RISKY SEXUAL BEHAVIOUR AMONG THE YOUTH OF SOUTH AFRICA

BY

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A dissertation submitted in partial fulfilment of the requirements of the degree of Masters of Social Sciences (Population Studies) in the Faculty of Human and Social Sciences, Population Training and Research Unit, North-West University, Mafikeng Campus

FACULTY OF HUMAN AND SOCIAL SCIENCES
POPULATION RESEARCH AND TRAINING UNIT

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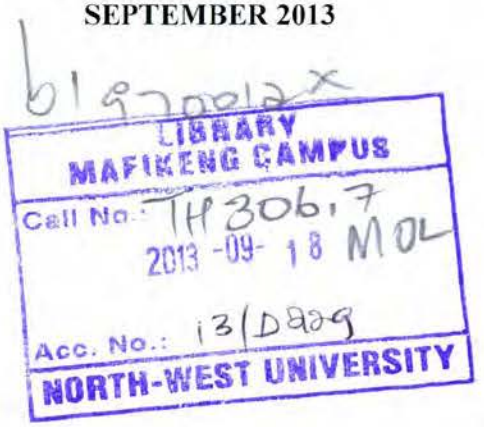
SEPTEMBER 2013



Declaration

I, ***Kobamo Mabel Molefe***, declare that this dissertation for the Masters Degree in Population Studies at the North-West University Mafikeng campus hereby submitted, is my own work, and has not previously been submitted by me for a degree at any other university. All the design and execution in this study is my own and all materials contained herein have been duly acknowledged.

Signature.....

Abstract

Background: Risky sexual behaviour among the youth of South Africa is one of the major health concerns in the country because it is associated with negative reproductive health outcomes such as high teenage pregnancies and exposure to sexually transmitted infections including HIV/AIDS.

Objective: The main objective for this study is to examine the factors influencing risky sexual behaviour among the youth in South Africa in order to make recommendations for strategies that would help reproductive health programmes in planning.

Data and methods: The research uses data from the 2003 South African Demographic and Health Survey. The study population comprised of 4597 female youth aged 15-34 years old. Bivariate analyses and multinomial logistic regression were used to determine the factors affecting risky sexual behaviour among the youth. The factors that were significant in the multiple regression models were regarded as the most important variables associated with risky sexual behaviour.

Results: Out of 4597 female youth, 114 (2.5%) had low risk sexual behaviour, 2112 had medium risk sexual behaviour and 278 had high risk sexual behaviour. The results revealed that risky sexual behaviour varies by background variables. Risky sexual behaviour increases with age, is higher among urban than rural youth is higher among youth with secondary education than youth in other educational categories. In addition, the results showed that risky sexual behaviour vary according to province of residence. The highest risky behaviour was observed in Kwa- Zulu Natal (22.7%) and Western Cape (21.5%), whereas North West and Eastern Cape (5.1% and 3.9%) respectively, had low risky sexual behaviour. The multi-nominal analyses indicate that having a radio and marital status were significantly associated with risky sexual behavior), [OR=1.23, CI=1.23].

Conclusion: The study concludes that policies and programmes designed at reducing risky sexual behaviour among the youth should continue be supported and encouraged. Since having a radio is associated with low risky sexual behaviour, it is

suggested that messages encouraging the youth on safe sex by use of condoms, reduce number of sexual partners, avoid receiving money or gifts in exchange of sex should continue to be reinforced through radio. Furthermore, parents should also be taught through a radio on how to educate their children to practice safe sex. Finally, the results show that there is still need for further research on risky sexual behaviour among the youth. Future research should, among other things, focus on strategies to delay sexual debut among the youth, the role of parents and good cultural practices.

Acknowledgement

My sincere gratitude is hereby expressed to God almighty that strengthens me all the way from the beginning of the study to the end.

My supervisor, Professor Martin E. Palamuleni, for his utmost guidance and positive comments

Professor Moses Kibet, for his words of encouragement whenever we meet; Mr Phillemon Selemela and his wife Lerato, for always being of great help at any time.

I sincerely thank my husband Lebone, for his support and encouragement in my studies, our three kids, Karabo, Lefoko and Kitso, may God richly bless you.

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List of Abbreviations

ABC	Abstain, Be faithful and Condomise
AIDS	Acquired Immune Deficiency Syndrome
CDC	Centre for Disease Control
DHS	Demographic and Health Survey
DOH	Department of Health
FHI	Female Health Institute
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Counselling
MRC	Medical Research Council
PEP	Post Exposure Prophylaxis
SADHS	South African Demographic and Health Survey
SANHIV	South African National Human Immunodeficiency Virus
STI	Sexually Transmitted Infections
SPSS	Statistical Programme for Social Science
UNAIDS	United Nations for Acquired Immunodeficiency Syndrome
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Risky behaviours are behaviours that can have adverse effects on the overall development and well-being of youth (Guzman & Bosch, 2007). In other words, risky behaviour refers to that behaviour that might prevent youth from future successes and development. This includes behaviours that cause immediate physical injury, as well as behaviours with cumulative negative effects. Risk behaviours also affect youth by disrupting their normal development or prevent them from participating in typical experiences for their age group (Guzman & Bosch, 2007).

Risky sexual behaviour can impact the lives of youth and those around them. Is therefore essential that parents, educators and other concerned adults become aware of the prevalence of these behaviours, the factors that increase their likelihood and what can be done to prevent those risks (Perkins & Borden, 2003).

In both developed and developing countries, the increasing incidence and prevalence of sexually transmitted infections including HIV among adolescents and youth present a serious challenge to their health and well-being (Adler et al., 1996; Friedman et al., 1997). This is as a result of risky sexual behaviour that the youth involve themselves in. In developing countries, up to 60% of all new infections are among 15-24 year olds (Pettiforet.al. 2004).Economically, people are indulging in unsafe sexual relations in exchange of money thus resulting in epidemics of HIV, which need the government to intervene in one way or the other by implementing Anti-Retroviral sites in hospitals.

Parents are reluctant to discuss sexual matters with their adolescents; lack of intensified school based sex education programme further contributes to adolescents' poor understanding of sexuality. As a result many adolescents have misperceptions about sexuality; this exposes them to risky sexual behaviour.

Young people are vulnerable to sexually transmitted infections (STIs) because they may not know about STIs and HIV/AIDS; for example, among young men and women aged 15-24 years, for every one man four women are infected with HIV (Tigawalana, 2010). Those who would like to use condoms may not be able to obtain them from health centers because they are scared of going to the clinic to obtain condoms. Youths are unable to discuss condom use with their sexual partners; one can say this could be due to cultural influence and the way they are brought up. Girls are commonly socialized to be submissive to men (Zelaya et al, 1997).

1.2 Problem statement

High risk behaviours have been of particular interest to professionals because of their prevalence in youth of today (Guzman & Bosch 2007). Many of these behaviours cause a large number of deaths and injury among the youth, or have negative impacts on society. Sexual behaviour is considered to be another group of high-risk behaviour for youth because of the potential physical (e.g., STIs) and socio-emotional risks they present (Gutmacher Institute, 2006). Youth may or may not be ready for the social and emotional implications of sexual activity, and many sexually active youth do not use safe sexual practices, e.g., condoms.

Given that the burden of new HIV infections in developing countries is concentrated among the young and females, there is emerging awareness, that even with knowledge of how to protect oneself from infection, such information may not always be usable in daily situations of economic and social disadvantage that characterize the lives of many young people, especially females (UNAIDS, 2004).

Understanding how factors such as one's age, sex, and socio-economic status confer vulnerability to unsafe sexual behaviour among young people are important for designing appropriate health, social and economic development policies and programmes. HIV/AIDS is still largely considered a medical and public health problem, with most interventions emphasizing individual to prevent infection (Campbell 2003; Barnett & Whiteside 2002).

Although ranked as a middle-income country, South Africa has the eighth most unequal income distribution in the world (UNDP 2003). The current study explores how relative social and

economic status influences the sexual behaviours and experiences of youth in South Africa. During 2010 alone, an estimated 1.2 million adults and children died as a result of AIDS in sub-Saharan Africa (Dorrington, et.al. 2010). Based on the above, South Africa alone had 81% and 76% male and female deaths respectively. This calls for more awareness campaigns to be re-enforced by both government and non-governmental sectors including youth organizations.

A national survey conducted in 2008, results show that an estimated 5.2 million people were living with HIV/AIDS in South Africa in 2008 and over 250,000 died of AIDS. Furthermore, among females, prevalence is highest in 25-29 years (32.7%) and males 30-34 (25.8%), (Shisana et.al. 2009). An estimated HIV prevalence between ages 15-49 year old was 15.6% in 2002, 16.9% in 2005 and 16.9% in 2008 (SANHIV Survey 2008). Several research has been carried out on the prevalence of HIV/AIDS but there is little being done on creating awareness on the risky sexual behaviour practices that the youth are involved in. The estimated HIV prevalence among South African youth from 2005 to 2008 ranges from 10.3% to 16.8% respectively. The number increased drastically which also indicate that there is still much to be done.

Table 1shows the prevalence of HIV/AIDS by province as a result of risky sexual behaviour among the youth. Kwa-Zulu Natal and Mpumalanga are the most highly affected, this could be due to cultural influence where polygamy is mostly practiced. On the other hand, it could be due to accurate reported cases unlike in other provinces where cases are not reported.

Table 1: HIV/AIDS prevalence by province from 2005-2008 in (%)

Province	2005	2008
Kwa-Zulu Natal	16.5	15.8
Mpumalanga	15.2	15.4
Free State	12.6	12.6
North West	10.9	11.3
Gauteng	10.8	10.3
Eastern Cape	8.9	9.0
Limpopo	8.0	8.8
Northern Cape	5.4	5.9
Western Cape	1.9	3.8
National	10.8	10.9

Source: South African National HIV survey, 2008

Table 2: HIV prevalence among South Africans by age and sex, 2008 (%)

Age	Male	Female
15-19	2.5	6.7
20-24	5.1	21.1
25-29	15.7	32.7
30-34	25.8	29.1

Source: South African National HIV Survey, 2008

Table 2 indicates the rate at which HIV spreads among the youth. The higher the age, the more the number of infections and the most infected are the females which clearly explain their poor negotiation skills in sex and selling sex for money resulted in them getting infection more frequently. This also calls for one to assess the knowledge, attitude and behaviour of the youth in relation to sexual relationships.

