

SEXUAL RISK BEHAVIOUR AMONGST YOUNG PEOPLE IN THE VHEMBE DISTRICT OF THE LIMPOPO PROVINCE, SOUTH AFRICA

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ABSTRACT

This study entailed a quantitative, cross-sectional survey amongst young people in four villages of the Vhembe district of the Limpopo province. The purpose of the research was to determine the sexual health risk behaviour indicators prevalent amongst young people that could contribute to the spread of HIV and AIDS in this district. The objectives of this study were (1) to identify sexual risk behaviour, (2) to establish the prevalence of substance use before sexual intercourse, (3) to determine the prevalence of coerced sexual intercourse and (4) to determine the prevalence of forced sexual intercourse amongst young people in the Vhembe district.

Purposive sampling was used to select the four villages that participated in the study and simple, random sampling was used to select the respondents. A total of 400 respondents participated in the study, 227 of which were female and 173 were male. The following sexual risk behaviour indicators were identified (1) early sexual debut, (2) teenage pregnancy and (3) early marriage. It was found that young people expose themselves to sexual intercourse without condoms, and that they are likely to have sexual intercourse without a condom in return for reward, and to have sexual intercourse with a famous person. Approximately 20% of the sexually active respondents had used substances before sexual intercourse. Alcohol and marijuana ('dagga') were most commonly used amongst those respondents taking substances before sexual intercourse, and these were used predominantly in coerced and forced sexual intercourse.

OPSOMMING

Die studie was 'n kwantitatiewe, deursnee-opname wat onder jongmense in vier dorpie in die Vhembe-distrik van die Limpopo-provinsie uitgevoer is. Die doel van die navorsing was om vas te stel watter aanwysers van risikogedrag ten opsigte van seksuele gesondheid onder die jongmense voorkom wat moontlik tot die verspreiding van MIV en vigs in hierdie distrik bydra. Die doelstellings van hierdie studie was om (1) seksuele risikogedrag te identifiseer, (2) die voorkoms van middelgebruik voor seksuele omgang te bepaal, (3) die voorkoms van gedwonge seksuele omgang en (4) die voorkoms van geforseerde seksuele omgang onder jongmense in die Vhembe-distrik te bepaal.

Doelgerigte steekproefneming is gebruik om die vier dorpie wat aan die studie deelgeneem het, te selekteer en eenvoudige ewekansige steekproefneming is gebruik om die respondente te selekteer. 'n Totaal van 400 respondente het aan die studie deelgeneem, waarvan 227 vroulik en 173 manlik was. Die volgende aanwysers van seksuele risikogedrag is geïdentifiseer (1) vroeë seksuele debuut, (2) tienerswangerskap en (3) vroeë huwelik. Daar is gevind dat jongmense hulself aan seksuele omgang sonder kondome blootstel, en dat hulle waarskynlik seksuele omgang sonder 'n kondoom sal hê in ruil vir vergoeding en seksuele omgang met 'n bekende persoon sal hê. Ongeveer 20% van die seksueel aktiewe respondente het middels voor seksuele omgang gebruik. Alkohol en marijuana ('dagga') was die algemeenste middels onder diegene wat middels voor seksuele omgang gebruik het, en dit is meestal in gedwonge en geforseerde seksuele omgang gebruik.

INTRODUCTION

The scourge of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) remains one of the challenges that compromises the lives of many South Africans in both urban and rural communities. There are approximately 5.6 million people living with HIV and AIDS (PLWHA) in this country. The total prevalence of HIV in South Africa is 12% of the population, with almost half a million new infections and another half a million people dying of AIDS every year. Although the Limpopo province is one of the provinces with a lower HIV prevalence, estimated at 7% of its population, a steady increase in new infections has been observed. Poverty, migrant labour, limited resources, risky sexual behaviour and inadequate knowledge of the prevention of HIV and AIDS have been identified as factors that contribute to the increase in new HIV infections (Avert 2009:2).

