CHAPTER 1
OVERVIEW

1.1 Significance Of The Study

Most authors acknowledge the prevailing high rate of pregnancy in South African adolescents. Olivier (1996), conducted a study in South Africa on adolescent sexual behavior. She reports that adolescents hold hands, kiss and engage in sexual intercourse. A reported 23,8% of teenagers were sexually active. Of this group 18,9% of them were in grade ten, 24,1% were in grade eleven and 27,7% in grades 12 and 10. In gender terms, 30,1% of the sexually active individuals were boys and 18,4% were girls.

Given the difficult life changes that adolescents must make and the implications of ill informed sexual decisions, it seems appropriate that standardised sex education programs be thoroughly researched for adolescents. These programs should be designed to give adolescents knowledge about sex, sexuality, pregnancy and related matters. It should also help them to acquire sound attitudes and values with regard to the above mentioned aspects. It is suggested that if adolescents have knowledge about sex, sexuality and pregnancy, and if they have acquired appropriate and positive attitudes and values they are more likely to make sound decisions in life and become sexually responsible.

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The study will establish adolescents' perception on sexuality and identify educational needs as far as sexuality is concerned. It will also endeavor to examine the efficiency of a program that is currently aimed at black adolescents.

1.2 Research Goal

To evaluate the effectiveness of a sex education program designed by the "Planned Parenthood Association of South Africa" (PPASA). The program is used extensively in South Africa and is designed to allow learners to make informed sexual choices. The program therefore attempts to be, amongst other things, an intervention against unplanned pregnancy and sexually transmitted diseases. It is not altogether clear how useful the program is, and evaluations of the program are

ongoing (Foster, 1998). Given the unsatisfactory statistics cited above it seem necessary to assess the efficacy of the program with a population of disadvantaged students.

1.3 The Research Domain

This study is limited to a Black school in Kroonstad, Maokeng. The learners are aged between 12 and 17 and are in grade 9, 10 and 11. The research looks at the PPASA program and compares it to other programs from other countries, predominantly from America. There are myriads of sex education programs, which have been developed internationally, and it is important to see if the PPASA program is able to meet the needs of a diverse South African population. Given the political changes in South Africa over the last decade, it is also important to assess whether the sexuality programs that are used in the country can address the needs of the majority population. This project there has four main themes. The first is to explore the period of life - adolescence - that the learners find themselves in. The second is to take stock of sex education programs, particularly the PPASA program, and the third is to scientifically assess the efficacy of the existing PPASA program. Finally this project will make recommendations based on its findings.

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CHAPTER 2
ADOLESCENCE

2. 1 Introduction

(Kaplan, 1998) notes that adolescence is a period of transition between childhood and adulthood. It is characterized by mood swings, unrealistic ideas and egocentrism. During this period, it is not uncommon for individuals to display deviant, confused but understandable behavior that often disappears when the period ends. Some of the confusion is brought about by rapid physical changes as well as cognitive development that takes place during the period. Of key concern here, are the choices, which face adolescents in regard to sexual behaviors.

During adolescence, teenagers embark on a journey from childhood to adulthood with the intention of establishing their own values, identity, a sense of right and wrong and developing self-esteem and self-control. On their way to adulthood, adolescents have an important task of setting up a firm foundation for a future direction so that they can become fulfilled human beings and meaningful contributors to the society. The journey to adulthood is filled with obstacles and temptations that cannot be avoided, for example peer pressure, which often lead to excessive types of behavior (Gidish, 2001).

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Kitch (1997), explains that many parents experience a tough time whilst trying to connect with their children during adolescence. She suggest that to break down the wall of silence parents have to:-

(a) create a "listening climate".
(b) learn the art of "parallel conversation".
(c) present a united front.
(d) give their children privacy.
(e) become consultants instead of managers.
(f) write down what they cannot bring themselves to say to their teenagers.
(g) take what they get from their teenagers.

2.2 Adolescence As A Biological Phenomenon

Adolescents have outgrown the need for continuous parental care, yet they are not ready for adult responsibilities. The transition form childhood to adulthood is characterized by a disharmonious process of biological maturation that is complicated by sociocultural factors. Contemporary adolescence is a transition from traditional educational methods and a conservative value system towards a rapidly changing technological and highly complex social system (Wolman, 1998).

2.3 Adolescent Biology

Refer to appendix A for structures of the male and female reproductive systems as well as functions of different parts.

During adolescence a number of changes take place in a number of domains of functioning. Physical changes bring the arrival of puberty, psychological and social changes are characterized by the establishment of an identity and being accepted by peers. A lot of risks are taken to declare autonomy and to form interpersonal relationships outside the family (Trad, 1994).

2.4 Adolescent Sexuality

Adolescents are faced with an important developmental task of satisfying their sexual needs in a socially acceptable way that should contribute to the positive development of their identity. The newly developed sexuality should also integrate well with interpersonal relationships. Heterosexual relationships that get established during adolescence give the young adult a chance to develop an identity as a sexual being (Louw, 1996).

2.4.1 What Is Sexuality?

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Sexuality embraces ideas about physiology, pleasure, fantasy as well as anatomy. It also refers to the quality of being sexual or having sexual intercourse. Sexuality points to both internal and external phenomena. It occupies a space where sexed bodies in all shapes and sizes deals with recognition or preoccupation with what is sexual (Bristow, 1997).

Olivier (1996), posits that sexuality is not only based on the physical development and functioning of an individual, it is also intertwined with values, social and ethical norms, customs, emotional adjustment and personal ideals. Sexuality involves integration of the physical, emotional, social and intellectual aspects of an individual's personality that expresses masculinity or femininity. Therefore, sexuality is a part of an adolescent's reaching-out to reality.

According to the feminist social constructionist perspective, sexuality is regarded as a historical construction that is subject to change in meaning, expression and experience as a result of changing historical conditions. Sexuality is a continuum of penetration and orgasm. It is expressed from one sex through to the opposite sex (Fredman & Potgieter, 1996).

2.4.2 Factors Affecting Sexuality

Greathead, Devenish and Funnel (1998), expostulate that friends, the media, teachers, religious institutions, culture and society contribute in affecting the sexuality of an adolescent. Parents also play a major role since they represent the first contact that the child has with modeled behaviors. Parents are the first educators in the child's life, thus they influence the setting of life patterns by their attitudes to males and females. They also instill values and beliefs that deal with male and female roles.

Olivier (1996), also acknowledges that in a quest to express his or her sexuality, an adolescent is faced with a variety of factors that turn into obstacles. Those factors are:-

(a) Ignorance about sexual matters.
(b) Early maturation.
(c) The involvement of contemporary teenagers in sexual activities at a tender age and an increase in sexual activity.
(d) The "new morality" which encourages liberal and permissive ideas about sexual issues.
(e) Norm confusion in relation to sexual norms.
(f) Inadequate parental sex education.
(g) The fact that sexuality is still a sensitive and strange issue that educators find difficult to discuss with adolescents.
(h) Vulnerability to exploitation, especially through peer group pressure.
(i) Inaccurate, tempting and explicit information by the media.
(j) Negative societal influences like changing value systems, for example, the greater acceptance of premarital sexual activities by contemporary societies. Family structures have also changed, single parents are prevalent in societies worldwide.

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2.4.2.1 Primary Sexual Changes During Puberty

Ovulation is accompanied by an increase in the size of the vagina, clitoris and uterus in females. In males primary sexual changes are characterized by the enlargement of the penis and testes that coincides with sperms production (Birch, 1997).

2.4.2.2 Secondary Sexual Changes During Puberty (See Appendix D)

2.4.2.2.1 Female External Changes

Puberty in females is marked by and increase in weight as well as a growth spurt. The body shape becomes round and hips broaden to widen the pelvic bones to allow for the birth of a baby. Breasts become rounded and fat is deposited on hips and breasts. Hair grows on the body, face, pubic area and in armpits. Sebaceous glands become active and oil production in hair and skin is stimulated. The body sweats to get rid of waste products and to regulate the body temperature. The voice deepens due to the enlargement of the larynx (Greathead et al., 1998).

2.4.2.2.2 Male External Changes

A pubescent boy experiences a growth spurt and his body muscles become larger. His shoulders broaden but hips become narrower. Less fat is deposited in the body and breasts enlarge slightly. A lot of hair develops on the body including the face and chest. Sebaceous glands produce a lot of oil and sweat glands secrete large quantities of sweat. The larynx grows larger in males, and that causes vocal chords to stretch, thus causing a lower tone of voice (Greathead et al., 1998).

2.4.2.3 Consequences Of Early And Late Maturity

Boys largely view early maturation as a plus. Early maturation in boys contribute in helping them to become more popular and developing a positive self-concept. However, that can “motivate” teenage boys to become delinquents and drug abusers. This is even complicated by the fact that their larger size makes them seek company of older boys who may involve them in activities that are inappropriate for their age. Girls who mature early become popular and that enhances their self-concept (Feldman, 1997).

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Late maturation in boys affects their self-concept, thus such boys are found to be less attractive most of the time. Their social life suffers a lot because girls prefer taller boys as dates. Late maturing girls tend to be overlooked in dating as well as mixed-sex activities, as a result they acquire a low social status (Feldman, 1997).

2.4.2.4 Hormones In Adolescence

According to Bee (1995), during adolescence a number of hormones (Table 2.1) act in a complicated manner. Figure 2.1 simplifies the functioning of hormones and shows the difference between patterns for boys and girls.

