

# UNIVERSITY OF CAPE TOWN



## DEPARTMENT OF SOCIAL DEVELOPMENT

### **AN EXPLORATION OF THE SOCIO- CULTURAL FACTORS INFLUENCING CONDOM USE INTENTIONS AND BEHAVIOURS OF MIGRANT YOUTH IN SOUTH AFRICA**

A minor dissertation submitted in partial fulfilment of the requirements for the  
award of the Degree of Master in Social Science in Social Development

By

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Faculty of Humanities

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April 2017

Supervisor: Dr. Johannes John-Langba

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Masters in Social Development

2017

Supervisor: Dr. Johannes John-Langba

## COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signed by candidate

Signature: Signature removed Date: \_\_01 April 2017\_\_

## ABSTRACT

Migrant health has become a critical issue in current HIV intervention discourses as this particular cohort has an increased vulnerability to HIV infection. The purpose of this study is to explore socio-cultural determinants influencing condom use intentions and behaviour of young migrant youth residing in Cape Town, South Africa.

This qualitative study employed purposive and snowballing sampling techniques to explore with migrant youth their intentions and behaviour towards condoms use within their socio-cultural contexts. The interviews were in-depth open ended questions and conducted in English. The sample were drawn from 20 single respondents from Sub-Saharan Africa, notably from Zimbabwe, Nigeria, Congo, Cameroon, Kenya and Malawi. The mean age was 23 years with a range of 20 years to 25 years, the gender distribution was even with 10 males and 10 females.

The research findings indicated that young migrants have a good understanding of the functions of condoms and the positive preventative tool it is for pregnancy and sexually transmitted infections. However the use of condoms, even when freely available, is a contested issue as socio cultural influences have an impact on the intentions and behaviour towards condom use among young migrant youth.

Findings indicated traditional norms on sexual behaviour prohibits young migrants to freely discuss safer sexual options and methods of safer contraceptive choices. Traditional gendered norms in sexual relationships and gendered expectations of condom use are current issues that migrant youth are grappling with.

The nexus between socio-cultural norms and safer sexual choices such as condoms use places young migrants' at-risk cohort as they are currently outside of the realms of socio-cultural contexts, with higher education expectations and delay of marriage customs.

As the results cannot be generalised to the entire migrant youth population due to the small sample size of only 20 young migrants' narratives, the need for further research on a larger sample might provide more insight into current realities of transitioning young migrants who lives outside of the boundaries of current socio-cultural paradigms.

## **DEDICATION**

This dissertation is dedicated to my late grandmother, Mrs Rachel Festers, who believed in my abilities and encouraged me to further my education and to forge a path for those who is following behind me.

This dissertation is also dedicated to my parents, Mr. Abe and Delia Titus, thank you for the opportunity to further my education and selflessly giving of yourself and pour it into me. To my brothers and sister, all things are possible if you strive for the best and persevere to the end.

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**To GOD be the Glory great things He has done.**

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## Table of Contents

ABSTRACT .....	i
DEDICATION.....	ii
ACKNOWLEDGEMENT .....	iii
CHAPTER ONE: INTRODUCTION .....	1
1.1 Introduction .....	1
1.2 Background and Content .....	4
1.3 Statement of the Research Problem .....	9
1.4 Rationale and Significance of Research Study .....	12
1.5 Research Topic.....	13
1.6 Research Objectives.....	13
1.7 Main Research Questions .....	14
1.8 Clarification of Concepts .....	14
1.9 Structure of Report.....	23
CHAPTER TWO : LITERATURE REVIEW .....	25
2.1 History of Migration in South Africa .....	25
2.2 South African Legislation and Policy Reforms .....	27
2.3 Migrant Health and Management in South Africa .....	30
2.4 The Health of Migrant Youth .....	32
2.5 Sexual Risk behavior of Migrant Youth .....	33
2.6 Socio-Cultural Determinants .....	33
2.7 Gender, Migrant and Condom Use .....	34

2.8 Theoretical Framework .....	36
2.9 Conclusion .....	40
CHAPTER THREE: METHODOLOGY .....	41
3.1 Research Design .....	42
3.2 Population and Sampling .....	42
3.3 Gaining Entry .....	44
3.4 Data Collection Approach .....	44
3.5 Data Analysis .....	47
3.6 Data Verification .....	47
3.7 Ethical Consideration .....	48
3.8 Limitations .....	52
3.9 Reflexivity .....	53
3.10 Conclusion .....	54
CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS .....	55
4.1 Socio-demographic profile of Participants.....	56
4.2 Framework for analysis .....	56
4.3 Migrant youth experiences of using condoms .....	58
4.4 Socio-Cultural factors determine the intentions of Condom Use .....	63
4.5 The association between cultural values and intentions to Condom Use .....	66
4.6 The association between gender and Condom Use Intentions and Behaviours .....	69