Sexual risk behaviours are defined as sexual activities that may expose an individual to the risk of infection with HIV and other sexually transmitted infections (STIs), for example, unprotected sex, early sexual debut, using alcohol or drugs before sexual intercourse, multiple sexual partners, forced or coerced sexual intercourse and sexual intercourse for reward. A lack of knowledge about HIV and AIDS and poverty have been identified as factors that increase the chances of young people engaging in risky sexual behaviour (Avert 2009:3). According to Traore (2005:22), another risky sexual behaviour that is common amongst PLWHA is engaging in unprotected sex, therefore putting themselves in danger of re-infection and also spreading HIV to unsuspecting victims. When an individual who does not know their HIV status engages in unprotected sex with a partner whose HIV status they do not know, that individual is also taking the risk of being infected or infecting their partners.

Although in past decades, HIV-prevention programmes focused on risky sexual behaviour amongst young people, the continued increase in new cases could be an indication that sexual risk behaviours are

still occurring in many communities. The United Nations (UNs) has identified some indicators of risky sexual behaviour, which are low levels of education, early sexual debut, unprotected sexual intercourse, teenage pregnancy, multiple partners, sexual intercourse for reward and forced sexual intercourse (Brook, Brook, Pahl & Montoya 2002:1102). These indicators were used in this study to determine the extent of sexual risk behaviour amongst young people in the participating villages. According to Asimwe-Okiror, Opiyo, Musinguzi, Tembo, and Caraël (1997:1761), changes in sexual behaviour amongst the urban Ugandan population resulted in a decline of HIV prevalence over a period of time.

PROBLEM STATEMENT

Although access to health facilities has improved in many rural communities, access to youth health services, health information and voluntary counselling and testing (VCT) is still a problem. In many rural communities in the Vhembe district, young people face different challenges related to their sexuality, such as poverty, unemployment and diseases, which have an influence on their perception of the world and of themselves. Lack of information and guidance about sex and sexuality make young people vulnerable to diseases and physical, emotional and economic exploitation. They unknowingly engage in sexual risk behaviours that might expose them to diseases and unplanned pregnancies.

The purpose of the study was to determine the sexual health risk behaviour indicators prevalent amongst young people that could contribute to the spread of HIV and AIDS in the Vhembe district of the Limpopo province. The objectives of this study were:

- to identify sexual risk behaviours amongst young people
- to determine the prevalence of substance use before sexual intercourse, and
- to determine the prevalence of coerced and forced sexual intercourse amongst young people.

The article discusses the sexual risk behaviours of young people between the ages of 15 and 26 years in four rural villages of the Vhembe district. The results of this study could be used to develop intervention strategies for the prevention of STI and HIV in these communities.

RESEARCH METHOD AND DESIGN

A quantitative, cross-sectional survey to identify the sexual risk behaviours of young people was conducted by trained research assistants in the villages of Mashobye, Gidjana, Mukhomi and Valdezia in the Vhembe district, using a self-administered questionnaire, from 4 to 10 October 2005. The questionnaire was translated into Xitsonga and back into English to ensure that the meaning remained the same. A pilot study was conducted at Nghomunghomu village, which is rural and has characteristics similar to the four villages under study.

The approximate average youth population in each village was 2500, and was based on the UNs definition of youth. It was estimated that young people aged between 15 and 25 years constituted approximately 40% of all young people in these villages. The population of this study included all young people aged 15 to 25 years who had lived in the four participating villages between September 2004 and October 2005. Random sampling was used to select respondents for the survey (see Table 1).

Eight research assistants (two per village) with a tertiary education qualification, or registered at tertiary education institutions, were selected and trained. A pilot study was conducted to determine whether the instrument would yield the expected results. The data were analysed and adjustments made to the instrument, and the pilot study results were not included in the main study. Of the 400 questionnaires that were administered (100 in each village), all were returned, however, some questionnaires were incomplete in a few respects. Data analysis was done using the Statistical Package for Social Sciences (SPSS) program.

