support, she was not using any form of contraception and had not accessed any counselling or health care services. She had not disclosed the pregnancy to her mother until the birth was imminent, and her mother did not say anything even though she could see that her daughter was pregnant. Johannesburg-Soweto is the most urbanised and one of the best-resourced areas of the country. Yet we were unable to offer sufficient help to this young mother with regard to the choice to be pregnant or not, enjoyment of a normal pregnancy, preparations for the baby with family support, and having her mother meet the boy and his family.

One of the greatest barriers to assisting young people is their fear and shame about talking to the people who could potentially help them, viz. family, educators and health professionals. To date none of the young women we have seen told such people that they were pregnant until it was too late. They and their partners – at least those men who knew about the pregnancy – were depressed and anxious and did not know what to do about the situation. Other studies suggest that young people who become pregnant feel confused about their options and are ashamed and worried about the response of their families, teachers and others.[6]

Open and accepting communication among people who can help is necessary to deal with the personal and social problems of unwanted early pregnancies. Family members, teachers and professional nurses say that they wish teens in trouble would speak to them, so that they can assist them in making the best choices. However, studies of sexuality communication indicate that even when parents and schools think that they are talking to teens about sex, adolescents feel that they have not communicated enough.[7]

If we are serious about reducing teen pregnancy rates, when it comes to teen sexuality and protection, repeated talking and listening are required. Young people must be reassured that when they get into difficulty they can turn to us, and our behaviour must demonstrate that we will assist them rather than harangue and harass them. Access to services that enable adolescent boys and girls to make sexual and reproductive choices with the assistance of caring adults requires change to a mindset that is genuinely helpful.

1. Ncayiyana DJ, Ter Haar G. Pregnant adolescents in rural Transkei. *S Afr Med J* 1989; **75:** 231-232.
2. Evans RC. Adolescent sexual activity, pregnancy, and childbearing: Attitudes of significant others as risk factors. *Child and Youth Services* 1987; **9:** 75-93.
3. Scott-Jones D, Turner SL. The impact of adolescent childbearing on educational attainment and income of black females. *Youth and Society* 1990; **22:** 35-53.
4. Shame of our child moms. *The Independent* 2005; 26 March.
5. Department of Social Development. Media Briefing By The Ministers Of Health And Social Development On *The Programme Of Action Of The Social Sector Cluster.* 28 June 2005. **http://www.pmg.org.za/briefings/briefings.php?id=232** (last accessed 26 September 2005).
6. Buchanan M, Robbins C. Early adult psychological consequences for males of adolescent pregnancy and its resolution. *Journal of Youth and Adolescence* 1990; **19:** 413-424.
7. Albert B, Brown S, Flanigan C, eds. 14 and younger: The sexual behavior of young adolescents (Summary). *National Campaign to Prevent Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen Pregnancy. **http://www.teenpregnancy.org/resources/reading/pdf/14summary.pdf** (last accessed 12 October 2005).

Survey of sexual behaviour among Anglican youth in the Western Cape

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To the Editor: The sexual behaviour of young people in South Africa is clearly important with regard to their risk of acquiring HIV/AIDS and other sexually transmitted infections (STIs). As many young people are exposed to the teaching of the church on this issue, church organisations, which reach into almost every community, can make a significant contribution towards the reduction of risky sexual behaviour. This study explored the sexual behaviour of youth (aged 12 - 19 years) within the Anglican church in the Western Cape and the relevance of messages such as 'no sex before marriage'. The study makes recommendations on the design of more effective church-based interventions.

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Method

Multistage cluster sampling was used to select 65 out of 131 churches in the Cape Town Diocese according to their location and predominant racial composition. A questionnaire was developed with reference to similar surveys commissioned by the loveLife consortium[1] and the Christian Community

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organisation[2] in the USA and after piloting was completed by members of either the youth group or confirmation class. The questionnaire was administered confidentially by multilingual research assistants, and prior parental consent was obtained. Altogether 1 306 questionnaires were completed and analysed using Statistica version 7. In addition youth were given the opportunity to attend focus group discussions (FGDs). Three FGDs were held, with a total of 25 young people chosen to represent rural, urban and peri-urban areas, both genders, and those who were and were not sexually active. Youth in the FGDs explored their sexual experiences and perceptions of the church's influence on their behaviour. The transcripts were analysed according to the framework method.[3]

Results

The female/male ratio among respondents was 59:41%, the urban/rural ratio was 64:36%, and the ethnic breakdown was 78% coloured, 12% black and 10% white. Key results are shown in Tables I and II.

In the FGDs parents were seen as an important source of information, but were often perceived to be uncomfortable answering questions about sex. Schools were also perceived as an important source of information, but the sex education messages were not individually targeted and dealt primarily with biological information on sex and HIV. Little attention was given to skills in relationships, communication and considering the personal consequences of sexual activity. Although 72% of the respondents had received teaching on sex in their church, this did not appear to impact on their sexual behaviour. The church's message on sex was perceived to be ineffective because it was delivered by elders, had a negative content and upheld marriage as the ultimate goal. Many participants did not aspire to get married and therefore the message 'no sex before marriage' appeared irrelevant.

