almost 80 million women and adolescent females conceive unplanned pregnancies globally, of which 38% can be considered as an epidemic (Boah et al., 2019). A study conducted in Southeast Asian by Lopez, Mukaire and Mataya (2015) asserted that both adolescent boys and girls engaged in unhealthy sexual practices at a very young age. Furthermore, it was reported that 50% of sexually active adolescents never wore condom and 35% had incorrectly wore or used condoms (Boah et al., 2019). Sani (2018) asserted that 24% of adolescent lack knowledge of using condom and they were unaware of sexual transmitted Diseases (STD's), HIV and AIDS. Itodo et al. (2020) alluded that adolescent in France do not trust condoms that it shields them from contracting STI's, HIV and AIDS. Thus, Gonorrhoea continues to rise among adolescent in France (Itodo et al., 2020). The purpose of this study is to develop the intervention program to promote healthy sexual practices among adolescent in Limpopo Province

### **Outline of the Procedures**

The study will be conducted in Vhembe District Municipality in Limpopo Province. Learners between the age of 13 to 35 years enrolled under the selected circuit in Vhembe district will be recruited to form part of the study. Learners under the age of 18 years, parental consent will be requested before forming part of the study. Life orientation educators will form part of the study. School Governing Body members will be recruited to form part of the study. A focus group discussion interviewed will be conducted. Additionally, the respondents consent form

will be obtained prior actual data collection. The interview session might take an estimate 45 minutes to make sure that clarity-seeking questions are clarified. The consent form to record an interview will be sought from the participants. The interview will be conducted in Xitsonga and Tshivenda then translated to English. The responsibility of the researcher will be to listen, observe, and guide the respondents through the interview session until fundamental aspects about the interview guide have been explored. An audio tape recorder will be used to record the interview sessions.

**Risks or Discomforts to the Participant:** (There is no harm expected to the participants during their participation in the study).

**Benefits** : (Publications will be done in accredited journals nationally and internationally).

Reason/s because the Participant May Be Withdrawn from the Study: (There is no harm expected on the participants during their participation in the study.)

**Remuneration** : (There will be no remuneration for participating in the study.)

Costs of the Study : (No costs will be incurred by the participants)

**Confidentiality** : (To ensure confidentiality, the participants will not require to provide their names or identity numbers. Participants will be given a unique code for this study to avoid the use of their names and identity. The completed questionnaires will be stored in a safe lock by the researcher.)

**Research-related Injury** : (In the event of injuries, no injuries will be anticipated in this study as it only involves answering questions).

## **General:**

### **Persons to Contact in the Event of Any Problems or Queries:**

(Dr. Mudau A.G and 015 962 8601) Please contact the researcher (072 858 8418), my supervisor (079 493 2339) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Snr Prof Jabulani Makhubele on 015 962 8313 or [Jabulani.Makhubele@univen.ac.za](mailto:Jabulani.Makhubele@univen.ac.za)



## CONSENT FORM

I ..... hereby confirm that I have been informed by the researcher, Khosa Ntiyiso Vinny, about the nature, conduct, benefits, and risks of this study - Research Ethics Clearance Number: FHS/22/PH/22/0303.

I have also received, read, and understood the above written information (*Participant Letter of Information*) regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

I understand that significant new findings developed during this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
--------------------------	------	------	-----------

I,.....	.....	.....	.....
---------	-------	-------	-------

(*Khosa Ntiyiso Vinny*) herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

.....	Date.....	Signature.....
-------	-----------	----------------

Full Name of Witness (If applicable)

.....	Date .....	Signature.....
-------	------------	----------------

Full Name of Legal Guardian (If applicable)

.....	Date.....	Signature.....
-------	-----------	----------------

## Appendix 16: Consent for audio recording Individual consent



I \_\_\_\_\_ agree to answer participate in the study and the interview may be recorded by the investigator/ researcher.

Parent consent for less than 18 years.

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_ give consent for my child's answers in the individual interview/ group to be audio recorded.

I understand that:

➤ The Participants identity information and responses will remain confidential throughout the study

My child Identity will be protected and remain anonymously.

➤ The tapes will be locked and kept safe throughout the study, only the researcher and Supervisor will have access to the tapes.

➤ After the completion of the study, tapes will be destroyed.

➤ There are no risks, incentives (rewards) or benefits involved in the study.

I also confirm that the details above have been explained to my child.

Signed:

Name:

Date:

\_\_\_\_\_

## Appendix 17: Assent Form

### Introduction

I, Khosa Ntiyiso Vinny, am a registered PHD student in the Department of Public Health at the University of Venda conducting research on a study under the topic: ***An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province.***

The purpose of this study is to develop the intervention program to promote healthy sexual practices among youth in Vhembe District, Limpopo Province. This information will enable the researcher to come up with a programme that will assistance in improving healthy sexual practices or safe sex education and help prevent school going pupils from adolescent pregnancy, STI's and HIV infection. Participation in this study is not forceful, therefore, you can withdraw from participation at anytime without providing any reason.

### Can anything bad happen to you?

In case you have physical, emotional, spiritual, economic, social problems, if you were being misled to have sexual intercourse some statements may remind you of such an event. School social workers providers will be available in case signs of any distress to provides counseling.

### Can anything good happen to you?

In this study, participants will benefit from the knowledge, that will enhance the health and well-being.

### Will anyone know that you were participating in the study?

No third party will know that you were part of the study because all your answers will be strictly kept in a confidential manner. You will also not be requested to write your name or id number on the questionnaire. The Information collected will not be associated to any name in the report of the study and will only be accessed by the researcher.

### Who can you talk to about the study?

For further information please do not hesitate to contact me at 072 858 8418/0781139522 for clarity.

### What if you do not want to participate?

Participation in this study is voluntary. When you are participating, even though your parents/legal guardian have agreed on your behalf to take part in the study, you are not forced to do so. You are also allowed withdraw from the study at any time without prejudice.

I \_\_\_\_\_ agree to participate in the study / I disagree to participate in the study.

\_\_\_\_\_

Minors Signature

\_\_\_\_\_

Date

# Appendix 18: Research Instrument

## Questionnaire

### Section 1 Demographical Information.

1.What is your gender? 1=Male 2= Female	
2. How old are you? 1=10-15 2=16-20 3=21-25 4=26 and above	
3. Which grade are you in? 1=Grade 08 2=Grade 09 3=grade 10 4=Grade 11 5=Grade 12	
4.Under which circuit does your school belongs? _____	
5. Who do you live with at home? 1= Both parents 2= mother 3= father 4=brother 5= sister 6= Grandmother 8=others	
6. Do you have a child? 1=yes 2=no	
7 If your answer is yes in question 5, how many? 1= one child 2= two children 3=other	
8. Which religion do you practice? 1= Christianity 2= Traditional 3= Islam 4= other	

### Section B Knowledge of adolescent about the promotion of healthy sexual practices.

Statements	1=Yes	2=No
9. Do you discuss the choice of contraceptive with your sexual partner?		
10. Are you in favour of a workshop about contraceptives for women and men together?		
11. Does your sexual partner like using contraceptives?		
12. Do you think there is a need for more information on contraceptive methods and their uses?		
13. Do you think that abstaining from sexual activities will help to prevent STI's, HIV/AIDS and Pregnancy?		
14. Would the introduction and teaching sex education help to prevent STI's, HIV/AIDS and Pregnancy.		
15. Can STI's, HIV/AIDS and Pregnancy be prevented by supplying contraceptives program at clinics and school.		
16. Would teaching religious and moral values to adolescents help to prevent STI's, HIV/AIDS and Pregnancy.		
17. Would programs linked to contraceptive services e.g. in life orientation, help prevent STI's, HIV/AIDS and Pregnancy		
18.Would parental education support help prevent STI's, HIV/AIDS and Pregnancy		

19. Can social support and parenting help prevent STI's, HIV/AIDS and Pregnancy		
20. Have you ever used any type of contraceptive?		
21. If yes, which method did you use? (tick all that apply)		
Condoms		
Pills		
Injectable		
Implants		
Intra-uterine Contraceptive Device (IUD)		
Natural method		
Female sterilization		
Male sterilization		
Emergency Contraceptives		
Standard days method		
Combined hormonal contraceptives		
Progestogen- only contraceptives		
Abstain		
22. On the method selected on question 21 above, did you comply with the instruction on the usage of that contraceptive method?		
23. Do you think there is a need for more information on contraceptive methods and their uses?		
24. If yes, where will you get your contraceptive information? (Tick all that apply)		
Family		
School (Life orientation Teachers)		
Peer		
Church		
Radio/Newspaper/Television/posters		
Social media		
Boyfriend		
Girl friend		
Internet		
Sugar mama		
Sugar daddy		
Health care facilities/workers		

**Section C Factors and Sexual Risk Behaviours that influence the promotion of healthy sexual practices**

Statements	1=Yes	2=No
25. Are you having unsafe/unprotected (skin to skin) sex currently?		

**Why are you having, or did you have unsafe/unprotected (skin to skin) sex? (You can**



mark more than one)

Statements	1=Yes	2=No
26.It makes me feel very good		
27.I want to satisfy my own sexual needs better		
28.I want to please my partner and that is why I have sex without a condom		
29.Condoms are not 100% safe anyway		
30.It makes me feel like a real man/woman when I have unprotected sex		
31.I have a long and steady relationship so there is no need for condoms		
32.Partner refuses to use a condom and I don't want to lose her/him		
32.There was no condom available at the time Sex was not planned		
33.Was offered money for unsafe/unprotected (skin to skin sex?)		
34.It is more enjoyable		
35.Partner is faithful and cannot cheat on me		
36.Wanted a pregnancy		
37.Was under the influence of alcohol / drugs		
38.Specify other		

**What made you decide to have sex in the very first time?**

Statements	1=Yes	2=No
39.Wanted to experiment (curiosity)		
40.Was encouraged by my friends		
41.Boyfriend/girlfriend persuaded me		
42.Was raped/forced		
43.Culture expects me to have sex at my age		
44.Was under the influence of alcohol (drugs)		
45.Other (please specify)		

**In your opinion, is sex without a condom**

Statements	1=Yes	2=No
46.more enjoyable		
47.risky to be encouraged		
48.to be discourage		
49.If you needed money for school or to buy something you really liked, would you agree/accept to have unsafe/unprotected (skin to skin) sex?		

