

**INDISCRIMINATE SEXUAL PRACTICES BY THE YOUTH
AND ITS CONSEQUENCES**

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DECLARATION

I declare that the dissertation for the Degree of Master of Arts in Social Work at the University of North-West hereby submitted, has not been previously submitted by me for a degree at this university or any other university, that it is my own work and that all material contained herein has been duly acknowledged.

(ii)

DEDICATION

This dissertation is dedicated to the memories of my late father Mr Kagiso John Sebopo and my father-in-law Mr Lekobakoba Peter Mooki may their souls rest in peace.

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In particular I would like to thank

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ABSTRACT

Teenagers have the highest rate of sexually transmitted diseases of any age group. Factors responsible for this include sexual experimentation which often follows initiation of intercourse and adolescent's reluctance to use contraceptives. Teenagers are typically reluctant to consider the possibility that a potential sex partner may have a sexually transmitted disease and often lack the communication skills necessary to discuss this possibility, placing them at even greater risk of contracting one.

A large percentage of teenagers are engaging in risky sexual practices. Teenagers cite lack of sexual education from more reliable sources like their parents and schools. They receive most of their sexual information from their peers and the massive mass media. The information received from these sources is usually sensational and misleading.

Parents keep the children ignorant because they are of the opinion that less sexual knowledge will be more protecting. They fear that if they inform their children about sex they will go out and experiment. Therefore parents are not talking to their children about sex because most cultures and mostly in the Black community it is taboo to talk to children about sexual issues or matters. Therefore because of lack of sexual education teenagers are at risk of contracting sexually transmitted infections including HIV/AIDS, teenage pregnancy, abortion, prostitution and sexual abuse.

Sexual education should start at an early age most preferably at nursery school level. If children are given factual information about sex they will know how to handle their sexuality. They will not be pressurised to indulge in pre-marital sex by their peers. Therefore, information should be provided by parents and schools as most teenagers prefer to receive their sex information from a more reliable source.

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CHAPTER ONE

GENERAL INTRODUCTION AND METHODOLOGY

1. INTRODUCTION

In light of the continuing high levels of teenage pregnancy (one million pregnancies per year) the sharp increases in rates of STD's among persons 15 to 24 years of age and the increasing rate of HIV infections in adolescents it is imperative that we identify sex education programs that appear to be effective in reducing sexual-risk taking behaviours (Hyde and De Lamater, 2000:626).

According to Hyde and De Lamater (2000:614) "sexuality education should be a central component of programs designed to reduce the prevalence of sexually related medical problems including teenage pregnancies, sexually transmitted diseases; HIV infection and sexual abuse".

It is not always easy to talk about sexually transmitted diseases even to a medical practitioner. People are frequently embarrassed if they have an infection in the region of their genitals and fear that they are somehow dirty or diseased.

Curtis (1991:89) states that "societies are often reluctant to recognise that young people are sexually active whereas parents and schools may prefer to moralise rather than give factual information and practical help. Even where young people have access to information about safer sex, they may still find it difficult to put their knowledge into practice. Romantic ideas may override

awareness of the risks, serious relationships may be seen as a defense against HIV and other sexually transmitted diseases and love is not using a condom hence the increasing number of teenage pregnancies and the prevalence of HIV and AIDS.

According to Dickson and Leming (1990:393) child sexual abuse crosses all social, economic and racial boundaries and affects a wide range of people and families. It can start when a child is as young as two months, with the most vulnerable years between six and eight. Children's lack of knowledge and uncertainty about behaviour often lead to their exploitation and victimization. Children often believe offenders who tell them that the sexual activity is all right. Unexpected behaviour change of an adult can throw them off guard. The concepts sex, sexual and sexuality will be used interchangeably in the text.

2. PROBLEM STATEMENT

According to Hyde and De Lamater (2000:612) children are given no sexuality education in the home. Rather they learn about sex from the media and peers and the result is a massive amount of misinformation. Relying on friends for information is a classic case of the blind leading the blind. It is preferable for young people to hear and learn about sex from their parents. However parents still find it difficult to discuss sexual matters with their children, either because they still consider sexuality as a taboo or because they are embarrassed or ashamed to talk about it. HIV and AIDS is a serious problem and the majority of victims are most probably teenagers because they lack sexual information especially from their parents.

In this regard Mogotsi (1996:86) exclaimed that the most threatening finding in her research was the minimum role played by parents in sexually informing their children. Subsequent to the findings of Mogotsi, the Girl Child Survey (1998:17) remarked that "schools do not offer sexuality education as part of their curriculum, and some cultures prohibit families from discussing issues of sexuality with their children until they go to an initiation school or turn 21. This scenario leads to a high level of ignorance and misinformation for girls and boys regarding their sexuality. The result is that children receive most of their sex "knowledge" from peers and the media which may lead to devastating consequences.

Anderson and Okoro (2000:2) concurs with the last statement that peoples' lifestyle is influenced to a great extent by television, the media and peer pressure. Lack of sexual knowledge may lead to unprotected sexual relations placing adolescent girls at risk of unwanted pregnancies and both girls and boys at risk of sexually transmitted diseases including HIV and AIDS. It has been mentioned by Rischer and Easton, (1995:468) that about 63 percent of all STI's occur in people under 25 years of age. Some of these diseases such as yeast or protozoan infections of the genital mucous membranes are fairly innocuous (harmless) whereas others such as chlamydia and gonorrhea cause amongst others reproductive problems. All are embarrassing, painful and dangerous and because of lack of sexual education, young people become victims of these sexually transmitted diseases.

Furthermore, Kimmel and Weiner (1995:346) found in a study of 212 adolescents involved with the juvenile justice system that because of lack of information these youngsters were at high risk for sexually transmitted

diseases HIV and AIDS and unintended pregnancies (Kimmel and Weiner, 1995:346).

The problem area can thus be summarized as follows : Teenage pregnancies, HIV/AIDS, venereal diseases and child sexual abuse are constantly on the increase. The main reason for the increase can mainly be ascribed to the ignorance of sexual matters especially among the youth. Sexual ignorance may lead to vulnerability and possible exploitation of young people of which the resultant effects can be devastating and possibly lethal. Although sex education is mainly the responsibility of parents and schools, these two institutions are apparently hopelessly failing in this task. Young people therefore turn to peers and the media for sexual information. These two sources are not only sensational but equally uninformed. A great number of young people are therefore exposed to various dangers which should have been prevented.

3. OBJECTIVES

Uys and Basson (1991:28) define objectives as more specific measurable expectations of the aims. They enable the researcher to determine whether the problem has been solved and what recommendations may be made.

The following are the objectives of the study:

- * To clarify the concepts sexuality and sexual education.
- * To determine the role played by parents and schools with regard to sexual education.

- * To determine the effects of insufficient sexual education resulting in pathologies such as teenage pregnancy, sexually transmitted diseases and child sexual abuse.
- * To determine measures of preventing child sexual abuse, teenage pregnancies and sexually transmitted diseases.

4. SIGNIFICANCE OF THE STUDY

- * The study will benefit teenagers because it will help them to exercise responsibility regarding sexual relationships.
- * Policy makers will benefit from the study because they will realize the importance of sexual education and urgently consider ways of coming up with a policy that will address sex education as well as the concomitant dangers associated with sexual ignorance especially among young children.
- * Young people will be provided with an opportunity to question, explore and assess their sexual attitudes in order to develop their own moral and sexual values.

5. HYPOTHESIS OR ASSUMPTIONS

A hypothesis is defined as follows :

As this research undertaking is descriptive, it is not possible to merely formulate and test a hypothesis. For this reason the researcher is compelled to rely on assumptions.

According to Bailey (1987:128) an assumption refers to something that is taken as a fact or believed to be true without proof.

The following are the assumptions of the study :

- * Lack of life skills education and more specifically sexuality education most probably contribute to an alarming rate of teenage pregnancies and the prevalence of HIV and AIDS.
- * Young people are more vulnerable to social and health problems because they do not get relevant information about sexual matters from their parents and or schools.
- * Society expects women to be submissive therefore they are not allowed to control their own sexuality.
- * Purposeful sex education will help to prevent unplanned pregnancies child sexual abuse and STI's diseases.

6. LIMITATIONS

Introduction

- * Since the research undertaking is limited to the central region of the North West Province, the findings may not be representative of the phenomenon in its totality.
- * Lack of resources such as the availability of relevant books may to a great extent hamper the literature basis and guidance necessary to assist the researcher in her findings and ultimate conclusions.

7. DEFINITION OF CONCEPTS

* SEXUALITY

According to Davidson (1990:5) sexuality refers to feelings and activities connected to a person's sexual desires be it male or female.

* SEXUALITY EDUCATION

Hyde and De Lamater (2000:612) define sexuality education as the lifelong process of acquiring information about sexual behaviour and forming attitudes, beliefs and values about identity, relationships and intimacy.

* PREVENTION

Martin and Viviers (1996:5) define prevention in terms of primary, secondary and tertiary prevention.

— PRIMARY PREVENTION

Primary prevention refers to early intervention that enables people to avoid problems of dysfunctioning. It is mostly directed at large groups of people (communities) who do not currently manifest problems. According to Maforah (1991:62) the aim of primary prevention is to restrain the prevalence of a disorder/problem by anticipating the disorder before it becomes manifested in any way.

— SECONDARY PREVENTION

Secondary prevention is aimed at the identification of problems and early intervention into the lives of individuals, families and groups who

are at risk of developing social problems before the situation becomes critical (Maforah, 1991:62).

– TERTIARY PREVENTION

Programmes designed to reduce the residual effects and adverse consequences of rooted disorders/problems are formally designated as tertiary prevention; but are better known as curative or rehabilitation measures.

*** CHILD SEXUAL ABUSE**

Wolfgang (1994) cited in Hope (1999:41) define child sexual abuse as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully understand as well as they are unable to give informed consent to and which violate the social taboos of family roles.

*** TEENAGE PREGNANCY**

According to Barker (1987:247) teenage pregnancy is pregnancy contracted at the age of adolescence, which its age limit is not clearly specified but extends roughly from the age of 13 to the late teens when physical growth is nearly complete.

*** SEXUALLY TRANSMITTED DISEASES**

In a broad sense sexually transmitted diseases can be divided into STIs and HIV/AIDS. The acronym of STI is sexually transmitted diseases or also known as venereal diseases. These diseases are mainly spread by sexual contact. The acronym for HIV/AIDS is Human

Immuno-Deficiency Syndrome. The HIV when contracted will progressively weaken the immune system. In the AIDS related complex there is evidence of moderate immuno-deficiency from increased susceptibility to more serious opportunist infections or tumours which take advantage of the weakened immune defence against them (Anderson & Okoro, 2000:10).

8. METHODOLOGY

Haralambos (1990:64) define methodology as the study of research methods with the nature and quality of the data produced by various methods, logic and rationale behind the use to which those data are used in research.

8.1 Research Design

According to Claire Bless and Higson-Smith (2000:63) research design relates directly to the testing of hypothesis. It is a specification of the most adequate operations to be performed in order to test a specific hypothesis under given conditions. According to Anderson (2003:17) the main purpose of research design is to describe the characteristics of the phenomenon; to estimate the proportion of people in a specified population who hold certain views or attitudes; discovering or testing whether certain variables are associated.

The researcher will use descriptive design as this design will help to describe the variables of the phenomenon including the necessity and extent of sexual education as well as the possible results of sexual ignorance such as child sexual abuse, teenage pregnancies and sexually transmitted infections. According to Uys and Basson (1991:38) a descriptive study is the collection of accurate data on the domain of a phenomenon to be studied.

8.2

Methods of data collection

The researcher will use the following methods of data collection :

* **Literature studies**

Kranthwont cited in Grinnel (1988:434) states that the purpose of literature review is to provide the basis and background for the study. According to Anderson (2003:3) after the problem has been identified and the researcher has decided to undertake research on the topic, the researcher starts with relevant, pertinent and recent literature studies. The aim of literature studies is to place the research in a theoretical perspective by reviewing the available literature related.

The researcher intend reviewing past studies to determine previous research and information documented on sexual education, results of insufficient sexual knowledge and possible guidelines and measures to be taken to rectify the present situation regarding sexual education.

* **Questionnaires**

The new Dictionary of Social Work cited in de Vos (2000:152) define a questionnaire as a set of questions on a form which is completed by a respondent in respect of a research project.

* **Personally administered questionnaires**

Structured questionnaires were handed out to respondents who were requested to complete them on their own. However, the researcher was available to deal with possible problems respondents experienced.

The researcher limited her contribution to the completion of the questionnaires to the absolute minimum (de Vos, 2000:154).

Especially multiple choice questions were included in the questionnaire whereby respondents were expected to choose from a number of alternatives to present their responses. The structuring of the questionnaire was implemented to make it easier for learners to complete.

★ **Experience surveys**

Experts in the field of health sciences educators, social workers and researchers were consulted so that relevant expert information could be collected from them.

8.3 Validity of the measuring instrument

Grinnel (1988:112) define validity as the degree to which a measuring instrument measures what it intends to measure.