RESULTS AND DISCUSSION

The results and discussion are presented in the following sections, (1) the socio-demographic profile of the respondents, (2) the educational background of the respondents, (3) knowledge of own HIV status and that of the sexual partner, (4) multiple sexual partner relationships, (5) unprotected sexual intercourse and condom use, (6) practice of sexual intercourse in return for reward (money, lift, favours or other forms of payment), (7) use of substances before sexual intercourse, (8) occurrence of coerced sexual intercourse and (9) occurrence of forced sexual intercourse.

1. Socio-demographic profile

The details of the frequency and percentage distribution of the respondents' social and demographic characteristics are presented in Table 2. Of the 400 respondents, 56.8% were female and 43.2% were male, with the majority (83.5%) aged between 18 and 25 years. Only 66 (16.5%) of the respondents were 17 years and younger. The majority (89.9%) of the respondents were unmarried. However, approximately two-thirds (64.1%) of the unmarried respondents reported having sexual partners. In effect, 335 (83.8%) of all the respondents were sexually active. The sexual partners were predominantly aged 20 years and older. Amongst the 40 who were married, 7 (17.5%) had an early marriage at the age of 15 years and younger, 24 (60%) were married between the ages of 18 and 20 years and only 9 (22.5%) were married between the ages of 21 and 25 years. Therefore, 77.5% of the married participants wed at the age of 20 years and younger, which could be considered as early marriages. The majority (70.5%) of the respondents did not have any children. Amongst those who had children, 80% of the respondents (both married and unmarried) had their children at the age of 20 and younger. This meant that the majority of those respondents had teenage pregnancies and early sexual debuts, as the majority of them could have been sexually active before falling pregnant. An analysis of the socio-demographic profiles of the respondents indicates the prevalence of three of the UN indicators for sexual risk behaviour (1) early sexual debut, (2) teenage pregnancy and (3) early marriage. Although these results may not be significant when compared to the whole group of respondents, their presence suggests that these sexual risk behaviours were taking place in the community and therefore cannot be ignored. These results are in line with the findings of a study conducted in Zimbabwe by Pettifor, Straten, Dunbar, Shiboski and Padian (2004:1439), who found that women who had an early coital debut, multiple partners and had not completed high school had a significantly higher risk profile for contracting HIV and AIDS. These indicators for risky sexual behaviour made younger women more vulnerable to HIV than men, because of the biological make-up and immaturity of their genitalia, and injuries that could occur during sexual intercourse. Such injuries allow the HIV virus from infected semen to gain entry into their bodies (Macleod-Downes, Albertyn & Mayers 2008:72).

TABLE 1
Details of research methods/techniques used

Data collection method	Questionnaires administered per village	Questionnaires administered	Respondents	Gender of respondents	
				Female	Male
Pilot study	1 (in one village)	1	50	25	25
Survey	100	400	400	227	173



2. Educational background of respondents

Almost all the respondents reported having received some measure of formal education, with approximately 72% that were educated at the secondary education level and higher. Over two-thirds (68.2%) of the respondents were still attending some level of formal education. The majority (73.9%) of those who had received some formal education had also received life skills or life orientation education during the time of their formal education. A cross-tabulation of their level of formal educational attainment and current school status showed that over three-quarters of the respondents still at school at the time of the study were between higher primary and matriculation education (see Table 3). Their educational level and the fact that the majority of the respondents had received life skills or life orientation education put them in a better position to avoid sexual risk behaviour based on the UNs indicators. According to the UNs, a low education level is a predisposing factor towards HIV amongst young people. However, a comparison between respondents who received life skills or life orientation education and condom use showed that condom use was much lower amongst respondents who received life skills or life orientation education (23.3%) than those who did not (76.7%). These findings are contrary to those of a study conducted by Stanton, Kahihuata, Fitzgerald, Neumbo, Kanduumombe and Ricardo *et al.* (1998:2474–2475) amongst young people who followed the 'My future is my choice' programme at Namibian schools, and which indicated a marked reduction of sexual risk behaviours, increased condom use and knowledge about HIV and AIDS amongst young people who had followed the programme.