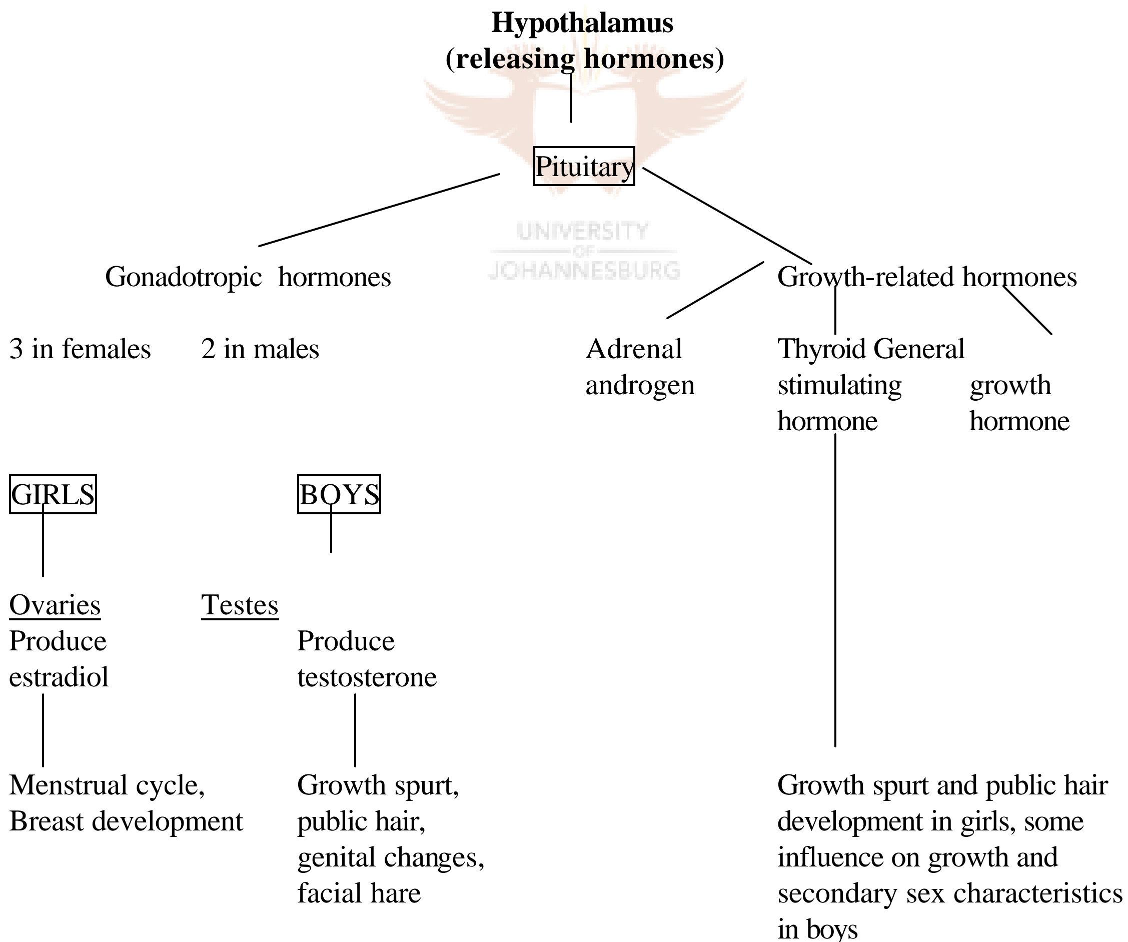

Figure 2.1 Puberty hormones and their functioning.

Table 2.1 Major hormones involved in physical growth and development		
Gland	**Hormone(s) secreted**	**Aspects of Growth Influenced**
Thyroid	Thyroxine	Normal brain development and overall rate of growth.
Adrenal	Adrenal androgen	Some changes at puberty, particularly the development of secondary sex characteristics in girls.
Testes (in boys)	Testosterone	Crucial in the formation of male genitals prenatally; also triggers the sequence of primary and secondary sex characteristic changes at puberty in the male.
	Estradiol	Development of the menstrual cycle and breasts in girls but has less characteristics than testosterone does for boys.
	Growth hormone, activating hormones	Rate of physical maturation; signals other glands to secrete.

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<u>2.4.2.4.1 Hormones And The Menstrual Cycle</u>

The menstrual cycle is continuous and involves ovulation, endometrial lining changes as well as the shedding of that lining. Oestrogen and progesterone are secreted at different levels during the menstrual cycle. These changing levels cause mood changes and irritability before and/or during menstruation. A young girl starts to menstruate around the age of eight once breasts have started to develop (Greathead et al., 1998).

Greathead et al. (1998), divides the menstrual cycle into 4 categories, namely:-
(a) Days 1-5
(b) Days 6-13
(c) Days 14
(d) Days 15-28

(a) <u>Days 1-5</u>
The menstrual cycle starts on the first day of bleeding. The endometrial lining and the unfertilized egg are got rid of. Bleeding can last for 2-8 days.

(b) <u>Days 6-13</u>
Hormones secreted by the pituitary glands cause one egg to mature in one of the two ovaries. Oestrogen is produced and the endometrium is thickened in preparation for possible implantation. Around day 13 or 15 progesterone is produced, it also increases the thickness of the endometrium so that the fertilized egg can be easily implanted. As soon as the egg is matured, ovulation occurs and the egg is transferred from fimbriae to fallopian tubes.

(c) <u>Day 14</u>
The ovum moves along the fallopian tube towards the womb. If a sperm cell from a male is in the tube around that time, fertilization will take place. If fertilization does not take place, the egg will reach the uterus around day 21 and it will disintegrate. The levels of progesterone and oestrogen fall and that causes the endometrial lining of the uterus to be passed out in the form of blood.

(d) <u>Days 15-28</u>
Between days 15-28, menstruation can take place. The first day of menstruation is day one of the whole cycle, which is then repeated as it, has to continue.

2.4.2.5 Erection, Ejaculation And Nocturnal Remission

Testes produce testosterone thus ejaculation and nocturnal remission take place. Adolescent boys experience ejaculation spontaneously or it may be caused by a number of psychosexual stimuli like erotic pictures, sounds, smells, words or even athletic activities. Erection is a sign of virility. The first ejaculation normally occurs due to masturbation or nocturnal emission that often follows an erotic dream. Most adolescent boys get humiliated and embarrassed by nocturnal emission, though some feel proud about it (Louw, 1996).

2.4.3 Research Done On Adolescent Sexuality

The Medical Research Council of South Africa conducted research in Cape Town on adolescent sexuality with particular interest in street children. It was argued that street children were at risk of contracting sexually transmitted diseases due to their minimal resources, vulnerability and generally unstable lives. Their research indicated that adolescent street children were involved in risky sexual behaviors like engaging in sex with multiple partners and not using condoms (Adolescent, 1996). A program was subsequently designed to help adolescent street children acquire lifeskills and knowledge on sexuality and AIDS.

The MRC considered the project to be difficult as they encountered a range of obstacles including the issue that imparting information did not often result in changes of behavior. To this end it was found that life skills programs which covered areas like anger management and communication helped mediate sexual behaviors (Adolescent, 1996).

McPhail (1998), states that a lot of adolescent sexuality research has been conducted in developed countries. The research was conducted among college and high school students. The purpose of the research was to establish the learners' knowledge of HIV, attitudes towards the disease and the sexual behavior of adolescents. Other researches were based on measuring and classifying risks taken by adolescents in their sexual lives. It was found early on that HIV knowledge does not change behavior and that most adolescents do not use condoms to prevent HIV transmission. This early research led to changes in the way education programs were developed. High risk behavior relates to the way adolescents view themselves in a heterosexual society. Adolescent sexuality research in developing countries has limitations because most of the time it focuses on

HIV knowledge and sexual behavior instead of focusing on the influence complex social negotiations of sex may have on HIV transmission.

2.5 Adolescent Sexual Knowledge

Mayekiso Twaise (1993), conducted a study in South Africa to find out the extent of parents involvement in educating their adolescents about sexual matters. The basic finding was that the adolescents he canvassed mostly had inadequate sexual knowledge. His survey covered such aspects as menarche, knowledge and use of contraceptives, sexual activity and the causes of teenage pregnancy. It was also discovered that adolescents acquire most of the sexual information from their peers and that there was very little communication between themselves and their parents before the onset of puberty. Only 14.2% of young girls reported that parents imparted sexual information to them after their first menstruation.

This support the view of the Family planning Association (1993) who argue that adolescents learn about sex from a range of sources including the media, friends, teachers and finally parents. This flies in the face of their research which indicates that most adolescents would prefer to learn about sex from their parents and/or teachers but are often forced to rely on friends for information and advice which is sometimes unreliable or incorrect.

Like adolescents, most teenagers similarly report (Most teenagers, 2000), that friends rather than parents are their main source of sexual information. Clearly parents are failing to talk about sex to their children despite the HIV/AIDS pandemic. There are almost certainly complicated reasons for this, including perhaps that many parents feel either embarrassed or ill-equipped to engage on the issue. Some parents believe that talking to teenagers about sex is tantamount to giving them permission to be sexually active . Parents fail to understand that being sources of information about sex to their children gives them an opportunity of relaying their moral values. However, surveys indicated that most teenagers would like to learn about sex from their parents.

Parents who start to impart sexual knowledge to their children at a tender age find it easier to continue doing so when their children grow up. Providing adolescents with sexual knowledge protects them from getting wrong information and learning values that are different form those of their parents. Adolescents cope better if they can discuss what they hear, see and experience with a caring parent. Lack of sexual information causes adolescents to try out new things, and in the process they get into trouble because they are ignorant. Concerned teenagers will also develop fears and anxieties around issues of sex and sexuality (Maker, 2000).

The Allen's study (FPA,1993) confirms that young people want to learn about sex from their parents. Teachers and doctors are regarded as reliable sources of information but teenagers find it difficult to talk to them, they prefer talking to their parents .

In one report, Kaiser (2000), notes that 37% of teenagers learn about sexual information from friends, particularly African youth (41%) as compared to whites (24%), coloureds (22%) and Indians (29%). About 17% of teenagers get the information from teachers, 14% from a family member, 4% from parents and 9% from television.

Adolescent boys and girls have to be told the same message with regard to sex, they should also be treated the same way. If girls are told that they should not have sexual intercourse whilst boys are not, girls are likely to learn that sex is dangerous and bad, but boys will learn that there is nothing wrong with having sexual intercourse whenever they feel like it. Teenagers should get the same sexual knowledge so that they can be able to share responsibility and possible consequences of their sexual decisions (Most teenagers, 2000).

Madima (1996) states that adolescents are sexual beings and they need to openly discuss sex and related matters. They have sexual feelings, thus it imperative that they be provided with basic facts of life. Parents and the community at large should provide sex education. An atmosphere of respect and understanding needs to be created so that adolescents can discuss their fears and uncertainties openly and honesty.

Although sex education is imperative for teenagers, evidence suggests that safe-sex behavior does not always correspond to one's knowledge about risk of infection. In an Australian study among high school learners it was found that 83% of learners agree that condoms prevent the spread of STDs but 38% indicate that they had not thought about AIDS. This shows that some teenagers underestimate their own level of risk by preferring not to think too much about "what would happen to them" (Heaven, 1996).