4.7 Predicting Intention to use condoms .....	72
4.8 Acculturation and condom use .....	73
4.9 Conclusion.....	76
CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS .....	77
5.1 Introduction .....	77
5.2 Conclusions .....	79
5.3 Recommendations.....	80
REFERENCES .....	82
APPENDIX A .....	94
APPENDIX B .....	95

## CHAPTER ONE: INTRODUCTION

### 1.1 Introduction

Migrant Health has become a key global public health concern, with the rapid increase of forced migration due to political instability (wars/conflict), violations of human rights and extreme poverty. With unprecedented influx of migrants to more political and economic stable countries, it placed a burden on the host countries to manage and control the high proportion of migrants and yet have to ensure that the human rights and needs of migrants are met- such as shelter, health and education (WHO, 2016).

The increased rate of HIV/AIDS within this particular migrant cohort, has increased significantly and thus deemed for major concern. It requires a renewed focus and action to ensure incidence rates decrease and prevalent rates stabilises. A grave concern is the alarming increase of HIV infection in the younger generation with special reference to the youth population between the ages of 15- 24 years (WHO, 2016).

South Africa has similar trends of increased migration rates, in relation to the current global migration patterns, particularly in the context of neighbouring African countries. Cross border migration has increased substantially, especially with undocumented and/or illegal migration. Following a similar trend as international migration motivations – which are due to political unrest, extreme poverty and ill health. South Africa remains challenged to ensure migrants have the same basic human rights and their standard of living is on par with other South African citizens (Magadi, 2013, RSA, 2016).

South Africa is challenged with the HIV/AIDS epidemic, with one of the countries with the highest HIV prevalence rates in the world. The population group with the highest and fastest growing HIV incidence rates is the youth cohort, with an increased concern with the migrant

youth population. The South African National Strategic Plan (NSP) for HIV, STI and TB (2012-2016) policy reform focused on the youth and migrant populations as key priority areas to curb HIV infection however there is a paucity in literature regarding migrant youth as a reference cohort (Magadi, 2013).

Studies has shown HIV susceptibility amongst the youth population in South Africa, is based on non-condom usage behaviour despite large scale preventative messaging regarding condom use and safe sex education (Magadi, 2013). Research has shown that young people in South Africa, even migrant youth, have low rates of condom usage and various determinants and factors were highlighted as possible challenges or barriers (Bekker & Hosek, 2015; Odimegwu & Somefun, 2017).

Migrants have distinct social and cultural backgrounds derived from their country of origin, than those in their receiving countries. National programmes directed to manage and decrease youth HIV incidence rates can not only be informed by the indigenous or local understanding of determinants, which are challenges the native youth cohort experience regarding condom use. Migrant youth takes on a hybrid identity fundamentally rooted in their cultural ancestries and heritages coupled with their socialisation within the local communities they are currently residing with. However to a greater degree a stronger pull or influence was linked to their social and cultural ties of their country of origin (Kirpitchenko & Mansouri, 2014). It has to be taken into consideration that migrant youth intention and behaviours towards condom usage might possibly be diverse in context and rationale as those who are citizens of South Africa (Pfarrwaller & Suris, 2012).

The determinants of condom usage have been extensively researched yet little is known about the social and cultural factors which influence condom usage amongst migrants, especially African migrant youths. However, qualitative research showed an increased understanding how

social and cultural forces shape young people's sexual behaviour and provide reasons why information campaigns and condom distribution programmes as independent variables do not show significant changes in behaviour (Odimegwu & Somefun, 2017).

The theoretical context of this dissertation is based on the Theory of Planned Behaviour (TPB) and Theory of Acculturation, based on the work of Icek Ajzen (1985) and John Berry (1980) respectively. The concept of TPB proposed that individual's attitude towards behaviour, subjective norms and perceived behaviour control, together shapes individuals intentions and behaviours. The TPB is frequently used in health research to help better predict health related behavioural intention. The PTB theory has improved the predictability of intentions in various health- related fields such as condom use, leisure, exercise, etc (Carmack & Lewis-Moss, 2009). In this regard, the theory would provide a good theoretical framework in understanding condom use intentions and condom use behaviour amongst African migrant youth. It provides a framework to understand young migrant's behaviour and action in ultimately utilising condoms or distance themselves from using condoms, despite understanding and knowledge about HIV infection and risky sexual behaviour.