Questions arose as to (1) whether young people use the knowledge and skills gained during life skills or life orientation education to avoid risky sexual behaviour and (2) what else is needed to encourage them use the knowledge and skills gained. Carey, Maisto, Kalichman, Forsyth, Wright, and Johnson *et al.* (1997:532) suggest that education alone does not change behaviour unless it is accompanied by a motivation to reduce HIV risk. Therefore, there is a need for programmes that will motivate young people to avoid risky sexual behaviour.

3. Knowledge of own and sexual partner's HIV status

The majority of the respondents ($\pm 90\%$) had never taken an HIV test and a similar proportion of the sexually active respondents did not know the HIV status of their sexual partners ($\pm 76\%$). A lack of knowledge about own HIV status and that of the partner is considered a sexual risk behaviour, because there is a danger that individual can become infected or infect their partners if safe sex is not practised. In the study conducted by Carey *et al.* (1997:537) it was found that women who knew their HIV status were eager to increase their knowledge of HIV and risky sexual behaviour. They were also inclined to adopt safer sex, engaged in less sex and avoided risky behaviour that could result in risky sexual activities.

The non-use of HIV-testing services was found to be significantly higher amongst young people who had received life skills or life orientation education during formal education (72.3%), compared to those who had not (27.7%). Similarly, the non-use of HIV testing was higher amongst young people aged between 21 and 25 years (50.4%), compared to those aged 20 years and younger (46.9%). There were more women (55.8%) who had not taken an HIV test compared to men (44.2%). There were also more unmarried young people (90.6%) and those who had attained at least a secondary education level (68.9%) who had not taken an HIV test.

Many young people are afraid of taking an HIV test because of fear of stigmatisation and rejection by partners, family and friends. Some take the test but are afraid of disclosing their HIV-positive status because of fear of reprisal by their partners. Many studies have shown that being HIV-positive is a risk factor for violence against women: There are women who have been

assaulted or even killed because they had disclosed their status to their partners and community (WHO n.d.:1).

TABLE 2
Socio-demographic data of respondents

Demographic characteristics	Number of respondents	Percentage
Age (N=399)		
15–17 years	66	16.5
18–20 years	171	42.9
21–25 years	162	40.6
Total	399	100
Gender (N=397)		
Female	227	57.2
Male	170	42.8
Total	397	100
Marital status (N=395)		
Married	40	10.1
Unmarried	355	89.9
Total	395	100
Age at marriage (N=40)		
≤ 17 years	7	17.5
18–20 years	24	60.0
21–25 years	9	22.5
Total	40	100
Unmarried with sexual partner (N=357)		
Sexual partner	229	64.1
No sexual partner	128	35.9
Total	357	100
Age of sexual partner (N=231)		
≤ 17 years	35	15.3
18–20 years	74	38.6
21–25 years	106	46.1
Total	249	100
Respondents with children (N=400)		
Married with children	41	10.2
Unmarried with children	77	19.3
Never had a child	282	70.5
Total	400	100
Age when first child was born – married group (N=41)		
≤ 17 years	22	53.7
18–20 years	11	26.8
21–25 years	8	19.5
Total	41	100
Age when first child was born – unmarried group (N=77)		
≤ 17 years	27	35.1
18–20 years	38	49.3
21–25 years	12	15.5
Total	77	100
Level of education of respondents (N=396)		
No education	11	2.8
Lower primary	12	3.3
Higher primary	94	23.7
Secondary	180	45.5
Matric	63	15.9
Tertiary	35	8.8
Total	396	100
Current learning/student status (N=385)		
Not at school	113	28.3
Still at school/tertiary education	272	68.2
Total	385	100
Received life skills/orientation during formal schooling (N=368)		
Received life skills/orientation	272	73.9
Did not receive life skills/orientation	79	21.5
Total	368	100