The aspect of validity was attended to by comparing the contents of the measuring instrument with the objectives of the study.

The following procedures were followed to determine the validity of the questionnaire :

★ **Face validity**

The questionnaire was referred to a research expert to verify the face validity of the measuring instrument.

★ **Content validity**

According to Grinnel (1988:112) content validity is concerned with the representativeness of the contents of the measuring instrument.

The researcher used content validity to measure if the measuring instrument (questionnaires) covered the study's objectives and that the questions asked were relevant and sufficient to come to a successful conclusion. In this regard a pilot study was also undertaken to determine the measurability of the questionnaires.

9. **SAMPLING**

According to de Vos (2000:191) sampling refers to the "element of the population considered for actual inclusion in the study, or it can be viewed as a subset of measurements drawn from a population in which we are interested". In this study the researcher decided to draw a probability sample in order to secure some form of representation.

Probability sampling is defined by Seaberg (1988) cited in de Vos (2000:195) as follows : "a probability sample is one in which each person (or other sampling unit) in the population has the same known probability of being selected. In addition the selection of persons from the target population is based on some form of random procedure". In drawing the sample, simple random sampling was specifically used.

According to de Vos (2000:195) "simple random sampling is when each individual case in the population theoretically have an exactly equal chance of being included".

The procedure followed to draw the sample included the following :
the researcher secured a list of all high schools in the Mmabatho/Mafikeng area. By means of simple random sampling she selected three schools. Thereafter, using simple random sampling a grade was attached to each school. Questionnaires were handed out to all children in the selected grade in the selected school.

10. DATA ANALYSIS

According to Seaman (1987:333) data analysis is the process by which the researcher summarises and analyse the data that have been collected. The researcher used descriptive and inferential statistics. According to Singleton (1988:389) descriptive statistics is concerned with organising and summarising data at hand to make it more intelligible. Inferential statistics that can be made when generalizing the data. The researcher mainly used univariate distributions by describing each variable by itself using frequency distribution tables.

11. DIVISION OF THE REPORT

Chapter 1 - General introduction and methodology

Chapter 2 - Theoretical perspectives

Chapter 3 - Teenage sexuality

Chapter 4 - Consequences of indiscriminate sexual practices

Chapter 5 - Measures to prevent indiscriminate sexual practices

Chapter 6 - Data analysis

Chapter 7 - Main findings and recommendations

CHAPTER TWO

2. THEORETICAL PERSPECTIVES

2.1 INTRODUCTION

Theories are formulated to offer a better understanding of certain phenomena. It is for this reason that the following theories which have some relation to sexuality are discussed.

2.2 EVOLUTIONARY PERSPECTIVES

According to Hyde and De Lamater (2000:26) evolution is a theory that all living things have acquired in their present forms through gradual changes in their genetic endowment over successive generations.

Two theories under evolutionary perspectives will be discussed namely socio biological theory and evolutionary psychology.

2.2.1 Sociobiological Theory

According to Hyde and De Lamater (2000:26) sociobiology is defined as the application of evolutionary biology to understand the social behaviour of animals including humans. Sexual behaviour of course is a form of social behaviour and so the sociobiologists often through observations try to understand why certain patterns of sexual behaviour have evolved in humans.

Evolution occur via natural selection and one major criterion of selecting a partner in humans is through physical attractiveness. In addition to natural selection evolution also occur via sexual selection. In many species males

compete among themselves for the right to mate with females. The theory predicts that men should compete with each other in ways that involve displaying material resources that should be attractive to women. Examples might be giving impressive gifts to potential females, or showing of possessions for example cars, stereos etc. (Hyde and De Lamater, 2000:26).

One of the most controversial ideas is the argument by some sociobiologists that rape is the product of evolutionary selection because it is adaptive for the male. They have even suggested that human males are larger than females as a result of evolutionary selection that make large males more successful at rape. The argument is that human males could reproduce either by courtship, bonding with a female and then reproduce or else by rape. Rape would be predicted for those males that lack the resources to carry on a successful courtship and win a consenting female, or in response to a female's rejection of his advances. In this theory it would seem that males have the right to sexuality either with or without the consent of a female. However, in the social order of the present society this theory seem to be unacceptable.

2.2.2 Evolutionary Psychological Theory

According to this theory males and females face different adaptive problems in the short term or casual relationships. In short term relationships a woman may choose a partner who offers her immediate resources such as food or money. In a long term relationship a woman may choose a partner who appears able and willing to provide resources for the indefinite future. A male may choose a sexually available female for a short term or casual relationship, but may avoid such a female partner when looking for a long term relationship (Hyde and De Lamater, 2000:27).

2.3 PSYCHOLOGICAL THEORIES

Psychological theories, however refer to the psychoanalytic theory as well as the learning theory.

2.3.1 Psychoanalytic Theory

According to Freud he discussed this theory in terms of psychosexual stages of development. The first stage lasting from one year of age is the oral stage. The child's chief pleasure is derived from sucking and otherwise stimulating the lips and the mouth. The second stage which occurs during approximately the second year of life is the anal stage. During this stage the child's interests is focussed on elimination.

The third stage of development lasting from age three to five or six is the phallic stage. The boy's interests is focussed on his phallus (penis) and he derives most pleasure from masturbating. Perhaps the most important occurrence in this stage is the development of the oedipus complex. In the oedipus complex the boy loves his mother and desires her sexually. He dislikes his father whom he sees as a rival for the mother's affection. The boy's hostility towards his father grows, but eventually he comes to fear that his father will retaliate by castrating him (cutting off his prized penis). Thus the boy feels castration anxiety. Eventually the castration anxiety becomes so great that he stops desiring his mother and shifts to identifying with his father, taking on the father's gender role and acquiring the characteristics expected of males by society (Hyde and De Lamater, 2000:26).

For a girl the phallic stage begins with her traumatic realization that she has no penis, perhaps after observing that of her father or brother. She feels

envious and cheated, and she suffers from penis envy wishing that she too had a wonderful wand. Presumably she thinks her own clitoris is totally inadequate, or she is not even aware that she has the organ she believes that at one time she had a penis and it was cut off, and she holds her mother responsible for this defect. Thus she begins to dislike her mother and shifts her affection to her father forming her version of the oedipus complex which is called the electra complex.

Following the resolution of the oedipus or electra complex, children pass into a prolonged stage known as the latency stage which lasts until adolescence. During this stage the sexual impulses are repressed and little is done sexually. With puberty, sexual urges reawaken and the child moves into the genital stage. During this stage sexual urges become more specifically genital and the oral, anal and genital urges all fuse together to promote the biological function of reproduction. Sexuality becomes less narcissistic (self directed) than it was in childhood and is directed towards other people as appropriate sexual objects.

2.3.2 Learning Theory

To help people understand their own sexuality three principles of modern learning theories will be reviewed namely operant conditioning, behaviour modification and social learning theory.

2.3.2.1 Operant Conditioning

According to Hyde and De Lamater (2000:26) operant conditioning refers to the following process. A person performs a particular behaviour (the operant). That behaviour may be followed by a reward (positive reinforcement) or

punishment (negative reinforcement). If a reward follows the person will be likely to repeat the behaviour again in the future. With punishment the person will be less likely to repeat the behaviour. Thus if a behaviour is repeated/rewarded, it may become more frequent whereas if it is repeatedly punished, it may become very infrequent or even be eliminated. For example if a woman repeatedly experiences pain when she has intercourse (perhaps because she has a vaginal infection) she will probably want to have sex infrequently or not at all. In operant conditioning terms sexual intercourse has repeatedly been associated with punishment (pain) and so the behaviour becomes less frequent.

2.3.2.2 Behaviour Modification

Behaviour modification involves a set of techniques based on principles of classical or operant conditioning, that are used to change (modify) human behaviour. In particular these techniques can be used to modify problematic sexual behaviours, such as untimely orgasm or deviant sexual behaviours such as child molestation.

An example of a technique used in modifying sexual behaviour is olfactory aversion therapy. In aversion therapy the problematic behaviour is punished using an aversive stimulus. Repeated pairing of the behaviour and the aversive stimulus should produce a decline in the frequency of the behaviour or its total extinction. In olfactory aversion therapy the problematic sexual behaviour is punished using an unpleasant odour. Such as the odour of spirits or ammonia as the aversive stimulus. With the help of a therapist the patient first identifies the behaviour chain or sequence that leads up to the problem behaviour. Then the patient imagines one event in the chain and is

simultaneously exposed to the odour. This form of therapy not only punishes the behaviour but also creates the perception in the patient that the behaviour is under his or her control.

2.3.2.3 Social Learning Theory

Social learning theory recognise two processes namely imitation and identification. These two processes are useful in explaining the development of gender identity or one's sense of maleness or femaleness. For example it seems that a little girl acquires many characteristics of the female role by identifying with her mother and imitating her.

Most sexual behaviours in society are kept rather private and hidden, imitation and identification therefore, have less of a chance to play a part. However, some of the more open forms of sexuality may be learned through imitation. For example a boy might see a movie in which a hero's technique seems to "turn women on", then he tries to use the same technique with his own dates. If the behaviour is not reinforced he will stop performing it. If it is reinforced he will repeat it.

If a woman feels efficacious at using the female condom, she will expand more effort eg. a woman who use a female condom find it difficult to use it at first and with practice she can learn how to use it properly. (Going to the drug store to buy one) and will show greater persistence in the face of difficulty. (Continuing to adjust it until it fits properly) than she would have done before). The concept of self efficacy have been widely used in designing health intervention programs such as those that encourage individuals to use condoms to prevent transmission of sexually transmitted infections and HIV

infection. These programs provide opportunities for participants to practice the behaviours and be successful.

2.4 SOCIOLOGICAL THEORIES

According to Hyde and De Lamater (2000:27) sociologists are most interested in the ways in which society or culture shapes human sexuality. In this regard the following three sociological theories will be discussed :

2.4.1 Social Institutions

According to the sociological perspective sexuality is influenced by powerful social institutions such as religion, the family, the economy, medicine and the law.

2.4.1.1 Religion

Christian religion has contained within it a tradition of asceticism, in which abstinence from sexual behaviour especially before marriage is seen as virtuous. The tradition has also been oriented towards procreation, with the belief that sexuality is only legitimate within a traditional heterosexual marriage and only with the goal of having children (a precreational ideology). This view has created within our culture a set of norms or standards for behaviour, which for instance excludes premarital sex, extra-marital sex and homosexual sex.

2.4.1.2 The Economy

The nature and structure of the economy also influence sexuality. Before the industrial revolution most work was done in the family unit in the home or farm. This kind of togetherness permitted rather strict surveillance of family members sexuality and thus strict norms could be enforced. However with the

industrial revolution people, most frequently men, spend many hours per day at work away from the home. Thus they are under less surveillance, and scenarios such as extra marital affairs and homosexual sex can be acted out more frequently.

In recent times evidence of the extent to which the economic conditions, and especially the unemployment rate, can affect the structure of the family and thus sexuality. For example if a group of men such as lower class Black men, have less access to jobs and have a high unemployment rate, they are understandably reluctant to marry, knowing that they cannot support a family. The result is a great number of female-headed households with sexuality occurring outside marriage and children born without a legal father. There is thus sufficient proof that a culture's economy may have a profound effect on patterns of sexuality, marriage and child-bearing.

2.4.1.3 The Family

The family was an important economic unit before the industrial revolution, producing goods necessary for survival. As that function waned after the industrial revolution, there was increased emphasis on the quality of interpersonal relationships in the family. At the same time love was seen as an important reason for marriage. A triple linkage between love, marriage and sex was formed. Ironically the linkage became a direct one between love and sex (removing marriage as the middleman). Some people argued that if premarital sex is performed in the context of a loving relationship it was permissible, as was homosexual sex again if the relationship was a loving one. This is termed the relational ideology.

The family exerts a particularly important force on sexuality through socialization of children. Parents socialize their children by teaching them appropriate norms for behaviour in many areas including sexuality. Other factors such as peer group pressure and the media also have an important socializing influence.

2.4.1.4 Medicine

The institution of medicine is a further factor that has influenced sexuality for many years. Medical practitioners inform people what is healthy and what is unhealthy. In the late 1800's doctors warned that masturbation could cause various pathologies. Today sex therapists tell people that sexual expression is natural and healthy and sometimes even prescribe masturbation as a treatment. People tend to have great confidence in medical advice and their pronouncements based on therapeutic ideology can amongst others have an enormous impact on sexuality.

2.4.1.5 The Law

The legal system as an institution can also influence sexuality. From a sociological perspective the law influences people's sexual behaviours in a number of ways. Firstly, laws determine norms. Generally people think that what is legal is right and what is illegal is wrong. Thus a society in which for instance prostitution is against the law its practice will also be considered to be wrong. Secondly, laws are the basis for mechanisms of social control as they may specify punishment for certain acts and therefore discourage people from engaging in them. An example is public sexual acts such as exhibitionism or even nudity on beaches. One wonders how many people would have preferred to be nude at beaches if they did not fear arrest.