*Instruction: Tick only one (1) response per statement*

<b>Statements</b>	<b>Strongly</b>	<b>Not sure</b>	<b>Disagree</b>	<b>Strongly disagree</b>
50. Health care staff do not respect patients during consultation				
51. Language barrier used to give instruction by health care associated with contraceptives				
52. Health care are swearing on me				
53. Health care provides their relatives with contraceptives				
54. Health practitioners wanted consent from my parent to take contraceptives or family planning				
55. Health practitioner informed my parent about the consultation I made regarding contraceptives				
56. Lack of contraceptives made me not to visit health facility				
57. Health practitioner do not keep confidentiality of adolescent accessing health facility/ contraceptives				
58. The average waiting period at the public health facility is very long				
59. I feel more comfortable visiting a private health facility than a public health facility				
60. The queue to see a health worker at public facility is often long and moves at slow pace				

Statements	Agree	Strongly	Not sure	Disagree	Strongly disagree
61. Informed choice of contraceptives					
62. Elements of quality of care					
63. Essential screening procedures for administering the contraceptive method					
64. Health care referral and follow-up for contraceptive usage as appropriate					
65. Health care should ensure that adolescent visited health facility contraceptive must test HIV/AIDS and pregnancy					
66. Health care should provide contraceptives education in the health facility.					
67. Health care should refer adolescent for counselling before taking contraceptives					
68. The health care must use the language that I understand during my visit in the health facility.					
69. The health care must provide explanation on the use of contraceptive opted by adolescent using the local language of adolescent.					
70. Health care should explain the side effects of the contraceptive opted by adolescent.					
71. Health cares should explain what to do in terms of missed dose of the contraceptive.					

## Appendix 19: Interview Guide for Learners

### Section A: Demographic data

1. How old are you? 1=10-15 2=16-20 3=21-25 4=26 and above	
2. Which grade are you in? 1=Grade 08 2=Grade 09 3=grade 10 4=Grade 11 5=Grade 12	
3. Who do you live with at home? 1= Both parents 2= mother 3= father 4=brother 5= sister 6= Grandmother 8=others	
4. Do you have a child? 1=yes 2=no	
5 If your answer is yes in question 4, how many? 1= one child 2= two children 3=other	
6. Which religion do you practice? 1= Christianity 2= Traditional 3= Islam 4= other	

### Section B: Questions on the promotion of healthy sexual practices?

- Ideally in your opinion, have you heard of STI's, HIV/AIDS and pregnancy?
- In you understanding, what must be done to increase knowledge regarding the prevention of STI's, HIV/AIDS and pregnancy?
- In your opinion, what can be done to minimize the risky sexual behaviour in school?
- What types of sexual risky behaviour do you think your friends could be exposed to?
- What challenges do you experience when accessing contraceptive regarding the promotion of healthy sexual practices?
- Ideally in your view, what strategies should be considered in order to promote healthy sexual practices?
- In your view, do you think culture play significant role in promoting healthy sexual practices by emphasizes that girls/boys must respect and be submissive to their partners when it comes to sexual intercourse

## Appendix 20: Interview Guide for Life Orientation teacher

### Section A: Demographic data

Age group	20-29		40-49		
	30-39		50 above		
Gender	Male		Female		Other
Ethnicity	Tsonga			Sepedi	
	Tshivenda			Zulu	
	Ethiopian			Zimbabwean	
	Northern Sotho			Ndebele	
	Other:				
Marital status	Never married			Married	
	Living together			Divorced	
	Partner deceased			Separated	
Education level	JC Standard 6			National diploma in education	
	Education degree			Postgraduate Ed	
	Master Education			Other:	
Employment	Student Teacher			Private teacher	
	Casual jobs			Pensioner	
	Formal full-time employment				
Period of	0-5		6-10		11-15
Employment	Other:				
Religion	Christianity			Traditional religion	
	Other:				

### Section B questions on measures, factors and sexual risk behaviour to promote healthy sexual practices.

- As a life orientation teacher, what is your view in relation to sex education in order to promotion of healthy sexual practices?
- In your view, What mechanism can be used to promote healthy sexual practices among adolescents?
- As LO teacher, What challenges do you experience when teaching sexual education in promoting healthy sexual practices in school?
- In your view does culture plays a role in teaching sexual healthy practices?
- In your capacity, Have you received, or you need, any training in associated with STI'S, HIV/AIDS and pregnant for school going adolescent?
- Does school provide school health nurses and school social for awareness of sexual healthy practices and the provision of family planning? If yes, does it provides a positive outcome? If no, why?
- Ideally in your view, what strategies should be considered to facilitate the promotion of healthy sexual practices?

## Appendix 21: Interview Guide for School Governing Body

### Section A: Demographic data

Age group	20-29		40-49	
	30-39		50 above	
Gender	Male		Female	Other
Ethnicity	Tsonga		Sepedi	
	Tshivenda		Zulu	
	Ethiopian		Zimbabwean	
	Northern Sotho		Ndebele	
	Other:			
Marital status	Never married		Married	
	Living together		Divorced	
	Partner deceased		Separated	
Education level	No education		Secondary school	
	Tertiary level		Primary school	
Employment	Self employed		Unemployed	
	Casual jobs		Pensioner	
	Formal full-time employment			
Religion	Christianity		Traditional religion	
	Other:			

### section B question in the promotion of healthy sexual practices.

- In your view, what is your in promoting healthy sexual practices among leaners in this school?
- How do you determine whether leaners are sexually active or not?
- As an SGB member, do you provide awareness in school regarding to STI's, HIV and unplanned pregnancy and what are the pioneers of this programmes?
- How do cultural practices, in your opinion, contribute to the promotion of healthy sexual practices particularly STI's, HIV /AIDS and unplanned pregnancy?
- Ideally in your view, where should leaners seek help from the issues related to STI's, HIV and pregnancy and do you think it is appropriate and why?
- In your view, As SGB member, what challenges do you experience when initiating awareness regarding the promotion healthy sexual practices in school?

- Ideally in your view, what strategies should be considered to facilitate the promotion of healthy sexual practices?

## Appendix 22: Focus Group Discussion Transcripts for Learners

**Researcher:** ideally have you heard of STI's, HIV/AIDS and unplanned pregnancy?

**Participant 09 (Learner), Male, 18 years:** HIV is a disease created from the United Kingdom countries, this disease kills many people. HIV is when two people rape each other if one have HIV it is transmitted to another one. Whenever, they rape each other they must wear condom. Man must wear condoms in their penis so that whenever they had HIV the female partner must not contract HIV or sexual transmitted infections.

**Researcher:** what about the woman, because there are women's condoms nowadays.

**Participant 09 (Learner), Male, 18 years:** when they wear condoms it yields transmission of HIV.

**Researcher:** ok.

**Participant 10 (Learner), Male, 21 years:** I will talk about teenage pregnancy under age children give birth to child while they still young. Because at home when they were guided, they do not take guides, they do not listen to their parent. Similar to now a boy can lie to you that he loves you, while his aim is to have sex with you, when you are pregnant, he rejects you that he is not responsible for this pregnancy. This leads to lack of concentration when you are at school because you always think oy your child that maybe he/she is left at home alone, maybe she/he didn't eat. This leads you as mother to drop out of school.

**Participant 11 (Learner), Female, 19 years:** I will share with you, how you can contract HIV. When a man to have sex with a HIV positive woman without condom. When you are having sex then the woman start to bleed HIV if will be transmitted to the man.

**Participant 12 (Learner), Female, 16 years:** i will share with you about teenage pregnancy. there youth who live alone at home without the parent or guardian. They do not have law or guides at home, they used to go to the boys, they sleep with different boys. They have sex with multiple boys and they fell pregnant, they do not know who's responsible for this pregnancy or who impregnated her. When they go to the clinic, they find out that they are also pregnant and they are HIV positive. When she's tried to investigate who's the father of the child and who infected her with hiv she does not get the answer. It further makes an individual not to concentrate on education and and and it lead to the individual to comitsociet. after find



out theta they are pregnant she does not inform other so that they can help her, she just kill herself.

**Participant 13, Female, 16 years:** teenage pregnancy I think its all bout children who love money whenever, you gave them money they gave you vagina. these girl are In a transitional sex . they act as sex workers.

**Participant 14 (Learner), Male, 15 years:** I think this one is the reason that make people to give birth to an HIV child. I also think that STI is contracted when you love sex too much. Or you sued to have sex every day from morning afternoon and night.

**Participant 10 (Learner), Male, 21 years:** I wanted to speak about STI, I think STI is when a a lady does not bath and go to sleep with boys, when she sleeps with boys, the boys contract that discharges, then it course a drop.

**Participant 11 (Learner), Female, 19 years:** there this type of STI that is caused by abortions from the traditional healers. When a girl do abortion in the Sangoma's and she is not yet clean, it needs boys to come and have unprotected sex then she will be cleaned .it will results in swollen penis and testes.

**Participant 09 (Learner), Male, 18 years:** 'ku wela 'is when the lady being prophet that she is pregnant the lady goes and do abortion and you find that the lady does not know who impregnated her. They gave her options on whether you want a child or you wanna do abortion. They gave her herbs and she drinks to abort the pregnancy. then they told her she needs to be cleaned by a boy. By having unprotected sexual intercourse.

**Researcher: what should be done to prevent STI's, HIV and unplanned pregnancy.**

**Participant 10 (Learner), Male, 21 years:** is to use condoms, to prevent.

**Participant 09 (Learner), Male, 18 years:** to prevent HIV and STI as well as unwanted pregnancy, you can do abstinence and be faithful and condomize. That the best of all prevention measures.

**Participant 12 (Learner), Female, 16 years :** you must protect yourself by making sure that whenever, you are having sex with someone you must protect yourself by wearing a condom. And also your partner must wear condoms as well.

**Participant 11 (Learner), Female, 19 years :** before you have sex with your partner you must first test HIV and STI diseases. After the results you can have unprotected sexual intercourse.

**Researcher: what should be done to minimize the risky sexual behaviours?**

**Participant 14 (Learner), Male, 15 years:** When others are taught about sex education they want to practice. Which results in unhealthy sexual practices. I feel like life orientation further promotes youth to engage in sexual activities.

**Participant 12 (Learner), Female, 16 years:** I took the idea that we must not engage in sexual intercourse before the age of 18 or 21 years.

**Participant 10 (Learner), Male, 21 years:** we must not have sex before you are married. You will have sex after marriage, we must abstain. Other traditions allow it that you cannot have sex before marriage. My tradition is after marriage that's where I can start to open my legs and have sex.

**Participant 09 (Learner), Male, 18 years:** I don't know what to say.

**Participant 11 (Learner), Female, 19 years:** we need to have good friends who do not influence others. Let's say we are friends with this girl, and I used to have sex, don't you think that I might force her to have sex with me.

**Participant 12 (Learner), Female, 16 years:** mine I prefer to have sex when I completed education and working.

**Researcher:** what type of risk behaviours that you think your friends could be exposed to.

**Participant 11 (Learner), Female, 19 years**

: my friend stated intimacy with girls and I saw them kissing each other, they also go out to have fun in the resorts.