Values are given as means (N = 00.00)

TABLE 3
Educational level of the respondents

Educational level	Number of respondents per educational level (percentage)				
	Lower primary	Higher primary	Secondary	Matriculation	Tertiary
Not at school	1.9	17.3	27.9	39.4	13.5
Still at school	4.1	27.6	54.5	6.3	7.5
Level of education of all respondents	3.5	24.7	47.1	15.6	9.1

4. Multiple sexual partner relationships

Engaging in multiple sexual partner relationships is considered one of the risky sexual behaviours responsible for the spread of STI, HIV and AIDS. In this study, over three-quarters (81.4%) of the respondents had one or two sexual partners in the previous three months. Approximately 14% had three to four sexual partners and 5% had five and more partners in the preceding three months. The average number of sexual partners per individual that had been sexually active in the previous three months was 1.74. Larkin (2000:139) suggests that poverty and the need to survive sometimes force women into risky sexual behaviour, for example, prostitution and multiple partners. However, in a 2005 study conducted in Nigeria amongst men, multiple sexual partners, polygamy and extramarital sex were found to be high-risk behaviours in wealthier men. On the other hand, these risk behaviours were more common amongst urban-based men than their counterparts in the rural areas. Furthermore, wealthier men were likely to have had an earlier sexual debut than poorer men and were more likely to engage in high-risk sexual behaviours (Mitsunaga, Powell, Heard & Larsen 2005:481–483).

5. Unprotected sexual intercourse and condom use

The prevalence of condom use amongst young people in this study was just above 50%. Approximately 51.7% of the respondents reported using a condom during their last sexual intercourse, meaning that approximately 48.3% had sexual intercourse without a condom, putting themselves at risk of contracting HIV. There was no significant variation in the non-use of condoms during last sexual intercourse across all the demographic characteristics considered. However, there was a higher report of non-use of condoms during last sexual intercourse amongst adults (57.8%) when compared to teenagers, women (51.4%) when compared to men, unmarried respondents (75%) when compared to married respondents, and respondents who had attained secondary education or higher (65.8%) when compared to people with lower than secondary education. Condom non-use was also higher amongst respondents who had received life skills or life orientation education during formal education (76.7%) when compared to those who had not. There was also a low level of contraceptive use amongst the respondents: The condom was the most commonly used method of contraception (45.5%), followed by injectable contraceptives (19.3%) and some respondents (17.6%) reported not having used any contraceptive method.

6. Practice of sexual intercourse in return for reward

Sexual intercourse in return for reward was not widespread (16.5%). Amongst those who had sexual intercourse in return for reward, the age at first sexual intercourse for reward was predominantly during their late teens. Respondents who had attained a primary education or lower (62.5%) were significantly more likely to have had sexual intercourse in return for reward when compared to respondents with a secondary education or higher (37.5%) The use of alcohol before sexual intercourse in return for reward was not common (16.7%). Conversely, the practice of sexual intercourse in return for reward without a condom was predominant (64.9%).

Another risky behaviour related to reward is what is popularly known in the participating villages as '*ku hluva huku yi karhi yi hanyu*', often referred to as '*ku hluva*'. The direct translation of this phrase is 'pulling out a live chicken's feathers'. All the

respondents had knowledge of this practice and had knowledge of a young woman who practised it. Amongst the respondents, all those who indicated that they practised *ku hluva* were girls, constituting approximately 9.2% of the respondents. More than half (55.8%) of those who practised sexual intercourse in return for rewards had also practised *ku hluva*, and respondents aged 20 years and younger were more likely to practise *ku hluva* than those above 20 years of age.