2.4.2 Sexual Scripts

According to Hyde and De Lamater (2000:27) sexual behaviour and virtually all human behaviour for that matter is scripted, much as a play in a theatre. That is sexual behaviour is a result of elaborate prior learning that teaches people an etiquette of sexual behaviour. According to this concept little in human sexuality is spontaneous. Instead people have learned an elaborate script that tells them, who, what, when, where and why they do what they do sexually. For example the "who" part of the script tells people that sex should occur with someone of the opposite gender, of approximately their own age, of their own race, etc.

2.4.3 Reiss's Sociological Theory

Reiss's sociological theory was proposed by Ira Reiss in 1986. This theory argues that societies regard sexuality as important because it is associated with physical pleasure and with self disclosure.

According to Reiss sexuality is linked to the structures of any society in three ways :

Firstly, because sexuality is the source of reproduction it is always linked to kinship and all societies seek to maintain social order through stable kinship systems. This linkage then becomes the explanation for sexual jealousy which is universal and cross-culturally although it exists in varied forms. Jealousy is a way of setting boundaries on a relationship that is considered very important enough so that it should not be breached. Marriage is typically of such a relationship and jealousy in marriage about extra-marital affairs exists in all human societies.

Secondly, sexuality is always linked to the power structures of a society. Powerful groups in any society generally seek to control the sexuality of the less powerful. Males are more powerful than females in most societies, so sexuality becomes linked to gender roles and males exercise power over female sexuality.

Thirdly, sexuality is closely linked to the ideologies of a culture. Societies define carefully what sexual practices are normal or abnormal and which are right or wrong. Some societies define homosexuality as abnormal whereas others define it normal. Similarly some cultures take a permissive attitude towards pre-marital sex both for males and females, whereas some are permissible for males only and not for females.

2.5 THEORIES THAT EXPLAIN WHY PEOPLE ARE SEXUALLY EXPLOITED

Hope 1999 identified three theories why people are sexually exploited. The theories are known as the prevention, the cleansing and the retribution theories.

2.5.1 The Prevention Theory

This theory is based on the assumption that all sexually active people are likely to be HIV or AIDS infected. If an individual is uninfected and wishes to engage in safe sexual activity, this can only be done with a partner who is uninfected, and by implication with one who is not yet sexually active. However, the only sure group that fits this criteria are children aged four to twelve years. As a result an increasing number of young children are being targeted as partners for safe sexual relationships (Hope, 1999:41).

2.5.2 The Cleansing Theory

This theory suggest that by engaging in sexual relations with a specific target group, HIV and AIDS can be passed from an infected individual to his or her partner. During this passage the infected individual is simultaneously cleansed of the virus. The target population have changed with time. At present children form the most popular and accessible target group (Hope, 1999:41).

2.5.3 The Retribution Theory

This theory reflects a belief which is most prevalent in peri-urban settings. It argues that individuals who know and believe themselves to be infected by HIV try to spread the infection to all sectors of society. It is uncertain whether this is a response born out of anger, or a desire for revenge, or a reflection of unity among marginalised individuals where both triumph and set backs are shared. Irrespective of the underlying cause the result is the deliberate and indiscriminate transmission of HIV/AIDS (Hope, 1999:41).

2.6 THE FEMINIST THEORY

According to Burt (1980:229) one result of male dominance over women is that women are excluded from political decision making processes which affect them. With women excluded from positions of political and economic power the feminist theory maintain that women are considered unequal participants in interpersonal interactions. At the extreme women can be viewed by men as property or sex objects.

This theory implies that men are dominating all aspects of female sexuality including deciding which sexual activities suits them.

Burt further states that sexual gratification is not considered a prime motive by the feminist theory but rather seen as the use of sexuality to establish or maintain dominance and control of women by men.

2.7

CONCLUSION

This chapter on theories was done by the researcher to have a better understanding of the phenomenon of human sexuality. A number of theories were discussed as each theory defined human sexuality differently. Theories therefore are a core of the research. The theories provide meaning to the research because they provide the researcher with knowledge on how to go about doing the research. They are therefore the researcher's tools for research. This chapter on theories helped the researcher to have an understanding of human sexuality before even attempting to go any further because the theories were used as a base for the research. Theories therefore play an important part in the undertaking of any research because they provide the researcher with an understanding of the topic and how to go about doing it.

Theories help the researcher to understand what previous researchers found on the topic to be researched. It is therefore important for every researcher to incorporate theories in their research studies.

CHAPTER THREE

3. TEENAGE SEXUALITY

3.1 INTRODUCTION

According to Kimmel and Weiner (1995:342) sexual feelings increase in intensity after puberty, reflecting the greater amount of sex hormones circulating in the body for both females and males. Masturbation, sexual dreams and fantasies, day dreams and tentative explorations of sexual behaviour with others are typical. Romantic fantasies, feelings of falling in love, feeling uncomfortable or attracted by love scenes in movies and wanting to be near sexually attractive persons are usual.

Drawing on their unique childhood experiences of sexuality, adolescents gradually begin to discover their own particular sexual interests. They also learn their immediate social environment. These include previous experiences in similar situations, fantasies and expectations and stories from friends and in the popular media. The task of integrating one's own sexual feelings, moral values and the sexual scripts into a reasonably coherent set of personal sexual beliefs and behaviour is the primary struggle of teenage sexuality (Kimmel and Weiner, 1995:342).

Some of the most pressing issues in teenage sexuality will be discussed below including among others sexual education because lack of sexual education leads teenagers to practice sexual behaviours that endanger their health and lives.

3.2**SEXUAL INTERCOURSE**

According to Jones (1985:47) sexual intercourse is usually thought of as the pinnacle of human sexuality and for most people it is. But it should be seen for what it is "the culmination" of sexually stimulating events during which both partners receive and give pleasure to each other and express their loving feelings. A young woman has the right to refuse a demand for sexual intercourse. No is a good oral contraceptive. The different attitudes to sexual intercourse of a teenager's parents and of his or her friends, cause conflicts which can lead to emotional insecurity. The pressures by young men on young women to permit sexual intercourse can be intense and difficult to handle, hence a need for sexual education for both young men and women.

3.3**A DECISION ABOUT SEX**

Jones (1985:63) states that "if your decision is that you will enjoy a sexual relationship with one or many partners, two consequences may occur. The first is that the woman may become pregnant. The second is that one or both of them may contract a sexually transmitted disease. It is unwise for anyone to enter into a sexual relationship just because their friends are doing it or because the man is putting on pressure. You are ready for a complete sexual relationship when you have decided that you are comfortable and secure and not when you feel that you must do as your friends do or you will run the risk of being rejected or scorned by them".

3.4**MASTURBATION**

According to Kimmel and Weiner (1995:348) many children discover methods of masturbation. They usually also learn that this behaviour makes parents anxious and learn to feel guilty about doing it, or they may learn that it is a

private activity that is normal if it is done in an appropriate place and time. Finding ways to stimulate oneself sexually is a useful way to become acquainted with one's genitals and with the kind of stimulation that is exciting. It is useful to get to know one's sexual responses and to accept those responses and one's genitals as a healthy part of oneself. Contrary to masturbation, coitus, oral stimulation of the genitals and especially anal intercourse may expose persons to sexually transmitted diseases such as HIV/AIDS.

3.5

SEXUAL ORIENTATION

Adolescents discover that their sexual feelings are directed towards persons of the opposite ender, or towards persons of the same gender or both. For some this may reflect childhood or prenatal influences manifested earlier by sexual feelings. Those teenagers who discover that their sexual orientation is towards persons of the same gender often face considerable social stigma placed on same gender sexual feelings, behaviour and relationships. Thus lesbian and gay adolescents learn to hide their sexuality. Usually they cannot go to their parents for support (Kimmel and Weiner, 1995:355).

The social stigma and parental rejection may lead the teenager to run away from home, to establish a self-sufficient life in an urban area where the social support of other gay persons can be found. Unfortunately prostitution for survival and other serious problems may result (Kimmel and Weiner, 1995:336).

3.6 FACTORS INFLUENCING SEXUAL BEHAVIOUR

Apart from biological factors there are other factors that have an influence on teenager's sexual behaviour. These factors are discussed below :

3.6.1 Socialisation Process

According to Barker (1990:471) socialisation is the process through which human beings internalise the norms, values and beliefs of society. Human sexual behaviour is regulated and shaped by strong social forces in politics, religion and in medicine, so that in any one culture at any one moment certain forms of sexual acts and sexual expressions are seen as more normal than others. For most people talking about sex and sexual practices make them feel uncomfortable. This is because they have been socialised to regard sexual activity as something private.

Furthermore Naidoo (2003:17) states that sexual fantasy and sexual activity is controlled by social norms and values. This often results in a mismatch between what people express publicly and the actual thoughts, ideas, feelings and fantasies that they express within themselves, as well as the kinds of sexual activities people practice in the privacy of their bedroom. Most common socialisation agents are the family (parents), school, media and peers (these will be discussed later in this chapter).

3.6.2 Gender-role Stereotypes and Power

According to Miles (1992) in Naidoo (2003:17) gender, power and sexuality are intimately connected with one another. Sexuality is one of the main areas in which gender inequality is manifested in the society.

Gender refers to both the social and cultural characteristics associated with men and women respectively, hence people talk about masculinity and femininity. Once more social norms and values define what is masculine behaviour and appearance and what is feminine, for example women are expected to be passive and dependent on men. On the contrary men are trained to be confident, competent and in control (Naidoo, 2003:17-18).

According to Hope (1999:172) Black women in Malawi have no power to negotiate for safe sexual practices with their partners because sex is a taboo subject even between husband and wife. A woman who discuss sex openly is viewed as ill-mannered and promiscuous. As a result women have no power to strive for safe sexual practices with their partners, be it a husband or simply an ordinary sex partner.

Furthermore Hope states that there is no open dialogue between men and women, or between boys and girls in both formal and informal circles. Men simply decide on a certain mode of sexual behaviour and women are not supposed to question the decisions.

3.6.3

Culture

Richardson (1990:170) describe culture as the systems that codes the manner in which people in an organised group, society or nation interact with aspects of social and physical environment in which they live.

Sexuality is closely linked to the ideologies of a culture. The following cultural factors which have a bearing on sexuality are discussed.

3.6.3.1 Female Circumcision

According to Fogel and Lauver (1990:90) female circumcision is practised by many cultural and religious groups with more than 74 million women and girls mutilated by female genital operations in Africa. Two types of operations are practised. The first one is "excision" or "clitondectomy" which include the excision of the clitoris, the labia minora and the labia majora. The secondary operation is the "infibulation" which is the intensional closure of the vagina immediately after the excision. The vaginal walls are held together with sutures, thorns or paste so that a wall is formed to close the upper part of the vaginal vault. A small opening is left by inserting a stick into the wound to allow for elimination of urine and menstrual blood.

The immediate complications of female circumcision are urinary retention, haemorrhage, infection and shock. About 25 percent of women who have female circumcision experience one or more complications which may include pelvic inflammatory disease, chronic urinary tract infection, sexual difficulties and problems with labour and delivery (Fogel and Lauver, 1990:91).

3.6.3.2 Polygamy

According to Naidoo (2003:19) polygamy is a culturally acceptable practice particularly amongst members of the Black cultures in South Africa. Research has indicated that polygamy has hampered AIDS prevention strategies. However partners who practice polygamy need to be loyal and faithful to each other. The problem lies with young people who are more likely to imitate their parents. Richardson (1990:33) states that children often follow the same sex practices as their parents. Unfortunately adolescents tend to have more sex partners at an early age.

3.7**SEXUAL MYTHS**

The following sexuality myths are held and valued by a great number of people:

- A common myth is that withdrawing the penis before ejaculation can prevent pregnancy. In fact sperm may be present in the discharge from the penis before it is inserted in the vagina, so pregnancy may be present whether there is an ejaculation or not. Likewise, infection with sexually transmitted diseases such as HIV or AIDS can result without ejaculation, so a condom is important even if a man pulls out (Kimmel and Weiner, 1995:351).
- Men who are sexually stimulated will suffer physical damage or severe pain in the testicles if they are not able to have intercourse. Sometimes women feel it is their responsibility to help the man gain sexual release to prevent this physical damage (Kimmel and Weiner, 1995:351).
- A man need to have an orgasm to relieve his sexual tension whereas a woman is content to have sex without orgasm to please her man.
- Men are the sex experts who should always initiate sex.
- If a girl have sex standing up she will not become pregnant.
- Men need sex more than women.

3.8

SOURCES OF INFORMATION ABOUT SEX

According to Tsatsi (2003:67) many teenagers receive information about sex from various sources. However sometimes these sources are not reliable and therefore many teenagers receive incorrect information, which in turn may lead them to make dangerous decisions regarding their sexual lives. Teenagers therefore need to be well informed about safe sex practices, as well as the dangers of unprotected sex. This information need to be obtained from a reliable source.

3.8.1

Parents

Rice (1996:235) states that "if as some people maintain sexual education is in the home then parents are not doing a very good job". Fox and Inazu (1980) in Rice (1996:235) found out in their study that one third of the 449 mothers in their study have talked with their daughters aged 14-15 about sexual intercourse or birth control. Not quite one half had discussed menstruation and sexual maturity. According to Fox and Inazu's findings parents were not the best source of factual information about sex.