**Participant 10 (Learner), Male, 21 years:** I will talk about exchanging of girls, I sleep around with girls.

**Participant 14 (Learner), Male, 15 years:** my friends drink alcohol so much. You will find that a young girl at the age of 15 goes to tavern and bottle store and ask older people to buy her alcohol, sometimes they pour drugs on her bottle so that she can be over drunk. Then they take advantage of her by having sex.

**Participant 13, Female, 16 years:** I see peer pressure, where I ask my friend to go and we do sex work to gain money at the end. Then along the line she fell pregnant and being infected by HIV and AIDS.

**Participant 14 (Learner), Male, 15 years:** I wanted to speak about peer pressure, there is this young girl she's at grade 7, she's the type of person who goes to town by a taxi, she knows

all the taxi drivers by their names. She always comes home and she keeps on inviting me to go with her, Boys always get inside the house the way they want, they cook and eaten, this other day her three boyfriend had a fight with her at her home. This girl smokes and drink alcohol and people whom she associated with they smoke and drink.

**Participant 09 (Learner), Male, 18 years:** I have a brother, who always want to be accompanied to the soccer ground, to smoke dagga or weeds he recruited me to smoke with him. I refuse and leave him alone, im afraid that he can go and rape girls.

**Researcher: what are the challenges**

**Participant 10 (Learner), Male, 21 years:** when you go to the health facility we stay longer and they do not attend you, they will pass you. You can arrived in the morning and they treat you in the evening.

**Participant 11 (Learner), Female, 19 years:** I agree with what he had said, when we consults nurse they do not focus on the consultations they further inject you with contraceptives which I did not consult for, and they will be like you had grown up. This thing is very disgusting and I hate it. They must treat us equally we are young as well.

**Participant 14 (Learner), Male, 15 years:** the disgusting things that nurses do is to take their friends and relative who were not in the queues to be treated first while I was waiting for long period waiting for consultation. I hate local clinic because of that,

**Participant 13, Female, 16 years:** I went to the clinic I was on a critical situation, I had swollen penis, I sleep out and I was discovered by the security guard, they reply that he does not have guardian there is nothing they can do.

**Researcher: What are the strategies that can be used to promote healthy sexual practices.**

**Participant 14 (Learner), Male, 15 years:** we must implement law that whenever you are pregnant you must be fired at school and be a drop-out.

**Participant 10 (Learner), Male, 21 years:** I think a child who is pregnant must take gap year. So that they comeback without any pregnancy.

**Researcher:** we do not want learners to drop out or to relinquish gab school because of pregnancy? gap year will ruin someone's future which we do not want it to happen.

**Participant 11 (Learner), Female, 19 years:** I think teachers when they observe that the are high rate of teenage pregnancy in their school, they must establish peer groups for both male

and female learners. which will be guided by the social workers. Or we abstain from having sexual intercourse.

**Participant 09 (Learner), Male, 18 years:** I think we must have a meeting all learners in this school, where they will tell us that when ever we want to have sex we must wear condoms or girls must prevent or we abstain from having sex.

**Participant 12 (Learner), Female, 16 years:** I think they must take girls that when you are pregnant, and you wanna gave birth you might dies or the baby die because of loss of blood, early premature death, and etc.

**Participant 09 (Learner), Male, 18 years:** teachers must go class by class with nurse and inform student that they must not have sex at younger age, they will have sex when they are working because of its consequences.

**Researcher: do you think culture promote healthy sexual practices**

**Participant 11 (Learner), Female, 19 years :** no, I do not think so, because some of the culture want children to be married at a younger age. When ladies start to see their mistral cycle .

**Participant 09 (Learner), Male, 18 years:** may culture allows me to take a wife when I am working and I had completed the school. From 20 years up wards you can be married.

**Participant 10 (Learner), Male, 21 years:** in my culture I an be married at the age of 20 years. The issue of having sex at younger age my culture does not allows that.

**Participant 13 (Learner), Female, 16 years:** my culture allows me to be married and start to please my self with sex at the age of 21 and above.

**Participant 14 (Learner), Male, 15 years :** my culture allows me to be married and engaged in sex when im 21 years.

**Participant 12 (Learner), Female, 16 years :** my culture allows me to be 21 years and when I am at university I can do what I want regarding sex.

**Researcher : does culture promote healthy sexual practices through initiation school.**

**Participant 09 (Learner), Male, 18 years:** no, they are saying you are man, and you are allowed to rape woman.

**Participant 10 (Learner), Male, 21 years:** when you are there they say, you must get a girlfriend and you have sex.

**Participant 11 (Learner), Female, 19 years:** woman initiation school ruin and taught youth to have sex at younger age, our age group girls who went to initiation school.

**Participant 14 (Learner), Male, 15 years:** from the village where I live majority of younger girls who have children are the once who went to woman initiation school.so culture ruin their lives.

**Researcher:** does culture allows you to talk with your parent about sex?

**Participant 09 (Learner), Male, 18 years:** culture must taught us, to respect and it prohibit the issue of sex talk.

**Participant 10 (Learner), Male, 21 years:** you are given permission at the age of 21 years but they do not want you to come with a girl at home. So I feel being manipulated or control by my parent because I must exchange girls the way I please.

**Researcher:** thank you very much for your participation.

## Appendix 23: Focus Group Discussion Transcripts for SGB

**Researcher:** In your view, what is your role in promoting healthy sexual practices among learners in this school?

**Participant 01 (SGB), Male, 57 years:** owk, healthy sexual practices. They must abstain.

**Researcher:** as a follow-up, lets assume your school has 20 learners who are pregnant, how are you going to ensure other learners are not going to be pregnant, or to causes other stigmatizations?

**Participant 01 (SGB), Male, 57 years:** ok, aaa I can do or what I'm going to do, firstly, I will have to motivate learners who are not pregnant by means of giving them some rewards. I will gave them rewards.

**Researcher:** don't you think when you are giving them rewards you are buying them ?

**Participant 01 (SGB), Male, 57 years:** not to do because if they find themselves into aa in such a teenage pregnancy problems, aaa it's going to japertise their future. They won't further their studies because who is going to look after their children so they must make a point that they don't commit any mistake because aaa if they commit such a mistake it will not be reversible.

**Participant 02 (SGB), Male, 33 years:** I think I to engage with the health workers and social workers. We always engage social workers mmmm uhhh even health workers they always come here to guide learner. They come to teach them only. They teach them without any parental knowledge, there is no consent need from parent.

**Participant 03 (SGB), Male, 41 years:** OK as my role is uh I'm in SGB teacher component we're not dealing my special on sexual practices but we're dealing with the the behavior of learners how they conduct themselves and so we don't have a chance to call the learners and talk about talk with them about the sexual practices rather we talk about the the behavior the conduct how they must conduct themselves in in inside the school premises

**Researcher:** How do you determine whether these learners are sexual active or not?

**Participant 01 (SGB), Male, 57 years:** by seeing girls maybe playing with boys during the evening, coming home very late. Aaa watching evening movies, late movies. Reading aaa pornography

**Researcher:** In terms of aaa let's say, every school have code of conduct, how learners should behave, then you realize learners are not adhering to the conduct how do you deal with such learners inline to healthy sexual practices?

**Participant 01 (SGB), Male, 57 years:** here at school it is a challenge because if I involve my self in an affairs, I can be reported to the department I can be charged for that because I will be violating her/ his rights soo aaa , so if I was a principal I will invite social workers or invite officials from the department of health, to speak about being pregnant at aaa aaa uhh an early age. I guess that one will assist because I will be distancing myself in such situations. that's according to my view.

**Participant 02 (SGB), Male, 33 years:** we only see them according to their behaviours. What we always do we refer this learners to life orientation teachers.

**Participant 03 (SGB), Male, 41 years:** ok aaa when they arrived here they arrived being at grade 8 and they move to grade 9 learners are still discipline. When they reach grade 10 learners they start to not cooperate. They usually go outside, they are no longer discipline the discipline we saw in grade 8 and 9 had vanished. You saw that this leaners are now sexual active because they will be roaming around with boys or vice versa.

**Researcher:** in terms of respect , do learners respect life orientation educators, when they are in peer stage, what's you view?

**Participant 03 (SGB), Male, 41 years:**now when we see that this learners they are out of order, we speak with them , when we see it is out of hand we involve their parent. We speak about the behaviour of their children and indicate that they must monitor them because they are sexual active.

**Researcher :** ok, as an SGB member, do you provide awareness regarding STI, HIV/AIDS and unplanned pregnancy and what are the pioneers of this programmes?

**Participant 01 (SGB), Male, 57 years:** it will be difficult as an SGB member because aaaa Tradition or in our customary law, we are not allowed to speak to such a topic with aaa child. It is a taboo so, we can negotiate maybe with the principal to invite maybe a guess speaker. To alert learners about sexual activities.

**Participant 02 (SGB), Male, 33 years:** this one I cant lie. We don't do anything. Actually we normally tell this health workers all the programmes here at school concerning this sexual programmes. Then they just teach them no awareness.

**Participant 03 (SGB), Male, 41 years:** in our situation as we are next to the clinic most of the time we have nurses from the health department they usually come to speak to our learners about the health issues, life issues and sexual diseases as well as teenage pregnancy. The issue of teenage pregnancy they usually come and educate our learners because our school is next to the clinic. They usually come here and speaks to our learners.

**Researcher :** so when they speak with your learners do they speak about the contraceptives as measure to prevent STIs, HIV and unplanned pregnancy?

**Participant 03 (SGB), Male, 41 years:** aaah what they do they usually guide them to abstain, it just that learners are learners. They cannot abstain even when they were told , they will go to the clinic for family planning, even if there is no parent nurses will not deny them, the family planning they opted to use. They can say they have the rights and they are entitle to access sexual reproductive health. Learners a told to abstain we are always there to and hear the guidance from nurses.

**Researcher:** Ok Don't you think the school might require the auxiliary social worker to come and offer services such healthy sexual practices in the school?

**Participant 01 (SGB), Male, 57 years:** I think it is very much important each and every school , the department of aaa social development must assign a social worker to stationed here at school. So that he/she can assess each and every learner or child, because as a SGB of the school each and every day we are solving problems in this school. I think a full time social worker can assist a lot.