2.6 Adolescent Sexual Attitudes

In an American study it was found that teenagers react differently to their first sexual intercourse experience. Boys display favourable attitudes whilst 11% of girls feel "sorry" about what they had done. Only 23% of girls seemed "glad" about the first sexual intercourse experience. After a study was done among older teenage males and females, it was found that most of them experienced psychological and physiological satisfaction during the first sexual intercourse. Table 2.2 explains some of the attitudes that are experienced after having sexual intercourse (Heaven, 1996).

Table 2.2 Reactions to sexual intercourse among teenagers

Reaction	Boys %	Girls %
Those feeling "sorry"	1	11
Those feeling "glad"	60	23
Enjoyed subsequent coitus	80	70
Psychological satisfaction	67.4	28.3
Physiological satisfaction	80.9	28.3
Experiencing guilt		
Never	59.6	43.6
Seldom	23.4	19.1
Occasionally	11.7	24.5
Frequently	3.2	7.3

Teenagers have favourable attitudes towards different sexual practices. A survey was conducted in Britain among 2000 teenagers between the ages of 10 and 17. Half of the respondents felt that the society should accept all types of sexual relationships and not just heterosexual ones. Three-Quarters (75%) of the sample believed that there was nothing wrong with pre-marital sex but only 20% thought that the main reason behind having sexual intercourse was to have children. . As a group, they generally approve of oral sex but disapprove of homosexuality and extra-marital sexual affairs (Heaven, 1996).

In her useful analysis, South African researcher Olivier (1996) summarized the views, attitudes and needs of local adolescents. These are presented in Table 2.3.

Table 2.3 Views, attitudes and needs of adolescents with regard to their sexuality.

Views And Attitudes	Needs
Modern society	**Preparation for entrance into society**
- pressures	
- media	
- job opportunities	
Life skills e.g.	**Life-skills training**
- handling peer group pressure	
- decision making	
- choosing a career	
Information	**Sex education and information**
- birth control	
- AIDS	

Confusion: moral values	Emphasis on moral values
Influence: religious belief	Emphasis on religion
Influence: alcohol/drug abuse	Healthy recreational opportunities

2.6.1 Revolution In Sexual Attitudes

Traditional attitudes towards sexuality show a double standard in which males are given substantially more latitude than females. Males are accorded much more sexual freedom than women. Even within the context of marriage female sexual needs and values are often subjugated by those of the male partner. To some extent, it is argued that the double standard has now been reduced somewhat, and the attitudinal gap that exists between males and females has been narrowed (Kaplan, 1998).

Sexual behavior is now considered as a matter of personal choice and generally adolescents attitudes are very permissive as compared to those of their parents. Females are likely to believe that birth control should be used and that no one should be forced into having sexual intercourse. Females are also less likely than males to support pre-marital sex. Males, on the other hand, think that they have the right to demand sex and that contraception is the female's responsibility. Many women are committed to abstinence and view adolescent sexual activity as a barrier to future goal attainment. Men have a tendency to expect intimacy very early in a relationship but females tend to feel that intimacy relates to love and commitment (Kaplan, 1998).

Attitudes that adolescents have towards sexuality are affected by how they relate to their parents, their cognitive ability, peer relationships as well as the media. Most television programs and rock videos encourage liberal sexual attitudes and have a substantial impact on some adolescents (Kaplan, 1998).

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2.7 Adolescent Sexual Behavior

Sexual behavior in adolescent has changed over the years. Recently it has become more prominent due to an increase in nonmarital childbearing, abortions and morbidity and mortality that are associated with untreated sexually transmitted diseases. The current knowledge about adolescent sexual behavior is limited especially in relation to individual differences in the onset, escalation, maintenance and terminance of sexual relationship across this developmental phase (Tubman, Windle & Windle, 1996).

Kail and Cavanaugh (1996), report that American boys date when they reach 14 or 15 years of age, whilst girls begin to date a year earlier than boys. Dating serves many purposes including recreation, entertainment, companionship and establishing a status. In many cases it may ultimately lead to intimacy. Dating and romance involve members of the opposite sex. Interestingly where about 10-15% of adolescent boys and girls report that they once had a sexual

activity with a member of their own sex, only about 5% of adolescent boys and girls indicate that they are gay.

When children reach the adolescent stage, they develop an interest in heterosexual relationships. Peer pressure plays a major role because it determines who should or should not belong to a particular group. Most females report having been involved in sexual petting before marriage. Petting introduces adolescents to sexual practices and it teaches adolescents to communicate sexually. Some girls tease boys with words, styles of dress and seductive actions, though states that sexual teasing is cruel and has negative effects on a promising relationship (Teenagers, 1995).

Tarr and Aggleton (1999), conducted research on sexual behavior in Cambodia, a place in the Asia-Pacific region that has one of the most serious HIV epidemics. Two hundred and eighty one young men and women were interviewed and it was found that of the 135 young women, 40 were sexually active and they had had at least one experience of penetrative vaginal sex. Nearly a third (32%) of the adolescent females wanted to be involved in a long-term relationship with a male lover. None of the girls reported using any form of contraception or practicing safe sex. One hundred and forty six men were interviewed and 128 indicated that they had had at least one penetrative sex experience. Out of the 128 adolescents, 45 explained in clear terms that they would never use condoms. Eighty three said they would use it sometimes for paid sex but not with women with whom they are romantically involved.

Studies were conducted in Cape Town on sexual behavior. It was concluded that teenagers are divided into 3 categories. A third of teenagers are celibate, they have a decision to wait for marriage before they can engage themselves in sexual activities. Another third is involved in serious relationships and always takes part in regular sexual activities. The last third is made up of teenagers that involve themselves in high-risk behaviors which might lead to STDs and unplanned pregnancies (Kloot, 1996).

Garofalo, Wolf, Wissow, Woods & Goodman (1999), conducted research on high school students in Massachusetts. Some questions were based on sexual orientation and it was found that 3,8% of the respondents were (129 students) gay, lesbian or bisexual. Some were not sure about their sexual orientation. Gender, age, race, sexual orientation and health-risk behavior were linked to suicide attempts.

Research was conducted in the Eastern Cape on adolescents of all race groups. The aim of the research was to find out how adolescents view their sexuality. The results indicated a rise in sexual involvement as relationships become more serious. 23,8% of respondents were sexually active. Out of the whole sample 30,1% of girls and 18,4% of boys were sexually active. English speaking teenagers (30,4%) were more sexually active than Afrikaans speaking teenagers (12,8%). It was also learnt that sexual activity increases as learners graduate form one standard

to another. 18% of Std 8 adolescents were sexually active but 24,1% in Std 9 and 27,7% in Std 10 were sexually active. About 55,8% of all adolescents who are sexually active discussed the use of contraception before being engaged in sexual intercourse. Religious beliefs followed by the mother and fear of AIDS influence sexual activities of adolescents. Tables 2.4 illustrate other findings of the study (Olivier, 1996).

Table 2.4 An indication of whom/what has the strongest influence on adolescents in respect of sexual issues.

Influence	Girls	Boys
1 most important	Religious beliefs	Friends
2	Mother	Sexual partner
3	Fear of AIDS	Religious convictions
4	Fear of pregnancy	Fear of AIDS
5	Friends	Mother
6	Sexual partner	Fear of pregnancy
7	Father	Television
8	Television	Father
9	School	Magazines
10 least important	Magazines	School

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2.8 Cultural Influences On Adolescent Sexual Attitudes And Behavior

Sexual attitudes and behavior are learnt, thus there are cultural differences. Americans still teach their children to control and inhibit sexual behavior despite the “sexual revolution”. The White South African culture is the same as the American culture and it is based on Western values. That suggests that White South African adolescents are also taught to inhibit their sexual behavior. Culture also prescribes the age at which an adolescent can start to date and establish relationships with the opposite sex. In South Africa this is typically around ages 14-15 (Louw, 1996).

Sexual attitudes and behavior differ from one culture to another. Younger adolescents are a bit conservative about sexual activities as compared to older ones. Sexual attitudes and behavior of

politically conservative and religiously active adolescents are more conservative than those of politically liberal and religiously inactive adolescents. Frequent sexual intercourse takes place at an earlier age in adolescents who have limited academic qualifications. Premarital sexual intercourse also takes place more frequently amongst urban area adolescents than in rural area adolescents (Louw, 1996).

2.9 Changed Values And Sexual Behavior

The values and norms of a society in relation to sexual behavior give an individual a frame of reference for his or her sexual activities. Values and norms change rapidly, for example, today sexual attitudes as well as sexual behavior are characterized by frankness and permissiveness with regard to pre-marital sexual intercourse.

Changed values in sexual behavior have created an atmosphere of freedom and openness on the subject of sexuality. Thus today's adolescents have an opportunity of discussing about issues like masturbation, homosexuality, pre-marital sexual intercourse and cohabitation openly and honesty. Their attitude towards sexual behavior is characterized by mutual trust in one another as sexual partners. Contemporary adolescents accept one another unconditionally and have freedom of choice in sexual matters (Louw, 1996).

2.10 Sexual Activity

Heaven (1996), emphasizes that not all teenagers are involved in sexual intercourse activities. Some of the reasons that they give for abstaining from sex are fear of contracting sexually transmitted diseases, personal and religious values as well as not being ready for sex.

Almost everyone eventually has a first sexual experience. However, the timing of the event has developmental implications. Early initiation of sexual intercourse exposes an adolescent to unplanned pregnancies and contraction of sexually transmitted diseases. Adolescents are physically more at risk than adults to contract sexually transmitted diseases because their reproductive organs and immune system are not yet matured (Capaldi, Crosby & Stoolmiller, 1996).

Antisocial behavior that develops in childhood and continues into adolescence is one of the strongest predictors of early onset of intercourse. Antisocial adolescents initiate sexual intercourse at an earlier age due to poor impulse control. Adolescents describe their first sexual intercourse experience as an event that just "happened" instead of being properly planned. Parents who supervise peer group activities and limit unsupervised activities contribute in delaying the first sexual intercourse experience of their children. Adolescents who have academic achievements and those who experience anxiety delay the first intercourse experience. Anxiety is associated with disengagement from antisocial behavior, inhibition of social situations and lack of risk-taking behavior. In a Harris poll conducted in 1986, adolescents indicated that they do not engage themselves in sexual intercourse activities as they fear the danger of sexually transmitted

diseases (65%). 62% indicated that they fear getting pregnant, 50% fear being discovered by parents and 29% do not want their reputations to be ruined (Capaldi et al., 1996).