According to Mpete (2003:14) the parent as the primary educator is responsible for the total education of the child. As the family, sexual education form a part of the total education of the child. However it seems that parents shift their obligation elsewhere as far as biological and physiological information is concerned. In a recent investigation undertaken by a well known magazine mentioned by Van Rooyen and Louw (1994:8) 46% of the teenagers involved reported that their parents had never spoken to them about sex matters. In this regard Van Rooyen and Louw (1994:10) indicated that only 25% of the teenagers in this study had received sex education from their

parents. As far as girls are concerned this education mainly consisted of a few cryptic facts and warnings about menstruation.

- * Barriers to parents providing information about sex
- According to Moore Rosenthal and Mitchel (1996:107) there are certainly many barriers to parents providing information about sex. A primary barrier is that of embarrassment for both the parent and the young person. Despite possible participation in the free love ethos of the sixties and seventies most parents of today would have received messages from their own parents that sex was essentially embarrassing and would find some of the embarrassment still operative.
- Parents may share with others in the society the fear that giving young people information will provide them with unspoken permission to go out and experiment with it. An implicit or explicit assumption may be that keeping children relatively ignorant will ensure the desirable restraint (Moore et al, 1996:108).
- Perhaps the most difficult to deal with of all the barriers is the challenge to parent's own values, that the questioning or rebellion the adolescent may provide. These values dearly held by most adults are central to the information and advice parents are in a position to offer. To feel their values rejected as uninteresting and old fashioned can be profoundly painful. For all these reasons it would seem that sexual education and STI prevention is difficult for many parents to undertake.

Some understandably feel it is better left to schools and health services (Moore et al, 1996:108).

- According to Colombini and Hilber (2002:2) parents often struggle to understand and adapt to external forces that are reshaping the way people are living and working. Globalisation has entered into the lives of people everywhere with profound effects on family structure, social cohesion and cultural and social norms. Where families once lived collectively in Southern Africa, economic imperatives younger members are compelled to migrate to urban areas for jobs and perceived better futures. Strong community ties have given way to more individualistic lifestyles with individuals and nuclear families trying to make it on their own. Without the continued influence of the extended family community and traditional patterns of socialization, people and young people in particular, often find themselves in circumstances where what they had been taught regarding how to organise their social and sexual lives no longer applies.

3.8.2

Schools

According to Van Rooyen et al. (1994:11) society looks to the school to produce future citizens who will be able to meet the challenges of a rapidly changing world, a world in which some of the values may be quite out of place tomorrow. The school must form a bridge between the safety and intimacy of family life and the community. It offers the child the opportunity of working and living with others.

According to Mitzel (1982:1713) educators are often lacking knowledge about sex and wisely are reluctant to teach it, however willingness to teach may be improved through course work. Furthermore Hurlock (1988:276) state that most educators feel that sex education should be more than just reproductive health. It should, they believe, be all inclusive covering the emotional aspects of sex as well as the physical. It should include information about sex roles, pregnancy and its possible complications, childbirth with its potential dangers, the use of contraceptive and the prevention and treatment of sexually transmitted diseases. Therefore it would seem that to present scope of sex education is limited to reproduction only (Hurlock, 1988:276).

Learners receive so many confusing messages regarding sexual issues that it becomes difficult for them to make appropriate decisions. Educators should assist learners to arrive at a set of values with which they feel comfortable.

3.8.3

Peers

Tsatsi (2003:70) states that peer pressure plays an important role in many aspects of a teenager's life, including sexual decisions. Teenagers sometimes feel isolated and want to feel that they belong to a particular group or want to be accepted by a certain group of people. In order to achieve this they must blend in with the members of these groups, and therefore they often engage in activities that they would not normally engage in and this include sexual practices that may be risky.

Since the school and parents are providing limited information about sex, teenagers rely on their friends or peers for sex information, which are usually distorted (Hurlock, 1988:276).

3.8.4**The Mass Media**

Popular media emphasize sexual images where unmarried characters frequently focus on issues of sexuality. There are few references on television to birth control and the possibility of contracting diseases. Sexuality is shown as dangerous especially for girls, who are often portrayed as victims of sexual encounters who have limited power in sexual negotiations. Males and females are viewed as antagonists with danger and desire coexisting as girls seek to maintain male relationships (Kimmel and Weiner, 1995:345).

According to Hurlock (1988:276) books, educational films and magazine articles written by specialists in sex education give both correct and adequate information, however for romantic idealistic teenagers these sources may seem cold and impersonal and the facts too scientific. Information obtained from romantic stories, movies, television or comics will have more appeal. But the adequacy of this information depends on the teenager's interpretation of what is said or done. The information can readily be distorted and often is.

According to Tsatsi (2003:35) mass media and television in particular is crucial in the socialisation of children. Television hampers the socialisation process through its programmes which reflect acts of violent sex. The fact that a number of children have become television slaves indicates that parents allow television to bring up their own children as an excuse to address issues such as sexuality. Children however are exposed to sexual messages in their daily lives provided by the mass media.

3.9 SEXUAL EDUCATION

It has become obvious that young people do not receive sufficient education. Literature indicate that parents and schools spend limited time or no time in educating youngsters sexually and that young people mainly receive their distorted sex education from peers and the media. For this reason it has become vitally important that youngsters should receive purposeful sexual education most probably from both parents and schools.

3.9.1 Purposes of Sexual Education

According to Hyde and De Lamater (2000:64) the goals of sexual education should be the following :

3.9.1.1 Information

To provide accurate information about human sexuality including growth and development, human reproduction, anatomy, physiology, masturbation, family life, pregnancy, childbirth, parenthood, sexual response, sexual orientation, contraception, abortion, sexual abuse, HIV/AIDS and other sexually transmitted diseases.

3.9.1.2 Attitudes, Values and Insight

To provide an opportunity for young people to question, explore and assess their sexual attitudes in order to develop their values, increase self esteem, develop insights concerning relationships with members of both genders and understand their obligations and responsibilities to others.

3.9.1.3 Relationships and Interpersonal Skills

To help young people develop interpersonal skills including communication, assertiveness and peer refusal skills as well as the ability to create satisfying relationships sexual education programmes should prepare students to understand their sexuality effectively and creatively in adult roles.

3.9.1.4 Responsibility

To help young people exercise responsibility regarding sexual relationships including addressing abstinence, how to resist pressures to become prematurely involved in sexual intercourse and encouraging the use of contraceptives and other sexual health measures.

CHAPTER FOUR

4. CONSEQUENCES OF INDISCRIMINATE SEXUALITY

4.1 INTRODUCTION

According to David Harrison Chief Executive officer of Love life statistics show that 42% of 15 to 17 year old South African teenagers are engaging in sex. Yet even more revealing figures indicate that 51% of sexually active young people have had sex before their fifteenth birthday, while 20% said they engaged in sexual acts at the age of 12 and under. In light of South Africa's HIV pandemic these statistics are frightening indeed (True Love Magazine, February 2004:88).

Approximately one in every eight sexually active young women between 15 and 19 years of age falls pregnant. The rate of child abuse resulting from emotional frustration in these situations is higher than normal. The variety of sexual acts in which young teenagers are participating is varied and in most cases highly experimental. They are mostly having unprotected sex unaware of the risk of sexually transmitted infections including HIV, and pregnancy (True Love Magazine, February 2004:88).

Young people engage in indiscriminate sexual practices which make them vulnerable to sexually transmitted infections, HIV, pregnancy, abortion, sexual abuse and prostitution. In this chapter the consequences of indiscriminate sexuality will be discussed.

4.2 TEENAGE PREGNANCY

4.2.1 Introduction

The development of physical and sexual maturity among teenagers is not always accompanied by an ability to handle their sexuality in a responsible manner. A great number of teenage sexual activity result in pregnancy. Sexual activity among young people takes place without contraception being used or even considered, although the possible consequences of pregnancy and childbirth are not desired. Probably most teenage couples do not even contemplate such an outcome. This is specifically the case among the under 16 year olds. For many at this age sexual activity has not bearing on the future, since consideration of the future does not impinge on their present daily lives. As long as the teenage culture encourages young people to believe that everyone else is doing it, sexual intercourse as an automatic part of a relationship is likely to occur (Hudson and Ineichen, 1991:6-8).

4.2.2 Reasons Why Teenagers Become Pregnant

According to Wendkos and Olds (1993:566) young girls become pregnant because they use no method of contraception at all. Two thirds of sexually active teenagers do not use birth control and 27 percent never use it at all. Some teenagers cite lack of knowledge about contraceptives, embarrassment about seeking contraceptives, or fear that their parents will find out that they are sexually active as reasons for falling pregnant. Some feel that using contraceptives is too much trouble, or they forget to take adequate measures. Some feel that it is the man's responsibility.

According to Jones (1985:63) a few girls have sex to become pregnant, perhaps because they want to escape from or hurt parents they do not get on

with well, or because they believe a boy will have to marry a girl who is pregnant and they believe themselves that to in love.

4.2.3 Emotional Responses to Pregnancy

Poe (1990:94) states that "discovering an unintended pregnancy can be a very shocking experience and coping with it can be very traumatic. A typical response of a pregnant teenager is denial thinking "it could not happen to me". Anger and confusion are typical reactions at this point. She may be angry at herself for letting it happen, at her boyfriend for getting her into the situation and at her friends who remain carefree. She may be confused about what to do and how to tell her parents, the baby's father or her friends.

A pregnant teenager may feel depressed and consider or attempt suicide at some point. Finding someone with whom she can discuss is essential for a pregnant teenager. Some teenagers are close to their parents and can discuss the situation with them. Parents are usually upset initially but may turn out to be very supportive and understanding.

4.2.4 EFFECTS OF TEENAGE PREGNANCY

4.2.4.1 Physical Effects

Wendkos and Olds (1993:564) states that teenage girls are more prone to such complications of pregnancy as anaemia, prolonged labour and toxemia. Young mothers are twice as likely as older mothers to bear low birth weight babies, they are two to three times more likely to have babies who die in the first year and their children are twice as likely to suffer from neurological defects.

4.2.4.2 Social Effects

The health problems of teenage mothers and their children result from social causes rather than medical ones. Many of the mothers are poor, do not eat properly and get inadequate prenatal care or none at all. If early, regular and high quality medical care is made available to pregnant teenagers, the likelihood is that pregnancies and deliveries in this age group will not entail any higher medical risks than those of women in their twenties (Wendkos and Olds, 1993:564).

According to Poe (1990:107) the chances that a pregnant teenager will live much of her life in poverty are high because poverty and poor employment opportunities are closely associated with non-marital child-bearing. It has been indicated that a large percentage of families headed by single females are poor.

4.2.4.3 Educational Effects

Even with the best care however and the best of physical outcomes, teenage mothers still experience problems. They are less likely to finish high school, than are their age mates who do not have babies, and many who do so at much later ages (Wendkos and Olds, 1993:565).

According to Poe (1990:196) pregnancy can be disruptive to a teenager's schooling. All the emotional trauma often makes it difficult for her to concentrate on her studies. In addition she may miss school because she does not feel well or must keep doctor's appointments during school hours. Although schools cannot legally forbid pregnant girls to attend school, some teenagers find it difficult to meet the requirements of a regular high school

programme. Many pregnant teenagers drop out of school and do not ever complete earlier grades. Poe further mentioned that pregnancy causes high school girls to drop out of school than any other factor. Especially teenagers under the age of eighteen when having their first child are more likely to drop out of school than those who delay child bearing.

4.2.4.4 Economic Effects

Financial problems haunt the lives of teenage mothers. Although many may receive assistance at least for a short while they have difficulties in maintaining themselves and their babies. Furthermore many teenagers become pregnant not only once but several times during their teenage years. The risk is highest for those who drop out of school, those who remain sexually active and those who do not use reliable methods of contraception (Poe, 1990:107).

According to Poe (1990:107) the following statistics show the repetitive nature of teenage pregnancies :

- * Three fifths of teenage pregnancies are second pregnancies.
- * About 43 percent of teen mothers have a second child within three years.
- * Some 25 percent of those whose first pregnancy ended in abortion have a repeat pregnancy within two years.

While having one child as a teenager will negatively affect a young woman's educational and economic opportunities, a second child severely compounds

the problems brought about by teenage pregnancy. Teenagers who drop out of school experience difficulty in finding a job because of their insufficient educational background. It is also difficult for them to secure stable jobs and therefore put financial strain on their parents (Wendkos and Olds, 1993:565).

4.3 SEXUALLY TRANSMITTED INFECTIONS

4.3.1 Introduction

Sexual relations usually involve considerable intimate contact with another person. Thus a variety of diseases may be passed from an infected person, who may or may not have symptoms of the disease, to his or her sexual partner. These diseases are known as sexually transmitted infections (Kimmel and Weiner, 1995:376).