Ku hluva was described as a practice where men are cheated or coerced out of their money by girls. The girl pretends to be in love with and could even have sexual intercourse with the man to gain access to his money. It was indicated that the relationships become active just before payday and that the perpetrators disappear immediately after they have gained access to the money. The girl might even co-habit with the man just before payday and leave immediately after getting what she wanted. Depending on the needs of the perpetrator, the victim is lured into spending his money on what she needs. The girls have more than one partner, based on timing of the paydays: For example, a girl can have a pensioner partner who obtains his grant at the beginning of the month, another who gets his salary on the 15th of each month, another partner who is paid a salary on the 22nd of the month and one who receives a salary at the end of the month. In other words, one girl could have at least four partners that she obtains money from every month. What was of concern was that the respondents did not see this practice as prostitution; they viewed it as a game and did not appear to realise the dangers related to it. It appeared that the victims themselves seem unperturbed about this to the extent that some of the young people believe that the girls who practice *ku hluva* cast some spell on, or bewitch them.

When asked if *ku hluva* was not some form of commercial sex work or prostitution, all participants responded in the negative. Their explanation was that prostitution is 'selling your body in the street to strangers in return for money' while *ku hluva* is about entering into a relationship that might sometimes not be sexual. Although some of the girls claimed that they did not necessarily have a sexual relationship with their victims, the chances for sexual activity were very high. They claimed that for pensioners who lived alone, they assisted only with cleaning, cooking and/or buying groceries and once they had received the money, they left. According to the study, the majority of the victims are elderly, widowed, divorced or single men who are habitually intoxicated and live alone.

7. Use of substances before sexual intercourse

Of the respondents, 20.4% reported using a substance before sexual intercourse, of which alcohol was the most frequently abused when compared to other abusive substances such as marijuana ('dagga'), glue, benzene and aerosol sprays (see Table 4). The reported use of any abusive substance before sexual intercourse was significantly higher amongst teenagers (70%) when compared to youths older than 20 years of age. It was also high when comparing unmarried people (65%) to married people. There were more respondents (60%) with a secondary education who used alcohol when compared to people with a lower education level. With regard to the use of alcohol before sexual intercourse in return for reward, there was no significant difference across age groups, sexes, marital status, level of education and exposure to receipt of life skills or life orientation education either during formal education or at initiation school.

There was a close relationship between substance use before sexual intercourse and non-use of condoms: Amongst the respondents who used substances before sexual intercourse,



approximately 73.1% had sex without a condom. A study conducted by Ehrenstein, Horton and Samet (2004:159–166) indicates inconsistent use of condoms amongst PLWHA with alcohol problems and the use of a condom was less likely when substance use preceded sexual intercourse with a person who was not their partner. There was also a correlation between the use of alcohol and multiple partners. Although many studies indicate that there is a relationship between alcohol consumption and non-use of condoms, a study by Leigh, Ames and Stacy (2008:37) indicates that alcohol use in sex is not related to condom use amongst men and women. However, there is a close correlation between drug use and non-use of condoms, and they further argue that alcohol use is associated with sexual risk behaviours amongst drug users.

8. Occurrence of coerced sexual intercourse

Table 5 shows that the occurrence of coerced sexual intercourse was lower at 26.9% and the non-use of a condom during coerced sexual intercourse was notably high (55.8%). Sexual intercourse due to peer pressure was low (16.3%). The non-use of condoms during sexual intercourse due to peer pressure was high (47.1%) but slightly lower than general non-use of a condom during the last sexual intercourse in the general population reported earlier (48.3%). The non-use of a condom during coerced sexual intercourse was significantly higher amongst young people aged 21 to 25 (58.1%) when compared to teenagers (41.9%). A greater proportion of the respondents who did not use a condom during coerced sexual intercourse comprised men (58.1%), the unmarried respondents (87.1%), and the respondents with secondary education or higher (64.5%).