**Researcher: Ok. How do culture practices contribute to the promotion of healthy sexual practices particularly STI, HIV/AIDS and unplanned pregnancy in this school?.**

**Participant 01 (SGB), Male, 57 years:** I don't think so, I can say aaa to me, I doubt if aaa cultural practices promote healthy sexual practices. I don't think so because isn't it in our tradition it is a taboo to give children condoms. So in countries where are cultural activities is practiced like Swaziland, KwaZulu-Natal you will find that aaa HIV is gaining a momentum because they don't use condoms, because aaa children are encourage to get marriage in an early age. Even the head of state you will find that there is a a day in KwaZulu natal where the king or head of state is given an opportunity to choose aaa his wife among the teenagers. So I think tradition is not contributing to the promotion of healthy sexual practices. Culture is fueling teenager to be more vulnerable to teenage pregnancy and HIV.

**Participant 02 (SGB), Male, 33 years:** mmm hey this one. According to our culture we advise this kids to go to a initiation schools or to go to the doctors for circumcision. Actually in our



culture is a taboo to talk about sex with your kids, so there is no need to talk about with a parent. According to culture is a taboo to talk about it, but I don't say we don't teach learners here at school we teach learners. But in our culture we can't talk about sex.

**Participant 03 (SGB), Male, 41 years:** ok aa when it come to cultural practices, I think this days even their parent are this days parent they speak with their learners about sexuality. Parent are open to tell their children about sexuality and the preventions, things had changes, there is no more taboo of sex talk between a child and elderly. We are living in a changing world even the parent have changed , they are speaking with their learners. Even educators they do not hide anything, we speak to this learners.

Uumm I think the cultures a played a role it depends on the ethnic group, it depends on the ethnic group. If we can go to KwaZulu Natal when I say it depends on the ethnic group there they promote virginity, they promote virginity and when they promote virginity those who enters in that cultural activity, if you are a girl you must be a virgin. On that side it promotes but for the Tsonga and Venda there is no ceremony for virginity examination, where they look whether a child is still a virgin or not. So there is that misconception, there is misconception of cultural activities. Our children are not told what to do or to practice the sexual activities they are not told. Infect they have to be protected to have healthy sexual practices. But because these days children they feel like the know better than their parent or educators when it comes to sex.

**Researcher :** Ok, ideally in your view where should learners seek help on the issue related to HIV,STIs and unplanned pregnancy? and do you think it is appropriate and why?

Participant: to do what?

**Researcher:** where they can go or access assistant or help regarding the issue of STI, related to the prevention measures?

**Participant 01 (SGB), Male, 57 years:** health department especially clinics, yeah , they will get assistant from the clinics. Because they will also be given injections for prevention. I think that's where they will get assistance. In other department is they do not have anything to eat I think they will go there for assistant and application of grant and foods. But for prevention I prefers the department of health, because sometimes they use to send nurses here at school we used to give them slot to teach learners about sexuality aspects and their preventions.

**Researcher:** Ok looking at the issue of mmm injections, as I heard you well. Don't you think they will exposing themselves to STIs and HIV. Yet , they might be preventing pregnancy but in the other had exposing themselves to sexual diseases?

**Participant 01 (SGB), Male, 57 years:** Yeah, they will be exposing themselves.

**Researcher :** do you think that injections will be necessary helping these learners?

**Participant 01 (SGB), Male, 57 years:** yeah, we will be helping them, because they will not get pregnancy bu they will have such disease.

**Researcher :** and we want this learners not to be exposed to any vulnerable diseases, in other words you are saying prevent pregnancy, HIV and STIs does not have negative impact on the life and future of a learner.

**Participant 01 (SGB), Male, 57 years:** sometimes you will find out even if they are using condoms as we are living in country which aa is a lawless country, you will find that on their way back home they can be raped by criminals. If they can be injected such injections you will find it will help them a lot.

**Participant 02 (SGB), Male, 33 years:** They seek help in our local clinics and hospitals mmmm it is appropriate.

**Researcher:** As an SGB member, have you come across rejection or consent from the parent?.

**Participant 02 (SGB), Male, 33 years:** 12 years and above they can consults for sexuality in the local clinic, I always see them.

**Participant 03 (SGB), Male, 41 years:** I think where they can seek help, we have got those who can run the awareness campaigns, they are the right organization that can speak with these learners. They speak with learners about STIs , HIV and pregnancies. Even in the classroom life orientation teachers heave to talk about these issues. Even if we know that these learners are from poverty striking family it leads them to fall in love with older people because of exchange of money to sustain their families. I think even the government here must intervene . To indicate these learners who become pregnant they are traying to resolve the issue of poverty because of child grant. Even if their parent are educated and unemployed poverty strikes them and girls becomes vulnerable to change multiple partners. So they seek help for the self through transitional sex and they go for old people,

**Researcher: So in terms of consulting the health facility what is your opinion in relation to the promotion of healthy sexual practices?**

**Participant 03 (SGB), Male, 41 years:** mmm the health facility, ok , I think when it come to health the department of health must provides trainings, workshop continuously . Because you find that it is done once in a year. They must offer sustainable education, and programmes to reduce the infections of sexual diseases and teenage pregnancy. it mustn't be done once in two years it must be conducted always, three times in a year I think it will be ok. The first three terms that's where learners are jumping around and having sex, while the last term they are settling and reading books because of exams. these awareness must always come regularly and they must not forget that there are this learners in this school.

**Researcher : in your view as an SGB member, what challenges experiences when initiating awareness regarding the promotion of healthy sexual practices?**

**Participant 01 (SGB), Male, 57 years:** yeah hey, challenge no one in most of the time learners are not interesting in listening what the guest speaker. they resistant from educators you find that are educators are not ready to assist the people who are here , who are promoting campaign they just distance themselves from such thing is happening they just stand far away from it. they just isolate themselves. Although it is a resistant if though it is a silent resistance.

**Participant 03 (SGB), Male, 41 years:** Most of the learners a very young they don't understand about the challenges, at least 12 and 13 years they understands when they teach them about sex. But they provide us with positive response but in our views, you see this learners when they teach them they always laugh, that's where we identify that when you teach them it seems as if you are insulting them, some of them they understand more especially the bigger once but the young kids or young once they always laugh and it seems as if you are insulting the actually. Which means they don't understand about sex education actually.

**Researcher : Ideally in your view, what strategies should considered in facilitating the promotion of healthy sexual practices?**

**Participant 01 (SGB), Male, 57 years:** Mmm the strategies, strategy number one aaaa aaa is that one of abstaining , I think it is number one. Aaa number two I think learners we must invite former learners to come and educate them, and to motivate them. About the important of abstaining, because if they abstain it give them an advantage to further their studies. Because if they do not do that they allows themselves to be used by aaa aaa older people you will find that they wont go anywhere, their future will be japertise, infect their future will be

determined by the government they will rely on a social grant. Their future will be determined by the politician and the politician are very happy because they know where to get more votes from people who are disappointed. Disappointed people is simple for the politicians to win them because they have nothing to do rather than to accept what they are offered or they are being given.

**Researcher: do you think the issue of having having your own auxiliary social worker it will be another strategy to mitigate the problem of unhealthy sexual practices?**

**Participant 01 (SGB), Male, 57 years:** you mean at school ,Researcher: yes

**Participant 01 (SGB), Male, 57 years:** yeah, that can be the answer of all the problems, because such social worker will give himself or herself enough time to speak to each and every learner who is having a problem at that moment.

**Researcher :** as an SGB member don't you think you can develop SOP that emphasizes a mandatory awareness campaigns, invitations of health workers in each term , what is your view in relation to that?

**Participant 01 (SGB), Male, 57 years:** yeah, I concurred with what you are saying, it will work a lot, even the community will also benefit , because such a social worker will also assist parents. In fact social worker can assist in alleviating poverty in the community because the community members will be taught about the importance of this. She or he will explain the advantages of the project as a result each and everyone will benefit in this project

**Participant 02 (SGB), Male, 33 years:** I think is to conduct more workshop about sex, we must engage with sexual workers and health workers, we must conduct more workshop about healthy sexual practices until they understand what is going on related to sex and its preventions. We further educate learners abstain and sustain education as a priority. The awareness campaigns in our school include SGB, educators and learners to ensure that we keep on reminding each other in educating our kids. Because we are the one who will be with these learners we have to continue educating them. For instance, parent at home they must educate them and ensure that they abstain. While teachers at school must keep on teaching them to abstain and to prevent themselves against sex diseases.

Furthermore we are planning to develop policy within the school to host awareness every term. The awareness themes consist of Gender-based violence, cyberbullying, rapes or forced sex, as well as unprotected sexual intercourse. The school must work hand and glove with Department of Social Development, the Department of Health, South African Police Services and another health stakeholder as well as our community.

**Participant 03 (SGB), Male, 41 years:** aaaa aa these learners know more and better than old people. As SGB member they think we are joking some of them they don't listen but some will listern and it produces a positive outcome other it seems like you have not done anything because they think they know better than you.