According to Vaughan and Litt (1990:315) adolescents have the highest rate of sexually transmitted infections of any age group. Factors responsible for this include sexual experimentation which often follows initiation of intercourse activity among adolescents. Adolescent's reluctance to use contraceptives. Furthermore teenagers are typically reluctant to consider the possibility that a potential sex partner may have a sexually transmitted infection, and often lack the communication skills necessary to discuss this possibility, placing them at even greater risk for contracting a sexually transmitted infection.

At present enormous attention is given to HIV/AIDS forgetting the existence of a host of other sexually transmitted diseases which are equally dangerous, highly contagious and can also lead to death.

4.3.2 Diseases

The following diseases are discussed to indicate the extent of STI's and to make people aware of their existence.

4.3.2.1 Genital Herpes

Genital herpes is transmitted through direct contact with blisters or open sores through petting, sexual intercourse, anal or oral sex. Symptoms of this disease include tender painful blisters on sexual organs and surrounding areas, painful urination or bowel movements, blisters in vagina or on the cervix, tender and enlarged lymph glands and possible fever. Symptoms erupt for an infectious period and then go away while the disease is dormant. The blisters reappear from time to time. They may be reactivated by stress, hormone changes, sun-bathing, food allergies, colds or fatigue. The risk of cervical cancer is increased in women with herpes. A pap smear is recommended every 6-12 months. Herpes may also be linked with cancer in males. There are serious dangers to an unborn child (Kimmel and Weiner, 1995:378).

4.3.2.2 Genital Warts

According to Kimmel and Weiner (1995:378) genital warts are transmitted by direct contact with warts through vaginal, anal or oral sex. Painless warts appear one to three months after contact. They are detected by examining genital areas regularly with fingers (especially in and around vaginal and rectal openings) and looking for new bumps in the skin. Visually they appear soft, pink or red in single or multiple clusters in most areas of the body. In hard areas they are small, hard and yellow-grey. They are highly contagious and

can spread into the vagina and rectum. They may be transmitted to the child at delivery.

4.3.2.3 Gonorrhea

Gonorrhea is transmitted through sexual contact with someone who is affected. Symptoms appear within two weeks. 80 percent of women and up to 20 percent of men show no symptoms. In women symptoms are greenish or yellow-green vaginal discharge and irritation of the vulva. In men symptoms are painful urination and discharge from the urethra. In both sexes it may infect the throat through oral genital contact or the anus through anal intercourse. Serious long term effects may occur if it is not treated.

4.3.2.4 Chlamydia

Chlamydia is likely to be misdiagnosed as gonorrhea in affected males for it frequently causes inflammation of the urethra and other areas of the excretory system that result in a milky discharge similar to that seen in other diseases. Chlamydia can also infect the female reproductive system, moving from the vagina through the uterus and into the uterine tubes. It produces lesions in the uterine tubes that can eventually seal the tubes as a result of scarring, making the woman infertile in the process. Often women first discover their problem as a result of their inability to become pregnant (Rischer and Easton, 1995:468).

Chlamydia infections can also increase the incidence of potentially life-threatening ectopic or tubal pregnancies. In such cases the tubes are open enough to allow the young "embryo" to travel to the uterus for implantation. Infected mothers can also transmit the infection to their babies during birth

usually in the form of conjunctivitis (inflammation of the eyes) or pneumonia (Rischer and Easton, 1995:468).

4.3.2.5

Syphilis

According to Kassner (1977:146) syphilis is an infectious of an acute and chronic relapsing nature. It is characterised by a primary lesion and a secondary eruption involving the skin, bone, viscera and central nervous system and cardiovascular systems. Syphilis has increased considerably through-out the world. Young people between the ages of 15 to 30 are especially involved. Syphilis follows three stages :

* **Primary Syphilis**

After about three weeks of infection a papule appears which becomes larger and becomes an indurated "chancre" (a hard painless swelling) bleeding easily on touch. Occasionally infection occurs without the presence of a chancre. Lymph nodes in the groin are enlarged. The chancre is found at the site of contamination usually the genitals as well as on the lips, fingers or breasts. This stage last between three to four weeks. After the chancre has disappeared the disease is not transmitted any more by sexual intercourse, only the spirochaetes will be found in the blood and saliva

* **Secondary Syphilis**

The onset of secondary syphilis is often accompanied by constitutional symptoms such as fever, headaches, malaise whereas the majority of patients have a rash and or generalised lymphadenopathy. The secondary syphilitic rash may be macular, papular or papulo-

squamous which is usually symmetrically distributed and classically non-irritant. It can also be seen on palm of hands and the soles of the feet. Lesions in the warm moist areas such as on the vulva or in the peri-anal region become enlarged and are called condylomata. Scalp involvement often result in hair loss and a patchy alopecia.

* **Tertiary Syphilis**

Tertiary syphilis is the destructive stage of the disease. In untreated or inadequately treated patients the signs and symptoms of these late manifestations usually occur many years after the initial infection and any organ of the body may be involved. At this stage the disease is non-infectious and although serological tests are usually positive, some cases may present negative serological findings.

According to Kassner (1977:148) tertiary syphilis is characterised by disabling manifestations in the cardiovascular, central nervous or other systems. The destructive gummata consist of lesions of the skin, viscera, bone and mucous membrane. The gummata causes deformity for example the nose, palate and thickness of the tongue. Tabes dorsalis is a form of neurosyphilis and may occur five to fifteen years after the primary stage. This condition is characterised by pain "pins and needles" in the hands and feet. The patient becomes ataxic and walks with difficulty. Tertiary syphilis is progressive unless treated properly.

4.3.2.6 Pubic Lice

According to Kimmel and Weiner (1995:378) public lice are transmitted by skin to skin contact and also from bedding, clothing, toilet seats and chairs.

Symptoms include itching, pin head-sized dark spots on underwear (may be eggs or blood spots) and possible rash. Over the counter medicine may kill active lice but not all eggs so a reinfestation is possible.

4.3.2.7 Trichomonas Vaginalis

According to Kimmel and Weiner (1995:378) *Trichomonas vaginalis* is transmitted by a parasite found in some men and women with no symptoms. It is passed back and forth during intercourse with the male rarely showing symptoms. It may be passed during lesbian love making through vaginal contact. It is also transmitted by moist towels, bathing suits, underwear, wash cloths and toilet seats. Female symptoms are yellow-green or grey, thin, foamy vaginal discharge, foul odour and vaginal irritation. It often flares up around the time of menstruation. It is more common among women taking contraceptive pills. If untreated it may be linked with cervical cancer in women and urethral blockage in men.

4.3.2.8 HIV/AIDS

The Acquired Immunodeficiency Syndrome (AIDS) was first identified as a new phenomenon in 1981, when the Centres for Disease Control (CDC) received several reports of gay men who had developed unusual conditions namely pneumocystis, carini pneumonia and kaposi sarcoma. Immunological investigations of these men revealed deficits in their cell mediated immunity with severe CD4 + lymphocyte depletion. In 1983 French researchers identified a new retrovirus now known as the Human Immunodeficiency Virus (HIV) as the cause of AIDS. Test for the detection of antibodies to HIV became available in 1984 to 1985.

The mentioned signs of HIV/AIDS are the following :

* **Major signs**

- More than 10% weight loss
- Chronic diarrhea (for more than one month)
- Prolonged fever (intermittent or constant for more than one month)

* **Minor signs**

- Persistent cough (for more than one month)
- Generalised pruritic dermatitis
- Recurrent herpes zoster
- Oropharyngeal candidiasis
- Chronic progressive and disseminate herpes virus infection

* **Transmission of HIV**

In addition to blood HIV has been demonstrated in semen, cervical and vaginal secretions, breast milk, urine, lymphocytes, cell free plasma, cerebrospinal fluid, saliva and tears. Transmission does not occur as a result of exposure to all of these fluids since the concentration of HIV varies massively between them. Fluids implicated in transmission include blood, semen, cervical and vaginal secretions and breast milk.

Sexual intercourse is responsible to 70-80% of all HIV transmissions globally. Differentiating between vaginal and anal intercourse is not important. Other well documented modes of transmissions include unscreened blood, sharing of contaminated injection equipment by injecting drug users and from mother to child. Vertical transmission from mother to child occurs in the uterus at the time of delivery and through breast milk.

4.4 CHILD SEXUAL ABUSE

4.4.1 The Concept Child Sexual Abuse

Child sexual abuse is an act where an adult or older person uses his or her power to involve a child in a sexual activity that is inappropriate to the child's age. Power comes in many forms and may include physical, financial and position or occupation held. Sexual abuse can occur without touch as in obscene phone calls or exposing one's sexual organs. Sexual abuse can also include breaking down barriers to privacy such as exposing children to sexual information or activities that are inappropriate to their age or understanding level (Hook, 2001:2).

Magezis (1999:135) states that boys and girls can be sexually abused, but girls have a much greater risk or chance of being abused by their father or other men than boys do by women.

4.4.2 The Extent of Child Sexual Abuse

According to Dickson and Leming (1990:393) child sexual abuse can start when a child is as young as two months with the most vulnerable years between six and eight. Children's lack of knowledge and uncertainty about behaviour often lead to their victimization.

Of all forms of child abuse sexual abuse features most prominently. In a study conducted by De Villiers and Prentice (1990) it was found that at the Transvaal Memorial Institute Clinic in Johannesburg, 90% of all reported cases were sexual, at Coronation Hospital it was 54.5% and at Chris Hani Baragwanath 63% (Desmond, 2001:18).

4.4.3 Effects of Child Sexual Abuse

According to Hook (2001:12) sexual abuse severely affects the child. Some children may not show their suffering but that does not mean that sexual abuse is not affecting them. In the majority of cases abused children suffer short and long term effects. The following are effects of child sexual abuse :

4.4.3.1 Physical Effects

According to Anderson (1999:1) physical effects comprise of psychosomatic pains which include headaches, stomach ailments, bladder infections, cramps, sore throat due to oral sex, skin disorders such as rashes and blemishes, vaginal or pelvic pain, thrush and recurring bouts of cystitis. Sleep disturbances, nightmares, insomnia and bed-wetting may also result. Physical damage may include urinary tract infections, discharge or sexually transmitted infections and possibly AIDS.

4.4.3.2 Behavioural Effects

Reference is made to self destructive behaviours, eating disorders such as bulimia or anorexia nervosa and alcohol and drug abuse. Self destructive behaviour displayed in strong suicidal tendencies or deliberate attempts at self harm such as scratching, biting or piercing parts of the body, negative self image, low self esteem and lack of self worth and self confidence. Homosexuality and other sexual problems may also result (Sanderson, 1990:60).

4.4.3.3 Relationship Effects

According to Anderson and Okoro (2000:15) reactions such as isolation, hostility towards parents of opposite sex, general mistrust and insecurity may

be observed. Of importance in this regard is the child's fear of intimacy and avoidance of forming serious relationships.

4.4.3.4 Educational Effects

Sudden retrogressional changes in the child's educational performance and concentration. Other obvious factors may be that the child becomes unsociable and isolates himself or herself or starts taking a sexual interest in friends or fellow learners (Anderson and Okoro, 2000:18).

4.5 ABORTION

Abortion is the termination of a pregnancy before the foetus is able to survive independently outside its mother's uterus (Jones, 1985:77).

It is also necessary to consider abortion as a consequence of indiscriminate sexual practices for two reasons. Firstly, before 1996 (the promulgation of the Pregnancy Act) especially teenagers made use of backstreet abortionists with sometimes lethal consequences. Although abortion is now legalized it is understood that some girls because of ignorance still use illegal abortionists which may be extremely dangerous to their health. Secondly, the legalization of abortion can possibly be seen as an encouragement to teenagers to continue with sexual practices as they have a backdoor open in the event of becoming pregnant. Abortion, whether practised legally or illegally, do traumatise the receiver of this service and may imprint on the person short and long term effects.

For the purpose of this study particulars concerning this act are briefly discussed.

Pregnant girls/women who for various reasons use abortion as a form of contraceptive since abortion can be done on demand at any government hospital or clinic according to the Choice on Termination of Pregnancy Act of 1996.

The Choice on Termination of Pregnancy Act of 1996 states that :

- * All South African women have the right to choose to terminate a pregnancy within the first 12 weeks.
- * A woman can request a termination of pregnancy from a health worker at a hospital or clinic.
- * A doctor or midwife who's had special training can perform the procedure.
- * Any woman of any age can undergo the procedure. She does not require her partner's or parent's consent.
- * Any woman who is 13-20 weeks pregnant can request a termination of pregnancy if :
 - the pregnancy will be harmful to her own or the physical or mental health of the foetus.
 - continuing the pregnancy will cause major social or economic problems for the woman.

- * After 20 weeks a woman can request a termination of pregnancy if her own health or the health of the foetus is in danger. In this case only a doctor can perform the termination. The decision must be made with the opinion of an additional health worker.

Apart from psychological risks abortion may also entail physical risks. According to Chamberlain and Dewhurst (1977:197) the risks of termination of a pregnancy may be :

- * Firstly it is said that it leads to haemorrhage, that is whenever pregnancy is interfered with, bleeding is a major complication.
- * Secondly there can be infection. All terminations of pregnancy must be done under aseptic conditions with sterile instruments, but even so the introduction of sterile instruments, but even so the introduction of infection may occur. The patient will feel ill with a headache and lower abdominal pain.
- * The third risk is damage to the genital tract. In early pregnancy the uterus and the cervix are soft and can be easily damaged. Perforation to the uterus and tears to the cervix may occur easily. Therefore, whatever the reasons for abortion and despite the manner in which an abortion is practised, the consequences are not conducive to the physical or mental health of especially a young person.