Table I. Demographics and sexual behaviour of Anglican youth (*N* = 1 306)

	%
Sexually active (vaginal, oral and anal)	31
Vaginal sex	18
Oral sex	13
Anal sex	4
Belief that oral sex is actually sex	33
Belief that anal sex is actually sex	50
Males sexually active	40
Females sexually active	21
Pregnant	3
Belief that being physically forced to have sex by someone you know is not rape	10
Have seen other people having sex in real life	45

Table II. Characteristics of sexually active youth (*N* = 405)

	%
No use of contraceptives during first sexual encounter	65
Sex for material gain	6
Threatened into having sex	10
Raped	13
More than one sexual partner	66
Suspect partner of being unfaithful	29
First sexual experience in the home of one partner	75
First sexual experience with member of own peer group	90
Girls not wanting their first sexual experience (persuaded, tricked, forced)	50
Have seen other people having sex in real life	66

Engaging in sexual activity was perceived to be due to peer pressure (being accepted within the group's norms and values), the need to give and receive love, seeing other people having sex, threats, material gain, positive media images and boredom. Some also mentioned financial incentives such as receiving the child-support grant. Abstaining from sexual activity was perceived to be supported by peer pressure, parental influence and sharing of experience, girls understanding the world view of boys through having a mixed peer group and the confidence to 'say no', as well as access to a variety of other extracurricular activities. Fear of HIV/AIDS, religious guilt and incentives for remaining a virgin were mentioned infrequently.

Discussion

The rate of sexual activity among Anglican youth is similar to the 38% (for grades 8 - 11 in the Western Cape) reported by the South African Youth Risk Behaviour Survey (SAYRBS).[4] This implies that church-based youth do not behave significantly differently from their larger peer group. However only 3% reported a pregnancy compared with 13% in the SAYRBS, which could imply that church-based youth who fall pregnant drop out of the church community. Indeed, sexually active church-based youth appeared to have a higher rate of multiple partners (66%) than in the SAYRBS (48%). Although outside the church health interventions are aimed at reducing the incidence of HIV, primarily through promoting condom use, it was interesting that fear of contracting HIV and use of condoms were not major issues among youth in this study.

Conclusion

Based on the findings of this study a number of recommendations can be made to try to improve the impact of church interventions. All communities should be included because sexual activity among churchgoing youth involves both genders and takes place in every geographical location or community.

The first recommendation is to have peer educators who are closer in age to the youth than at present and who can act as opinion leaders and role models for change. This finding is supported by the findings of Christian Aid.[5] In this way peer pressure can be harnessed to support postponement of sexual debut and abstinence. Training courses should initially focus

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on equipping these peer educators. In particular the confidence of teenage girls to negotiate around sex and express their choice should be strengthened. Secondly, the church should emphasise building of healthy relationships as a goal and not focus only on marriage. In addition churches should assist with the provision of other activities for youth to engage in. Thirdly, parents should be equipped to be more open about their own mistakes and to speak more freely about sexual matters, using an age-appropriate approach. Parents should not delegate responsibility for sexual education to schools as personal values, relational issues and consequences of sex may not be addressed there. While sexuality programmes may aim to prevent the transmission of HIV/AIDS, the focus of the intervention should not be on HIV itself but on the broader issues of healthy relationships and growth of the whole person as sexuality involves the physical, emotional and spiritual wellbeing of an individual. The message should promote a positive vision of faithful, respectful and loving relationships rather than a negative one of 'not doing' or avoiding sex. Youth should be encouraged to explore the discrepancies between their behaviour and their personal goals and values as a motivator for change, rather than simply receiving instruction in the required behaviour. In addition, loss of virginity or even becoming pregnant should not lead to a permanent sense of failure or religious stigmatisation, but should be reframed as a lapse in sexual behaviour from which the person can learn and regain a 'secondary virginity'. Lastly the church can provide information to correct many of the common misunderstandings revealed in this research such as that 'forcing someone you know to have sex is not rape' or that 'anal and oral sex are not real sex'.

The full research report can be accessed on **www.fikelela.org.za**

1. Pettifor AE, Rees HV, Steffenson A, *et al*. *HIV and Sexual Behaviour Among Young South Africans: A National Survey of 15 - 24 Year Olds*. Johannesburg: Reproductive Health Research Unit, University of the Witwatersrand, 2004.
2. Clapp S, Helbert KL, Zizak A. *Faith Matters: Teenagers, Religion and Sexuality*. Fort Wayne: LifeQuest, 2003.
3. Ritchie J, Spencer E. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R, eds. *Analyzing Qualitative Data*. London: Routledge, 1994: 173-194.
4. Reddy S, Panday S, Swart D, Jinabhai C, Amosin S, James S. *The South African Youth Risk Behaviour Survey*. Cape Town: Medical Research Council, 2003.
5. Garvey M. *Dying to Learn: Young People, HIV and the Churches*. London: Christian Aid, 2003.

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