Schoolgirls are the most vulnerable group who contract the infection, because of the socio-economic status they find themselves in; they get tempted to be used by older men in exchange for money (Luke, 2005). This may represent the underlying pattern of sexual dynamics in South Africa where intergenerational sex is common, and a high risk for HIV infection. Immediately they got the infection from older men, they spread it among their age group, which will make a cycle of infection. Youths of today compete to have sexual partners, by so saying one will find a youth with more than one sexual partner and most of them don't know what is actually expected of them to have a relationship.

This is true of teenage girls in South Africa, for I quote: "from one end of the room, partitioned by a curtain, a voice came, loud and harassing, came through the silence. 'Spread your legs! Tell me, where is it paining? Now tell me properly, is it paining or not? How are we supposed to understand anything if you won't talk? Okay. Now you can go!'" suddenly another nurse's voice boomed: "everybody go and pass urine and come back!" (Shyamala, India). This is one of the attitudes service users get from service providers, further than this it is as a result of unprotected sex practices among the youth. In South Africa study conducted in Mpumalanga (Piet Retief) results showed that teenagers were scared to go to the health facilities when they need condoms or suffering from STIs because nursing staff might tell their parents, too strict and treated them in a hostile fashion, no enough information at the clinic (Meyer-Weitz et.al. 1999).

Risky sexual behaviour more pronounced among the youths include among others:

- Having sexual intercourse with many partners, without using condom; Young people engage in sexual practices with more than one partner because they like competition, they think that it is a status to have more than one sex partner;
- having sex with commercial sex workers, without using a condom. Due to the economic burden that the youth find themselves in, they use sex in exchange of money to fulfill their needs. Sex without condoms pays more than when using condom;
- continuing to have sexual contact with symptoms of STI and without using condoms. Some of the STI's like syphilis are painless, one can continue to spread the infection without realizing that he or she got the infection;
- not getting any treatment for STI; Young people are usually scared to seek medical treatment when they have STI related conditions, the reason could be the attitude of the nursing staff or lack of knowledge as to where to go for treatment; and
- not taking the medication prescribed for an STI correctly, or not finishing treatment (WHO, 2001).Usually people are reluctant to finish the course of treatment irrespective of the explanation given. It is a common practice that when one feels better, he or she don't continue to take medication. By not completing treatment prescribed, causes the infection to recur.

1.3 Rationale of the study

South African youth frequently engage in a range of high-risk activities including risky sexual behaviour. Evidence from a number of local studies reveals that our youth use alcohol, tobacco and other drugs, engage in unprotected sex and as a result are victims of violence (Muller & Lombared, 2003). Engagement in risky sexual behaviour is considered to be another group of high risk behaviours for youth because of the potential physical and socio-emotional risks they present. Furthermore, the study emanates from the overwhelming results of HIV/AIDS pandemic in sub-Saharan Africa and South Africa in particular that has reached staggering proportions, especially among the youth (Shisana et al., 2005).

Given the above background, the study will give possibilities for contributing to knowledge at both the theoretical and practical level. First, the theoretical importance of the study is that it might help in educating youths on the dangers of risky sexual behaviours including HIV/AIDS to their reproductive health. To take precautionary measures before involved in sexual relationships. It will further help policy makers and reproductive health programmes to provide guidelines for user-friendly services for the youth. Secondly, knowledge about the interrelationship between risky sexual behaviour and selected background variables will help inform policy makers on measures to alleviate the problem. This is of particular importance to the South African government in putting more emphasis on integrated health care services and taking services to the people.

1.4 Objectives of the study

1.4.1 Main Objective

The primary objective of this study is to examine the factors influencing risky sexual behaviour among the youth in South Africa in order to make recommendations for strategies that would help reproductive health programmes to address risky sexual behaviour among the youth in South Africa.

1.4.2 Specific Objectives

The following are the specific objectives:

1. To investigate the relationship between risky sexual behaviour and background characteristics of female youth; and
2. To determine the factors influencing high risk sexual behaviour among the youth in South Africa.

1.5 Research Question

In order to achieve the above objectives the study seeks to answer the following research questions:

- What are the factors responsible for the determinants of risky sexual behaviour among the youth in South Africa?
- What is the likelihood of the youth practicing risky sexual behaviour given their demographic and socio-economic differences?

1.6 Organization of the report

The study is organized into five chapters. Chapter one is the introductory chapter covering background of the study, problem statement, objectives and rationale of the study. Chapter two deals with literature review, where a review of relevant literature on risky sexual behaviour was done. Chapter three is methodology that includes sources of data, method of presenting data and method of analysis. Chapter four covers analysis and presentation of results. The last chapter, chapter five is the conclusion and recommendations on findings of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews studies on risky sexual behaviour among the youth focusing on the factors that contribute to risky sexual practices. Studies from South Africa and other countries were reviewed.

2.2 Risky behaviour among youth in South Africa

The definition of the behaviour which constitutes risky sexual intercourse has varied from one study to another, with the obvious result of difficulty in making sound comparisons between investigations (Channon & Madise, 2004). Some researchers have noted that a number of definitions of high risk sexual intercourse are overly harsh in applying the classification, with all sexual intercourse outside of a cohabiting relationship being classified as high risk (Channon & Madise, 2004). Other definitions are more prescriptive in that unmarried partners in an exclusive relationship are not classified as risky (Channon & Madise, 2004). Risky sexual intercourse also needs to be defined to take account of infidelity by one partner, who then exposes the faithful partner to (STI) that has been transmitted from other partners. Passive exposure is therefore important to include when modelling those who have engaged in risky sexual behaviour. Various studies have commented on the risky sexual behaviour of South African youths (Simbayi, et.al. 2004). Several studies have looked at such behaviours as one set of sexual intercourse, non-condom use during sexual intercourse, inconsistent condom use, and multiple sex partners, having sexual relations with older men and sex with an infected partner (Brook, et. al., 2006).

Studies conducted in South Africa suggest that young men and women engage in sexual intercourse at an early age. The 1998 South Africa Demographic and Health Survey and the South Africa-based Health System Trust (2001)estimate that the mean age of first sex is 18 years for females, whereas using a variety of data sources conclude that the national average is 15 years for girls and 14 years for boys (Hallman, 2004). A study conducted in Kwa-Zulu Natal

indicates that nearly 46% of all sexually experienced young women had reported that their first sexual encounter had been coerced (Jejeebhoy & Bott, 2004).

According to SADHS 2003, 5.5% reported first sex by age of 15 and 42% by age of 18 in the age group 20-24. Less than 6% of women reported they had had sex by the age of 15 years. The median age at time of first sex was approximately 18 years, and virtually all the women had sex by age 23. There was evidence that the peak of the rate of entry into sexual relations occurs at age 18 and that younger cohorts of women are entering sexual relations at a younger age. Furthermore, available statistics indicate that onset of sexual intercourse varies by province. The 2003, SADHS suggest that females in Eastern Cape (11% for girls and 21% for boys) start sexual activity at an earlier age compared to other provinces, Western Cape 5% (Department of Health, 2007; Berry & Hall, 2007).

Table 3: Percentage of youth (15-24 years) who had first sex by age 15 (South Africa, 2003).

Province	**Female**	**Male**
Eastern Cape	11	12
Free State	6	15
Gauteng	6	13
KwaZulu-Natal	2	6
Limpopo	9	14
Mpumalanga	9	10
North West	6	12
Northern Cape	6	9
Western Cape	5	12
South Africa	6	12

Source: Department of Health, Medical Research Council and OrcMacro (2007) ***South Africa Demographic and Health Survey 2003***. Pretoria: Department of Health.

Compared to ten years ago, the general trend is that the age at first sexual intercourse is increasing. Generally, for most of the African countries, the median age has increased with the exception of Namibia where it has decreased. A large number of adolescents have their first sexual intercourse by age 18. This means that, compared to ten years ago, there has been a drop in the proportion of youth who have had sexual intercourse before they celebrate their eighteenth

birthday. In other words, youth aged 20-24 years in 2003 were less likely to have had sexual intercourse by the age of 18 compare to those interviewed in the early 1990s. Age at first sexual intercourse for urban women was slightly older than rural women.

Women with higher education levels had their first sexual intercourse at the latest age across all age groups and those with no education at all, had sexual intercourse at a later age than those with sub A to standard 5 education. A study in the Northern Province (Health Systems Development Unit, 1997) reported that sexual debut appeared to peak between 14 and 16 years for males and females, while in Swaziland, documented age of first sexual intercourse is 15-17 years (Jennifer, Khaled & Rochelle, 2010).

Another study was conducted in South Africa where the effects of age at sexual debut on sexual behaviour among South African youth were investigated (Zuma, Setswe, Ketye, Rehle & Mbelle, 2010). Among 2 875 respondents who ever had sexual intercourse, 39% had early sexual debut (16 years and below). Males were significantly more likely than females to report early sexual debut 44.6% and 35.1% respectively. In the same study, multiple sexual partners were significantly more common among those that had early sexual debut than those who had late sexual debut (10.4% versus 4.8%).

The earlier the age at sexual debut may be due to various factors like lack of knowledge, low literacy level, low self-esteem and poor negotiation skills on the part of females who may be afraid to say "no" to sex. In a study conducted in Zimbabwe, a weak association was found between greater knowledge and later age at first sex (Gregson et al., 1996). They found that the more a person is knowledgeable about sex related issues, the more precautious that person will be about entering into sexual relationship. Early sexual debut in adolescents is correlated with multiple sexual partners, STIs, teen pregnancy, and emotional consequences. Human immunodeficiency virus (HIV) and many other STIs such as herpes, Chlamydia, gonorrhea and syphilis are easily transmitted during oral, vaginal or anal sex.

A regional study by the Soul City Institute reported four main reasons why young people are involved with multiple partners (Soul City Institute, 2008). Other studies have also agreed with

these findings (Hallman, 2004). These reasons are dissatisfaction in the relationships, culture, financial and alcohol related problems. First, many participants in the study talked about being sexually dissatisfied with their 'steady' or 'love' partners. Men and women discussed looking for variety, sexual adventure and specific physical characteristics in additional partners. Furthermore, respondents spoke of a lack of communication between partners on sexual issues in relationships. This lack of communication between partners contributes to sexual dissatisfaction. Participants identified physical abuse, domestic discord, emotional abuse and neglect, and financial neglect by a spouse as reasons for seeking out other partners.