4.6 PROSTITUTION

According to Ruitenberg (1992:69) cited in Naidoo (2003:35) prostitutes and their clients are traditionally regarded as a most vulnerable group for AIDS infection because of their casual sexual behaviour. On account of the large number of changing sexual contacts within the prostitute's world HIV/AIDS can be transmitted to a large number of clients especially if they have unprotected sex.

4.6.1 Reasons Why Young People Engage in Prostitution

Mojaki and Khaya (1998) identified the following reasons in their study entitled "The profiles of urban prostitution and HIV/AIDS awareness among prostitutes in the North West Province".

4.6.1.1 Financial Pressure

Financial situation at home force most high school girls to engage in prostitution. Most of them practice prostitution to assist their struggling single parents especially their mothers. They do so to pay for their school fees and that of their siblings. Usually their mothers know about the prostitution.

4.6.1.2 Peer Pressure

Most of the respondents said that they engaged in prostitution because their close friends were also engaged in prostitution. It was therefore a way of being accepted in the group.

4.6.1.3 Punishing Parents

Some girls cited punishing parents as a reason for engaging in prostitution. This was the case with student respondents from families where the parents especially fathers were apparently very strict.

4.6.1.4 Childhood Sexual Abuse

Thirty five percent of the respondent high school learners found themselves in prostitution as a continuation of their being sexually abused since childhood by adults. Therefore they viewed sexual intercourse with adults for money as a way of life. Some of them were sexually abused by their own parents, therefore they made a point of getting away from their parents by being financially independent through offering sexual services.

4.7 CONCLUSION

Lack of knowledge leads to unprotected sexual relations placing teenage girls at the risk of unwanted pregnancies, abortion, prostitution and boys at risk of sexually transmitted infections including HIV/AIDS.

CHAPTER FIVE

5. MEASURES TO PREVENT INDISCRIMINATE SEXUAL PRACTICES

5.1 INTRODUCTION

Looking at indiscriminate sexual practices by the youth the solution seem to be prevention in terms of primary, secondary and tertiary prevention. According to Maforah (1991:62-63) preventive measures can be classified into three categories namely primary, secondary and tertiary prevention. The aims of primary prevention is to strain the prevalence of a disorder before it becomes manifested in any way. Secondary prevention involves consequences that seek to reduce the disorder. Programmes designated to reduce the residual effects and adverse consequences of rooted disorders are formally designated as tertiary prevention but are better known as curative or rehabilitation measures.

5.2 Primary Prevention

According to Anderson and Okoro (2000:18) the aim of primary prevention is to restrain the prevalence of a problem before it manifests itself in anyway. By primary prevention much focus is placed on habilitation rather than rehabilitation.

Previous research indicate that parents and schools are not doing enough with regard to sexual education (Mogotsi, 1996, Girl Child Survey, 1998 and Anderson and Okoro 2000). Furthermore it was pointed out that whoever take responsibility for sexual education it should be done as part of a holistic approach such as comprehensive life skills programme.

According to the Department of Health's HIV/AIDS Directorate the introduction of life skills education to all school going youth is one of the most important strategies which needs to be introduced. Youth is being identified as crucial group for education and support, it has been recommended that the task of combatting HIV/AIDS and teaching sexuality should be the responsibility of the schools. To target the youth is the most appropriate way in preventing the risks of HIV/AIDS and other sexually transmitted diseases as well as teenage pregnancy. As young people engage in indiscriminate sexual practices at an early age most probably due to insufficient knowledge concerning sexual education (Tsatsi, 2003:63).

Maforah (1991) states that the aim of life skills is to instil in learners especially young children whilst in their most formative years a deep respect for the complexity and beauty of the human body and for life itself, so that they will consider it unthinkable to abuse their bodies in whatsoever way for example engaging in indiscriminate sexual practices.

5.2.1 LIFE SKILLS

According to Anderson et al (2000:9) life skills are defined as the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life. Nelson-Jones (1991:12) further indicates that life skills involves personally responsible choices. When people are being personally responsible they are in the process of making their own choices for example if teenagers are equipped with life skills they will be able to make responsible decisions with regard to their own sexuality. Life skills are self-held skills. They are competencies that enable people to help themselves as such they empower people.

The life skills education is based on the premise that many people develop emotional problems and or fail in personal adjustments because they failed to internalize the necessary coping skills either because of poor role models or an impoverished learning environment. Hence the relevance of the ecological perspective which states that people should learn to adapt to new situations in order for them to cope and avoid stress.

Life skills enable people to make decisions concerning daily routines. In addition, skills enhance and extend independence and enable people to live outside a supportive institutional unit. These skills serve as a means through people can achieve sufficient independence to live with dignity in a sheltered environment.

According to an article in Sowetan (27, August 1999:32) written by a psychologist from Wits University, life skills empower people with the following:

Firstly, being able to control anxiety, gaining skills in setting realistic career and life goals. Secondly, being able to solve problems that confront individuals in the course of their lives. Lastly, being able to cope with crises situations such as coping with failure. He further stated that it is of utmost importance that people should have the ability to cope with constant changes. Life is constantly making demands to which people must respond. Appropriate life skills will help people to experience changes in life without significant stress as they will be in a position to make the right decisions. However, basically the addition of any skills to a person's behavioural repertoire will make them, especially young people, to be potentially more self-empowered.

Nelson-Jones (1991:13) stated that it can be helpful to think of life skills as comprising of three dimensions:- attitude, knowledge and skills.

– **Attitude**

According to Feron (1990:65) an attitude is a mental and neutral state of readiness organised through experience exerting a directive or dynamic influence upon an individual's response to all objects and situations with which it is retaliated. Thus attitude is something that is internalised into a person as a result of experiences from the earliest days of childhood.

Life skills play an important role in children or adolescents because it is difficult to change the attitude of an adult. If adolescents are equipped with life skills they will have a better chance of changing their attitude towards life situations such as indiscriminate sexual practices. They will view sexuality in a different way because life skills would have instilled in them a positive attitude towards a healthy life style.

– **Knowledge**

Skills involves knowledge concerning what are the correct choices to make, for example for a teenager to make a correct choice regarding sexual practices she must have sufficient knowledge about sexuality and the possible consequences of indiscriminate sexuality (Feron, 1990:65).

– **Skills**

According to Feron (1990:65) the skills dimension entails the internalization of attitudes, behaviour and knowledge. In order to function successfully as a person and retaining a healthy life style. People should have knowledge and skills to handle various life situations that may arise as well as to access support and services when needed.

According to Anderson and Okoro (2000:9) skills that can be said to be life skills are innumerable and the nature and definition of life skills are likely to differ across cultures and settings. In any life skills programme however it is necessary to include some basic life skills which go hand in hand with sexual knowledge. They can be summarised as follows :

* **Self Esteem**

The concept self-esteem also include self concept and self confidence. Self esteem is the sense of personal worth and relates directly to the feelings one has about oneself or people about themselves. Self concept refers to the opinion people hold about oneself and is the result of a person's perception of their overall capabilities. Self confidence is a perception of a person's ability that is primarily dependent on other people's opinion of them. However a person can take responsibility for and develop his or her self confidence. The first step in developing self confidence is self acceptance (Anderson, 2004).

Of great importance for the learner or teenager is to know himself or herself and realise that he or she is a unique human being. To strengthen self esteem one needs to be assertive. Assertiveness is about interacting with another person in a manner where both individuals can negotiate to have his or her rights met. Once assertiveness have been acquired it should significantly increase the learner's self esteem and self efficacy (Magabe, 2000:20).

Relationships

According to Anderson (2004) relationships consists of the following:

- Individuals need to cooperate with and care about others.
- Each person is an important member in a relationship and has something to contribute.
- Individuals need to assume a number of roles and responsibilities to develop and maintain positive relationships.
- The development and maintenance of positive relationships lies on communication and consideration for others.
- Relationships are influenced by and also influence an individual's well being.

- Positive interpersonal relationships require individuals to assume responsibility for the well being of others as well as themselves.

Without positive value orientated relationships people, especially youngsters are vulnerable or perpetrators in sexual activities. For instance where a boy say to his "girlfriend" that she loves him she will allow him to have sex with her. In this event the boy's relationships are completely contrary to the above mentioned requirements and as such the boy can be seen as a sexual perpetrator.

* **Decision Making**

According to Anderson and Okoro (2000:25) life itself consist of a multitude of decisions that people are expected to take in their daily lives. Decisions also have an important influence on the quality of life of human beings. Teenagers need to have knowledge of decision making skills so that they are able to make the right decisions with regard to their sexuality.

Anderson and Okoro further states that decision making helps people to deal constructively with problems in their daily lives. This can have consequences for the healthy development of people especially young people by assessing different options and what effects different decisions may have.

In decision making people should be taught to consider the following steps in decision making :

- Identify the problem/decision to be made
- Gather information on the aspect
- Look at options
- Consider consequences
- Act on the decision
- Evaluate the results

5.2.2 CONCEPTUAL FRAMEWORK

Conveying sexuality to especially young people it is necessary to consider the developmental stages of the persons concerned. Anderson and Okoro (2000:13) mentioned that because of the early sexual maturity of youngsters and the increase of HIV/AIDS and child sexual abuse, sexual education should start early in a child's life and should be graded according to the developmental stage of the child. In this regard as part of the preventive or interventive measure or approach to sexuality it is important to consider the development of the individuals logical thinking. Cognitive development consists of age related changes that occur in mental activities.

According to Whalley and Wong (1987:126) there are four stages in the development of logical thinking. Each is derived from and build on the accomplishment of the previous in a continuous, orderly process. The course of intellectual development is divided into the following 5 stages or periods.

– **Sensory Motor (birth to 2 years)**

Children develop a sense of cause and effect towards objects and solve problems primarily through trial and error. They display a high level of curiosity, experimentation and enjoyment of novelty. Children become aware that an object has permanence, that it exists even through it is no longer visible. Towards the end of sensory motor period children begin to use language and representational thought appears as they imitate behaviour of others, even in the absence of those persons.

– **Pre-operational (2 to 7 years)**

The predominant characteristics of this period is ego-centricity. Ego-centricity in this sense does not mean selfishness or self-centeredness, but rather the ability to put oneself in the place of another. Children interpret objects and events not in terms of their relationships or their use to them. Thought is dominated by what they see, hear otherwise experience.

– **Concrete - Operational (7 - 11 years)**

During this period thought becomes increasingly logical and coherent. Children are able to classify, sort, order and otherwise organise facts about the world to use in problem solving. They realise that volume, weight and number remain the same even though outward appearance are changed. They are able to deal with a number of different aspects of a situation simultaneously through progressive changes in the thought processes and relationships with others. Thought becomes

less self-centered. Children can consider points of view other than their own. Thinking has become socialised.

– **Formal Operational (12 - 15 years)**

This period is characterised by adaptability and flexibility. Adolescents can think in abstract terms, use symbols and draw logical conclusions from a set of observations. They can make a hypothesis and test it, they can consider abstract, theoretic and philosophic matters.

Although these age norms are only the rough indicators of the intellectual development one may see that early adolescence is characterised by concrete operational thinking whereas later adolescence is characterised by formal operational thinking. This implies that sex education should be imparted to the children from concrete operational thinking (7 to 11 years) because at this stage children are able to classify sort, order and otherwise organise facts about the world to use problem solving. During this stage their thoughts become increasingly logical and coherent.

Given the intellectual changes that occur during the adolescent stage of development, it is perhaps important to note that formal operational thinking is thinking in the abstract. Therefore teenagers become capable of formal operational thinking, their cognitive abilities as well as their views about the external world changes.

5.3

SECONDARY PREVENTION

According to Martin and Viviers (1996:5) secondary prevention is aimed at the identification of problems and early intervention into the lives of individuals,

families and groups who are at risk of developing social problems before the situation becomes critical.

Teenager's attitude towards sexuality have undergone a revolution since the turn of the century. At that time 75% of all women under the age of 20 were virgins and approximately 90% of all men under the age of 20 have had sexual intercourse. In early 1960 a national survey found that 55% of teenage girls reported having sex by the age of 20. By 1988 more than three quarters of 19 year old females reported having had sex (Cunnigham 1993:265). According to Sorenson (1973) cited in Ingersoll (1982:192) by the age of 15, 44% of males and 30% of females have experienced premarital coitus.

The recent Government Statistics of HIV/AIDS reveal that there is a 65% increase in the disease among teenagers 15 to 19 years of age (Anderson and Okoro, 2000:12). Various studies indicating the extent to which young people are involved in premarital sexual relations found that boys and girls become sexually active from the age of 14 years (Anderson, 1994, Mogotsi, 1996, and the Girl Child Survey, 1998). As cited in Anderson and Okoro (2000:14) Van Coeverden, De Groot and Greatland (1987:434-436) found in their study that 81% of female adolescents were sexually active and the average age reported at first coitus was 14.7 years.