Berry's concept of acculturation is based on migrant's maintenance of heritage, culture and identity and the process of assimilation or integration – identifying with aspects of their societies of settlement. It provides an understanding how migrants selectively acquire or retaining elements of their heritage culture while simultaneously selecting elements from their receiving cultural context. Acculturation is most often studied in individuals living in countries or regions other than where they were born, which include migrants, refugees, and asylum seekers. *“Within the constraints imposed by demographic and contextual factors, individuals are able to purposefully decide which cultural elements they wish to acquire or retain and which elements they which to discard or reject”* (Nuynh, Nguyen, & Benet-Martinez, 2013).

This dissertation explores the socio-cultural perspectives which influence migrant youth's intentions and behaviours towards condom use. It provides an understanding how cultural ideologies and social contexts can influence young migrants' behaviours towards condom use. It investigate the pull cultural values coupled with social connections/ realities weights on the psyche of migrant youth in ultimately making decision regarding condom use in sexual relations.

This chapter provides an introduction to the research focusing on the socio-cultural determinants which influences condom use intentions and behaviours of migrant youth, residing in the Western Cape. In addition, this chapter will review the background to the problem, the statement of the problem, and the rational and significance of the research, the topic, aims and objectives of the research, the main research questions, the clarification of the concepts and conclude with the structure of the report.

## **1.2 Background and Content**

Migration patterns have changed on a global scale over the last four decades, with an increase of human mobility which more than doubled from 103 million (1980) to 232 million in 2013 (UN, 2013; Araoye, 2015). The high number of international migrant mobility was due to various reasons which included positive economic prosperity changes, coupled with negative global political current affairs such as political instability and poor governance; protracted conflict; increase of war zones areas; poverty; and disease (Araoye, 2015).

On a global scale, Europe and Asia accumulatively hosted approximately two-thirds of all international migrants worldwide in 2013, which accumulated to approximately 72 million international migrants in Europe and 71 million in Asia. Followed by North America with an estimation of 53 million migrants; Africa with 19 million, and Latin America and the Caribbean with 9 million (UNDESA, 2013).

Currently, European countries have an influx of international migrants especially refugees from the Middle East and protracted conflict African countries which created new challenges in international development agendas and protocols, particularly with receiving/ host countries. The management of migrants and refugees has become more complex and a global crisis as countries are challenged with regard to their border safety and foreign policies. The influx of refugees and illegal or undocumented migrants created major crises and issues around international human rights and domestic border controls. (Araoye, 2015).

Within the African continent, South Africa has been the hardest hit with this trend, with regard to the influx of migrants, particularly from African descent. In fact, in Southern African Development Community (SADC), the highest number of migrants and refugees resides within South Africa than any other African country (Araoye, 2015). The estimation of migrants and refugees in South Africa remains unclear due to the illegal entry of undocumented migrants. According to Araoye (2015) various governmental and research organisations within South Africa have different estimations of the number of migrants and refugees residing in South Africa. For instance, the Human Sciences Research Council (HSRC) estimated 4 to 8 million undocumented migrants in South Africa, whilst the Statistics South Africa (StatsSA) estimated between five hundred thousand to one million undocumented persons in the country (Araoye, 2015).

Migration from the Southern African Development Community (SADC) is largely based on forced migration due to political instability, conflict crises, poverty and war. Araoye (2015) cited a study highlighting the reasons why Africans leave their home countries for South Africa. According to the study, the majority of respondents from African countries cited political reasons for their decisions followed by economic advancement. This translated to over 70 percent of African migrants leaving their home countries for political and economic

motivations, a combination of these two factors strongly influences their decision to relocate to South Africa (Araoye, 2015).

South Africa has the second largest economy in Africa with a stable political landscape, and become a preferred destination country for most migrants from the SADC region. It is within this context that migration to South Africa has become a favourable destination for most SADC countries in search for social and economic prosperity with the prospects of a better quality of life. Currently the largest number of migrants entering South African borders (documented and undocumented) are from Zimbabwe, one of the neighbouring countries of South Africa and share a border and thus easier access to South Africa (Araoye, 2015).