Second, the study observed that cultural norms encourage men to have more than one sexual partner (Soul City Institute, 2008). Communities often celebrate men who are in relationships with more than one partner and condemn women who do the same. Cultural norms further require that women submit to men's authority. Respondents in the study also identified how strict socialization ensures that people accept cultural norms, values and practices that promote multiple sex partners. Third, the study observed that most people become involved in multiple sexual partners in order to survive. Other people have multiple relationships to get money for luxuries.

Lastly, alcohol was identified as a contributor to multiple sexual partners. In general, increased sexual activity was reported in bars. Participants said that when one is drunk one has to have sex. Participants also said they are more likely to have sex without a condom when they are drunk. A recent study in Cape Town also shows a relationship between alcohol use and multiple partners (Kalichman, and Simbayi, 2011).

2.3 Determinants of risky sexual behaviour among the youth

Studies have identified several factors that predispose youth to risky sexual behaviours (Brook, et. al, 2006; Soul City Institute, 2008; Kalichman) factors are inter-related, complex and vary from one society to another. For simplicity, in this study determinants of risky behaviour have been grouped into six categories:

2.3.1 Demographic

Age

Age is one of the most important variables affecting demographic parameters. Under these factors a number of issues have been shown to influence risky sexual behaviour. Some of these issues include age of the respondent, age at sexual debut and age of the partner. Studies indicate that age of the respondent is associated with risky sexual behaviour. Brook, et. al, (2006) argue that age has both a direct effect and an indirect effect on risky sexual behaviour via the parent–child relationship and associating with deviant peers. More recently, the National Youth Risk Behaviour Survey estimates that 4.4% of adolescent have had sexual intercourse before age 13(Center for Disease Control and Prevention, 2006).

One theory of the evolution of preferences towards risky behaviour might be that younger teens are both more impatient and more subject to peer pressure, which could increase risk taking by younger teens relative to older teens (Lewis, 1981). The most critical factors that influence the youth behavior are; biology, which may make some risky activities (e.g. sexual intercourse) more desirable with age; income, as older teens may have more of their own income that can be used to finance risky activities; and the law, in that some risky activities are explicitly illegal for younger teens but legal for older teens (Lewis, 1981).

Studies have shown that large age differences between partners frequently co-exist with female economic vulnerability, in which case female negotiation positions are weaker (Luke & Kurz, 2002). Age differences between partners inhibit female negotiations for safer sex practices; as a result discussing sensitive topics like condom use with sex partner threatens the stability of the relationship with potential negative consequences for female's economic security. It was also

found that young women of lower socio-economic status may be less assertive, have poorer negotiating skills and more accepting of traditional gender roles (Singh, Darroch & Frost, 2001).

Evidence from South Africa, Uganda and Zimbabwe indicates that relationships with older sexual partners carry higher levels than average risk of HIV infection for adolescent females because these men are more experienced sexually and of relatively higher economic means and hence more likely to have visited commercial sex workers (Gregson et al., 2002).
A study done in Uganda showed that almost 50% of young men and nearly 40% of young women surveyed reported having sex by the age of fifteen years (Konde-Lule et al., 1997), which is quite early when compared to 1980s being 18.5 for females and 19.2 for males.

Race

Risky sexual behaviour also varies with race. A study in the US indicated that African-American students were significantly more likely than Hispanic or white students to have ever had sexual intercourse (71.2%, 54.1%, 45.1% respectively), to have initiated intercourse before age 13 (20.5%, 9.2%, 5.5%), and to have had more than four sexual partners (34.4%, 16.6%, 12.4%), (Nicholson, 1999).

Place of residence

People living in the rural areas are the most vulnerable to STI, due to lack of knowledge, inaccessibility of health care services for them to get information about the infection and lack of supply of condoms and how to use them (Sweat &Denison 1995).

Family

Family disruption, e.g. divorce or change to single parent household- studies, has shown that the structure of a family provides a salient developmental context in the growth of children who usually have primary relationships with one or two biological parents and with or without younger siblings. Marital status of parents consistently show that living with a single parent is related to adolescents being more likely to have had sexual intercourse early (Miller, Benson &

Galbraith, 2001). Single or divorced parents more permissive sexual attitudes results in lesser parental supervision (Whitbeck, Simons & Kao, 1994).

2.3.2 Socio-economic factors

Education

Another factor that is associated with risky sexual behaviour among the youth is education. Studies have shown that education is the key to an effective response to reproductive health problems including HIV/AIDS, teenage pregnancies and abortion (Buchman & Hannum, 2001). It is important to appreciate that the effect of education can be seen at individual or family levels. At individual level studies show that educated women are more likely to know not only about safe sex but also how to confront risky sexual behaviours (Buchman & Hannum, 2001). In addition, educated women are expected to know how to prevent HIV infection, to delay sexual activity and to take measures to protect themselves. Education also accelerates behaviour change among young men, making them more receptive to prevention messages. Because of these attributes UNFPA and UNIFEM (2004) argue that universal primary education is not a substitute for expanded HIV/AIDS treatment and prevention, but it is a necessary component that complements these efforts to combat the spread.

Employment

The relationship between employment status and sexual behaviour is not well understood (Rich & Kim, 2002).On the one hand, some studies seem to indicate that employment opportunities were associated with a reduced risk of early intercourse and pregnancy (Kim, 2002). On the other hand, other studies suggested that employment of young people is associated with such behavioural problems as delinquency, smoking and using alcohol or drugs, and, in turn, how those problems raised the risk of early intercourse and pregnancy, thus suggesting that employment indirectly raises the risk of negative sexual and reproductive health outcomes (Rich & Kim, 2002).

Poverty

In some areas, sex work is increasing rapidly because of poverty and lack of access to employment opportunities for young people (Booysen and Summerton, 2002; Kelly and Parker, 2000; Wood et al., 1997). Lack of recreation facilities for the youth contributes to them involved in sex relationships. Due to poverty, girls find boyfriends or 'sugar daddies' to give them money in exchange of sex. The youth needs to be involved in various activities that will keep their minds away from drugs, sexual activities and violence. Projects in community settings can help engage them in fighting poverty.

People don't use condoms for financial reasons. A direct link between poverty and the increased risk of becoming infected with HIV exist, (Varga & Makabulo 1996; Wood, Maforah & Jewkes 1998). A number of respondents said that men don't give money if you insist on condom use (Agyie & Epema, 1992, Calves, 1999). Young women deliberately fall pregnant in order to qualify for government grants.

2.3.3 Life style and behavioral factors

Number of sexual partners

Having more than one sexual partner is high risk sexual behaviour especially if condom is not used. Some men consider having more than one sexual partner as making them feel like real men, proof of his manhood and making them popular (Hallman, 2005). Gender norms; for example, in most cultures is acceptable for men to have more sexual partners than women, and for older men to have sexual relations with much younger women (Ajala, 2007; Omorodion, 2006; Orubuloye, Caldwell, and Caldwell, 1993).

In South Africa, for example, having many sexual partners is reported as being equated with popularity and importance among young men (Karim & Morar, 1995). Interviews with high school students in Zimbabwe indicated that girls should stick to one sexual partner, while boys can have and indeed should have many girlfriends (Bassett & Mhloyi, 1991).

According to South African Demographic Health Survey conducted in 2003, questions about the number of partners were asked. Males, as compared to females in their early 20 years, are most likely to have multiple partners, followed by age 25-29 with 8.7% to 4.0% of females. The

Mandela Foundation-HSR national survey (2001) found that 9% of females and 23% of young males had more than one sexual partner in the year before the survey. Another study by Pettifor et al. (2004), presents higher prevalence, with 13% of females and 44% of males having multiple sex partners. Generally speaking, the younger the age, the more the number of sexual partners with males on the lead. Youth in the urban areas have more sexual partners as compared to youth in rural areas.

Education was used to determine the number of sexual partner. The survey found that the higher the education, the more the number of sexual partner's youth has. This is an expectation since youth at this age group like to compete with one another. Africans were found to have more number of sexual partners compared to any other racial groups.

Forced to have sex (Coercion)

Several studies have suggested that the experience of sexual coercion leads to a greater likelihood of risky sexual behaviour, such as early sexual debut, many sexual partners and inconsistent condom use (Biglan, et. al., 1995; Agardh, et. al., 2011). Furthermore, some studies reveal that between one-fifth and one-half of all the girls and young women around the world report that their first sexual encounter was forced. In South Africa, a number of studies indicate high prevalence of forced sex (Wood, Maforah and Jewkes, 1996). For instance, a study conducted in the rural Transkei area of South Africa revealed that among 13-17 year old females, 28% reported that their first sexual experience was forced (Buga et.al., 1996). In an informal settlement area of Cape Town, 18% of never pregnant girls and 32% of girls not currently pregnant, reported their first sex was forced or rape (Jewkes et al., 2001). Campbell (2003), reports that rape and emotional pressure are common in young people's first sexual experiences in a mining community outside of Johannesburg, South Africa.

Ever received gifts for sex

There is growing evidence that young people, especially women, engage in exchanges of sex for money, goods or favors. In a study of Nigerian university students, Edet (1997) quoted (in Barnett and Whiteside, 2002) suggests that a young woman may end up having as many as three simultaneous sexual relationships to make her way through university, that is her teacher (to

ensure good marks), a "sugar daddy" or "sponsor" (to pay her living expenses and school fees) and her boyfriend. It was also found that the presence of commercial sex workers in disadvantaged communities in South Africa where unemployment is high encourages other young women to exchange sex for gifts. Money and gifts influence young African girls in particular, not to suggest condom use in KwaZulu-Natal; they say men don't pay more if one insists on condom use (Kaufman and Stavrou, 2002).

Dating more frequently and the more the partners date each other, the more the chances are of them to get involved in sexual contact; simply because they cannot control their feelings. History of STI indicates that some partners enter a relationship with the history of sexually transmitted infection but they will not tell the new partner about the infection and whether they were treated or not. This is for fear of losing the relationship. It is for this reason that the standard treatment guidelines for STI say "syndromic" approach in the treatment of sexually transmitted infections to avoid a cycle of infection (Standard Treatment Guidelines and Essential Drugs List for South Africa, 2006). According to Reproductive Health Policy of South Africa, once a teenager comes to a health facility asking for contraceptives, the services should be provided without the consent of the parent; because this shows that the teenager is sexually active (National Contraception Policy Guidelines, 2001).