Caraël in Cleland and Ferry (1995), explains that World Health Organization conducted surveys in developing countries on sexual behavior and AIDS. The results indicate that by the age of 15 most adolescents had experienced their first sexual intercourse event. Other results are summarized in Tables 2.5 and 2.6.

Table 2.5 Percentage of men and women aged 15-19 years who were never married and who reported sexual intercourse in the last 12 months

Survey	Males (%)	Females (%)
Central African Republic	69	56
Côte d'lvoire	43	28
Guinea Bissau	51	30
Burundi	18	3
Kenya	54	44
Lesotho	33	16
Tanzania	37	24
Lusaka	16	10
Manila	15	0
Singapore	3	0
Sri Lanka	1	0
Thailand	29	1
Rio de Janeiro	61	9

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Table 2.6 Mean number of sexual partners in the last 12 months among never-married men and women aged 15-19 years.

Survey	**Males All**	**Sexually Active**	**Females All**	**Sexually Active**
Côte d'lvoire	0.9	2.4	0.3	1.6
Guinea Bissau	0.6	1.7	0.5	1.9
Togo	0.2	2.0	0.0	1.0
Kenya	0.5	1.6	0.4	1.5

Lesotho	0.7	2.3	0.2	1.3
Tanzania	0.9	2.5	0.4	1.7
Manila	0.2	1.8	0.0	0.0
Singapore	0.1	4.5	0.0	0.0
Thailand	1.0	3.8	0.1	4.3
Rio de Janeiro	1.6	2.6	0.1	1.7

According to Kaiser (2000), many adolescents become sexually active at a young age. After a survey was conducted in 2000, in South Africa, it was discovered that an overall of 31% of South African adolescents are sexually experienced. Fewer adolescent girls (28%) are sexually active as compared to adolescent boys (33%). Adolescents who live in rural areas are more likely to be sexually active than those who live in urban areas (34% versus 26%). 63% of those who do not attend school engage in sexual activities. 32% of respondents had sexual intercourse when they were 13 years of age or younger. 22% of the adolescents had had more than two sexual partners at the time of the survey whilst 18% indicated that they have multiple sexual partners at the moment.

Most mothers underestimate the fact that their adolescent children are sexually active. Jaccard, Dittus & Gordon (1998), illustrate that in Table 2.7

Table 2.7 Percentage of teens who report having sexual intercourse and percentage mothers who believe their teens have engaged in sexual intercourse

Sample	Teen Report Of Sex (%)	Mother Prediction Of Teen Sex (%)	Z Value For Difference
Total sample	58	34	9.29
14-years-olds	35	14	3.70
15-years-olds	53	27	6.19
16-years-olds	65	43	4.66
17-years-olds	75	53	3.75
Males	65	36	7.91
Females	50	33	4.71

Adolescents need parents who use every opportunity to talk to them about sexual intercourse. The subject involves family values, feelings and communication, so parents are the best candidates to help children make responsible decisions. Studies show that adolescents who talk to their parents about sexual intercourse delay engaging themselves in sexual activities. When those adolescents finally decide to take part in sexual intercourse, they use contraception (Talk to your teen, 1995).

2.10.1 Reasons For Sexual Activity In Adolescence

Greathead et al. (1998), shed light on some of the reasons why most adolescent boys and girls engage themselves in sexual activities. Girls do so because they:-

(a) want to please boys.
(b) want to be fashionable.
(c) are afraid of losing their boyfriends.
(d) cannot say "no" when forced into having sexual intercourse.
(e) feel obliged to "pay back" for the cost of the date.
(f) want to prove that they love their boyfriends.
(g) indulge in substance abuse.
(h) experience peer pressure.
(i) are curious to find out what it is like.

Boys engage in sexual activities because they:-

(a) do not want to hurt a girl's feelings.
(b) are afraid that girls may think that they do not love them.
(c) want to prove manhood.
(d) experience peer pressure.
(e) feel there is nothing to do on a date.
(f) wish to experience ejaculation.

2.10.2 Consequences Of Teenage Sexual Activity

Teenage sexual intercourse can result in pregnancy, STDs, cervical cancer, emotional hurt and sexual dysfunction. The younger the adolescent, the more potentially disastrous the results can be. Emotional problems relate to early sexual activity. Sexually active adolescents who have not yet reached emotional maturity experience feelings that range from intense happiness associated with physical pleasure to guilt and regret. They also feel ashamed and hurt. Most of them also experience fear, anxiety, disappointment, embarrassment and sexual dysfunction (Greathead et al., 1998).

2.10.3 Sexual Problems

2.10.3.1 Changing Attitudes

In the contemporary world, the sexual behavior of adolescents is almost a metaphor of permissive transformation. Teenagers routinely take part in any almost all types of sexual behavior. Social

norms that required marriage before the start of a sexual behavior are seen as old fashioned and no longer relevant. The sexual behavior of adolescents is no longer viewed as deviant as it is so common. Interestingly many adolescents reach sexual maturity earlier than previous generations and this stimulates early onset of sexual behavior (Watson, 1984).

2.10.3.2 Masturbation

This is the stimulation of genitals by hand or an object to give sexual pleasure. Males stimulate the penis and females the area that is around the clitoris. Masturbation is normal, it does not cause any harm. It only releases sexual tension, thereby reducing the need for sex (Greathead et al., 1998). Adolescents typically masturbate and experiment sexually with a friend of the same or opposite sex (Watson, 1984).

2.10.3.3 Cultural-Historical Comparisons

Sexual behavior conforms to social expectations. It has been argued that Freud's psychosexual theories of repressed sexuality emerged within a culture of rigid sexual mores. During Freud's time in Austria premarital sex was considered taboo, and the role of women highly subjugated by men. Freud's drive theory and his depiction of the structure of the unconscious reflected the stifling values he experienced in the society. In other parts of the world anthropologists determined that sexual norms differed in concert with the prevailing social attitudes. These attitudes are taken on by those in the society who come of age sexually – the adolescents. Depending on where they live and what the prevailing culture is, their values tend to reflect those values. Thus in South Africa, adolescents currently are exposed to a general loosening of attitudes, and less conservative attitudes than experienced by their parents. These adolescents use dating as a key mechanism for engaging with members of the opposite sex (Watson, 1984).

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2.10.3.4 Dating

Watson (1984) goes on to point out that dating nowadays commences earlier than previously. Dating is the forerunner to sexual experimentation, as it removes adolescents away from the family for short periods of time. Many adolescent females discuss the pressures they experience to become involved in physical relationships. Adolescent males also experience pressure, and sexual initiation is seen as a manifestation on manliness. Dating also sets up a socially sanctioned system of acquainting oneself with the opposite sex, but also of rotating through partnerships at any desirable rate. Dating often introduces the first experimentation with physical contact, in some cases leading up to sexual intercourse.

2.10.3.5 The Use Of Contraception

In 1977, the United States Court allowed adolescents to use contraceptives. Most adolescent girls believe that contraceptives make sexual intercourse less romantic. It is estimated that 50% of unmarried female adolescents do not use contraceptives and that only 20% use them consistently. In the last fifteen years, an increase in the use of contraceptives at all ages has been observed. Pills, loop and diaphragms are mostly used. There is also an increase in the use of condoms due to the herpes and AIDS epidemic. (Wolman, 1998). According to Kaiser (2000), 41% of sexually experienced adolescents do not always use a condom when they have sex and 69% of respondents in the 2000 Kaiser survey believe it is proper for males to use condoms.

2.11 Teenage Pregnancy

A substantial number of adolescent girls fall pregnant every year, profoundly effecting there lives in many ways. For example, pregnancy might mean the end of education and hence impacts on the vocational options for these individuals. In general an unplanned pregnancy results in fear and desperation for these girls, often throwing their relationships with their partners into disarray, and straining the relationships between themselves and their parents. Pregnancy is eminently avoidable, though does require that adolescents act with caution and restraint – behaviors which seem uncharacteristic of that age group. (Teenage pregnancy, 1995).

A society that has sexually active adolescents has a high risk of teenage pregnancy. The United States has the highest rate of teenage pregnancy in the world , 95 in 1000 teenagers become pregnant every year. In Africa, rural societies that used to protect the pregnant adolescent and her baby are breaking up. The societies are being affected by industrialization and urban life. The high incidence of adolescent pregnancies in the Republic of South Africa is cause for concern. One in twenty mothers who gave birth between 1973 and 1983 were 16 years old or younger. Not all pregnancies end in delivery, with some young girls choosing to abort (Nash, 1990).

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Adolescent pregnancy creates problems for both mother and child. Serious problems include health risks, dropping-out of school and losing employment opportunities, experiencing abortion trauma, going on welfare, being at risk for child abuse and increasing likelihood of divorce. Holden, Nelson, Velasquez & Ritchie (1993), posit that adolescent pregnancy falls can be explained under several psychological and social dimensions including cognition, psychosocial behavior and sexual behavior. In the first instance, pregnancy is seen as resulting from a cognitive deficit, for example, poor problem solving skills. From the perspective of psychosocial behaviors, pregnancy results from a socially induced variable like a low self-esteem. From a sexual behaviors perspective pregnancy is simply the result of sexual intercourse without protection (Holden et al., 1993).

One view is that unplanned pregnancy is a sign of a girl's deprivation. It is a sign of the need to love and be loved. In some cases adolescent pregnancy might be an instinctive reaction to a death or divorce or some other type of loss. Although sexual intercourse has serious consequences and thus requires "adult behavior", teenagers are clearly unequipped to behave like adults at a time when they are essentially children. Sexual behaviors require forethought and planning, yet teenagers most typically lack these sophisticated attributes. Rockey (1986) notes how teenagers who are sexually active often avoid contraceptives as this might expose their behaviors to their parents. They also might be ill-informed of the bodily changes that often arise as a result of contraceptives like the pill.

2.11.1 Research Done On Teenage Pregnancy

de Visser & Le Roux (1996), conducted research in Knoppieslaagte, a transitional area to the south of Pretoria. It was found that teenage pregnancy is unplanned in most cases. It also limits future options of the adolescent mother. In most cases, the young mother does not get support from the father of the child. Although teenagers adjust to motherhood after some time, black teenage mothers who were once pregnant view adolescent pregnancy as a problem.

In other research, themes that deal with socio-cultural conditions that contribute towards teenage pregnancy and schooling disruption were investigated. The sample of the study was made up of teachers and teenage mothers in "poor rural" schools. Several themes emerged in trying to understand teenage pregnancy. Firstly this type of pregnancy impacted on schooling, with many young mothers dropping out of school early. Secondly pregnant mothers were found to be grossly uninformed about sexual behaviors and sexual biology. Thirdly these teenagers tended to be under-supervised with little parental authority and guidance. Teachers identified what they saw as the key problems as inferiority complex, shame, poor parental communication and lack of medical advice (Mokgalabone, 1999).