The United Nations' Immigration Report (UNDESA, 2013) indicated that the current trend and movement of young adults have increased on a global scale with an estimation of thirty five million international migrants under the age of twenty, with an additional forty million between the ages of twenty and twenty-nine. Young migrants accounted for more than thirty percent of all international migrant stock worldwide (UNDESA, 2013). In addition, with regard to a gendered perspective, females account for approximately fifty percent of the international youth migrant population.

International migrants between the ages of fifteen and twenty-four account for 12.4 percent of the general international migrant stock, which accumulated to approximately twenty-seven million in mid-2010. In developed countries such as Europe and North America this age cohort accounted for fifteen percent of all international migrants when compared with developing countries which comprise of eleven percent. Trends showed that the youth and young adults between the ages of eighteen and twenty-nine are the most mobile among all age groups worldwide (UNDESA, 2013).

South Africa has shown an influx of migrant youth who are accompanying their parents, or migrating on their own for reasons such as economic advancement or to access better education infrastructure such as primary, secondary and even tertiary institutions. These are in line with international migrations trends and reasons young people migrate to more developed countries and cities (UNDESA, 2013). The high proportion of youth migration in South Africa emerged from African descended countries, with a higher concentration of migrants (legal and illegal) with close proximity of South African borders. As migration patterns and trends increased to a receiving country such as South Africa, it become crucial for South Africa to safeguard the health of all migrants, to ensure a healthy, prosperous and productive young cohort who can contribute to the social and economic development of South Africa.

The World Health Organization (WHO) estimated that 36.9 million people globally are infected and living with HIV/AIDS in 2014. Newly infected with HIV for 2014 were estimated at two million worldwide (WHO, 2015). A large proportion of the HIV infection resides in Sub-Saharan Africa with 220,000 infected with children under the age of fifteen. Most HIV transmission was due to their HIV positive mothers – HIV transmission pathways through pregnancy, childbirth and breastfeeding.

According to the WHO (2015) the population growth of Sub-Saharan Africa was estimated at 973.4 million, which constitute of eleven percent of the world's population. However this region “house” more than two-thirds (70 %) with an estimation of 25.8 million of the world's HIV infected people. Even though HIV prevalence rate varies amongst and between regions - with some very low and some exponentially high - it remains worrisome.

Southern Africa has been the hardest hit by the epidemic and is widely known as the “epi-centre” of the HIV progression on a global scale. South Africa had for years the highest prevalence rate on global terms however with significant decline rates it has positively

alleviated its position. Currently, Swaziland has overtaken South Africa and are leading with the highest prevalence rate of 27 %. South Africa remains the country with the largest proportion of people living with HIV (Avert, 2015). Western and Eastern Africa has continue to keep the disease under moderate levels within its region.

Furthermore, it is reported that an increase of HIV infection was found within the age cohort of 15-24 year olds (WHO, 2014). Sub-Saharan African youth accumulated 3.2 million HIV infections from the 5.4 million young people living with HIV globally (UNAIDS, 2015). Swaziland, Lesotho, Botswana, South Africa and Zambia remains the highest HIV prevalence rates for both female and males between the ages of 15 to 24 years and were identified at dangerous levels. However, young women are still disproportionately high with an HIV infection rate which is double than that of males. Research shown that amongst the women who are infected with HIV, four out of five occur in young women between the ages of fifteen and twenty-four years (UNAIDS, 2015). These countries need to respond with strategic HIV prevention programmes that will drive the HIV infection down and provide the youth the opportunity to strive and contribute socially and economically to their respective countries.

HIV/AIDS epidemic is largely driven by the young people and are particularly susceptible to HIV infection, even more at risk with a migrant status. Young migrants under the age of 30 are unfortunately a fast growing cohort with raised levels of HIV/AIDS in the world. It is estimated that 10.3 million people between the ages of fifteen and twenty four years are living with HIV/AIDS and over 3500 newly infections occurs daily amongst this group (UNAIDS, 2013).

Migration has placed an added vulnerability to migrant youth to susceptibility to HIV infection due to their migrant status and greater exposure to risky sexual behaviour (International Organization for Migration, 2010). Coupled with limited exposure to health education information, access and utilisation of health services, cultural, linguistic, educational and

geographic barriers, young migrants are increased risk for HIV, as well as a host of other communicable diseases (Musuriri, 2012). As they transition to adulthood, they become increasingly at risk for unsafe sexual and reproductive health behaviours which include early sexual debut, low levels of condom use and low levels of contraceptive use, which can result in high rates of unplanned pregnancies and sexually transmitted infections (STIs) such as HIV (Rijks, 2014).