Another study conducted in Dar es Salaam, Tanzania; showed that female youth were more than four times more likely to receive gifts or money for sexual favours than males (Urassa et al., 2008). Social and economic disadvantage often make it difficult for women to avoid coercive relationships and negotiate for safer sex within relationships (Jejeebhoy and Bott, 2003).
More than half of 141 street children recently interviewed in South Africa, for example, reported having exchanged sex for money, goods or protection and some indicated that they had been raped (Swart-Kruger & Richter, 1997).

Peer attitudes and behaviour

Peers' alcohol use, drug use and deviant behaviour: Most youths are controlled by alcohol and drugs to such an extent that their behaviour change completely. They find themselves sleeping with someone they don't know and contracting STI easily (Kalichman et al., 2006; Simbayi et

al., 2004, Smit et al., 2006). One study conducted in a community-based South African sample, found that alcohol use predisposes youth to risky sexual behaviour (Smit et al., 2006).

Peers' permissive values about sex: This will depend on what others say about sex, if they are brought up in families which teach them about sex, they will know what it takes to be in a sexual relationship early (Davidson et al., 2008).Sexually active peers: Boys and girls who are sexually active may influence those who are not sexually active to meet the standard of co-play.

Ignorance

Ignorance is the most common factor contributing to the risky sexual behaviour, especially among poor and less educated sections of the population Nicholson (1999). Such people may not know about the existence of STI, may have no information about how to prevent them and may not know how to recognize the symptoms or seek help and treatment Nicholson (1999). Young people may also be scared to take advice from adults due to culture barriers to talk about sex related issues with adults. The high social value placed on virginity may pressure parents and the community to ensure that young women are kept ignorant about sexual matters (Amaziyo et al., 1997; Caldwell et al., 1993). Female ignorance of sexual matters is often viewed as a sign of purity and innocence while having too much knowledge about sex is a sign of 'easy virtue' (Gupta, Weiss & Mane, 1996).

This emphasis on 'innocence' prevents young women from seeking information about sex or services relating to sexual health. Sexually active young women are also discouraged from discussing sex too openly with their own partners, since women are encouraged to be ignorant and inexperienced. This means that young women are unlikely to be able to communicate their need for safer sex with partners. A study done in Kenya revealed that young women felt that they did not have control over their sexuality. Instead, girls learned that sex was something that happened to them, it was not something they could initiate or actively participate in (Balmer et al., 1997).

Older sibling's early sexual behaviour and early age of first birth-having older siblings is also related to higher risk of adolescent pregnancy apparently through younger sibling's earlier onset

of sexual intercourse (Miller et al., 2001). The influence on younger sibling's pregnancy risk behaviour is strongest if older siblings have had sexual intercourse, especially if older sisters have experienced an adolescent pregnancy or birth (Widmer, 1997).

2.3.4 Psycho-social

Loneliness

Young people looking for unfamiliar sex partners in new places to overcome their loneliness are important factors in taking sexual risks (Abdool Karim 1992; Gilgen et.al., 2001). Such behaviour is often found among those who leave their homes to see new places or adventure and entertainment. They may also find better work as migrant laborers'and unknowingly accept the company of infected sexual partners, and then spread the infection to other sexual partners, including their wives (Daan Brummer, 2002).

2.3.5 Media Exposure

Media exposure as one of the variables predisposes youth to early sexual practices. Teens who watch a lot of television with sexual content are more likely to initiate intercourse in the following year (Collins et.al. 2004). Many observers have raised questions about whether one important source of the risk sexual behaviours among young people could be adolescents' escalating exposure to electronic media (Collins et al., 2004). A media portrayal of sex and sexuality encourages young people to experiment with sex which exposes them to teenage pregnancies and sexually transmitted infections. In most societies the basic moral message is no premarital sex, but TVs, movies, internet, magazines and newspapers provide an extremely provocative environment for sex education in youth life (Kren & Limaye, 2009). Several studies conducted, results show that young people's practice about sex was from the media (late movie shows on pornography).

2.3.6 Socio-cultural beliefs

Some cultural groups encourage sexual activity among unmarried youth, including multiple partners (MacPhail & Campbell, 2005) and with girls more marriageable once they have demonstrated their fertility, (Ajala, 2007; Amazigo et al., 1997; Omorodion, 2006; Orubuloye et al., 1993).

Another study conducted by Kriege found out that in Zulu culture, sex play was encouraged but regulated, where education regarding sexual matters was undertaken separately for boys and girls. Women were taught to be submissive and obsequious, men to be forthright and assertive (Kriege 1936; Van der Vliet 1974; Kies 1987). It was also mentioned that a young Zulu woman may simultaneously be under pressure from friends and boy-friends to have sex early and unprotected sex to have conceive a child and demonstrate her womanhood (Varga 1997).

In cultures where sex with very young girls is condoned, sexual intercourse is especially likely to cause trauma. In some countries, girls as young as 12 years may be married to men three times their age. Many cultures use words to describe male sexuality in a positive way and female sexuality in a more negative and judgmental way. Many women and men define sex largely according to what they believe gives men pleasure, particularly penetration (Hersh et al., 1998; Pettifor et al., 2004). Often women do not explore, let alone assert, because this is considered inappropriate. "Everything is centered on the pleasure of the man", says a Zimbabwean woman at a market (Richter, 1996).

Gender and vulnerability

It is often not enough to talk about risky behaviour without understanding the socio-cultural context. Various studies in Africa indicate that a wide gap exists in the social and economic condition between men and women (Lawoyin & Kanthula, 2010; Eaton et al., 2003). These differences are defined by social institutions including the family, church and educational systems/schools. Women are generally seen as subordinate to men and are socialized to be obedient and to their families. In addition to this, violence against women, adolescent girls and young children is prevalent, a problem that is compounded by the status of women in society which more often than not leaves them with little or no negotiating power on matters related to their sexual health. It is important to also consider the gender imbalance that exists when trying to understand HIV transmission among young people in the country.

In the majority of countries, there are strong pressures on young, unmarried women to retain their virginity (Weiss, Whelan & Gupta, 1996, Potchesky & Judd, 1998). The social pressure to remain virgins can contribute in a number of ways to the risks of STI and HIV which young

women face. Young women may engage in risky sexual practices, such as anal sex, as means of protecting their virginity (Gupta, Weiss & Mane, 1996).

A teenager's vagina is not as well lined with protective cells as that of a mature woman. Her cervix may be more easily eroded, potentially enhancing risk of STI and HIV infection (Guzman & Bosch, 2007). Young girls face potential bleeding at first intercourse through tearing of the hymen. In addition, girls aged 17 years or younger who have unprotected sex are at increased risk of developing cervical cancer (de Bruyn et.al. 1995).

All these factors make young women especially vulnerable at a time when their negotiating and economic power is least, making those easier targets for sexual coercion and exploitation. This situation is worsened when more men, especially in high HIV- prevalence areas, seek out younger female partners in the belief that they are least likely to be infected. In another study conducted in seven countries, Petchesky and Judd (1998) concluded that even where sexually active young women are aware of STI, HIV/AIDS and measures to protect against infection, they rarely have the power to ensure that condoms are used; this is due to the poor negotiating skills for use of condoms when it comes to sex.

Evidence from a variety of countries suggests that the age at which young people become sexually active is falling (Fee and Yousef, 1993). This shows that young people become sexually active much earlier than before, from 18 years to 14 years. This is a South African finding because we see most children coming for ante-natal care at 15 years.

2.4 Non condom use among the youth

Non condom use is one of the variables affecting risky sexual behaviour among the youth. Condom use is one of the major ways to prevent sexually transmitted infections and pregnancy (WHO, 2006). There are both male and female condoms available in the health centers, although male condoms are most widely used. Use of condoms depends on a number of factors; e.g., knowledge about the proper use, the source (where to get the condom), rationale for condom use, and attitude of both partners. There are a number of factors why young people do not use condoms. Most male youths said when they use condoms, they did not enjoy sex (Ross 1992; Karim et al., 1992; Pleck, Sonenstein & Ku 1993; Ankomah, 1998), and some associate condom

use with mistrust in a relationship and others may not use condoms due to its bad smell and lack of lubrication resulting in dryness and pain (Karim et al., 1992).

Although condom availability has increased in places such as night clubs and bars where casual sex encounters are initiated (Emanuel, Agha & Kusanthan, 2000), studies suggest that people do not have condoms readily available at the time of sex because of unplanned sexual activity (Karim et al., 1992; Kusanthan & Suzuki, 2000).

Condoms may also not be easily available and young people may feel too embarrassed to buy them from a pharmacy or other stores. Fear of the nursing personnel who supply condoms may also contribute to the reasons for not using condoms because of their remarks at health facilities when youth come to request for condoms. This is lack of user-friendly health services which delays young people to seek treatment early. They may also not take the full-prescribed course of treatment for an STI because of the tendency to hide the treatment from family and friends, or because of lack of information about the seriousness of the condition. Health services are rarely designed to meet their needs (Friedman, 1993; Zelaya et al., 1997, World Health Organization, 1998).