Ntombela – Motapanyane (1995), conducted a study in Umlazi to determine how black teenagers perceive their pregnancies. Respondents were between the ages of 15 and 20 years. Of the 116 respondents, 48% indicate that their pregnancy occurred the first time they had sexual intercourse. 62% of respondents knew that unprotected sex would lead to pregnancy. Only 22% had enough information on pregnancy, 78% had inadequate information on sexual matters. Most teenagers had negative feelings about their pregnancy. Their feelings ranged from being ashamed, guilty, angry, frustrated, unhappy to being disappointed.

Most teenage pregnancies are unplanned and they have serious consequences for the whole family. Macleod's (1999) South African research similarly indicated that teenage pregnancy generally:

(a) disrupts schooling and the socio-economic status.
(b) has obstetric outcomes.
(c) leads to inadequate mothering.
(d) causes neglect, maltreatment and abuse on the part of the mother.
(e) affects relationships within the extended family and the partner.
(g) aggravates demographic issues since it increases the population growth.

The Tintswalo PHCN class studied attitudes to teenage pregnancy. The studies were conducted in the North Eastern Transvaal. Fifty teenagers who were either pregnant or had had a baby the previous year were interviewed. Through this survey it was found that 92% of pregnant teenagers in the sample were frustrated and unhappy. Only 8% were satisfied. Some 40% of boyfriends were happy, while another 40% were unhappy with the remainder being indifferent. The bulk (74%) of parents were unhappy, with a minority (6%) being happy and 20% of the parent population is indifferent (Dlamini & McKenzi, 1991).

2.11.1.1 The Baby

Babies born to teenage mothers are generally small. The baby is subject to problems that affect single parent family, like having fewer opportunities due to lower income of parents. As the child is born to parents who might be unhappy and frustrated, the likelihood of parental abuse increases. The child can also be subjected to a range of complications like social or legal discrimination, neglect or abandonment (Greathead et al., 1998).

2.11.1.2 The Teenage Mother

The young mother is not ready for parenthood, as a result she may be impatient, insensitive, and show lack of empathy most of the time. The mother often experiences poverty as the child grows up in an environment where the father is mostly absent. During play teenage mothers show less inventiveness and patience, than maturer mothers. Whilst feeding, they similarly are less expressive and withdrawn. These behaviors impact on the developing psychological nature of the baby (Kaplan, 1998). The rate of suicide for teenage mothers is ten times higher than that of the general population. (Greathead et al., 1998).

During pregnancy the mother can experience medical complications like a difficult labour. Once the baby is born choices in all aspects of life become restricted , for example, education stops, life plans and career goals become disrupted, job opportunities become few and peers isolate the mother. Emotions that are experienced during pregnancy lead to disappointment, anger, depression, feelings of being trapped, loneliness, anxiety and insecurity. The rate of suicide for teenager mothers is ten times higher than that of the general population (Greathead et al., 1998).

2.11.1.3 The Teenage Father

Family members direct anger towards the teenage father and he gets blamed for the pregnancy. His feelings are seldom considered even though he is regarded as "responsible". Educational and occupational opportunities of the teenage father become restricted as he has to work to provide maintenance. The teenage father is not included in the choice of options most of the time and has no legal rights regarding the mother and child as the baby is born out of wedlock. He is also faced with a problem of deciding whether to marry or not and might be unable to provide adequately (Greathead et al., 1998).

Many adolescent fathers fail to admit paternity out of ignorance, fear, inability to deal with pregnancy, disbelief or refusal to accept fatherhood obligations. Teen fathers who are not married are often frightened, withdrawn, confused and feel guilty about their girlfriends (Kaplan,1998).

2.11.1.4 The Extended Family

They experience anger, guilt, failure and disappointment in their children and themselves. The girl's parents get involved in making decisions than those of the boy, whilst the boy's parents may believe that the girl is trying to "catch" their son. Adolescent pregnancy leads to great conflict and parents of both teenagers need support (Greathead et al., 1998).

The girl's family experiences shock when they learn about their unmarried daughter's pregnancy. Other siblings get affected in a sense that they help out and share the family's resources. Younger sisters of childbearing adolescents are at risk of becoming adolescent mothers because they develop a more accepting attitude towards nonmarital adolescent childbearing (Kaplan,1998).

2.11.2 Contraception Use

Many sexually active adolescents do not use contraception regularly. Some do not use it at all because they deny their sexuality and do not believe that they can get pregnant and are thus ignorant of basic biological processes involved in conception. Adolescents tend to be inconsistent in their use of contraceptives at the best of times, but become even more irresponsible when alcohol is a factor (Kaplan, 1998).

Some people believe that teaching adolescents about contraception promotes sexual activity and that if contraception was not available sexual activity would be prevented. However, research shows that the majority of teenagers were already sexually active for between 6 months and a year before attending a family planning clinic. Fear of pregnancy and sexually transmitted diseases do not always prevent adolescents from being sexually active. Thorough knowledge and

proper use of contraception can deter pregnancy at a time when it would prove disastrous. Lack of sexuality education leads adolescents to becoming tragic statistics (Greathead et al., 1998).

2.11.2.1 Research Conducted On Teenage Contraception

According to Lagana and Hayes (1993), many adolescents are not educated about contraception. Thus they do not use contraceptives as part of their sexual behavior. A study was conducted about contraceptive health programs for adolescents with a view of evaluating their effectiveness. They found out that certain contraceptives fail to produce desired results because important components of successful sexuality education are ignored. For example, programs that concentrate on affective and cognitive domains may not produce expected behavioral changes. They also found out that using contraceptives willingly does not automatically mean that the adolescent will use contraceptives continuously. This is a critical limitation of most contraception programs. Reliable use of contraceptives relates to strong commitment to one partner and not to promiscuity. Sex education programs should aim at discouraging sexual activities and providing contraception education.

In conservative societies contraception is viewed as immoral and an undesirable compromise. Research conducted on teenagers and their sexual activities revealed that there is a lot of ignorance and a breeding of myths about sexuality and pregnancy. Christians emphasize chastity so most parents find it difficult to discuss something "unclean" with their daughters. Mfono (1990) argues that the rate of pregnancy could be reduced through sexuality education programs and contraception rather than trying to inhibit sexual activity (Mfono, 1990).

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Freeman and Rickels (1993), conducted a study they called the Penn Study. They deduced that adolescents behave sexually in a particular way, for example, 89% of teenagers who became pregnant said they were not using contraception when pregnancy occurred. A lot of teenagers have limited and often incorrect information about reproduction and contraception. However, the teenagers knowledge of where to obtain contraceptives was greater than their reported use. 88% of respondents in the Penn Study could identify a place where they could obtain oral contraceptives. 22% of teenagers had obtained contraceptive information from their mothers, and 23% from other family members.

Contraceptive practices of young women in America started in the 1980's from there onwards the use increased, especially of condoms. However, the increase in the use of the condom is attributed to AIDS and other STDs with preventing pregnancy being a byproduct more than the central concern (Cooksey, Rindfuss & Guilkey, 1996).

In the Northern Province, South Africa, studies show that 25% of teenagers who are sexually active use contraceptives. This study was conducted in a semi-rural part among 40 Pedi-speaking adolescents from 14 clinics. Teenagers do not use contraceptives because they fear disruptive

side-effects and irregular menstruation. Teenagers indicated that not menstruating is a problem as they could be pregnant. They also thought that, that blood will come rushing out one day and cause death. Menstruating is also regarded as a process that flushes out dirt. Other obstacles to effective contraceptive usage are harassment of teenage adolescents by clinic nurses, having to wait with older women in clinics, lack of anonymity and being threatened by partners for using contraceptives (Wood, Maepa, Jewkes, 1997).

Further research was conducted in Nova Scotia, Canada. Its purpose was to determine whether female adolescents had knowledge about emergency contraception and its use. 85% of 411 females took part in the research and only 42% reported that they know about emergency contraception (EC). 8% do not know the time frame for EC use and only 2% had used the method before. 18% of adolescent females do not use contraceptives at all for sexual intercourse (Langille & Delaney, 2000).

Coleman & Ingham (1999), interviewed 56 men and women aged 16-19 years on two contrasting strategies that can be used to ensure condom, usage at first sexual intercourse with a new partner. The first one involves explicit discussion about contraception before intercourse and the second time involves a partner who takes responsibility for using condoms without discussing this with their partner. The first strategy was found to be effective and the second one was regarded as important, especially when young people are in situations whereby initiating discussion about condom usage is viewed as difficult.

A study was conducted to determine the impact of religious affiliation on intercourse risk and contraceptive use in adolescent women in the 1980's when church groups were involved in debates over reproductive and family issues. However, adolescent nonmarital sexual intercourse and birth rates increased to show that religious organizations are becoming less effective in transmitting their values. Data collected from surveys conducted in 1982 and 1988 confirms that religious affiliation has modest but stable effects on Black teenagers. Protestant affiliation have positive effects on White teenagers, they were less likely to be involved in sexual activities in 1988 than in 1982 (Brewster , Cooksey, Guilkey & Rindfuss, 1998).

2.11.2.2 Contraception Suitable For Adolescents

The male condom, female condom, pill, injection, spermicides and emergency contraception can be used to prevent teenage pregnancy. Abstinence is another option that can be considered. There is no contraceptive method that is completely effective except abstaining from sexual intercourse (Greathead et al., 1998).

2.11.2.3 Other Supposed Methods Of Contraception

Despite the wealth of available information on contraception, many adolescents hold to mythical notions and old-wives tales. Some of the less effective of these methods are (Greathead et. al., 1998):-

(a) Drinking "Essence of life".

(b) Sitting in hot water with cut onions.
(c) Drinking Epson salts, urine tablets, laxatives or Coca-Cola.
(d) Using vinegar to wash out the vagina.
(e) Giving yourself an enema.
(f) Drinking castor oil after intercourse.
(g) Placing an avocado pip into the vagina.
Clearly none of these methods have any established efficacy.