Condom use has been highlighted as a safety and effective measure against heterosexual transmission of HIV disease. However, it is a common fact that low levels of condom use amongst young people occur, even among migrant youth. Previous studies have highlighted various risk factors or determinants that underpin the limited use or non-use of condoms and identified it as barriers to condom usage. Various research projects highlighted socio economic, gender equity, socio-cultural determinants and others which block the use of condoms (WHO, 2010; Oyediran, Feyisetan & Akpan, 2011).

In the South African context limited knowledge is available to the HIV prevalence, predictions and importantly the socio-cultural determinants that influences behaviour or intentions regarding condom use within the African migrant youth population. In addition the risk of acculturation and HIV related risk behaviour have been studied among other migrant population in the world, but limited knowledge available regarding this relationship among the African migrant youth (John-Langba, 2007, Du & Li, 2015).

### **1.3 Statement of the research problem**

South Africa have a young population with thirty-five percent (18 million) of its overall population (52.9 million) between the ages of fifteen and thirty-five years (StatsSA, 2013). Additionally, with a high influx of migrant youth especially from Sub-Saharan Africa, increases the number of young people residing in South Africa. Migrant youth mainly resides

in metropolitan areas, such as Cape Town and Gauteng due to the attraction of economic opportunities and higher social mobility (Kondowe, 2014). The City of Cape Town have a challenge to estimate the number of young African migrants in the Western Cape as most of these migrants are illegal and undocumented and thus difficult to surveillance and monitored (City of Cape Town, 2010).

Migrants are distinctly identified as “hard-to-reach” population due to their history of displacement, sexual and gender violence and immigration status and thus place them at a higher level of HIV risk as their vulnerability is enhanced. Currently, South Africa does not have sufficient health statistics on migrants as they are excluded from national sexual behavioural surveys due to their immigration status (John-Langba. 2007).

As indicated earlier, the increase of HIV infections amongst young people residing in South Africa has increased alarmingly and the low rate of condom use is a great concern. Efforts to reduce the transmission of HIV are largely based on programmes to improve and increase condom usage, especially amongst the youth population. Most prevention programmes which was widely advocated on various platforms and initiatives have showed limited success of the uptake of condom use amongst the youth. It is evident programmes such as the ABC (abstain, be faithful, and condomise) have not shown significant results to the increase of condom use but showed an alarming decline of condom use. It is known that increased knowledge production and understanding of risky behaviours does not necessary lead to changes in behaviour. Research has shown that the youth cohort’s sexual behaviour is influenced by social factors which McMillan & Worth (2010) describe as individual and interpersonal factors.

Individual factors which comprise of knowledge and attitudes regarding condom use is easier to explore and have received much research opportunities, yet has not shown a decline in the rate of HIV infection. The interpersonal factors such as social and cultural contexts have not

been given much attention, and thus require a deeper level of investigation especially with the issue of condom usage. Social and cultural realities play a fundamental role on the psyche of an individual and decisions are influenced by these external social and cultural contexts (Nuynh, Nguyen & Benet-Martinez, 2013.)

International research have conclusively reached a consensus that social and cultural determinants influences young people's perception of sexual behaviour regardless of their attitude and knowledge on risk perception and protective value of condom use (Nuynh, Nguyen & Benet-Martinez, 2013; Iwara & Alonge, 2014; Kirpitchenko & Mansouri, 2013) . It becomes evident that investigations on factors of sexual risk behaviour and condom use among young people cannot include only individual characteristics with the knowledge-attitude-behaviour nexus, as these will not significantly imply changes to practises that enhance sexual risks. Contextual factors such as gender inequality, relations and partner characteristics, income, community, family practices, socio-cultural influences and macro socio-economic influences plays a major role on the sexual health of young people.

Socio-Cultural factors are important social realms that needs to be investigated, especially within the migrant youth cohort. Understanding these social realities and cultural praxis would provide a deeper understanding on how decisions are made for sexual practices and safer sexual practices and condom usage.

In light of these, socio-cultural determinants plays a vital role in the sexual health of the younger population with regards to condom usage, it is even more crucial within a diverse culturally background, migrant cohorts such as the African migrant from Sub Saharan Africa. Understanding the social and cultural influences that guides the young migrants and influences their practices of condom usage will determine whether these practices are towards safer sex or heightening their vulnerability to sexual risk taking.

#### **1.4 Rationale and Significance of the Study**

Numerous research conducted internationally into the lives of migrant youth on sexual risk, sexual behaviours and condom usage. A significant number of research studies have increased with regard to migrant youth's sexual health, due to the fast escalation of migration of youth within borders of countries (Sudhinaraset, Astone, Blum, 2012; Bam, Thapa, Newman, Bhatt, Bhatta, 2013).