2.5 Conceptual Framework

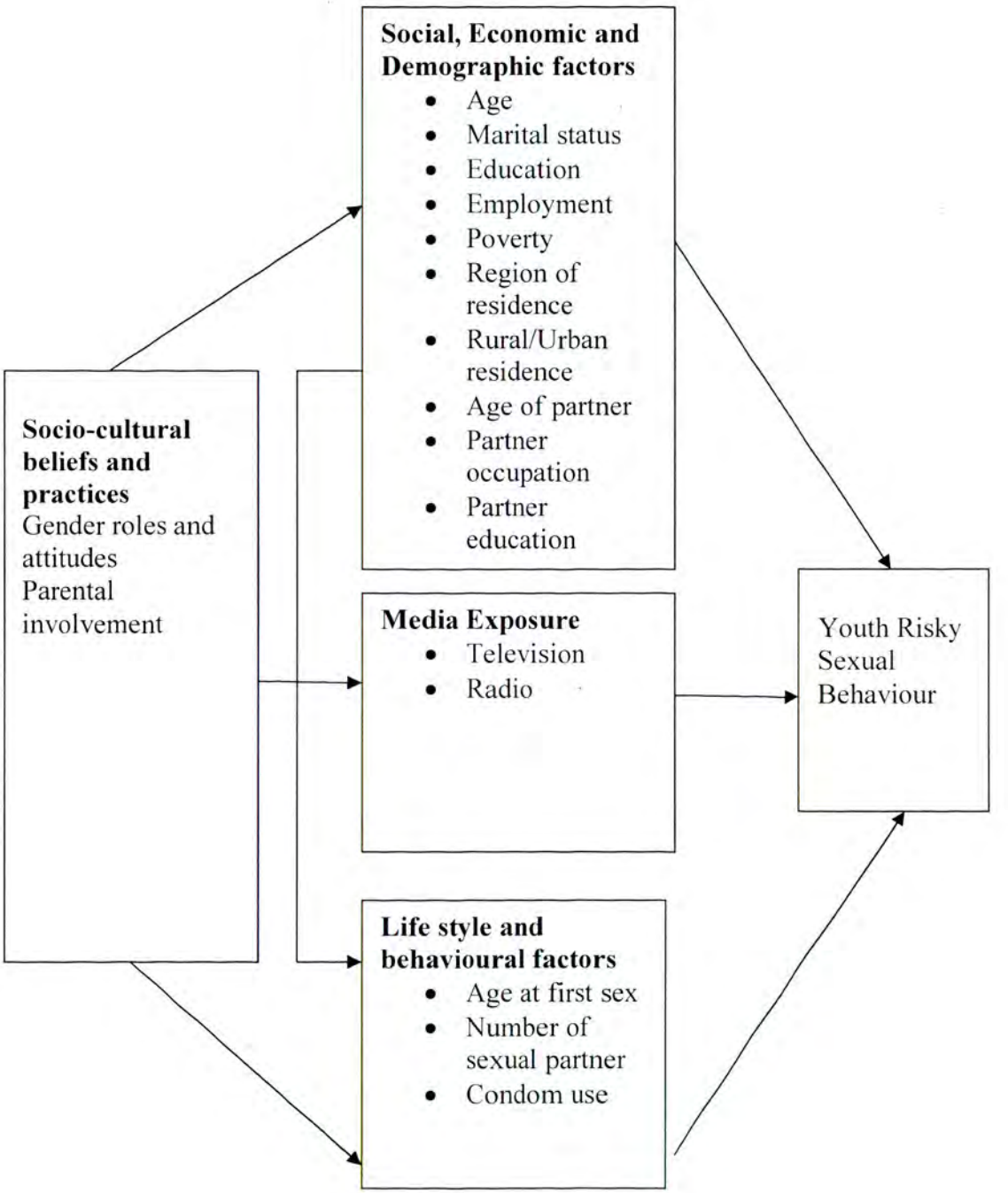
There are a number of conceptual frameworks that are used to study risky behaviours among the youth (Worth 1989; Richter 1996; Varga and Makubalo 1996; Abdool-Karim 2001; Campbell 2003; Singh and Das, 2011). The conceptual framework for this study is presented in Figure 1. Three groups of variables are used to examine factors influencing risky sexual behaviour among the youth. Socio-economic factors, environment and life-style of an individual can affect knowledge of the youth on risky sexual practices and use of condom. Socio-economic factors like education, employment, marital status and age will have an effect on the perception and attitude of an individual.

Early age at first sex may affect education through raising the risk of pregnancy among the scholars. Looking at South Africa's policy today, of allowing new mothers to return to school after the birth of their child also influence sexual behavior (Kaufman, de Wet, and Stadler 2001). People with better employment are those who are educated, this group will have more than one

sexual partner and practice risky sexual behaviour because they have money to give to girls. The outcome variable is risky sexual behaviour among the youth. Demographic, socio-economic and life style factors are assumed to be the underlying determinants of risky sexual behaviour.

A number of studies have shown that there is a mismatch between HIV/AIDS knowledge and risky sexual behavior among the youth including South Africa (Worth 1989; Richter 1996; Varga and Makubalo 1996; Abdool-Karim 2001; Campbell 2003).

Figure 1: Conceptual framework for the analysis of how socio-economic factors, environment, life style and media exposure influence Risky Sexual Behaviour



Source: This framework was adopted from Singh and Das (2011)

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The chapter presents the research methodology for the study. It includes a description of the source of data for the study and the statistical methods used in the analysis.

3.2 Sources of Data

The data used in this study came from the 2003 South African Demographic Health Survey (SADHS). The 2003 SADHS is a second national representative survey conducted in South Africa focusing on people in their reproductive ages 15-49 years of age. The main method of data collection is secondary, which is a means to reprocess and reuse collected information as an indication for betterment of the service or product. In secondary data information relates to a past period. It is more user-friendly as it can provide information that could not be obtained from original source.

The 2003 SADHS used five questionnaires namely, the Household Questionnaire, the Women's Questionnaire and the Men's Questionnaire, Adult Questionnaire and the Child's Questionnaire. The contents of these questionnaires were based on the model questionnaire for the measure DHS program (Department of Health, 2003).

The Household Questionnaire was used to list all the usual members and visitors in the selected households. The main purpose of the Household Questionnaire was to identify women and men who were eligible for the individual interview and collect basic information on the characteristics of each person listed, including age, sex, education and relationship to the head of the household. Information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facilities, materials used for the floor of the house, ownership of various durable goods, ownership, use of mosquito nets, care and support services received by orphans, and other vulnerable children and disability status of household members were also collected in the Household Questionnaires, (Department of Health, 2003).

The Women's Questionnaire was used to collect information from all women age 15-49. These women were asked questions on the following topics: Background characteristics, including education, residential history, media exposure, birth history and childhood mortality, knowledge and use of family planning methods, fertility preferences, antenatal and childbirth care, breastfeeding and infant feeding practices, vaccinations and childhood illnesses, marriage and sexual activity, woman's work and husband's background characteristics, awareness and behaviour regarding AIDS and other sexually transmitted infections (STI), maternal mortality and domestic violence.

The third questionnaire recorded detailed information on all men aged 15-59 years. The questionnaire was meant to collect information on why children were not staying with their biological mothers. This questionnaire collected similar information contained in the women's questionnaire, but was shorter as it did not contain questions on reproductive history, maternal and child health, nutrition, and maternal mortality (Department of Health, et.al. 2007).

The fourth questionnaire recorded information on adults. It was conducted in households not selected for the men's questionnaire. All eligible men and women aged 15 and above were interviewed with an adult questionnaire. The respondents were asked questions on recent utilization of health services, family medical history, clinical conditions, dental health, occupational health, medications taken, habits and life style.

The fifth questionnaire included the child's questionnaire. It was conducted in households in which there was a child under six years of age whose biological mother was either not alive or did not live in the household. Information about the child was collected from the guardian. This questionnaire was instigated by the fact that the level of child fostering in South Africa is relatively high and data on children's health collected only from biological mothers might result in biased information (Department of Health, 2007). In this study the women questionnaire was used.

3.3 Study population

The study population comprised of 4597 female youth age 15-34 years. These were extracted from 7041 women who were interviewed in the 2003 SADHS. The age range 15-34 years was used in line with the definition of youth in South Africa.

3.4 Method of analysis

For the purpose of addressing the research objectives, three statistical methods were employed, namely, the uni-variate, bi-variate and multivariate methods. The uni-variate analysis was performed to inspect the frequency distributions of the variables. Bivariate analysis was employed to examine the relationships of the dependent and independent variables. The Chi-square test is a test of association among different categorical variables. Lastly, multinominal logistic regression was used to assess the effects of the explanatory variables on each of the dependent variables.

The general model for multinomial regression:

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left|\frac{P_g}{P_1}\right| + B_{g1} + B_{g2} + \ldots + B_{gz}$$

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + \chi\beta$$

Where p_g is the probability that an individual with values X_1, X_2,$X_p$is in group g, Pg is the prior probabilities of group membership and βgi is the regression coefficients that are to be estimated from the data. Group one is the reference group. The regression coefficients β for the reference group are set to zero. Even though the choice of the reference group is arbitrary, it is usually the largest group or a control group to which the other groups are to be compared. This leaves g-1 logistic regression equations in the multinomial logistic model. If Y has three unique values A, B and C, C represents the reference group. The logistic regression model consists of two equations:

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left|\frac{P_g}{P_1}\right| + B_{g1} + B_{g2} + \ldots + B_{gz}$$

$$\ln\left[\frac{p_g}{p_1}\right] = \ln\left[\frac{P_g}{P_1}\right] + \chi\beta$$

3.5 Description of variables

The dependent variable

The variable of interest in this study is Risky Sexual Behaviour. In this study, risky sexual behaviour is defined as sexual behaviours that expose South African youth to the risk of sexually transmitted infections including HIV/AIDS. The dependent variable risky sexual behaviour was constructed from the following variables: condom used when having sex with others, sexual intercourse with other than your husband, sex with multiple partners, receives money or gifts for sex. The respondents were asked whether a condom was used the last time they had sexual intercourse with someone other than her husband or partner; those who did not use condom were coded "0" and those who used condoms were coded "1". Second respondents were asked whether or not they had sexual intercourse with someone other than their husband. Those who had sex with other than husbands were coded "1" and those who did not have sex with other than husbands were coded "0". Third, respondents were asked whether or not they had multiple sex partners. Those who did not have multiple sex partners were coded "0" and those who had multiple sex partners were coded "1". Fourth, respondents were further asked whether or not they receive money or gifts for sex. Those who receive money or gifts for sex were coded "1" and those who did not receive money or gifts for sex were coded "0". Lastly, respondents were asked whether they had sex with prostitutes. Those who had sex with prostitutes were coded "0" and those who avoid sex with prostitutes were coded "1".

This means that each item was given a score of "1" if the individual was deemed to have high risk and "0" if the individual was deemed to have low risk. The score of each item summed and individuals risky behaviour was ranked as low, medium and high based on the total score. In other words, an individual was categorized as having low risk if the total score was in the range 0 to 1; medium risk if the total score was 2 and high risk if the total score was 3 to 5. Other

researchers have also computed risky sexual behaviour in this way (Channon & Madise, 2004; Zhou, 2010; Zambuko & Mturi, 2005). The only difference arises from the variables that were used.