**Researcher :** thank you very much for your participation.

## Appendix 24: Health Talks

### Health talk 1a

**Topic:** How to express healthy sexual practices?

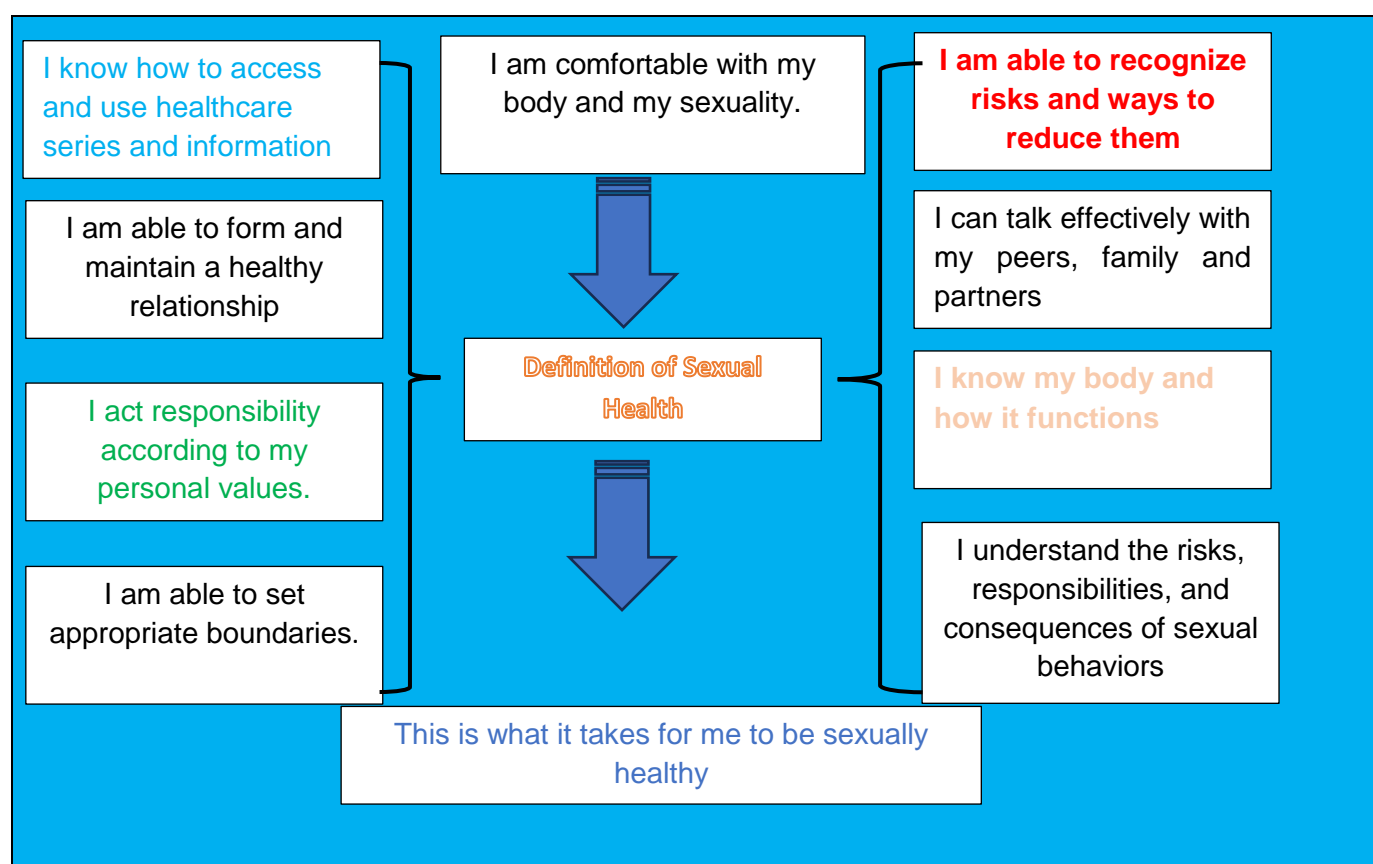
**Target:** Parents, pastors, teachers and community.

**Duration:** 45 minutes

**Method of giving health education:** team teaching method followed by rotational teaching

**Place:** during school visits, church visits, door-to-door visits and royal meetings.

**Teaching aid:**



**Purpose:** To equip teachers, parents and pastors with knowledge and skills on how to express healthy sexual practices.

### Objectives

*At the end of the lesson teachers, parents and pastors should be able to*

- ❖ To describes their understanding of healthy sexual practices.
- ❖ To explain how to use contraceptives in order to promote healthy sexual practices.

### Prior-knowledge

- ❖ What are healthy sexual practices?
- ❖ How to express healthy sexual practices.

### Introduction

Healthy sexual practices means awareness that provides knowledge, skills and informed decision made by youth in order to practice protected sexual intercourse.

### Content

#### Communication

- Interact with all genders in appropriate and respectful ways
- Communicate effectively with family and friends
- Ask questions of other adults about sexual issues, when necessary
- Are able to communicate and negotiate sexual limits
- Communicate respectfully their desires to have sex and not to have sex
- Accept refusals of sex without hostility or feeling insulted
- Can physically express feelings of attraction and desire in ways that do not focus on the genitals (ex: holding, caressing, kissing, etc.)
- Talk with a partner about sexual activity before it occurs, including limits, contraceptive and condom use, and meaning in the relationship
- Communicate with partners their intentions for the relationship (ex: only dating, want marriage)
- Listen to and respect others' boundaries and limits
- Are sensitive to non-verbal cues of others' boundaries and limits

#### Relationships

- Develop friendships that do not have a sexual agenda
- Avoid exploitative relationships
- Choose partners who are responsible, trustworthy, safe and giving
- Can be sexually intimate without being physical (ex: talk about sexual feelings, verbally express attraction, do things that awaken desire in partner)
- Can express themselves in ways other than genitally (ex: holding, caressing, kissing, etc.)
- Take personal responsibility for their own boundaries

#### Self-Esteem, Self-Worth

- Appreciate their own bodies
- Are sensually aware and able to stay conscious in their bodies
- Can touch their own bodies without feeling shame or disgust
- Allow themselves to experience pleasurable sensual and sexual feelings
- Have the capacity to nurture themselves and others, and accept nurturing from others
- Feel joy in sexual experiences of their choosing
- Know when they need touch rather than sex and try to get their needs for touch met appropriately
- Have a developed sense of self, an understanding of who they are
- Enjoy sexual feelings without necessarily acting upon them
- Accept refusals of sex without hostility or feeling personally insulted
- Allow themselves to be vulnerable
- Are comfortable with their sexual identity and orientation
- Are becoming aware of the impact of negative sexual experiences such as sexual abuse, and the impact of negative cultural messages on their sexual development
- Are taking steps to address issues that have arisen as a result of past experiences
- Feel confident in their ability to set appropriate boundaries
- Realize that, by working through sexual issues, individuals may heal psychological and emotional wounding from past experiences and damaging beliefs.

**Post-assessment:** Illustration on how to express healthy sexual practices.

**Material:** Information flyers

### Conclusion

Teachers, Parents, and pastors must be able to disseminate healthy sexual practices knowledge to youth. Pastors must be able to teach healthy sexual practices among their

disciple at church to ensure that disciples establish communication about healthy sexual practices among parent and their children.

### **Health Talk 1b (Psycho-social counselling).**

**Topic 2: Cultural environment, belief norms and values regarding healthy sexual practices.**

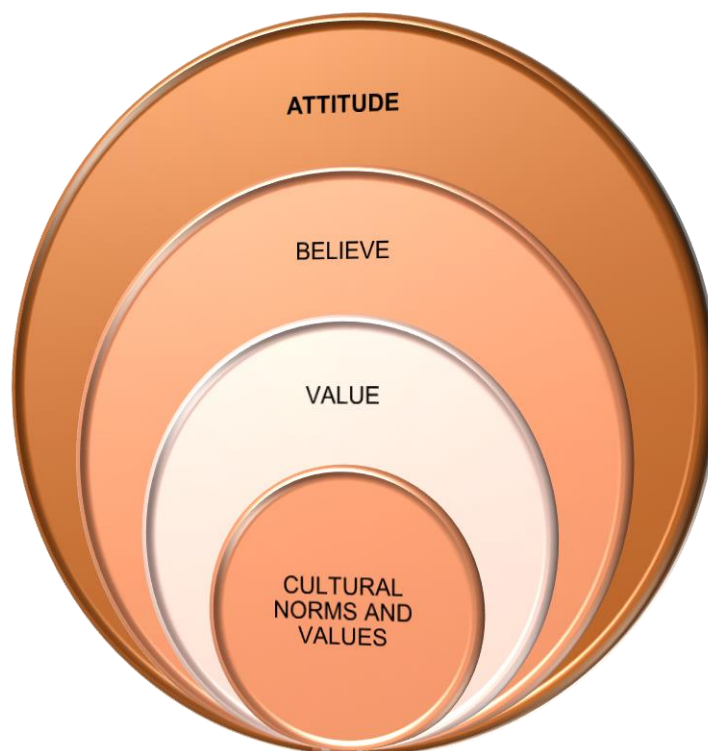
**Target: Parents, pastors and teachers.**

**Duration: 45 minutes.**

**Method of giving health education: Group discussion sessions.**

**Place: during school visits, church visits and door to door visits.**

**Teaching aid:**



1. Attitude: away from feeling or thinking about something
2. Believe: an idea that is accepted
3. Value: a person's own set of principles that they consider of great importance.



**Purpose:** To revive teachers, parents and pastors with knowledge and skills on how to express healthy sexual practices without cultural environment, belief norms and values regarding healthy sexual practices.

## Objectives

*At the end of the lesson teachers, parents and pastors should be able to*

- ❖ To describes their understanding about the Cultural environment, belief norms and values regarding healthy sexual practices.
- ❖ To express that healthy sexual practices between children and elderly people is not taboo as a way of reviving the Cultural environment, belief norms and values regarding healthy sexual practices.

## Prior-knowledge

- ❖ What are healthy sexual practices?
- ❖ How to express healthy sexual practices.

## Introduction

cultural norms and values are defined as hindrances between parents, teachers and children regarding healthy sexual practices discussion since culture prohibited elderly people to have sex talk.

## Content

### Education

- Realize the consequences of sexual activity
- Comprehend the impact of media messages on thoughts, feelings, values, and behaviors related to sexuality
- Understand that the drive for sex is powerful and can be integrated into one's life in positive and healthy ways
- Respect the right of all people to enjoy and engage in the full range of consensual, non-exploitive sexual behaviors

### Contraception, Protection, Body Integrity

- Take responsibility for their own bodies and their own orgasms
- If sexually active, use contraception effectively to avoid pregnancy and use condoms and safer sex to avoid contracting or spreading a sexually transmitted disease
- Practice health-promoting behaviors, such as regular checkups, breast or testicular self-exams, regular and routine testing for STDs

### Values

- Decide on what is personally "right" and act on these values
- Demonstrate tolerance for people with different values
- Are not threatened by others with sexual orientation different from theirs
- Show respect to others whose cultural values, ethnic heritage, age, socio-economic status, religion, and gender are different from theirs

### Spirituality

- Honor the sacred aspect of sexual union
- Understand that sexual energy is not separate from being human
- Understand that sexual union is one way human beings connect body and soul

**Post-assessment:** Illustration on how to express healthy sexual practices in line with cultural norms and values.

**Material:** Information flyers

### **Conclusion**

Parents, Pastors and teachers should be able to provide healthy sexual practices to youth without any fear of cultural norms. Since we want our children to sustain abstinence as well as contraceptive usage at a young age. The parents should share their experiences as a way of directing their child not to be the victim of unhealthy sexual practices by outlining the consequences of sexual intercourse.