Apart from voluntary sexual relations for pleasure many young people are also sexually exploited. Mogotsi (1996:86) said that when she asked the school children about their attitudes with regard to premarital sex 60.2% said that it was completely acceptable whereas 23.1% were uncertain whether it was right or wrong.

Gillis as cited by Anderson and Okoro (2000:14) indicated that one in three girls and one in six boys currently in South Africa experience sexual abuse before they reach the age of 18 years. The Star of 15 August, 1999, reported that one child out of ten is sexually abused per day in this country.

To curb the problem of indiscriminate sexuality and most specifically HIV/AIDS one need to identify the problem and intervene before the situation becomes critical. For example one must help those teenagers who are already engaging in sex to either abstain or condomise. Despite life skills education this can also be done by organising teenage groups that can assist their counterparts who are engaging in sexual activities that can endanger their lives. The following models or techniques can be used to prevent the identified problem from escalating.

– **Positive Peer Culture Model**

According to Okoro's (notes, 2001) positive peer culture model help young people to use their influence on others in a positive way. Teenagers tend to do things because of pressure from their friends. This model is based on the premise that young people in trouble given an opportunity will respond to caring and helping themselves and others, for example those teenagers who were helped to stop engaging in immature sexual activities can be used to model positive behaviours. In this way teenagers at risk will realise that they are going astray and therefore be more susceptible to the positive influence they may receive from their peers since teenagers have a way of influencing each other.

There are some groups that are already practising this model to help teenagers influence each other in a positive way. Examples are Youth for Christ in collaboration with Love life and Teenagers Against Drug Abuse as practiser in KwaZulu Natal. Most probably if more youth organisations in South Africa can incorporate this model in their interventions teenagers may learn to be more responsible and practice safe sex or preferably abstain from risky sexuality based on the positive influence they receive from each other.

– **Behaviour Modification**

According to Hyde and De Lamater (2000:26) behaviour modification is based on the assumption that behaviour is learned and therefore it can be unlearned or changed. Social workers, educators and other people who are dealing directly with teenagers can help them modify or change their sexual practices by outlining the dangers of immature sexual involvement. Once they realise that their behaviour is causing troubles for them they will definitely change that particular behaviour.

5.4 TERTIARY PREVENTION

According to Martin and Viviers (1996:5) tertiary prevention is aimed at individuals and families that are presented with critical problems or dysfunction. The focus is on intervention and the prevention of further problems.

Tertiary prevention include providing therapeutic services to a family where a problem has escalated, for example in a case where sexual abuse has already occurred.

According to Hope (1999:41) it has been suggested that parents should teach their children from a young age to say "No" when an adult touches their private parts, and to immediately tell their parents about it. The majority of children are too small to fight back. They are too scared or too bewildered to scream for help. They are easily threatened into silence. Often they do not even know what is about to happen when a man unzips his pants.

Most child sexual abuse is committed by a family member or someone close to the family. Hence the sexually abused children are often afraid to speak because their parents may think they are not telling the truth. They also have feelings of guilt. They may think that they are somehow responsible for what happened to them. Hence they would rather live with the horror than tell someone about it.

In tertiary prevention the social worker focuses on the individual child and reassure her that the abuse was not her fault. The programme aims at preventing abuse from recurring and to reduce negative consequences associated with it by using person centred approach. Here the social worker focus on the potential of the client to handle further abuses. The child will be equipped with knowledge and skills to defend herself.

CHAPTER SIX

6. DATA ANALYSIS

6.1 INTRODUCTION

This chapter consists of the data analysis and discussion of the information obtained during fieldwork. The respondents consisted of 238 learners from three different schools.

The respondents consisted of 47.8% males and 52.1% females. The majority of the respondents (54.6%) were 17-19 years, 39.1% were 14-16 and 6.3% were from 21 years upwards. 29.8% of the respondents were in grade 10, 36.6% in Grade 11 and 33.6% in Grade 12.

The respondents are also affiliated to different religious denominations, whereas 47.9% are Protestants, 35.2% are Catholics and 16.8% are Zionists. The majority of the respondents (50.8%) have both parents whom they live with, 34.9% have single parents, 13.4% are living with guardians and 0.8% are living with foster parents.

6.2 TABLES

In the following table the researcher looked at the relationship between parents and their children

Table 1
Parent child relationship

Relationship	Number of respondents	Percentage
Good	193	81.1%

Average	32	13.4%
Bad	7	2.9%
Uncertain	6	2.5%
Total	238	99.9%

The majority of respondents (81.1%) indicated that they have a good relationship with their parents. As a good relationship between parents and their children is a prerequisite for intimate discussions, the good relationship as indicated should have created the possibility for open talks between parents and their children about sexual matters.

The following table indicate where the respondents received most of their sexual knowledge.

Table 2
Source of sex knowledge

Source	Number	Percentage
Parents	52	21.8%
Teachers	46	19.3%
Health care workers	16	6.7%
Television	67	28.2%
Friends	49	20.6%
Other	9	3.4%
Total	238	100%

In the following table the respondents indicated whether their parents have had discussions with them on sexual matters.

Table 3**Discussions of sexual matters by parents**

Response	Number of respondents	Percentage
No discussions	84	35.3%
Very little discussions	124	52.1%
Sufficient discussions	30	12.6%
Total	238	100%

The following table indicate how much sexuality education the school provide.

Table 4**School as a source of sexuality education**

Response	Number of respondents	Percentage
No education	39	16.4%
Some education	147	61.8%
Sufficient education	52	21.8%
Total	238	100%

According to tables 2, 3 and 4 it is clear that firstly 48.8% of the children received most of their sexuality education from the media (28.2%) and friends (20.6%). Without elaborating on this information it should be clear that for nearly half of the learners the sex information received was either insufficient or merely sensational.

Secondly, only 28.8% indicated that they received some form of sexuality education from their parents. However in table 3 it is shown that only 12.6% received "sufficient information" from their parents. This information is a clear

indication that parents do not accept the responsibility of guiding their children with regard to sexual matters.

Thirdly, 19.3% of the learners mentioned that they received their sexuality education from teachers (schools). Of these 21.8% said that the information received was sufficient.

Looking at the above particulars it is n wonder that child sexual abuse, indiscriminate sex teenage pregnancy and HIV and AIDS are on the increase because young people do not receive purposeful sexuality education from either their parents or schools.

As a result of the lack of effective sex education, the respondents were asked who they think should be responsible for their sexuality education.

Table 5
Responsible informants for sexuality education

Informants	Number of respondents	Percentage
Parents	77	32.4%
Schools	14	5.9%
Parents and schools	130	54.6%
Invited experts	9	3.8%
Church	0	0%
Other	8	3.4%
Total	238	100.1%

The majority of respondents (54.6%) indicated that both parents and schools should be the main informants for sexuality education. Parents and schools should complement one another in this most important task. However, it has been indicated that they do not accept this responsibility as a result of being properly guided or trained to understand this task, or that they are embarrassed to talk to the children about sex, or that they are afraid talking about sex as they believe it may facilitate experimenting with sex.

The table below indicates the appropriate age at which children should be given sexuality education.

Table 6

Appropriate age for sexuality education

Age	Number of respondents	Percentage
8-11 years	65	27.3%
12-15 years	85	35.7%
16-18 years	33	13.9%
19+ years	30	12.6%
Graded system	17	7.1%
Uncertain	8	3.4%
Total	238	100%

The majority of respondents (35.7%) suggested that sexuality education should start from 12 to 15 years. The reason for their response might be because in the developmental phase of children this is the time where heterosexual relations become more serious.

It is from this age that a great number of teenagers are vulnerable to pregnancy and sexuality transmitted infections, hence they need sexuality education at an early age to safeguard them against sexuality originated social and health problems. It is also for this reason that 27.3% respondents were of the opinion that sexuality education should even start at an earlier age because ignorance of sex matters make especially girls more vulnerable to exploitation.

In the following table the responses concerning the main causes of sexual acts between teenagers are looked at.

Table 7

Main causes of sexual acts between teenagers

Main cause	Number of respondents	Percentage
Availability of contraceptives	60	25.2%
Peer pressure	120	50.4%
Sexual desire	52	21.8%
Uncertain	6	2.5%
Total	238	99.9%

Majority of respondents (50.4%) highlighted peer pressure are the main cause of sexual acts between teenagers. This is confirmed by table 2 in which teenagers indicated that they get most of their information from their friends, because parents fail to discuss sexual issues with them.

Availability of contraceptives are also high (25.2%) and may be a matter of concern. The availability of contraceptives may create the expression

amongst children that sexual relations are acceptable on condition that they use contraceptives especially condoms which is publicly encouraged. This is however a most sensitive but a debatable matter.

The table below highlight the main groups which are at risk of contracting sexually transmitted infections.

Table 8

People at risk of contracting sexually transmitted infections

Response	Number of respondents	Percentage
Teenagers	112	47.1%
Homosexuals	8	3.4%
Prisoners	4	1.7%
Prostitutes	41	17.2%
Married people	1	0.4%
Everybody	64	26.9%
Uncertain	5	2.1%
Other	3	1.3%
Total	238	100.1%

The majority of respondents (47.1%) indicated that teenagers are the most vulnerable group to contract sexually transmitted infections. This is due to the lack of factual knowledge about sexuality. This is an indication that teenagers are aware that they are at risk of contracting sexually transmitted infections and even AIDS, hence they highlighted in table 5 that they need timeous sexuality education which should be given to them by both parents and educators.

In the following table the researcher looked at the main effects or dangers in engaging in pre-marital sexual activities especially children as indicated by the respondents.

Table 9

Main effects or dangers in engaging in pre-marital sexual activities

Main effects or dangers	Number of respondents	Percentage
Teenage pregnancy	78	32.8%
HIV and AIDS or STI's	131	55.0%
		} 87.8%
No dangers at all	21	8.8%
Uncertain	8	3.4%
		} 12.2%
Total	238	100%

A total of 87.8% of respondents highlighted that the main effects or dangers in engaging in pre-marital sexual activities is the risk of becoming either teenage mothers or contracting sexually transmitted infections especially HIV and AIDS or both. This correlates with the findings in table 8 where teenagers indicated that they are at risk and can become victims of HIV and AIDS, teenage pregnancy and STI's.

Despite the fact that high school learners are aware of the devastating dangers of indiscriminate sex, they however continue to be sexually active. In this regard various studies found that boys and girls become sexually active from the age of 14 years (Anderson and Okoro, 2000:12). Mogotsi (1996) further found that 60.2% school children mentioned that pre-marital sex was acceptable whereas 23.1% were uncertain (Anderson and Okoro, 2000:13).

Of great importance is that 12.2% of respondents indicated that pre-marital sexual activities entail no dangers (8.8%) or that they are uncertain (3.4%).

It was also found by Van Coeverden De Groot and Greatland (1987:434-436) as cited in Anderson and Okoro (2000:13) in their study that 81% of female adolescents were sexually active and the average age reported at first coitus was 14.7%.

The table below indicate reasons why people delay to seek treatment for sexually transmitted infections.

Table 10

Reasons for delaying to seek treatment for sexually transmitted infections

Reasons	Number of respondents	Percentage
Embarrassment	100	42.0%
Shame	40	16.8%
They may suffer social stigma	32	13.4%
Little accessibility to health care	18	7.6%
People are not aware of the signs and symptoms	45	18.9%
Uncertain	3	1.3%
Other (specify)	0	0%
Total	238	100%

A total of 42.0% respondents indicated that people do not go for treatment even if they think that they are infected because they either are embarrassed

or do not want to know their health status in the event of being HIV positive. This might be because they are basically ignorant about sexuality and therefore do not have the knowledge or the courage to talk about sexuality and/or sexually transmitted infections or seek professional assistance.

Further reasons which prevent young people to undergo regular medical check-ups or even when they realize that they may be infected are reluctant to seek medical assistance because of embarrassment or social stigma attached to sexually transmitted diseases. A high percentage of respondents (18.9%) also mentioned that they are ignorant regarding the signs and symptoms of these diseases which also point to the fact that sexual education is an absolute necessity.

In the table below a question was posed to the respondents stating whether high school children should be allowed to be sexually active.

Table 11

High school children should be allowed to be sexually active

Response	Number of respondents	Percentage
Should be allowed	82	34.5%
Should not be allowed	132	55.5%
Uncertain	24	10.1%
Total	238	100.1%

Table 12**Their attitude whether they approve of pre-marital sex**

Response	Number of respondents	Percentage
Approve	65	27.3%
Disapprove	125	52.5%
Uncertain	48	20.2%
Total	238	100%

According to the above two tables the majority of respondents (55.5%) disagreed that children should be sexually active before marriage whereas approximately the same number (52.5%) disapproved of premarital sex. The respondents who indicated that they should be allowed to be sexually active (34.5%) or approve of premarital sex (27.3%) may be as a result of factual knowledge regarding sexual issues. This attitude might lead them to engage in risky sexual behaviours.