The independent variable

The independent variables were selected for inclusion in the analysis based on their hypotheses association with risky sexual behaviour among adolescents or their significance in previous studies on condom use and adolescent reproductive health. In this study, the following independent variables were included: Respondents' age, level of education, place of residence (rural or urban), province, marital status, employment, media exposure, partner's age, partner education and partner's work status (see Table 4).

Table 4: Description of study variables

Variable	Description
Risky sexual behavior	Low = 0-1 Medium = 2 High = 3-5
Partner's age	Less than 30, 30-34, 35-39, 40 and above
Work Status	Respondent working 0= Not working 1= working
Ever used condom to avoid AIDS	0= No 1= yes
Age of respondents	Age is in five year groups: 1=15-19 2= 20-24 3= 25-29 4=30-34.
Highest education level.	Highest level of education attained is divided into four categories: 0=none, 1=primary, 2= secondary, and 3= tertiary
Type of Place of residence	This variable was derived from the question on the type of place of residence; we compare urban residents with their rural counterparts. 1=urban 2=Rural
Marital status	0= never married 1= married
Province of residence	South Africa is divided into nine provinces as follows: 1= Western Cape, 2= Eastern Cape, 3= Northern Cape, 4= Free State, 5= Kwa-Zulu Natal, 6= North West, 7= Gauteng, 8= Mpumalanga and 9=Limpopo. A comparison of provinces was done.
Has radio	0=No 1=Yes
Has television	0= No 1 = Yes
Ethnicity	1=Black 2= Coloured 3= Indian/Asian 4= White

3.6 Limitations of the study

This study, like many other studies, has limitations. The study uses secondary data, which could make it impossible for the researcher to probe for some of the questions.

Questions on sexual risk behaviour may be biased as it involved retrospective measures of sexual risk behaviours, and respondents may not recall their sexual behaviour over 12 month's period correctly. There is a possibility of underestimation in sexual risk behaviours among women as South African females are very shy to discuss issues around sexuality and they are also influenced by cultural beliefs that people are not allowed to talk about sex in public settings. This leads to underreporting of sexual partners.

Age of sexual partners may be incorrectly reported as a result of wide age gap of males to females. The report may be biased with regard to sexual activity as youth will inflate age at first sexual intercourse. There were some variable that we expected to be of particularly importance (race, education), but the result created challenges.

CHAPTER FOUR

ANALYSIS AND FINDINGS

4.1 Introduction

The chapter presents the findings of the study. The chapter is divided into three parts. The first part describes the relevant background characteristics of the female youth who participated in the 2003 South African Demographic and Health Survey (SADHS). The second part examines the relationship between background characteristics and the dependent variable. These were explored using cross tabulations (bivariate analysis). In the last part the multi-nominal regression was run to identify significant factors affecting risky behaviour among female youth in South Africa.

4.2 Characteristics of respondents

The knowledge of the socio-economic characteristics of the respondents facilitates the interpretation of the findings in this study. The background characteristics of the respondents have been examined in terms of age, residence, educational level, region, respondents currently working, partner's age, marital status, whether the respondent has radio and television. Table 2 provides selected demographic and socio-economic characteristics of female youth in South Africa in 2003.

Age

Table 2 shows the distribution of the female youth aged15-34 who were interviewed in 2003 SADHS. According to the table, 31.5% of the respondents were aged 15-19, 26.7% were aged 20-24 years, 22.2% were 25-29 years and 19.6% were between the ages 30-34.

Place of residence

Table 5 indicates that 56.3% of the female youth were residing in urban areas and 43.7% of the youth were residing in rural areas. The findings suggest that most participants in the surveys came from urban areas. This is not surprising given that the 2001 census reported that the percentage of the population residing in urban areas were 60.7 in 2007 and 61.7 in 2010(World Bank Report, 2011).

Region

According to the Table 2, the largest proportion of the participants were from KwaZulu Natal (16.4%) followed by Limpopo Province (12.2%), Free State (11.6%) and North-West and Mpumalanga (11.3%). Eastern Cape was the least represented (7.3). The percentage distribution of the female youth from Northern Cape Province was 10.6% whereas Western Cape and Gauteng had 9.8% and 9.6%, respectively.

Educational level

The largest proportion of youth in the survey had secondary (77.5%) followed by those in primary (11.9%). The least group are those with non-education (1.9%).

Respondent work status

The majority of respondents were not working (77.3%). Only 21% of the female youth interviewed were working.

Partner's age

Majority of respondent indicated that their partners were within the ages 30-34 (7.9%) followed by those aged less than 30 (7.1%).

Has radio

Table 5 shows that 75.8% of the respondents have radios and only 24.2% have no radios.

Television

The majority of the respondent indicated that they had television (64.6%) and 35.4% had no television.

Marital status

The largest percentage of the youth were never married (69.2%) followed by those who were married (17.7%) and those living together (9.2%). The least group were the widowed (0.5%).

Table 5: Background characteristics of the study population

characteristics	No	%
Age group		
15-19	1450	31.5
20-24	1227	26.7
25-29	1019	22.2
30-34	901	19.6
Total	4597	100
Place of residence		
Urban	2590	56.3
Rural	2007	43.7
Total	4597	100
Province		
Western Cape	450	9.8
Eastern Cape	334	7.3
Northern Cape	488	10.6
Free State	534	11.6
Kwa-Zulu Natal	754	16.4
North West	519	11.3
Gauteng	440	9.6
Mpumalanga	519	11.3
Limpopo	559	12.2
Total	4597	100
Respondent educational level		
No education	87	1.9
Primary	548	11.9
Secondary	3563	77.5
Tertiary	398	8.7
Total	4596	
Work Status		
No	3555	77.3
Yes	997	21.7
Total	4552	99.0
Partner age		
<30	328	7.1
30-34	363	7.9
35-39	302	6.6
40+	156	3.4

Total	1149	25.0

Has radio		
No	1096	23.8
Yes	3442	74.9
Total		
Has television		
No	1609	35.0
Yes	2933	63.8
Total	4542	98.8
Ethnicity		
Black	3524	76.6
Coloured	581	12.6
White	163	3.5
Indian/Asian	328	7.1
Total	4596	100.0
Marital status		
Never married	3181	69.2
Married	815	17.7
Living together	423	9.2
Widowed	24	0.5
Divorced	29	0.6
Not living together	125	2.7
Total	4597	100

4.3 Relationship between Risky sexual behaviour and Background variables

This section examines the relationship between risky sexual behaviour and selected background variables. Risky sexual behaviour was divided into three levels, which are low, medium and high. The following discussion will be based on low, medium and high risky sexual behaviours.

4.3.1 Low risky sexual behaviour

Age

Table 6 shows that youth 15-19 are 22.9% at low risk. Those 20-24 are 33.5% at low risk. Youth aged 25-29 are 24.3% and those 30-34 are 19.3% at low risk. This shows that risky sexual behaviour increases with age.

Residence

The results show that youth in urban areas are less at risk of risky sexual behaviour (46.3%) than their rural counterparts (53.7%). This means that youth in urban areas are at a lower risk than youth in rural areas. This could be due to availability of resources and information, education and counseling (IEC) that they receive at their health care facilities.

Region

A small percentage was observed among the youth in Western Cape and Eastern Cape (6.9%) respectively as compared to youth in other provinces. This means that youth in these two provinces, only a few are at low risk sexual behaviour and that the majority practice high risky sexual behaviour.

Educational level

Youth with no education are 5.0% low risk and those with primary education were 17.9%. Youth in secondary education are 72.9% at low risk and those in tertiary education were 4.1%. This clearly shows that low risk sexual behaviour decreases with level of education.

Work Status

Youth who were not working are 86.3% at low risk than youth who were working (13.4%). This means youth who were working were more at high risk sexual behaviour.

Partner's age

Youth whose partners are younger than 30 are 41.0% and those whose partners are between 30-34 years are 28.3%. Youths whose partners' age is 35-39 and 40 years above were 15.4%. This means that risky sexual behaviour increases with increase in partner's age.

Has radio

The table shows that youth who has no radio are only 33.3% at low risk than those who has radio (66.7%). This means that youths who have radios are less at risk of sexual behaviour. This could be due to access to information.

4.3.2 Medium risky sexual behaviour

Age

In the medium risk of sexual behaviour, youths tends to have a balance in percentage. Youth 15-19 are the least in medium risk with 17.9% compared to other age groups. This means that risky sexual behaviour decreases with age.

Residence

Youth in urban areas are more at medium risk (57%) than youth in rural areas (42.3%). This clearly shows that youth in urban areas are slightly better than the youth in rural areas. It could be due to accessibility of services that give them information and immediate help.

Region

The results show less percentage of medium risk among the youth in Western Cape (9.2%). The following province is Eastern Cape with 7.1% medium risk. This means that youth from Western Cape and Eastern Cape are more at risk for risky sexual behaviour.

Educational level

Youth with no education shows the least percentage (1.5%) of medium risk. This means that risky sexual behaviour decreases with level of education.

Work Status

The table shows that youths who are not working are more at medium risk (74.0%) risk for sexual behaviour and those who are working are less at medium risk (25.9%).

Partner's age

Youth whose partners are less than 30 years are 28.3% at medium risk. Youth whose partners were 30-34 were 32.8% and those aged 35-39 were 50.1%. Youth whose partners were 40 years and above were 13.8% medium risk for sexual behaviour.

Has radio

The table shows that youth who has radio were 76.2% at medium risk for sexual behaviour and those who have no radio were 23.8% and at medium risk. This means youths who have no radios are more at risk for risky sexual behaviour.

Has television

The table depicts that youth who has television were 81.5% at medium risk and those who have no television are 18.5% at medium risk for risky sexual behaviour.

4.3.3 High risk sexual behaviour

Age

The highest percentage of those at high risk of risky sexual behaviour are in the age group 25-29 (38%) followed by 30-34 (35.2%). This shows that the higher the age, the higher the risk of risky sexual behaviour.

Residence

According to Table 6, youth residing in urban areas exhibited high levels of risky sexual behaviour as compared to their rural counterparts. Among the youths who reported high risk sexual behaviour, 70% were in urban areas as opposed to 29.5% in rural areas.

Province

The results further reveal that risky sexual behaviour was different for various provinces of South Africa. Kwa-Zulu Natal province shows the high rate of risky sexual behaviour (22.7%) followed by Western Cape (21.5%) and Free State (13.1%). This could be due to the cultural influence in Kwa-Zulu Natal where polygamy is highly practiced and men who are married had to marry a young lady. Gauteng province shows 10.8%. This could be due to the urban metropolitan in Gauteng.