2.11.2.4 Reasons For Non-Use Of Contraception

Greathead et al. (1998), explains that adolescents fail to use contraceptives because:-
(a) they do not want to admit to themselves that they are sexually active.
(b) they believe that planning and talking to partners about contraception takes away the romance and spontaneity of the moment and they feel guilty about anticipating sexual intercourse.
(c) the media does not often show people using contraception in sexual scenes.
(d) they are ignorant about sexual risks, different contraceptive methods and where the contraception can be obtained.
(e) most of the time the use their own do-it yourself methods. Rumours about what works best and what does not work exists in adolescent circles.
(f) they display risk-taking behavior.
(g) there are many half truths about side effects of reliable contraceptive methods.
(h) there is a lot of misinformation from friends.
(i) they fear that their parents will discover their contraceptives.
(j) have religious reasons for not opting to use contraceptives.
(k) have an unconscious desire to fall pregnant.

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2.12 Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are transmitted during sexual intercourse. They are caused by many viruses or germs. A pregnant woman can pass a sexually transmitted disease to her unborn baby. Swollen glands near sex organs, a burning sensation when passing urine and painful sexual intercourse are often signs of STDs. In a case whereby an individual experiences these symptoms a doctor should be consulted as soon as possible and his or her advice should be carefully followed (AIDS, 1995).

According to Greathead et al. (1998), there are different STDs. These diseases manifest themselves after different periods. Each one of them has particular symptoms and side effects if they are not treated. Appendix B adopted from Greathead et al., 1998 has common sexually transmitted diseases.

The reproductive rate of STDs is determined by human sexual behavior, for example adolescents are mostly explorative, due to multiple sexual partners STDs reproduce themselves quickly.

Poverty also determines human sexuality, people who live in disadvantaged situations express their sexuality as a survival mode (Reproductive rates, 1996).

2.12.1 Acquired Immune Deficiency Syndrome (AIDS)

HIV/AIDS is a special group of illness that you find in a person that has a very weak immune system because of contracting the HIV virus. HIV stands for Human Immuno Deficiency Virus, and results from a virus that enters the blood, mostly through sexual contact, to attack the immune system by way of weakening it. When the immune system is weak, and individual suffers from serious illnesses like pneumonia and TB. As soon as thee body can no longer fight germs and illnesses, the person is considered to have AIDS (Aids, 2000).

South African has the fastest growing HIV/AIDS epidemic. Between 1992 and 1999, the percentage of HIV/AIDS people has increased from 3% to about 18%. HIV prevalence among women who attend birth clinics has risen from 17,04% in 1997 to 22,8% in 1998 (Breed, 2000).

Over 3,2 million South Africans are infected with HIV/AIDS and are living with the disease. About 1500 new infections occur every day, 50% of them among the youth between 15 and 24 years of age. According to projections, the HIV epidemic in South Africa will increase in the next five years and will only reach a plateau between the years 2005 and 2010 (Burger, 1999).

HIV transmission increases exponentially in heterosexuals. If one partner is HIV positive, there is a 1% change of transmission. If one partner is HIV positive and the other one has a genital ulcer, there is an 8% change of transmission. Chances of transmission increase to 64% if one partner is HIV positive and both partners have genital ulcers. Having sexual intercourse twice in a row by such partners is like ensuring the transmission of the virus (Where STDs lead, 1996).

2.12.1.1 HIV And The Immune System

There are white blood cells in blood and their function is to fight germs and viruses that attack the body. The HIV virus attacks white cells. The virus also multiplies itself in white blood cells, eventually it kills all white blood cells that is has entered. At this stage the HIV person will then suffer from swollen glands, mouth infections, brain infections, skin infections, lung infections and experience weight loss (Vogel & MacPhail, 2000).

2.12.1.2 Contracting HIV

A person who is HIV positive has the virus in their blood, sperm or vaginal fluid as well as breast milk. During sexual contact, HIV is passed on in these fluids from one person to another. Being exposed to infected blood, for example during an accident promotes HIV transmission. Babies can be infected by their mothers during birth or breast feeding. An infected individual can pass the disease on if he or she has unprotected sexual intercourse (sex without using a condom) that is vaginal, oral or anal (Aids, 2000).

2.12.1.2.1 HIV/AIDS Symptoms

Protect Yourself (1995), stresses that AIDS can be identified by one of the following symptoms:-

(a) Inexplicable weight loss.
(b) Glands that are swollen in the neck, armpits or groin.
(c) Skin rash anywhere in the body.
(d) Persistent diarrhea.
(e) Chronic fatigue.
(f) Mental disorders.
(g) A persistent dry cough.

2.12.1.3 HIV/AIDS Prevention

To prevent the spread of AIDS, complete abstinence from sexual intercourse can be exercised. If at all one fails to practice celibacy, a monogamous relationship should be maintained, partners should remain faithful to one another. Before one can engage in sexual intercourse, it is imperative to know your partner's health status. People who look healthy can be HIV carriers, so it is appropriate to regularly go for HIV tests if one is sexually active (Komane, 2001).

2.12.1.4 HIV/AIDS Treatment

HIV or AIDS cannot be cured but research is being conducted in many countries including South Africa to develop vaccines that will prevent HIV infection. There are only medicines which delay the onset of AIDS-related diseases, but these are very expensive. Cheaper drugs are being developed by drug companies but at the moment those drugs are not yet widely available. HIV positive people can take medication to prevent diseases and hold off full blown AIDS, thereby enjoying fuller and longer lives (Department of Education, 1999).

2.12.2 Research Conducted On STDs

The highest rate of STDs is found in the United States. A recent study indicate that 15,3 million new cases of STDs occurred in 1996. Individuals run the risk of being infected with STDs due to their sexual behaviors that are determined by social and environmental factors of different

communities. People who are HIV positive run the risk of being infected with other STDs (Northridge, 1999).

Seubert, Thompson & Gonik (1999), surveyed obstetrician—gynecologists to determine partner notification of women with sexually transmitted diseases. 49% of 222 surveys were returned. 39% respondents were private practitioners, 38% were hospital-employed and 23% were university faculty physicians. Most respondents were able to identify the importance of partner notification for a number of STDs but could not identify all of those conditions. Physicians have to be educated so that they can be made aware of the required reportable STDs. Seubert et.al. also recommend that they should also be made aware of the role of partner notification as well as treatment in controlling the diseases.

A study was conducted to find out which behavioral risk factors are associated with HIV seroposivity among 1104 youth between the ages of 15 and 24. The study was conducted in Moshi, a rural area in northern Tanzania. Blood samples were taken for HIV testing. Seven in ten respondents indicated that they were engaged in sexual intercourse at least once in their lifetime. 60% of respondents drink alcohol and 50% of sexually experienced females report that they once received a gift for a sexual encounter. Behavioral risk factors that relates to HIV seroposivity are different in males and females. Cigarette smoking, the use of marijuana, a history of STDs relate to increased risk of HIV seroposivity. Females with STDs history, those who volunteered that they practiced oral sex and respondents who had four or more sexual partners were likely to be HIV positive (Tengia-Kessy, Msamanga & Moshiro, 1998).

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2.13 South African Sexuality Research

Buga, Amoko & Ncayiyana (1996), conducted a study in rural Transkei on sexual maturation, sexual behavior, contraceptive practice and reproductive health among Transkeian adolescents. About 76% of girls and 90,1% of boys are sexually experienced. The age of onset of sexual activity correlates with the age of first dating, menarche and semenarche. Boys started to be engaged in sexual activities at the age of 13 and girls at 14 years of age. 61,6% of boys and 42,3% of girls get engaged in sexual activities regularly. Boys had an average of 3 sexual partners but girls only 1. 48% of boys had a history of STDs as compared to 25% of girls. Only 62,1% of boys indicated that they use condoms. 23% of sexually active girls and 19,4% of boys use contraception. Rural Transkeian adolescents mature early due to early sexual intercourse initiation, high rate of pregnancy and STDs.

2.14 Conclusion

According to van Rooyen (1997), the urgent need for effective sexuality education is greater than ever because the education gives a child his or her sexuality knowledge and that of the opposite sex. It also directs and reinforce behavior positively. Sexuality education helps children to deal with emotional setbacks and develops them into morally independent, accountable, dedicated and responsible men and women.

During adolescence, children "grow into maturity" and are curious about sexuality, hence they demand information that relates to sexuality. Sexual emotions and drives should be handled in a socially acceptable and self-enhancing manner. Furthermore, adolescents should take responsibility for their sexual behavior and its outcomes (Weitz, 1990).

Roper in Cassell and Wilson (1989) states that radical changes have been observed in social institutions including the family. School sexuality education programs should supplement and enrich family sex education. Adolescents must be afforded an opportunity to acquire appropriate communication, decision making and conflict management skills. They should also be given information about dating, relationships and sexual relationships because the AIDS epidemic has created an environment in which open discussions about sexual matters can no longer be regarded as optional. Furthermore today's adolescents are bombarded with conflicting messages regarding sexual behavior, sexuality education can remedy that by helping adolescents to manage the conflicting messages in a mature way.

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In Cassell and Wilson (1989), Tatum reiterates that sexuality education is imperative to adolescents because it prepares them for life changes and helps them understand that the changes are normal. Sexuality education creates an environment in which appropriate life skills are acquired. Learners learn to understand themselves as well as the place of sexuality in human life.

CHAPTER 3
SEX EDUCATION PROGRAMMES

3.1 Introduction

PPASA stands for Planned Parenthood Association of South Africa. According to their annual report (PPASA, 1999), the PPASA is a national, non-profit organization that operates in all nine of South Africa's provinces. Its main objective is to provide integrated reproductive health education and services in this country so that people can acquire knowledge and thus make informed choices. According to their policy, PPASA monitors and evaluates community, and designs appropriate programs accordingly.

For the needs of this project, the Lifeskills and HIV/AIDS education program was selected. Within the PPASA stable however are a range of other programs, including:-

1. Adolescent Reproductive Health Services (ARHS).
2. Community-Based Distribution of contraceptives and reproductive health information(CBD).
3. Lifeskills and HIV/AIDS Education.
4. Men as partners (MAP).
5. Parent Education Program (PEP)
6. Women's Wellness Program.

3.2 Lifeskills And HIV/AIDS Education Program

3.2.1 Background

In 1994, the PPASA initiated the launch of five pilot projects. The projects included adolescent sexual and reproductive health service, community based distribution of low-dose pills and

condoms and reproductive health education, a male involvement program advocacy role and finally, a sexuality and life skills education project which was a teacher training program in primary and secondary schools. Through the sexuality and life skills project the PPASA has a life skills and sexuality curriculum in place. The curriculum was drawn up with the help of international experts. The sexuality and life skills educational project gave the PPASA the experience and reputation required to present the Lifeskills and HIV/AIDS Teacher Planning Project that was offered by the Department of Education (Foster, 1998).