In the following table the respondents indicated their participation in recreational facilities which may facilitate idleness and also prevent them from taking part in indiscriminate sex. In this regard the respondents were asked whether there was sufficient recreational facilities for them to take part in.

If young people have a positive value orientation towards sex, they may also engage in sexual activities which makes them vulnerable to the consequences. These figures to some extent correspond with previous information which indicated that young people are sexually active at an average age of 14 years whereas the majority of school children approve of premarital sex.

In the following table the respondents indicated their participation in recreational facilities which may facilitate idleness and also prevent them from taking part in indiscriminate sex. In this regard the respondents were asked whether there was sufficient recreational facilities for them to take part in.

Table 13

Lack of recreational facilities

Response	Number	Percentage
Sufficient recreational facilities	132	55.5%
Insufficient recreational facilities	88	36.9%
Uncertain	18	7.6%
Total	238	100%

Although more than half of the respondents (55.5%) mentioned that there were sufficient recreational facilities, this did not indicate whether they participate in it. Of greater concern however is that 44.5% indicated a lack of or uncertainty about recreational facilities. The above therefore, proves that a great number of children either have no recreational facilities or do not use these facilities.

The table below indicates what can be done to reduce the risks of sexually transmitted infections.

Table 14

Reduction of the risks of sexually transmitted infections

Response	Number	Percentage
Sexual abstinence	93	39.1%

Change attitude towards indiscriminate sex	11	4.6%
Make routine checks for STI's	12	5.0%
Use a condom	67	28.2%
Be faithful to one sexual partner	55	23.1%
Other	0	0%
Total	238	100%

The majority of respondents (39.1%) indicated that the risks of sexually transmitted infections can only be reduced by sexual abstinence whereas 28.2% agreed that condoms can be considered as a preventive measure. 23.1% indicated that a person should be faithful to one sexual partner. This shows that the majority of teenagers are aware of the ABC method of preventing sexually transmitted infections, but some are still not prepared to change their behaviour towards sex. Analysing this table it is clear that 51.9% possibly indulge in sex as they mentioned the use of condoms or being faithfully to one partner.

The following table explains measures to be taken to combat the dangers of indiscriminate sex.

Table 15

Best measures to combat the dangers of indiscriminate sex

Response	Number of respondents	Percentage
Abstinence from sex	82	34.5%
Purposeful sex education	17	7.1%
Safe sex	91	38.2%

Involvement of learners in activity groups	18	7.6%
Regular workshops and seminars on sexuality	22	9.2%
Uncertain	8	3.4%
Other	0	0%
Total	238	100%

The majority of respondents (38.2%) highlighted safe sex as the best measure to combat premarital sexual activities and 34.5% of the respondents considered sexual abstinence as the best measure. This correlates with the findings in table 14. The respondents agreed that safe sex should be practised. However the fact that 38.2% support safe sex may be an indication that they approve of teenage sexuality which implies a positive value orientation towards extra-marital sexual relations which makes them highly vulnerable for the consequences of indiscriminate sexuality.

6.3

CONCLUSION

According to the figures school children receive very little sex education from parents and schools. This correspond with the findings of Mogotsi (1996:86) that most school children receive their sex education from peers and exclaimed that the most threatening finding was the minimum role played by parents. Subsequent to the findings of Mogotsi, the Girl Child Survey (1988:17) remarked that schools do not offer sexual education as part of their curriculum, and some cultures prohibit families from discussing issues of sexuality with their children. This scenario leads to a high level of ignorance and misinformation for boys and girls regarding their sexuality.

In the present study it was found that 12.6% of the children received sufficient sexual education from their parents whereas only 21.8% mentioned sufficient education from schools. Because of insufficient sexual education learners are dependent on peers (50.4%) for their sexual information. The result of insufficient sexual knowledge make learners vulnerable to many devastating consequences such as teenage pregnancies, HIV/AIDS and other STI's.

The above information clearly indicate that there is a high prevalence of sexuality amongst school learners which makes them highly vulnerable for teenage pregnancy and sexually transmitted infections.

CHAPTER SEVEN

7. MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

The main purpose of this chapter is to review the findings emanating from literature and empirical research and to discuss conclusions drawn from them and to provide recommendations.

7.2 MAIN FINDINGS

7.2.1 Lack of Sexual Education

According to the research findings in table 1 the majority of respondents (81.1%) indicated that they have a good relationship with their parents. However despite the good relationship they have with their parents, the majority of the respondents (48.8%) reported that they received most of their sex education or information from friends and the media.

Furthermore, the majority of respondents (52.1%) indicated that they had very little discussions on sexual matters with their parents and 35.3% had no discussions at all. The finding also indicated that 61.8% received some education from the school. From that percentage only 21.8% said that the sexual education they received from the school was reasonably sufficient whereas 40% indicated that the sex education they received from schools were insufficient.

To prevent the devastating sexual consequences it is obvious that sexual education is an absolute necessity especially to young people which should

even start at nursery school level. As indicated by the research findings both parents and schools are not offering sufficient sexual education to their children and therefore revert to peers and the media for distorted sex information. This information provided to be more sensational than point out to young people (the dangers attached to indiscriminate sexuality).

Tsatsi (2003:70) stated that peer pressure play an important role in many aspects of a teenager's life, including the teenager's sexual decisions. Teenagers sometimes feel isolated and want to feel that they belong to a particular group or want to be accepted by a certain group of people. In order to achieve this they must blend with the members of these groups, and therefore they often engage in activities that they would normally not have engaged in including sexual activities that may be risky.

According to Moore et al. (1996:108) parents may share with others in the society the fear that giving children sexual information may provide them with unspoken permission to go out and experiment with it. However, an implicit or explicit assumption may be that keeping children relatively ignorant will ensure the more desirable restraint.

7.2.2

Reliable Sources of Sexual Information

The majority of respondents (54.6%) indicated that both parents and schools should be main informants for sexual education. This clearly indicates that even the youngsters themselves prefer to receive sexual information from a more reliable source. According to Tsatsi (2003:63) many teenagers as mentioned earlier on receive information from various sources. However, it has been emphasised that these sources are not reliable and even dangerous

to youngsters and therefore incorrect or sensational sexual information may lead them to make risky decisions regarding their sexual lives. Teenagers therefore need to be well informed about abstinence or safe sex practices as well as the dangers of unprotected sex. This information needs to be obtained from a reliable source on a continuous basis according to the development stage of the receiver.

7.2.3 People at Risk of Contacting Sexually Transmitted Infections

The majority of respondents (47.1%) indicated that teenagers are the most vulnerable age group to contract sexually transmitted infections. Vaughan and Litt (1990:315) stated that adolescents have the highest rate of sexually transmitted diseases of any age group. Factors influencing this include sexual experimentation which often follows initiation of intercourse activity among adolescents and adolescents reluctance to use contraceptives. The respondents also highlighted embarrassment as one of the reasons for delaying to seek treatment for sexually transmitted infections.

7.2.4 Youth Sexual Attitudes and Activities

Life-skills involves a great range of skills which persons need to possess giving them a great range of alternatives available to them. This includes providing them with life and social skills. Basically the addition of any skills to a persons behavioural repertoire will make especially young people to be potentially more self-empowered. Thus helping them to deal with daily problems and encounters such as sexual decisions they may experience. It should also be mentioned that the relevance to skill development by schools is the lack of concern for personal development and the betterment of society. We have frequently been charged with compartmentalising skills knowledge

in the school curriculum in which the learner can rarely relate the ideas of science to personal development and self-empowerment. Skills and knowledge are treated in the abstract so that they do not become a part of a learners personal mechanism for dealing with his world. Learners, by means of a properly organised continuous life skills programme, should be empowered to manage their emotions, to take advantage of their creative potentials, to cope with difficult problems, to spend their leisure time wisely, to think rationally and to know themselves.

The findings also reveal that teenagers apparently disapprove of premarital sex but at the same time acknowledge that teenagers engage in risky sexual behaviours because of their inherent sexual drive as well as the lack of recreational facilities.

According to Hudson and Ineichen (1991:6) physical and sexual maturity among adolescents is not accompanied by an ability to handle their sexuality in a responsible manner. A great number of teenager sexual activity result in pregnancy or sexually transmitted diseases. Sexual activity among young people as clearly indicated in the study takes place without contraceptives being used or even being considered, although the possible consequences especially pregnancy and childbirth are not desired. Probably most teenage couples do not even think about such an outcome. This is specifically the case among the sixteen year olds. It would seem that for many at this age sexual activity has no bearing on the future. Based on the above information writers, researchers and experts strongly recommend that sex education should be built into the school curriculum and offered to children at an early age.

7.3

RECOMMENDATIONS

Based on the main findings the researcher recommend that :

7.3.1

Sexual education should form part of the school's curriculum. It should in actual fact be introduced at nursery school level. Sexual education cannot be provided on its own. Of great importance however is that it should not be given on its own but should form part of a holistic approach such as a life skills programme and should emphasise child sexual abuse, teenage pregnancy, communicably sexual diseases and even substance abuse.

7.3.2

Parents should be primary educators when coming to the issue of sexuality since most children receive unreliable information from friends and the media. Parents should consider the consequences of keeping children ignorant with the assumption that they are protecting them from experimenting with sexual activities. The reality is that keeping them ignorant is destroying them because if they have the right information on sexuality they will most probably not engage in risky sexual behaviours. Parents must break the barriers that prohibit them from providing their children with sexual information for example the idea that talking to children about sex is a taboo.

The family must be able to sit together and talk about sexuality since young people are engaging in sex at an early age. If parents are open to their children about sexual issues, children will be able to open up even if they are already sexually active. Some girls become pregnant because they thought that if you have sex only once you cannot become pregnant. Most of the time teenagers do not know how to approach their parents, but if the parents provide an atmosphere which is conducive, teenagers will be able to approach

them with out fear. Possibly welfare organisations, church groups, schools and other interested professionals should arrange workshops or seminars to parents on a regular basis with better parenting programmes.

7.4

CONCLUSION

The research, which is absolutely pertinent at this stage, proved that young people become sexually active at a very young age. Because of lack of sexual information because parents and schools are not meeting their responsibilities in this regard, young people are put at risk to become pregnant or to contract sexually transmitted diseases. Young people's future are in a great number of instances shattered because of the ignorance and irresponsibility of the authorities, community leaders, education departments, professionals and parents. The sooner purposeful arrangements are made to empower parents and young people with the necessary life-skills including sexual education, the sooner this country will flourish.

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QUESTIONNAIRE ON SEXUAL EDUCATION

Please answer all questions by putting a cross (X) in the appropriate block of the question. Only give one answer to each question. We urge you to be completely honest as questionnaires and their answers will be kept confidential. We thank you for your co-operation.

1. What is your gender?

Male

Female

2. What is your age group?

13-16

17-19

20+

3. In which grade are you at present?

Grade 9

Grade 10

Grade 11

4. What is your religion?

Protestant

Catholic

Zionist

Other (specify)

5. Who are you living with?

Both parents

Single parent

Adoptive parent

Foster parent

Guardian

6. How is your relationship with your parents?

Good

Average

Bad

Uncertain

7. From whom did you learn about sex for the first time?

Teachers

Friends

Parents

Television

Health care workers

Other (specify)

8. Have your parents discussed sexual matters with you?

No discussions

Very little discussions

Sufficient discussions

9. Have you received sex education from your school?

No education

Some education

Sufficient education

10. Who according to your own opinion should be responsible for sex education?

Parents

Schools

Parents and schools

Invited experts

Church

Other (specify).....

11. At what age should one start with sex education?

8-11 years

12-15 years

16-18 years

19+ years

Graded system

Uncertain

12. In your opinion what do you consider to be the main cause of sexual acts between teenagers?

Availability of contraceptives

Peer pressure

Sexual desire

Uncertain

Other (specify)

13. In your opinion who are mostly at risk of contracting sexually transmitted diseases?

Teenagers

Homosexuals

Prisoners

Prostitutes

Married people

Everybody

Uncertain

Other (specify)

14. What do you consider to be the main effect/danger in engaging in premarital sexual activities?

Teenage pregnancy

HIV/AIDS or STI's

No dangers at all

Uncertain

15. Why do you think people delay to seek treatment for sexually transmitted diseases (STD's)?

Embarrassment

Shame

They may suffer social stigma

Little accessibility to health care

People are not aware of the signs and symptoms

Uncertain

Other (specify)

16. In your opinion should high school children be allowed to be sexually active?

Yes

No

Uncertain

17. What is your attitude towards premarital sex?

Approve

Disapprove

Uncertain

18. Lack of recreational facilities leads to unnecessary sexual activities.

Agree

Disagree

Uncertain

19. How can we reduce the risks of sexually transmitted diseases?

Sexual abstinence

Change our attitudes to STD's

Make routine checks for STD's

Use a condom

Be faithful to one sexual partner

Other (specify)

20. In your opinion what do you consider to be the best measure to combat the dangers of indiscriminate sex?

Abstinence from sex

Purposeful sex education

Safe sex

Involvement of learners themselves in activity groups

Regular workshops and seminars on sexuality

Uncertain

Other (specify)