Educational level

The results show that risky sexual behaviour in South Africa was inversely related to the level of education. Secondary school goers were more likely to practice risky sexual behaviour (76.1%) compared to tertiary and primary school goers.

Work Status

Respondents who were not working were more likely to be at high risk of sexual behaviour as compared to their working counterparts. This could be as a result of youth looking for some monetary support and exposed them to risky sexual behaviour.

Partner's age

The table again shows that risky sexual behaviour was very high among the youths whose partner's age ranges between 35-39 (35%) followed by those whose partners age between 30-34 (30.8%). Youths whose partners' age below 30 years are 25.6% and those whose partners' are above 40years 8.3%.

Has radio

The table further revealed that risky sexual behaviour was high among youth who had radios (93%) as compared to those who do not have radios (6.4%).

Has television

Television was also a predictor to assess the level of risky sexual behaviour among the youth. The result shows that youth who had television practiced more risky sexual behaviour (81.5%) as compared to those who do not have television (18.5%).

Marital status

The results again revealed that risky sexual behaviour in South Africa was inversely related to the marital status, with higher percentages of risky sexual behaviour among the married youth (63%) followed by those who never married.

Table 6: Relationship between Risky Sexual Behaviour and Background Variables

Age of respondent	Low risk %	Medium risk %	High risk %
15-19	22.9	17.9	3.0
20-24	33.5	29.9	23.9
25-29	24.3	27.7	37.5
30-34	19.3	24.4	35.2
	X^2= 9.34, p=0.02	X^2= 3.96 P=.266	X^2= 37.74 P=.000
Residence			
Urban	46.3	57.7	70.5
Rural	53.7	42.3	29.5
	X^2= 12.30, p=0.00	X^2= 0.04 P=.835	X^2= 12.76 P=.000
Region			
Western Cape	6.9	9.2	21.5
Eastern Cape	6.9	7.1	3.9
Northern Cape	16.1	10.3	6.3
Free State	15.6	10.1	13.1
KwaZulu Natal	11.5	14.6	22.7
North-West	12.4	11.9	5.1
Gauteng	7.3	10.7	10.8
Mpumalanga	10.1	12.7	7.9
Limpopo	13.3	13.3	8.5
	X^2= 19.30, P= 0.013	X^2= 22.97 P=.003	X^2= 53.48 P=.000
Educational level			
No education	5.0	1.5	0.6
Primary	17.9	10.8	5.7
Secondary	72.9	77.6	76.1
Tertiary	4.1	10.1	17.6
	X^2= 34.08 P= .000	X^2= 5.99 P=.200	X^2= 16.93 P=.002
Work Status			
Not working	86.3	74.0	58.3
Working	13.4	25.9	41.7
	X^2= 19.49 P= .000	X^2= .001 P=.979	X^2= 24.15 P=.000
Partner age			
<30	41.0	28.3	25.6
30-34	28.2	32.8	30.8

35-39	15.4	50.1	35.3
40+	15.4	13.8	8.3
	X^2= 9.65, P=.209	X^2= 4.63 P=.705	X^2= 10.10 P=.183
Has radio			
NO	33.3	23.8	6.4
Yes	66.7	76.2	93.6
	X^2= 12.91 P=.002	X^2= 2.36 P=.308	X^2= 30.721 P=.000
Has television			
No	50.0	35.5	18.5
Yes	50.0	64.5	81.5
	X^2= 21.41 P=.000	X^2= 1.16 P=.560	X^2= 30.721 P=.000
Marital status			
Never married	71.6	57.4	18.1
Married	2.8	26.4	63.6
Living together	18.3	12.4	14.2
Widowed	0	0.3	0.6
Divorced	0.9	0.7	0.6
Not living tog	6.4	2.8	2.8
	X^2= 76.54 P=.000	X^2= 16.199 P=.006	X^2= 142.95 P=.000

4.4 **Determinants of risky sexual behaviour**

This section looks at the correlates of risky sexual behaviour among the female youth in South Africa. Multi-nominal logistic regression was used to determine the factors affecting risky sexual behaviour among the youth. All the variables with exception of ethnicity that were found to be significant during the bivariate analysis were included in the multivariate analyses. When ethnicity was included in multi-nominal regression the odds ratios were abnormally high so that it was decided to drop this variable. As mentioned earlier, risky sexual behaviour was examined at three levels (low, medium and high). In the case of multi-nominal logistic regression, the high risk group was the reference category.

4.4.1 Determinants of low risk

Table 7 presents multi-nominal regression of risky sexual behavior and background characteristics, depicting low risk.

Age

The result shows that there is a positive relationship between low risky sexual behaviour and age. The youth aged 15-19 are 1.8 times more likely to have low risk than youth aged 30-34. Youths aged 20-24 are 1.5 times more likely to have low risk than those aged 30-34 and youths aged 25-29 are 1.09 times more likely to have low risk than the 30-34. The odds ratio declines with increasing age.

Residence

The table depicts that youth residing in urban areas are 0.4 less likely to have low risk than youth in rural areas. That means that youth in urban areas are more at risk for sexual behaviour. The data shows that all the youth in are more likely to practice risky sexual behaviour than the youth in rural areas.

Province

The table shows that youth in Western Cape are 0.3 less likely to have low risk than youth in Limpopo. The results further shows that youth in Eastern Cape are 0.9 less likely to have low risk than those in Limpopo and those in Mpumalanga are 0.3 less likely to have low risk. This shows that youth in Western Cape and Mpumalanga are at high risk of sexual behaviour than the youth in Limpopo. The data indicates that youth in Kwa-Zulu Natal are more likely to practice risky sexual behaviour than those in Limpopo.

Educational level

Youths' level of education is a strong predictor of low risky sexual behaviour showing an increase in risky sexual behaviour as education increases. Youth in secondary education are at higher risk than those in tertiary institutions. Those with no education are less likely to practice risky sexual behaviour than those with tertiary education. The results show that the higher the level of education of the youth the more risky their sexual behaviour.

Partner's age

Youth whose partners are less than 30 years of age are 0.4 less likely to have low risk than youth whose partners are 40 years and more. The results further show that youth whose partners are 35-39 are 0.3 less likely to have low risky sexual behaviour. The results show that risky sexual behaviour increases with high partner age. The data of all youth whose partners' age are high are more likely to practice risky sexual behaviour.

Work Status

The data shows that all the youth who are not working are 1.3 more likely to have low risk than youth who are working.

Has radio

The table shows that youths who have radio are 1.5 times more likely to have low risk than youth who don't have radios.

Has television

The data indicates that youth who have no television are 0.9 less likely to have low risk than those who have television. This shows that youths who don't have television are more at risk to sexual behaviour than youth who have television. Risky sexual behaviour increases with lack of media exposure.

Marital status

The data depicts that here is a positive relationship that has been observed between risky sexual behaviour and marital status. Youths who are not married are 0.4 times less likely to have lower risks than youth who are married. The data indicates that the risky sexual behaviour is more among youth who are not married. Data shows that residence plays a major in risky sexual behaviour among the youth. Youth who never married are more likely to practice risky sexual behaviour than those who are married.

Table 7: Results of Multi-nominal Regression of Risky sexual behaviour and background variables: Low Risk

	B	S.E	Sig.	Exp(B)	LB	UP
Age						
15-19	0.589	0.993	0.553	1.801	0.257	12.618
20-24	0.448	0.692	0.517	1.566	0.403	6.084
25-29	0.087	0.579	0.880	1.091	0.351	3.397
30-34(RC)						
Place of residence						
urban	-0.899	0.549	0.101	0.407	0.139	1.193
Rural(RC)						
Province of residence						
Western	-1.024	1.314	0.436	0.359	0.027	4.720
Eastern Cape	-0.049	1.321	0.970	0.952	0.071	12.679
Northern Cape	1.225	0.902	0.174	3.405	0.582	19.942
Free State	0.897	0.864	0.300	2.451	0.450	13.339
Kwa-Zulu Natal	0.590	1.103	0.592	1.805	0.208	15.665
North-West	0.170	1.105	0.878	1.186	0.136	10.337
Gauteng	1.120	0.969	0.248	3.066	0.459	20.483
Mpumalanga	-1.155	1.275	0.365	0.315	0.026	3.833
Limpopo(RC)						
Educational level						
No education	1.711	1.526	0.262	5.534	0.278	110.152
Primary	0.629	1.017	0.536	1.875	0.256	13.750
Second	-0.159	0.848	0.851	0.853	0.162	4.490
Tertiary(RC)						
Partner age						
<30	-0.710	0.291	0.369	0.492	0.104	2.315
30-34	-0.811	0.716	0.257	0.444	0.109	1.807
35-39	-1.154	0.779	0.139	0.316	0.069	1.452
40+(RC)						
Work Status						
Not working	0.296	0.489	0.546	1.344	0.515	3.508
Working(RC)						

Has radio						
No	0.425	0.644	0.509	1.530	0.433	5.409
Yes(RC)						
Has television						
No	-0.100	0.483	0.837	0.905	0.351	2.332
Yes(RC)						
Marital status						
Not Married	-3.115	0.593	0.000	0.044	0.014	0.142
Ever married (RC)						

4.4.2 Determinants of medium risky sexual behaviour

Table 8 presents results of multi-nominal logistic regression for medium risk. The results indicate that age and province are the most significant factors affecting medium risky behaviour.

Age

The data depicts that a slight positive relationship between risky sexual behaviour and age. Youth in the age group 15-19 are 0.8 less likely to have medium risk behaviour than those aged 30-34. Those in the 20-24 age groups are 0.6 times less likely to have medium risk. The result further shows that youth age 25-29 are 0.7 times less likely to have medium risk compared to the youth 30-34 age group. This indicates that risky sexual behaviour increases with age.

Place of residence

The table shows that youth in urban areas are 1.2 times more likely to be at medium risk that those in rural areas. This means youth in urban areas are at medium level of risky sexual behaviour than the rural ones.

Province of residence

The table shows that youth in the Western Cape are 0.3 times less likely to be at medium risk than youth in Limpopo. The Table further shows that youth in Mpumalanga are 0.9 times to have medium risk than those in Limpopo.