9. Occurrence of forced sexual intercourse

Amongst the respondents, 16.9% of them had forced sexual intercourse: 11.4% of them had forced sexual intercourse once or twice, followed by 3.4% who had it three to four times and 2.1% who had it five times and more. There were more women than men who had experienced forced sexual intercourse. Amongst those who had forced sexual intercourse, only 44.2% had forced sex with a condom. Forced sexual intercourse is violence against the victim that occurs in a situation where there is a power difference: The perpetrator has power over the victim, making it difficult for the victim to negotiate the use of a condom. Younger women are at particularly high risk as they are easily overpowered by the perpetrator and have a high chance of becoming infected with HIV, because of vaginal injuries and bruises sustained during rape or sexual abuse. Young people exposed to violence and constant sexual abuse may also turn to

drug and alcohol abuse, prior to the sexual abuse, to escape from the pain and therefore risk unprotected sex because of impaired judgement (Trisdale, 2005:2).

Many studies show that there is a very close link between gender-based violence and HIV and AIDS. Violence exposes young people to unsafe sex while, on the other hand, being HIV-positive also exposes people to being assaulted if their HIV status is disclosed (WHO n.d.:1). According to the WHO and UNAIDS (2009:3), young people who experienced sexual abuse and coerced sex during childhood are more likely to engage in sexual risk behaviours. On the other hand, violence against women may also increase the risk of HIV infection, as the victim is forced to have sex without a condom because of fear of assault.

ETHICAL CONSIDERATIONS

Ethical clearance for the study was obtained from the University of Venda Ethics Committee. Permission was obtained from the village leadership and parents of all young people who were below the age of 18 years. Informed, written consent was obtained from each respondent before participating in completing the questionnaire. Respondents were informed about their right to withdraw, their anonymity was maintained and assurance was given that all information would be treated in absolute confidence.

LIMITATIONS OF THE STUDY

The study was conducted in four rural villages in the Vhembe district that were purposively selected, with a sample that was randomly selected. The results cannot be generalised to young people in the whole community, as the study included only young people aged between 15 and 25 years. The translation of some concepts posed a challenge, as in some cases there were no Xitsonga concepts with similar meanings, and explanatory phrases had to be used, which could have led some participants in a particular direction with regard to their answers.

TABLE 5
Percentage and frequency distribution of occurrence of forced and coerced sexual intercourse

Behaviour	Number of respondents	Percentage
Number of times forced to have sexual intercourse (N = 378)		
Never coerced by anyone to have sexual intercourse	314.0	83.1
Once or twice	43.0	11.4
3–4 times	13.0	3.4
5 times and more	8.0	2.1
Number of people forced to have sexual intercourse (N = 76)		
1–2	50.0	65.8
3–4	14.0	18.4
5 and more	12.0	15.8
Total	76.0	100
Condom use during forced sex (N = 113)		
Used a condom	50.0	44.2
Did not use a condom	63.0	55.8
Number who had sexual intercourse due to peer pressure (N = 381)		
Never had sexual intercourse due to peer pressure	319.0	83.7
1–2	37.0	9.7
3–4	17.0	4.5
5 and more	8.0	2.1
Condom use during sexual intercourse due to peer pressure (N = 102)		
Had sexual intercourse due to peer pressure with a condom	48.0	47.1
Had sexual intercourse due to peer pressure without a condom	54.0	52.9

Values are given as means (N = 381)

TABLE 4

Percentage and frequency distribution of substance use before sexual intercourse

Substance used and frequency of use	Number of respondents	Percentage
Alcohol (N=386)		
0	307	79.5
Once or twice	48	12.4
3–4 times	19	4.9
5 and more times	12	3.1
Marijuana ('dagga') (N=380)		
0	340	89.5
Once or twice	17	4.5
3–4 times	12	3.2
5 and more times	11	2.9
Sniffed substances (N=382)		
0	349	91.4
Once or twice	15	3.9
3–4 times	9	2.4
5 and more times	9	2.4
Any abusive substance (N=281)		
Never used any abusive substance before sexual intercourse	242	86.1
Used abusive substance before sexual intercourse	39	13.9

Values are given as means (N = 00.00).