In May 1997, the Department of education awarded PPASA a tender to train teachers in five provinces, that is the Eastern Cape, Northern Province, Mpumalanga, Northern Cape and Free State. The PPASA plan was to train two teachers in every school, who would in turn train other teachers at their respective schools thereby effectively disseminating the information to learners (Foster, 1998).

3.2.2 PPASA Model

The teacher training pilot project of PPASA served as a model of implementing the tender. The project was designed on a train–the–trainer basis where a group of trained facilitators would conduct over a period of five days in each province. As specified in the tender, a subject advisor from each region was also recruited. A project manager who was a national co-ordinator for PPASA was appointed and he dealt with the budget and finances as well as monthly reports to the government. Each province appointed a PPASA provincial co-ordinator to observe provincial planning and training. Trainers facilitated workshops that were attended by teachers, they also did a small amount of administrative work including submitting weekly reports to provincial co-ordinators (Foster, 1998).

Along with the PPASA other stakeholders were the Department of Education, learners and parents. As the tender was a partnership between the government and the civil society, stakeholders were also drawn from both parties. The government appointed a four-person task team that was regarded as a project committee to oversee the project. The committee's task was to ensure that outlined outcomes were met. It also acted as a collective ombudsman to arbiter any hurdles that occurred along the way. The most important task of this team was to act as a bridge between training and implementation so that there could be a smooth planning for institutionalization of life skills in the new curriculum (Foster, 1998).

Extensive work was done once the tender was granted, including staff recruitment, booking of venues, transport and catering as well as preparing materials for the project. The following contingent was envisaged to run the project and subsequently recruited.

Table 3.1 – PPASA SEX-EDUCATION ROLE-OUT				
EASTERN CAPE	**FREE STATE**	**NORTHERN CAPE**	**NORTHERN PROVINCE**	**MPUMALANGA**
1 Co-ordinator	1 Co-ordinator	1 Co-ordinator	1 Co-ordinator	1 Co-ordinator
1 Administrator				
10 Trainers	4 Trainers	2 Trainers	12 Trainers	

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During the course they are provided with the following materials:-

(a) A Lifeskills and HIV/AIDS teacher training manual that served as a curriculum support tool and a training aid for teachers.
(b) Anatomical posters of a male and female.
(c) A choice game modeled on snakes and ladders. The game illustrated choices that are available to young people as well as their implications. This game was never used as consensus could not be reached with regard to how the game should be used in the classroom. The game deal with rape, teenage pregnancy and the termination of pregnancy.
(d) Three videos to emphasize the contents of the program. The videos deals with rape, teenage pregnancy and the termination of pregnancy.
(e) A condom demonstration.
(f) Contraceptive kits containing samples of contraceptives.
(g) Certificates for teachers who attended the workshop for five days in full.

The task team and provincial co-ordinators manage the logistics or organizing venues, transport and catering. Problems that are experienced in connection with booking venues, transport and catering did not relate to the project. They are problems that are common across government where stakeholders are not yet conversant with civil service regulations that govern logistics (Foster, 1998).

3.2.3 Training

The training methodology was based on the adult-learning principle, which makes the assumptions that adults learn best when they are treated as equals. The model also places an emphasis on previous experiences and endeavors to incorporate them through active involvement (Foster, 1998).

Foster (1998), states that the key issues discussed in the training program are human sexuality, sexual biology, human growth, contraception, teenage pregnancy, relationships, reproductive health, sexual abuse as well as drugs and alcohol. The actual training is conducted is a form of workshops. Time is allocated for discussion and multi-media activities making use of flip-charts, role-plays and videos. Evaluation is done continuously by the trainer, whilst the national offices sends representatives to as many training sessions as possible.

3.2.3.1 Participants

A lot of emphasis was placed on working with stakeholders and teachers. Appropriate participants were selected and school principals were made to understand the importance and necessity of life skills and sexuality education. One problem that arose initially, was that many teachers were not prepared for the training, they were just told to report without any briefing, which resulted in poor workshop attendance (Foster, 1998). A summary of the extent of teacher participation is presented below, bearing in mind that these figures are a little dated.

Table 3.2 Teacher participation in PPASA Workshops

	EASTERN CAPE	FREE STATE	NORTHERN CAPE	NORTHERN PROVINCE	MPUMALANGA
Total number of teachers in tender	4620	686	190	3054	686
Total number of teachers trained	3563	577	179	1885	399
Total number teachers certificated	2669	460	169	272	272
Total number of workshops conducted	139	29	9	100	20

3.3 Rationale

It is informative to peruse the key objectives of the PPASA. According to their report (PPASA, 1999), the Life Skills and HIV/AIDS teacher training project were formulated in line with PPASA's mission statement which is summarized as follows:

The PPASA:-

(a) is a dynamic national NGO that is committed to principles that are used to formulate the South African constitution.
(b) gives leadership in sexual and reproductive health as well as rights and recognizes that as a keystone to gender equity and sustainable development.
(c) critiques and actively promotes sexual and reproductive health policy nationally and internationally.
(d) looks out for opportunities to collaborate and form partnership with underserved communities, civil society and government.
(e) unique synergy of staff sexual volunteers in order to achieve its goals.

This indicates that the key role the PPASA envisages for itself as a national body, and along with the extensive number of workshops given, and participants reached, gives some indication of the importance of their programs. It is crucial that the materials used are of the highest calibre, as they potentially impact on the lives of millions of people.

3.4 Specific Goals For The Lifeskills And HIV/AIDS Teachers Training Project

A key requirement of the above program, was the wide dissemination of knowledge regarding sexual and reproductive health. The Lifeskills Education Program was specifically designed to focus on making informed sexual choices, thereby helping individuals to acquire skills that are required to manage relationships and to prevent pregnancy, STDs/HIV and sexual abuse. Some of these skills included are the raising of self-esteem, improved assertiveness and decision making, and importantly the communication and negotiation of safe sex practices (PPASA, 1999).

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More specifically, the PPASA detail their goals for the learner as follows:

(a) to provide learners with facts about sex and sexuality so that they can make informed decisions about their lives.
(b) to help learners acquire life skills that will lead to self esteem development and healthy relationships.
(c) to teach learners life skills that will help them solve their own problems and deal with conflict situations.
(c) to promote abstinence as the best option for preventing HIV/AIDS infection in school-going youth.
(e) to promote a positive change in behavior based on acquired skills, knowledge and attitudes learned (Foster & Straten, 1996).

In an effort to continually upgrade and develop the programs, the Lifeskills and HIV/AIDS teacher education project were recently strengthened with two new parts, namely "Stepping Stones" and "Men as Partners". Although the two programs are stand alone modules, the integrate well with the Lifeskills program, since all three programs touch reproductive health (PPASA, 1999).

3.4.1 Stepping Stones and Men as Partners (MAP)

This program was first developed in Uganda and its purpose was to educate literate as well as non-literate men and women on HIV/AIDS prevention and life skills. After the program was declared as successful in Uganda, PPASA entered into partnership with the Medical Research Council (MRC-CERSA) so that the Stepping Stone's curriculum could be adopted for South Africa. The South African version has expanded sections on sexual and reproductive health. It also covers activities that relate to gender equity as well as gender violence. The first South African version of Stepping Stones was introduced at a two week session in Johannesburg in September 1998. Educators of all PPASA projects attended that session so as to get acquainted with the use of the various aspects of the program (PPASA, 1999).

Workshops, professional training and informational materials were used to create awareness and facilitate attitudinal and behavioral change amongst participants through Men As partners. This project was initiated when PPASA commissioned a study on man's knowledge of, attitudes to and practices around sexual and reproductive health by the Reproductive Health Research Unit (RHRU). After a research dissemination meeting was held, a planning workshop for MAP was facilitated and a program was developed, along with training and materials. (PPASA, 1999).

The MAP program is simple to understand, it has information, education and communication (IEC) components. Currently, pamphlets that describe the programs and those that focus on key areas being developed. The subjects that these pamphlets cover are domestic violence, sexual violence, responsible sexuality (targeting men), gender, sexual and reproductive health (PPASA, 1999).

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3.5 Research Conducted On The Life Skills And HIV/AIDS Teachers Education Project

Health professionals as well as newly elected government officials in South Africa acknowledge the enormity of reproductive health care problems and the fact that the problems must be addressed. Fisher (1998), posits that the Planned Parenthood of New York conducted research in South Africa and came up with the following facts and statistics:-

(a) Children that are under the age of 15 years account for 37,1% of the population.

(b) The rate of pregnancy is 330 per 1,000 women under the age of 19 and teenage mothers give birth to four out of ten babies.

(c) It is estimated tat 200,00 illegal abortions are performed per annum, teenagers are well represented in this number.

(d) It is also estimated that maternal mortality rates for the majority black population are well over 100 per 100,000, individual fertility patterns reflect an average of five children per women.

(e) Thirty nine percent of African women do not use any form of contraception and about 80% of all women explained that their partners refuse to take responsibility for contraception usage.

(f) The rate of HIV infection is increasing rapidly in heterosexuals, that rate doubles every 13 – 15 months. HIV infection has also become common in young people

that are between 15 years and thirty years of age as well as in women and migrants.

(g) The prevalence of STDs amongst black youth between the ages of 15 and 24 is 7,4%. This is disturbing as STD infections can increase the likelihood of HIV transmission.

(h) It was estimated that one million individuals were infected with HIV at the end of Projections indicate that 20% of the work force will be infected with HIV by 2005. The projections include the youth and adolescents who still attend school and could avoid this tragedy.

(i) In 1994, 6,47% of pregnant adolescent were HIV positive, that statistic rose to 8,84% and 8,63% in age groups form 20-24 and 25-29 respectively.

(j) 98% of South Africans have heard about AIDS but widespread misinformation exists about its routes of transmission.

In the context of the findings of Planned Parenthood of New York the PPASA felt that there was a need for an effective and mass-based teacher training in life skills and HIV/AIDS prevention. That led to the introduction of the Life Skills and HIV/AIDS education project. The PPASA undertook to provide its services for follow-up work, the monitoring of training and implementation of the program in schools (Foster, 1998).