### **Health talk 2a**

**Topic 3: Myths about contraceptives**

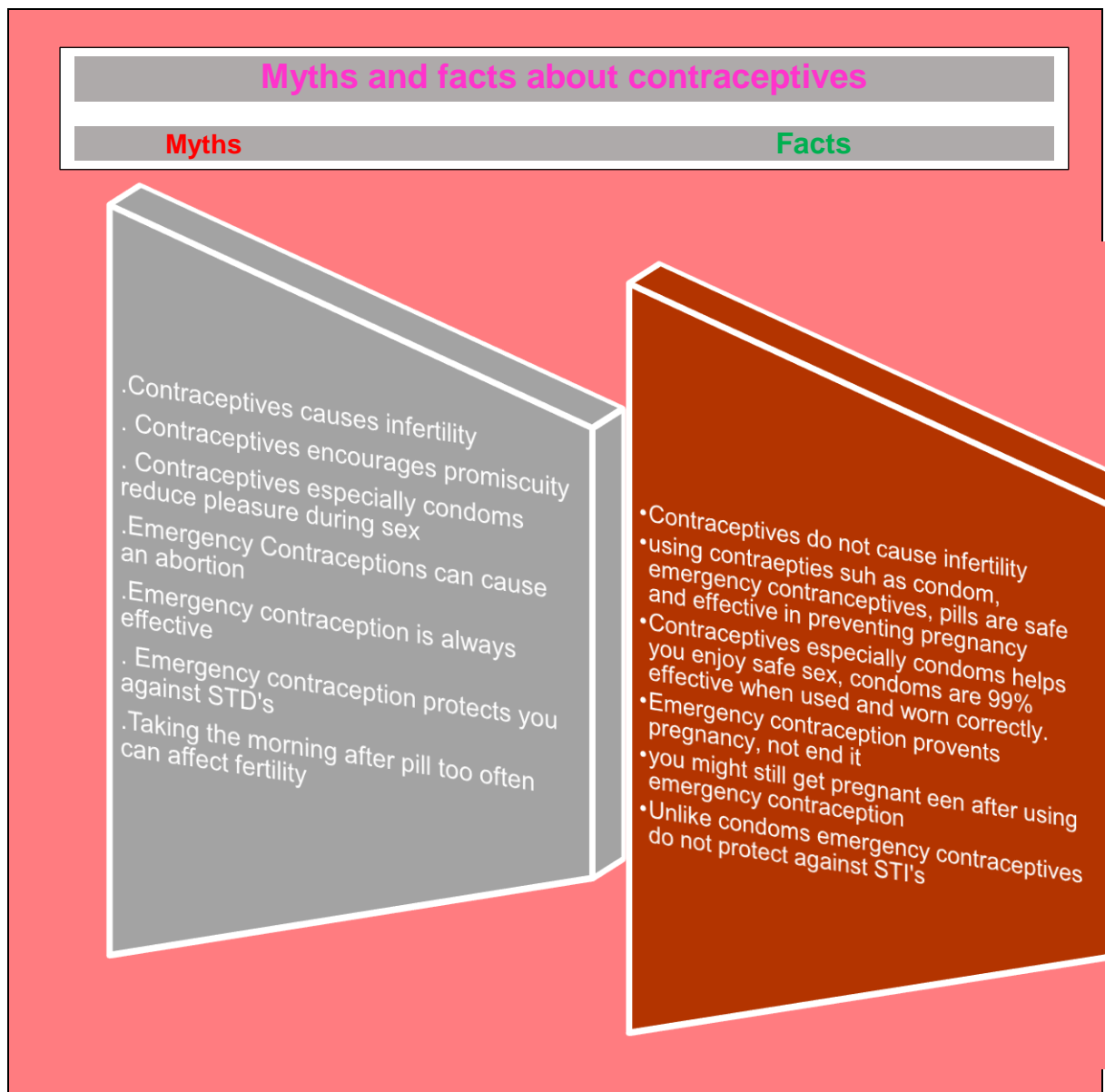
**Target:** Youth, family, and community.

**Duration:** 50 minutes

**Method of giving health education:** Problem-based learning

**Place:** during school visits, door-to-door visits and royal meetings.

**Teaching aid:**



**Purpose:** to dismiss myths about contraceptives that influence the promotion of healthy sexual practices.

### Objectives

*At the end of the lesson teachers, parents and pastors should be able to*

- ❖ **To identify myths and facts about contraceptives**

### Prior-knowledge

- ❖ What do you understand about myths regarding contraceptives?

## Introduction

Myths are assumptions about contraceptives that are not scientifically proven. However, the majority of learners use them as facts, while it is opinion. **Content**

<ul style="list-style-type: none"> <li>❖ Birth control will make me gain weight.</li> <li>❖ I heard the implant causes you to gain a bunch of weight.</li> <li>❖ The shot will make me gain a bunch of weight.</li> <li>❖ Depo (the shot) will make my hair fall out.</li> <li>❖ Birth control will imbalance my hormones and make me "crazy."</li> <li>❖ Birth control pills cause cancer.</li> <li>❖ Birth control will affect my ability to have children in the future.</li> <li>❖ IUDs can cause Pelvic Inflammatory Disease.</li> </ul>	<ul style="list-style-type: none"> <li>❖ No one uses birth control methods other than the pill and condoms.</li> <li>❖ I hear the ring falls out.</li> <li>❖ The patch can fall off.</li> <li>❖ I hear IUDs can tear through the lining of your uterus.</li> <li>❖ I hear IUDs can get lost in your uterus.</li> <li>❖ You can only get IUDs if you've already had a kid.</li> <li>❖ The implant hurts.</li> <li>❖ I want the implant but I'm afraid everyone will be able to see it.</li> <li>❖ I don't have to take birth control because they make male shots/male pills now.</li> </ul>	<ul style="list-style-type: none"> <li>✓ There are no benefits to birth control if you're not sexually active.</li> <li>✓ I don't need birth control because my partner pulls out.</li> <li>✓ I've had unprotected sex and didn't get pregnant, so I don't need birth control.</li> <li>✓ I only have sex during or right after my period so I can't get pregnant.</li> </ul>
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### List of facts about contraceptives

- ❖ A woman may experience short term side effects associated with use of combined oral contraceptive, including changes in bleeding patterns, headaches, and nausea. However, such side effects are not a sign of illness, and usually stop within the first few months of using contraceptives.
- ❖ The combined oral contraceptive does not cause infertility.
- ❖ After the pills are swallowed, they dissolve in the digestive system, and the hormones they contain are absorbed into the bloodstream. After they produce their contraceptive effect, the hormones are metabolised in the liver and gut and are then eliminated from the body. They do not accumulate in the body anywhere.

- ❖ There is no evidence that contraceptives affect women's sexual behavior. The evidence on contraception in general shows that sexual behavior is unrelated to contraceptive use. In fact, using contraception shows responsible behavior in order to avoid unintended pregnancy and sexually transmitted infections.
- ❖ There is no evidence that contraceptives affect a woman's sexual drive. Although some women using the pill have reported either an increase or decrease in sexual interest and performance.
- ❖ Most women do not gain or lose weight as a result of contraceptive use. A woman's weight may fluctuate naturally due to changes in age or life circumstances.

**Post-assessment:** Explain your understanding of contraceptives.

**Material:** Information flyers

### Conclusion

After a long discussion about myths, participants were able to distinguish between myths and facts regarding contraceptives in order to promote healthy sexual practices.

## Health talk 2b

### Topic 4: The benefits of healthy sexual practices

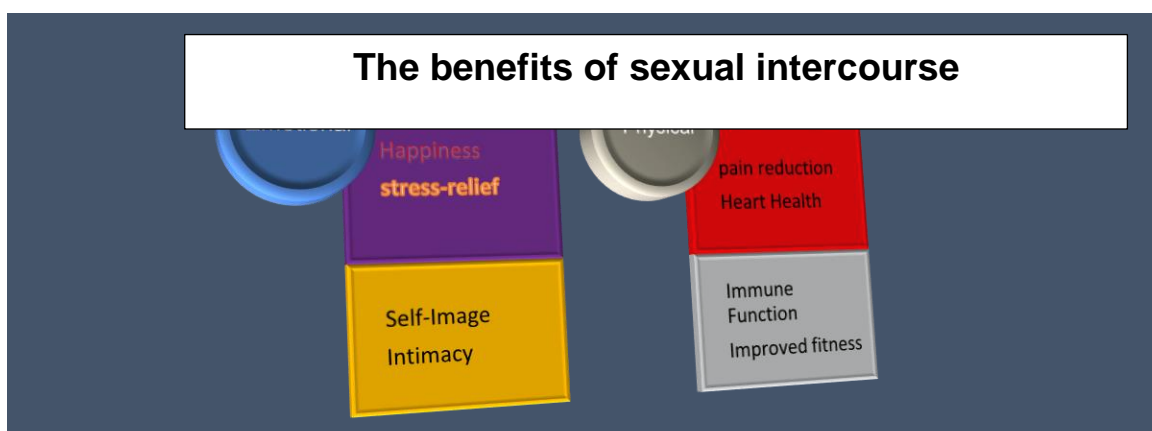
**Target:** Pastors, Parents, teachers, Youth, family and community.

**Duration:** 50 minutes

**Method of giving health education:** Participatory and community outreach

**Place:** during school visits, and royal meetings.

**Teaching aid:**



**Purpose:** to equip learners about the benefits of healthy sexual practices.

## Objectives

*At the end of the lesson teachers, parents and pastors should be able to*

- ❖ What is your understanding of the concepts healthy sexual practices.
- ❖ What are the benefits of healthy sexual practices?

## Prior-knowledge

- ❖ What do you understand about contraceptives?

## Introduction

The benefits of healthy sexual practices is defined as a good physical, intellectual, emotional, physiological, social fit for healthy and well-being of an individual.

## Content

### List of benefits

<ul style="list-style-type: none"><li>❖ Physical</li><li>❖ intellectual</li><li>❖ emotional</li><li>❖ psychological</li><li>❖ social</li></ul>	<ul style="list-style-type: none"><li>❖ Lower blood pressure</li><li>❖ Better immune system</li><li>❖ Better heart health, possibly including lower risk for heart disease</li><li>❖ Improved self-esteem</li><li>❖ Decreased depression and anxiety</li><li>❖ Increased libido</li><li>❖ Immediate, natural pain relief</li></ul>	<ul style="list-style-type: none"><li>❖ Overall stress reduction, both physiologically and emotional</li><li>❖ lowering blood pressure</li><li>❖ burning calories</li><li>❖ increasing heart health</li><li>❖ strengthening muscles</li><li>❖ reducing your risk of heart disease, stroke, and hypertension</li><li>❖ increasing libido</li></ul>
--	--	---

**Post-assessment:** Explain your understanding of the benefits of healthy sexual practices.

**Material:** Information flyers

## Conclusion

Participants acknowledge the general benefits of healthy sexual practices, however, learners should sustain not to be impregnated as well infected by sexual diseases until they complete school and have their own families. Both parents and teachers should continuously implement health talks with children at home and in schools.