CONCLUSION

The study was conducted amongst young people in the rural areas of the Vhembe district in order to determine the sexual health risk behaviour indicators that could contribute to the spread of HIV and AIDS. The study's objectives were to identify sexual risk behaviours amongst these young people, to determine the prevalence of substance use before sexual intercourse and to determine the prevalence of coerced and forced sexual intercourse amongst young people. The results indicate the presence of all the indicators of sexual risk behaviours amongst young people in the community that predispose them to STI and HIV infection. The identified sexual risk behaviours indicators could be ranked as follows (1) not knowing their own HIV status (90%), (2) no knowledge of their sexual partners' statuses (76%), (3) unprotected sexual intercourse (48.3%), (4) low educational level (29.8%), (5) multiple partners (19%), (6) coerced sexual intercourse (26.4%), (7) forced sexual intercourse (16.9%) and (8) sexual intercourse in return for reward (16.5%). The prevalence of the following risk behaviours was not significant (1) early sexual debut and (2) teenage pregnancy and early marriage when calculated against the whole sample, however, their occurrence could suggest a higher prevalence in the community.

In this study it was found that young people in the Vhembe district were likely to have sexual intercourse without a condom in return for money, and to abuse substances before sexual intercourse. There was a significant difference in the use of condoms between teenagers and older youths, which was higher amongst teenagers than amongst young people above 20 years of age: Teenagers were more likely to use a condom with their sexual debut than young people above 20 years of age. Young people above the age of 20 years, especially young men, were more likely to have sexual intercourse with a stranger or a famous person without a condom than teenagers. There was no significant difference across the selected socio-demographic characteristics regarding the non-use of condoms during sexual intercourse. Unmarried female teenagers with secondary education and life skills or life orientation education indicated that they would have sexual intercourse with more than one person without using a condom. These results indicate a low condom use, which is one of the effective methods of HIV and AIDS prevention amongst sexually active individuals. Studies have shown that efficient condom use amongst sexually active individuals is effective in the prevention of AIDS. However, for condoms to work, sexually active people must use them consistently and correctly, and avoid risky sexual behaviour. Therefore, condom promotion as a public health strategy should include identification of high-risk individuals and groups, prevention of risky sexual behaviour and rigorous measurement of the impact of HIV- and AIDS-prevention strategies (Hearst & Chen 2004:45). As many studies indicate a direct link between risky sexual behaviours, the need for interventions related to alcohol use to help reduce risky sexual behaviour and promote safer sex among young people cannot be overemphasised (Labrie & Earleywine 2000:321).

Although the prevalence of substance use before sex was low, its use during forced sexual intercourse and coerced sex was high and it was more common amongst teenagers and unmarried young people. The most commonly used substance was alcohol and there was a close relationship between alcohol consumption and non-use of a condom if alcohol preceded sexual intercourse. The prevalence of forced sexual intercourse was close to 20%, with more women who experienced it than men: A significant number of women had experienced forced sexual intercourse more than twice. Although the majority of the young people had received life skills or life orientation education and had higher levels of education, they still engaged in risky sexual behaviour, and did not use the skills and knowledge gained to prevent exposure to HIV and STI. There were similarities with the results of a study conducted by Sahlukassa, Agonafer, Tsegaye, De Wit, Gebremariam *et al.* (1999:1271), which showed that men who had good knowledge of HIV and its transmission still engaged in risky sexual behaviour, despite the knowledge and skills gained.

There appears to be a need for programmes that will motivate young people to use the knowledge gained during formal education. According to Ramos-Jimenez and Lee (2001:123), the sexual risk behaviour of men in the three Philippine cities in the study improved after following an intervention programme that strengthened their skills in self-control, self-esteem and how to be gender-sensitive. Taking some cues from such a study, young people in the Vhembe district could benefit from a sexual health programme that includes self-control, building self-concept and addressing gender issues in order to reduce sexual risk behaviour. This could also reduce the spread of HIV and AIDS in the community.

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