3.5.1 Current And Future Research

Up until now, no large scale research has been done, though anecdotal evidence suggests that the program is highly valued, not least by teachers, who have reportedly gained through understanding their own sexuality better. Foster (1998) also reports that teachers have been eager to transfer their new skills and knowledge to learners, and that rural areas in particular have demonstrated an enthusiasm for the materials. This is perhaps because in these areas the knowledge base is low and the reliance on myth and folklore is still largely prevalent. One reports, for example, notes that it is still widely believed that gin and tonic can abort a pregnancy and that pregnant women should not cook (Foster, 1998).

Community Agency for Social Enquiries (CASE), research agency is conducting the national impact assessment of the Lifeskills and HIV/AIDS Teacher Training Project. The research is imperative because it will assess whether the training that was provided was really effective as this can influence the tender that was awarded as well as those that will be awarded in future. PPASA has conducted impact assessment work by means of using its pre- and post- training questionnaires but its impact on the youth still needs to be assessed (Foster, 1998).

3.6 Overview Of The Lifeskills And HIV/AIDS Education Program

The Lifeskills and HIV/AIDS education program for Secondary School teachers is explicitly explained in a manual for the teacher training project. Each section has worksheets for valuation purposes (Foster & Straten, 1996) as well as the following sections:-

(a) Preparatory notes for teachers.
(b) Understanding human sexuality.
(c) Sexual biology.
(d) Human growth and development.
(e) Contraception and teenage pregnancy.
(f) Making relationships work.
(g) Reproductive health.
(h) Sexual abuse.
(i) Drugs and alcohol.
(j) Questionnaires.
(k) Directory.

The program is geared towards sex education in contemporary times and the tone is therefore one of caution and responsibility, without being prescriptive or conservative. The preparatory notes for teachers explains the role of the life skills teacher and give useful ideas regarding presentation, media, discussion forums and lesson objectives (Foster & Straten, 1996).

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The introductory section on human sexuality, makes the point that sexuality is as much to do with self-esteem as it is to do with biology. Important in the section is that ones sexual choices also reflect personal values and the differing natures of both genders are discussed. Because of the pervasive nature of peer pressure, adolescents are guided to understand that their behaviors should reflect their own values and not those of the outside world (Foster & Straten, 1996). The program acknowledges the difficulties and temptations of sexual pressure, be they internal or external, and thus spends some time giving direction in decision making, emphasizing that all decisions have consequences, and that decisions regarding sexual practices often impact on other people as well.

The biology of sex, including the reproductive processes are dealt with as well. It s deemed as important to educate both gender learners on such issues as menstruation and hormonal changes. The program proceeds to detail the issues of ovulation and fertilization, as well as the males sexual equipment including his production of 150 million sperms per day. In addition to the basic biology,

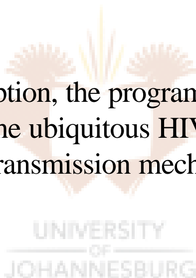
the entire human sexual response is discussed in detail. Besides the knowledge that this imparts to the learners, it also facilitates the process of the learners becoming comfortable talking about sensitive issues.

The next part of the program focuses on pregnancy, foetal development, labour and birth. This section should awaken learners to the realities of child birth, the dramatic changes to the woman's body, and the very real responsibilities of creating life. The program next details issues related to human lifespan development from infancy to old-age.

3.6.1 Contraception And Teenage Pregnancy

Naturally, as Foster and Straten (1996) advise, a key part of the program is that to do with contraception. The full nature of all contraceptive devices are discussed, as well as the relative merits and risks of each method. The program encourages women to track their monthly cycles and warns against such methods as withdrawal and rhythm. The pros and cons of each method are debated, including myths related to condom use, and also last ditch scenarios like the abortive pill which can be taken up to 72 hours after unprotected sex. In the unfortunate event of an unplanned pregnancy, all the issues related to teenage pregnancy are also addressed in the program.

Coupled with the discussion on contraception, the program also includes an important section on sexually transmitted diseases including the ubiquitous HIV/AIDS. The nature of the main types of infections are discussed including their transmission mechanisms, symptoms and treatments.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3.6.2 Relationships

A further key emphasis in the program is on teenage relationships. Given the uncertainties, myths and pressures that exist at this age, the value of this section is self-evident. Given the potential hurts that ensue from relationships, as well as the complex dynamics that exists between families, peers and partners, this section probes the intricate nature of these complex unions, leaving lots of room for teenagers to bring in their own experiences into discussions.

3.6.3 Other

In addition to the issues above, the program also goes into areas such as safe sex, sexual abuse, incest, rape and substance abuse. Since the aim of the program is not only to inform, but to impact on behaviors, a program evaluation is routine to explore how well the learners have integrated the

various aspects of the program. Addresses and contact numbers or organizations and parties that can offer help if it is needed are also made available to the learners.

In the final analysis, the PPASA program seems to be well structured and comprehensive. Given the dearth of empirical research on the matter, the efficacy of the program is uncertain, especially given the vast discrepancies in South Africa's schooling infra-structures. Although many other countries have well established sex education programs, in South Africa this is relatively new, and sex educators are only coming to grips with the difficulties of such programs in a developing country. It thus might be useful to establish how other countries have dealt with the same problem.

3.7 Sex Education In Other Countries.

3.7.1 "Dollar–A-Day "And "Worth The Wait"

The diverse population of America has prompted the development of several programs. "Dollar-a-day" was introduced in North Carolina in 1990 with the aim of alleviating subsequent teenage pregnancy for young teenagers who had already fallen pregnant. The program used a token economy with the girls being awarded a dollar for each day that they remained nonpregnant . Brown, Saunders and Dick (1999) report that Dollar-a-Day was very successful and was incorporated into the Health Department budget so that is could continue as a permanent service to the adolescent population

"Worth the wait" was implemented in 1996 in Central Texas schools. The program educated teenagers about medical, social, legal and economic consequences of early sexual activity in simple language. Parents were similarly informed about the consequences of teenage sexual activity, and were invited to contribute ideas as to what curriculum should contain."Worth the wait " received positive feedback from school districts, political leaders, students, teachers, parents and the community (Henderson, 2000).

3.7.2Teen Outreach Project

The program is presented around New York and it involves counseling sessions and weekly volunteer community service assignments. Small group discussions that are based on a specially developed curriculum are conducted. The discussions emphasize life plan and goal setting for teenagers who are between 14 and 16 years of age. A three year evaluation shows that Teen Outreach was successful because only a few teenagers become pregnant. Participants were also not likely to fail or dropout of school (Dryfoos, 1990).

3.8 Other Strategies In Sex Education Programs.

3.8.1 Pledging

Some church groups encourage teenagers to sign pledges to abstain from sexual relationships before marriage. It has been found that teenagers who sign pledges abstain from sexual relationships 18 months longer than those who never signed pledges. However, pledging was treated more as a fad than a commitment, as a result more teenagers did not keep the full commitment of no sex before marriage (The sex-ed debate, 2001).

3.8.2 Abstinence

In Utah an abstinence program was introduced to high school students during the 1980's and it was called "Sex Respect". The program was designed to change the attitude that learners had towards sexual activity. It enjoyed a significant success, particularly amongst female, who seem easier to persuade in this regard (Olsen, Weed, Ritz & Jensen, 1991).

Fucci (2000) describes another abstinence project developed in Chicago. "Project taking charge" was established for junior high school level and proved to be highly successful, with pregnancy-free graduation classes being commonplace. Although abstinence might be difficult to promote, when practiced by teenagers it is the surest protection against pregnancy and sexually transmitted diseases. Kaplan (1998) for example describes how an Atlanta program designed for grade eight learners, taught them how to identify sources that encourage risky behavior including sexual intercourse. They were then taught skills that helped them to resist these difficult pressures.

3.8.3 Contraception Education.

This strategy has had mixed results. One unsuccessful program in Seattle involved in making condoms available to high school learners. The programs motivated learners to obtain condoms from other sources as well, however, the sexual activity rate as well as the rate at which condoms were used never increased. The percentage of sexually active teenagers decreased slightly from 46% to 42% (Kirby et al., 1999).

3.9 Why Do Sexuality Education Programs Fail ?

Many sexuality education programs fail to achieve their goals or they have a small positive effect. According to research, some programs fail because a lot of time is spent on safe, noncontroversial topics like basic biological information but little time is allocated to issues like contraception and disease prevention issues. Risk taking behavior is also discussed in general terms. Sexuality education often comes too late, that is after adolescent have begun having intercourse (Kaplan, 1998).

Ineffective programs are less focused and cover too many areas. They do not take a clear stand against unprotected sex but they go for a nonbiased and nonjudgmental model that encourages students to make their own decisions. Most of the time, the programs are lecture centered with an adult giving biological information or warnings without dealing with pressures to have sex that are very common in teenage life (Kaplan, 1998).

Successful programs concentrate on alleviating sexual risk-taking behaviors that lead to HIV other STDs or pregnancy. Some of the programs emphasize abstinence in order to avoid pregnancy and STDs. Alternatively adolescents are urged to delay sexual intercourse. Other programs focus specifically on methods of contraception and how the contraceptives are obtained. Life skills are stressed as they help adolescents to set goals for their lives, learn to say no to sex, negotiate and communicate within relationships. It is also very important to get rid of the myth that everyone has sex by the age of fifteen or so because this pressurizes teenagers to engage in early sex. Effective programs teach resistance in skills which relate to having sex at a later age if presented with biological information and AIDS education (Kaplan, 1998).

Another effective strategy has involved using the social learning theory. This approach argues that behavior like delaying sexual intercourse or using contraception are affected by an understanding of what should be done to avoid intercourse or use protection. Once this belief has been adequately communicated and internalized, delayed sex or taking precautions often follow. Students are also encouraged to develop a high self efficacy expectation (Kaplan, 1998).

Successful programs give adolescents basic information about risks of unprotected intercourse and they use active engaging methods like small group discussions, role playing and brainstorming. The programs also address social or media influences on sexual behavior as well as the social pressure to have sex. Sometimes peer leaders or respected leaders are used to serve as role models and practice communication, negotiation and refusal skills. Group values and norms are reinforced against unprotected sex. The values and norms are designed to match the experience and needs of adolescents (Kaplan, 1998).

3.10 Conclusion

The prevalence of adolescent pregnancy and the spread of sexually transmitted diseases should be reduced. Families should impart sexual education information to children. Parents must learn to communicate with their kids. Most parents indicate that they want their children to be taught sex education at school. Thus schools have a responsibility to teach sex education because research indicate that most sex education programs do not lead to greater sexual experimentation. They also do not lead to a greater increase in sexual activity in adolescents (Kaplan, 1998).

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