## Health talk 3a

## Topic 5: Consequences of unhealthy sexual practices

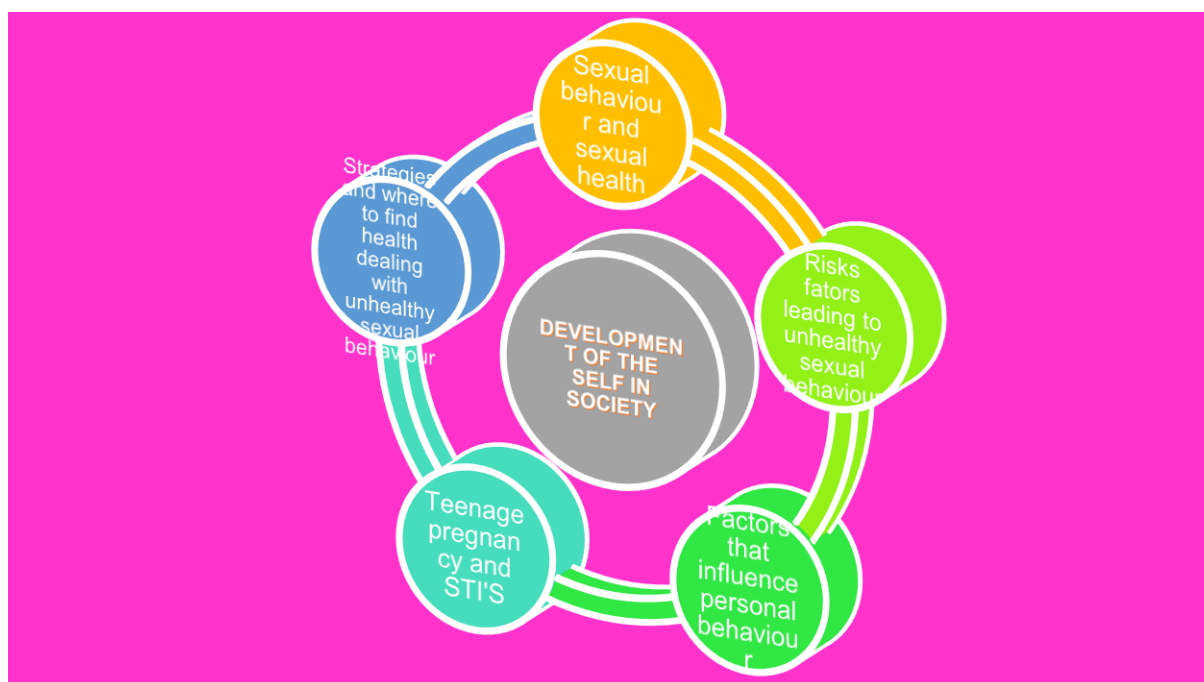
**Target:** Youth, family, churches, schools, and community.

**Duration:** 50 minutes

**Method of giving health education:** group discussion, Team teaching and rotational teaching.

**Place:** awareness campaign at schools, community outreach, and royal meetings.

**Teaching aid:**



**Purpose:** to determine the consequences of unhealthy sexual practices.

### Objectives

*At the end of the lesson teachers, parents and pastors should be able to*

- ❖ To identify the implications of unhealthy sexual practices.
- ❖ To determine ways to prevent the consequences of unhealthy sexual practices.

### Prior-knowledge

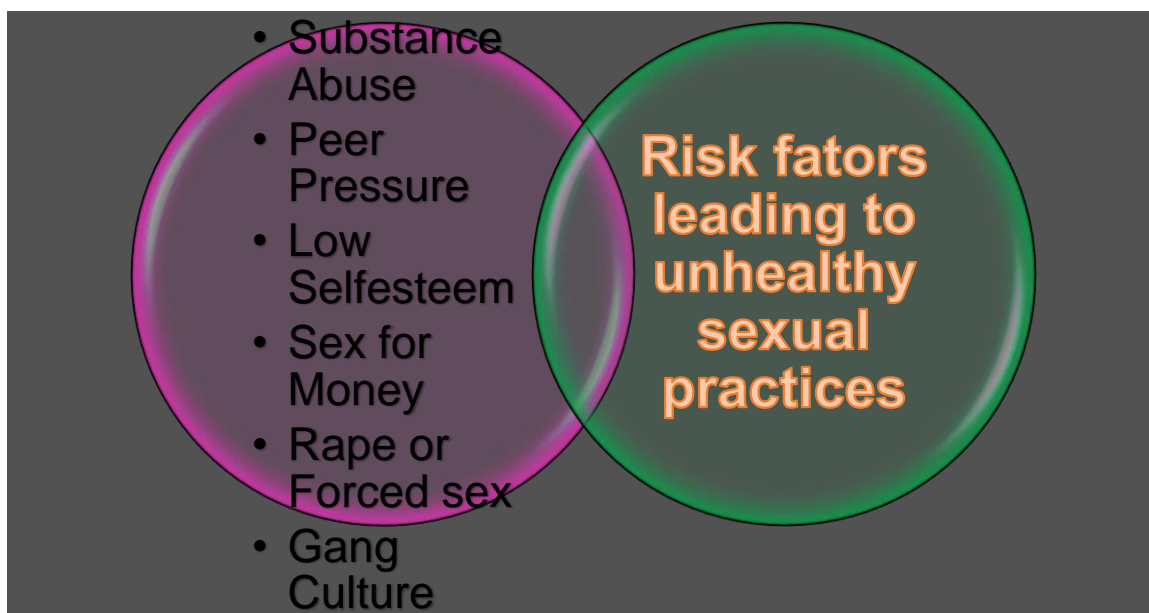
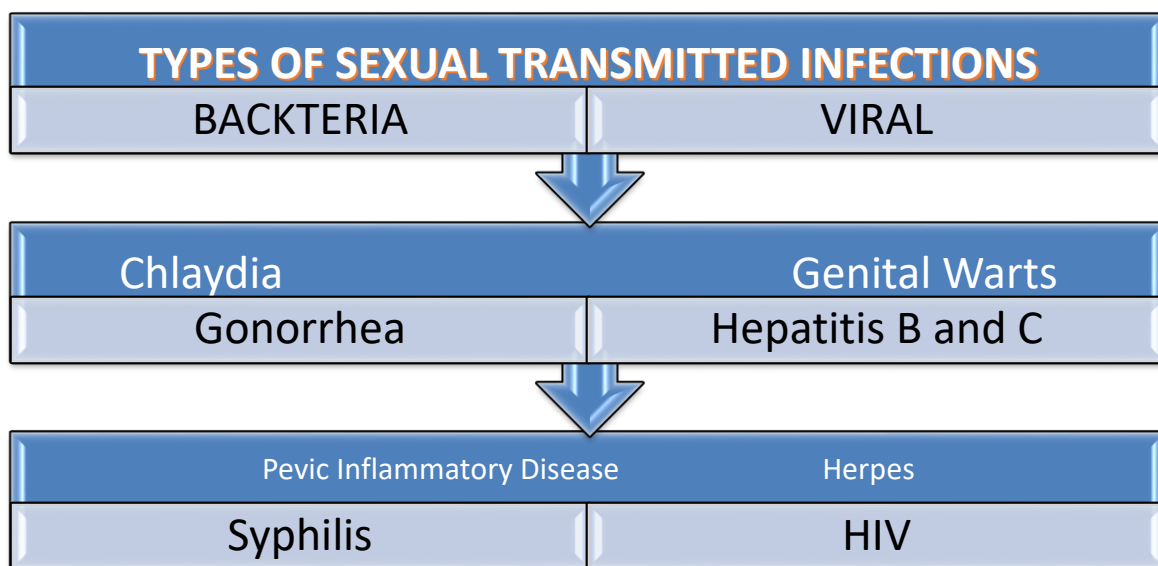
- ❖ What do you understand about unhealthy sexual practices?

### Introduction

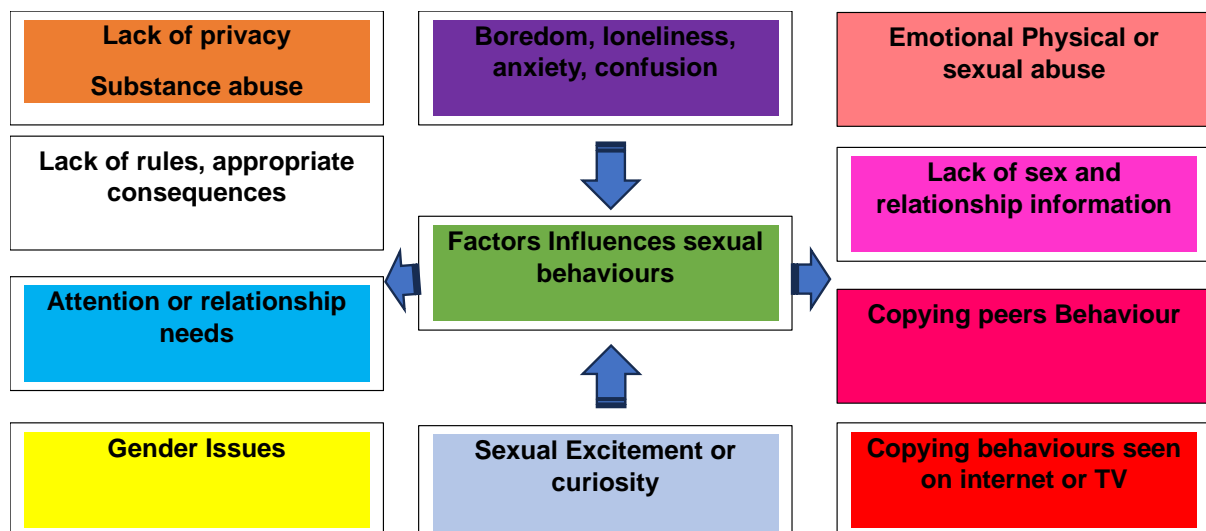
Unhealthy sexual practices is defined as engagement in unprotected sexual intercourse.

### Content

<b>Strategies and where to find help dealing with unhealthy sexual behaviour</b>
Abstinence -not engaging in any sexual activities
Change of behaviour- if you are sexually active, you must make sure you act responsibly by using condoms
<b>Where to find help</b>
Health centers (Clinics, Hospital)
Health Professionals (Nurses, Medical Doctors) and Community Healthcare Workers and Health Promoters
Social Workers and Psychologist







### **Sexual diseases**

**Post-assessment:** Explain your understanding of contraceptives.

**Material:** Information flyers

### **Conclusion**

Sexual diseases that can be contracted during unprotected sexual intercourse were outlined and more intensive information was taught during the training.