Education

Data shows that education plays a major role in risky sexual behaviour. Youth with no education are 2.3 times more likely to have medium risk than youth in tertiary education. The primary education youth are 1.8 times more likely to have medium risk than their tertiary counterparts. Youth in secondary education are 1.0 times more likely to have medium risk. The results show that risky sexual behaviour increases with level of education.

Partner age

Youths whose partners are aged less than 30 years are 0.8 less likely to have medium risk than youth those whose partners are 40 years and above. The table further shows that youth whose partners' age 35-39 are 0.4 times to have medium risk. This means that risky sexual behaviour increases with age.

Work Status

Youths who are not working are 1.0 times more likely to have medium risk than youth who are working. The data shows that youth who are working are more at risky sexual behaviour.

Has radio

Radios played a significant role in risky sexual behaviour among the youth. The table shows that youths who had no radios are 3.2 times more likely to be at medium risk.

Has television

The results show that youth with no television were 1.1 times more likely to have medium risk behaviour.

Marital status

Marriage was a good predictor of risky sexual behaviour. Youths who are not married are 0.6 times less likely to have medium risk behaviour compared to married ones. This means that youth who are married are more likely to practice risky sexual behaviour.

Table 8: Results of Multi-nominal Regression of Risky sexual behaviour and background variables: Medium Risk

	B	S.E	Sig.	Exp(B)	LB	UP
Age						
15-19	-0.182	0.636	0.774	0.833	0.240	2.896
20-24	-0.459	0.349	0.188	0.632	0.319	1.252
25-29	-0.331	0.243	0.172	0.718	0.446	1.155
30-34(RC)						
Place of residence						
Urban	0.231	0.273	0.397	1.260	0.738	2.150
Rural(RC)						
Province of residence						
Western Cape	-1.172	0.471	0.013	0.310	0.123	0.780
Eastern Cape	-0.365	0.565	0.518	0.694	0.230	2.099
Northern Cape	-0.022	0.531	0.967	0.978	0.346	2.768
Free State	-0.885	0.454	0.051	0.413	0.170	1.004
Kwa-Zulu Natal	-0.273	0.454	0.548	0.761	0.313	1.852
North-West	-0.199	0.545	0.714	0.819	0.282	2.382
Gauteng	-0.487	0.506	0.336	0.615	0.228	1.658
Mpumalanga	-0.016	0.494	0.974	0.984	0.374	2.591
Limpopo(RC)						
Level of education						
No education	0.842	1.094	0.441	2.322	0.272	19.823
Primary	0.609	0.460	0.185	1.839	0.747	4.527
Secondary	0.043	0.288	0.881	1.044	0.593	1.837
Tertiary(RC)						

Partner age						
<30	-0.164	0.433	0.704	0.848	0.363	1.981
30-34	-0.261	0.377	0.489	0.770	0.368	1.613
35-39	-0.762	0.366	0.037	0.467	0.228	0.956
40+(RC)						
Work Status						
Not working	0.079	0.214	0.713	1.082	0.712	1.644
Working(RC)						
Has radio						
No	1.175	0.414	0.005	3.239	1.439	7.292
Yes(RC)						
Has television						
No	0.160	0.271	0.555	1.174	0.690	1.996
Yes(RC)						
Marital status						
Not married	-0.436	0.266	0.102	0.647	0.384	1.090
Married(RC)						

4.5 Summary

This chapter examined the risky sexual behaviour among the youth of South Africa using the 2003 South African Demographic Health Survey. The results show that risky sexual behaviour varies by background variables; age, educational level, working class, type of place of residence, partners' age and media exposure. The multi-nominal regression show that place of residence, partner age and radio were found to be correlates of risky sexual behaviour among the youth in the study.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATION

5.1 Introduction

The last chapter presents the conclusion on risky sexual behaviour among the youth. The main objective of the study was to find factors that predispose youth to risky sexual behaviour. Amongst other factors, were early sexual debut (first sexual encounter at age 16 or younger), not using condoms and if used, not using it consistently.

5.2 Conclusion

The study sought to establish the determinants of risky sexual behaviour among the youth of South Africa. The data drawn from the South Africa Demographic Health Survey 2003 was used to achieve this objective. The result revealed the mean age of sexually active youth for South Africa to be 16 years. Low risky sexual behaviour increases and decreases with age. Youth in urban areas (46.3%) practice low risk behaviour as compared to their rural counterparts (53.7%).

Risky sexual behaviour is high among the Kwa-Zulu Natal and Western Cape youth followed by Gauteng province. This could be due to cultural practices in Kwa-Zulu Natal and peer pressure that the youth find themselves in, in urban areas.

Educational level, work status, partner age, radio, television and marital status were found to have significant impact on risky sexual behaviour among the youth of South Africa. Risky sexual behaviour increases with level of education and youth who are not working were at high risk of sexual behaviour; that means youth who are not working, depend solely on people who are working. This addresses research question one: "What are the factors responsible for risky sexual behaviour among the youth in South Africa?" The findings revealed that high risky sexual behaviour increases with age, educational level and partner age. Work, radio and marital status were also good determinants for risky sexual behaviour among the youth.

The findings of this study suggest that youth are not sufficiently aware of risky sexual behaviour practices. Of great concern is that youth have some misconceptions about the fatality and avoidance of risk sexual behaviour. High risk sexual behaviour increases with age.

The most serious challenge for condom promotion is the full-scale campaigns on its use during pre and extra-marital sex. Youths may have problems in obtaining condoms and don't know how to use them correctly. Fortunately, reproductive health promotes condom use through behavioural change activities. Youths need to have the skills to use condoms consistently and correctly.

Education of the youths contributes positively to risky sexual behaviour and use of condoms. In this study, the older youths are the least to use condom. This addresses research question two: "How is the sexual behaviour of South African youth in the HIV/AIDS epidemic?" The analysis also indicated that the urban youth were more at high risk sexual behaviour than the rural counterparts. This could be due to peer pressure and youths in urban areas are there to further their studies where parents are not around. Therefore, many experiences and bad behaviour by following others are mostly noted.

The study concludes that place of residence (Western Cape) in particular, partners' age (35-39 years) and youth without radios were the most important correlates of risky sexual behaviour among the youth of South Africa.

Lack of knowledge and misconceptions about HIV/AIDS are key factors in the prevention effort; access to relevant services, confidence and social power to initiate and sustain behavioural change in order to prevent the spread of HIV/AIDS (Cindy, 1998, Gupta & Wiess, 2000).

5.3 Recommendations

Factors that seem to be associated with risky sexual behaviour among the youth in this study are: Province of residence, partner's age, radios as means of media exposure and knowledge of the term 'risky sexual behaviour'.

Parents and caregivers

Given that age of the partner is one of the most important factors affecting risky sexual behaviour, the study recommends that efforts should be put in place to discourage young women from going out with older men. Parents serve as gatekeepers in the home and are usually the first point of contact for information within a child's community. As such, they should be in a position to provide pertinent sexual health information to their children as part of their development and growth. Parents can be encouraged to help dispel myths and stigma related to STDs including HIV/AIDS and by educating their children from a suitable age on sexual health matters as this may allow for an early acceptance of and comfort with their sexuality so it becomes a healthy norm, and taboos against such discussions are broken.

Parents are also in a position to embrace positive gender ideologies, and put them into practice as they interact with one another within the home, breaking down stereotypes that are associated with sexual risk behaviour. Health providers should be able to work with parents in discussing sexual and reproductive health issues with their children. Parental proximity and mere survival may be important to the well-being and sexual decision making of young people in this country (Hallman, 2004). In addition to physical and financial resources, parents may provide positive role modeling, effective communication about sexuality and safe sexual behaviors, enhancement and support of academic achievements and monitoring of activities with peers (Perrino et. al. 2000).

Youth

The active involvement of youth in HIV prevention activities will ensure opportunities for young people to make meaningful contributions to the development, implementation and sustainability of interventions, policies and programs that promote sexual health within their socio-cultural environment (Magnani et al., 2005; Campbell & MacPhail, 2002). Youth participation serves as a catalyst for engendering positive attitudes and promoting practices that embrace positive and more progressive gender ideologies. For young people out of school, avenues of youth participation through forums and workshops should continue to be organized for youth training of trainers that would allow for peer to peer education and discussions that would create a

sustained capacity for youth to promote and adopt healthier lifestyles. Not only is this study important for intervention planning, but there is also need for a continuous review of these studies as behaviour changes with time.

Health providers and services

Health providers serve as frontline responders in public health and therefore play an important role in meeting the sexual health needs of youth (Department of Health, South Africa, 2005). Due to socio-cultural sensitivities around sexual health, it is vital that health providers acknowledge the importance of sexual health as part of the overall health needs of today's youth. Such recognition will encourage youth to take responsibility for their sexual health. Clinic or hospital staff including nurses and doctors can contribute to changing negative attitudes and sexual risk behaviours by encouraging interaction between themselves and young people who come in for visits and refraining from judgment of their sexual behaviour. Providers may need to be specifically trained on providing youth friendly, sexual health services with a view to dispelling harmful gender ideologies and practices that increase the risk of HIV infection (Caldwell, 2000).

Delaying sexual debut

One of the strategies to avoid risky sexual behaviour is to delay sexual initiation during adolescent stage. Practical skills, coupled with social support from family members and peers, are essential for adolescents to achieve the confidence and ability to refrain from early sexual activity (Zuma et al., 2010).

Perceive social norms – they must feel that the desired behaviour is acceptable and approved of by their peers; there is positive social pressure from peers and role models, example; "it's the in thing to use condom, everybody is doing it".

More workshops and more time to be dedicated to the youth to allow maximum participation where they will be free to express their views; youth must say what interest them most and then implement it.Further research is needed to understand factors associated with risky sexual behaviour among the youth. In future, studies may wish to explore other variables associated

with risky sexual behaviour. For instance such aspects as early sexual debut, sex under the influence of alcohol and drugs should be examined. In addition, more research into the social-cultural and psychological factors that contribute to the risky sexual behaviour needs to be carried out. Since other researchers have commented that most research on risky sexual behaviour are mostly done among African population in Kwa-ZuluNatal (Hallman,2004), it may be recommended that similar studies should look at other population groups and target also the young population in other provinces. This will also serve to develop policies that are driven both by evidence and the reality on the ground based in the lives of youth.

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