## Appendix 25: Information Flyers

### HEALTH TALKS

- ❖ *How to express healthy sexual practices?*
- ❖ *Cultural environment, belief norms and values regarding healthy sexual practices.*
- ❖ *Myths about contraceptives*
- ❖ *The benefits of healthy sexual practices*
- ❖ *Consequences of Unhealthy Sexual practices*

### CONTRACEPTIVE METHODS

- ❖ Intra-uterine devices [IUD]
- ❖ Progestogen-only contraceptives
- ❖ Combined hormonal contraceptives
- ❖ Emergency contraception
- ❖ Standard days method
- ❖ Male sterilisation
- ❖ Condoms both Male and Females

**N.B Condoms prevent STIs, HIV and Pregnancy.**

- **This other contraceptives methods prevent pregnancy, however, you maybe exposed to sexual diseases.**
- **Abstinence prevent yourself from any sexual activities and its end results**

### PROMOTION OF HEALTHY SEXUAL PRACTICE



## Facts about Contraceptives

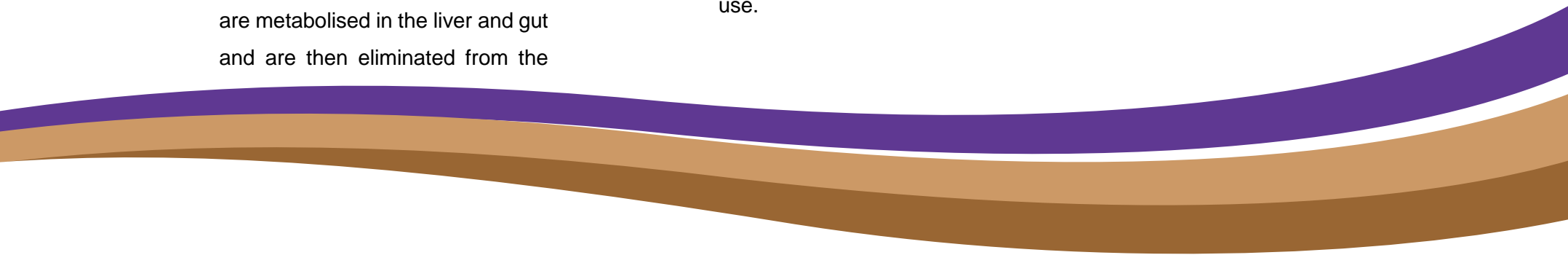
- ❖ A woman may experience short term side effects associated with use of combined oral contraceptive, including changes in bleeding patterns, headaches, and nausea. However such side effects are not a sign of illness, and usually stop within the first few months of using contraceptives.
- ❖ The combined oral contraceptive does not cause infertility.
- ❖ After the pills are swallowed, they dissolve in the digestive system, and the hormones they contain are absorbed into the bloodstream. After they produce their contraceptive effect, the hormones are metabolised in the liver and gut and are then eliminated from the

body. They do not accumulate in the body anywhere.

- ❖ There is no evidence that sexual behavior. The evidence on contraception in general shows that sexual behavior is unrelated to contraceptive use. shows responsible behavior in order to avoid unintended pregnancy and sexually transmitted infections.
- ❖ There is no evidence that contraceptives affect a woman's sexual drive. Although some women using the pill have reported either an increase or decrease in sexual interest and performance.
- ❖ Most women do not gain or lose weight as a result of contraceptive use.

## IMPORTANCE OF CONTRACEPTIVE REGARDING HEALTHY SEXUAL PRACTICE

### BIRTH CONTROL

- ❖ No one uses birth control methods other than the pill and condoms.
  - ❖ I hear the ring falls out.
  - ❖ The patch can fall off.
  - ❖ I hear IUDs can tear through the lining of your uterus.
  - ❖ I hear IUDs can get lost in your uterus.
  - ❖ You can only get IUDs if you've already had a kid.
  - ❖ The implant hurts.
  - ❖ I want the implant but I'm afraid everyone will be able to see it.
- 

## **Appendix 26: Agenda for validation of the developed programme**

**Theme: Dissemination of Study findings and validation of intervention programme to promote healthy sexual practices**

**Venue: Circuits and Venues**

**Date: July/ August 2023**

**Time: 9: 00**

**Programme Director:**

- 1. Opening**
- 2. Welcome and introduction**
  - ✓ *Circulation of attendance registers.*
  - ✓ *Distribution of programme validation questionnaires.*
- 3. Purpose of the meeting**
- 4. Presentation of the study findings and programme developed**
- 5. Completion of validation programme.**
- 6. Questions and Discussion.**
- 7. Vote of thanks**

# Appendix 27: Attended register

## Attendance Register

Subject: Dissemination of study findings and validation of intervention programme.

Circuit and School: Vhembe District Circuits

Date: July/ August 2023

Group number: Circuit Managers, School Management, LO Teachers and SGB

No	Name and Surname	Institution	Contact no	Email address	Position / Role	Signature
1.	SELAPYANE K.R	HLALUKWENI HIGH	0714748664	kiselapyaner@gmail.com	EDUCATOR	[Signature]
2.	NDOYIHADA K.P	HLALUKWENI HIGH	0719978356	Ndoyihada.kp@gmail.com	EDUCATOR	[Signature]
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4.	SITHOLE P	HLALUKWENI	0736780546	Sitholepik@gmail.com	EDUCATOR	[Signature]
5.	GALA G.F	HLALUKWENI	0725315665	galafici10@gmail.com	EDUCATOR	[Signature]
6.	KRAUSE L	HLALUKWENI	0781284520	lucy.krause@gmail.com	EDUCATOR	[Signature]
7.	MAHABA K.E	HLALUKWENI	0660509281	Mahabakemmanuel@gmail.com	PRINCIPAL	[Signature]
8.	MAHABI L	HLALUKWENI	0832473501	lifelaysen@gmail.com	SOCIAL WORKER	[Signature]
9.	MAHARI T.M	KHATISA	0732693262	maferoni.mkhahisa@gmail.com	DEPUTY PRINCIPAL	[Signature]
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11.	Khwanda M.B	KHATISA	0822911469	mbhambukhwanda@gmail.com	EDUCATOR	[Signature]
12.	Mushtara T.D	KHATISA	0820835944	debrahkhusha@gmail.com	EDUCATOR	[Signature]
13.	MAHEBELE R.H	KHATISA	0781599229	Mahabehle.rh@gmail.com	EDUCATOR	[Signature]
14.	MAHABAM P	MAHABAM	0664848433	mabamphozi@gmail.com	Circuit Manager	[Signature]
15.	Hungwane R.N	Mqomanelele Central	0765074666	hungwaner@gmail.com	Admin Clerk	[Signature]

Compiled by : Mr. Ntiso Vinny Khosa (Ph.D. candidate)

## Appendix 28: Validation Tool

### Validation of Intervention Programme

Indicate your response to the listed statements regarding the development of an Intervention Programme to promote healthy sexual practices among youth in the Vhembe District.

**N.B** Rank the level of importance in the developed intervention programme based on Quality

Descriptions of Items	Agree	Strongly Agree	Disagree	Strongly Disagree	Level (1, 2, 3)
1. Is the developed intervention programme relevant to school learners?					
2. Should be the intervention offered as a separate subject in schools?					
3. Is the subject matter comprehensive?					
4. Are stipulate periods per week sufficient?					
5. Is the programme achievable?					
6. Do you concur with the selection procedures of life orientation educators and other stakeholders?					
7. Do you agree with teachers' training procedures?					
8. Are the roles of educators in life orientation lessens clear?					
9. Are the roles of Nurses in the promotion of healthy sexual practices clear?					
10. Are the roles of social workers in the promotion of healthy sexual practices clear?					
11. Are the roles of SGB/parent clear in the promotion of healthy sexual practices?					
12. Are teaching tactics too clear?					
13. Are learner assessment strategies relevant to life orientation?					
14. Is the execution setting conducive?					

Improvement of healthy sexual practices [1. Very Important, 2. Somewhat, 3. Not Important]

#### Comments:

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*Thank you for your participation. God May Bless and protect You.*



## Appendix 29: Proof of English Edit or Proof Reading

### CONFIRMATION OF PROOFREADING

This serves to confirm that I have proofread this thesis and have made the necessary corrections, suggestions, and emendations:

#### **An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province**

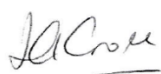
By:

**Khosa Ntiyiso Vinny**

I have been proofreading articles, Honours, Masters and Doctoral dissertations, research reports and theses for the past 16+ years for, *inter alia*, the following institutions: University of the Witwatersrand; GIBS; University of Cape Town; Milpark; Mancosa; University of KwaZuluNatal; University of Johannesburg; Unisa; Tshwane University of Technology; Stellenbosch; Henley Business School, Regenesys, University of Pretoria, University of Zululand, Vaal University of Technology, Nelson Mandela University, University of Limpopo, the Da Vinci Institute and, more recently, the Stadio Group.

I have also undertaken proofreading for publishers, such as Oxford University Press, Knowledge Resources and Juta & Company, companies, institutions, and non-governmental organisations.

I have a major in English, and excellent knowledge of Afrikaans.



Jennifer Croll

BA(Wits); H.Dip.Lib. (UCT); B.Tech.(LIS), B.Inf.Sc.(Hons)(Unisa); MM(Research), MM(Strategic Marketing)(Wits).

Email: [crolljennifer@gmail.com](mailto:crolljennifer@gmail.com)

Mobile: 072-351-7997

Date: 19th December 2023

## Appendix 30: Author Guidelines, *gender and behavior Journal*



### Author Guidelines

#### **Content:**

**GENDER & BEHAVIOUR** welcomes scholarly manuscripts from authors all over the world on a wide array of subjects concerning psychological and behavioural aspects of gender in general. All manuscripts MUST respect the dignity of HUMANITY. Articles published or submitted for publication elsewhere are not accepted. Authors are solely and fully responsible for the statements and views contained in their articles. Neither the Editorial board nor the Ife Center for Psychological Studies/Services accepts responsibility for author's views and statements

**Book Review:** Two copies of the book/manuscript to be reviewed are to be submitted to the Project Coordinator. Gender and Behaviour Ife Centre for Psychological Studies and Service. P.O. Box 1548 Ile-Ife. Osun State, Nigeria. Or through Emails: ifepsey@yahoo.com or wanawake2002@yahoo.com.

**Manuscript Preparation:** Prepare manuscripts according to the Publication manual of the American Psychological Association (4th Edition, 1994; APA 750 First Street, NE, Washington, 20002-4242). Follow "Guidelines to reduce Bias in Language (pp. 46-60)

Limit manuscripts to 25 pages of text, including references.

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**Manuscript and Disk submission:** Submit two (2) manuscript copies to: Project Coordinator, Gender and Behaviour, Ife Centre for Psychological Studies/Service, P.O. Box 1548 Ile-Ife, Osun State, Nigeria. Send by Emails: ifepsey@yahoo.com; wanawake2002@yahoo.com Please make sure that the content of the files exactly matches that of the printed, accepted, finalized manuscripts (provide revised printout). Submit camera ready figures.

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An intervention programme to promote healthy sexual practices among youth in Vhembe District, Limpopo Province

### An intervention programme to promote healthy sexual practices among Youth in Vhembe District.

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