Although there exist an increasing amount of research into migration in the South African context (Landua & Segatti, 2013; Chereni, 2013), not much research has been done into migrant youth, with particular reference to socio cultural determinants of condom usage. The effect that social and cultural dynamics have on decision making processors of young people with regard to safe sexual health choices, have not been evaluated and assessed.

In addition, research focused on qualitative methodologies showed that strong social and cultural connections influences young people's sexual behaviour and can provide significant insights into reasons why information campaigns and condom distribution programmes are not sufficient to affect positive change behaviour (Marston & King, 2006).

The most fundamental rationale for this study is to understand the socio cultural factors which influence young migrants' intentions and behaviours towards condom use. Understanding these patterns will provide a framework to redirect appropriate strategic intervention programmes which could ultimately lead to an increase in condom usage amongst young migrant youth. Alleviating the national burden of South Africa of increased HIV infection which is positively correlated with low condom use amongst the young cohort residing within South Africa.

It place also an increased awareness that the youth cohort in South Africa is not a homogenous group and thus provide significant policy reform contribution, aligning the Youth Policy to provide the space for migrant youth as a sub group. The unique cultural, social and historical contexts, prescribed the need for appropriate, context based approach to ensure sexual health issues and sexual risk campaigns are effective and relevant to this particular cohort of young people residing within the South African borders.

### **1.5 Research Topic**

The topic of the research study is as follows:

“An Investigation into the Socio-Cultural factors influencing the Condom use Intentions and Behaviours of Migrant Youth in the Western Cape, South Africa”.

### **1.6 Research Aims and Objectives**

The aim of the study was to explore the socio-cultural factors that influence the intentions and behaviours of migrant youth towards condom use. The research study targets youth between the ages of 18 – 25 years, a smaller cohort than referred to in the South African National Youth Policy (NYP) (2009). The specific objectives of the study include to:

1. Examine migrant youth experiences of condom use in South Africa.
2. Identify socio-cultural factors influencing the condom use intentions and behaviours of migrant youth.
3. Examine the linkages between cultural believes on attitudes and condom use.
4. Examine the gender dimension of condom use intentions and behaviour among migrant youth.

## 1.7 Main Research Questions

The purpose of the study was to identify socio-cultural factors that influence condom use intentions and behaviours amongst migrant youth in the Western Cape, South Africa. The researcher intends to understand the social and cultural dynamics which influences the intentions and behaviours of African migrant youth in the Western Cape. To achieve the objectives of the research the following questions were included:

1. What experiences do youth migrants have with condom use in the Western Cape, South Africa?
2. What socio-cultural factors determine the intentions of youth migrants to use condoms during sexual intercourse?
3. What are the linkages between cultural values and intentions to condom use?
4. What are the linkages between gender and condom use intentions and behaviours among migrant youth?

## 1.8 Clarification of concepts

This section will provide the key concepts and their respective definition and application, and provide context of how they will be used in this study.

- Migrant

According to the International Law, a migrant is “*a person who takes up residence in a foreign country*” (IOM, 2013). International migration is defined “*as the movement of people across state borders, temporarily, seasonally or permanently, for a host of voluntary or involuntary/forced reasons*” (Musariri, 2012).

The International Organization for Migration (IOM) (2013) provides a useful categorization of migrants, which identified 2 types of migrants, namely: voluntary migrants and force migrants.

Voluntary migrants comprise of labour migrants, family reunification, foreign students, illegal (irregular) migrants, high skilled business migrants and return migrants (Harttgen & Klasen, 2008).

Forced or Involuntary migrants are defined by refugees, asylum seekers, displaced persons, environmental migrants, trafficking, human smuggling and illegal migrants. Forced migrants migrate to other states and countries due to conflict, wars, persecution and in some cases to escape drought, hunger and poverty (Harttgen & Klasen, 2008).

Illegal/ irregular or undocumented migrants are defined as: *“foreign citizens who is present on the territory of a State, in violation of the regulations on entry and residence, either after entering the county illegally or whose residence entitlement (e.g. as a tourist or a visa holder) has expired”* (UNDESA, 2013). Illegal/ irregular or undocumented migrants, are often vulnerable due to no access or limited access to formal labour markets, and lead to low wages and abusive treatments. In particularly women, are faced with forced prostitution and sexual abuse as their illegal status provide them no legal protection and their rejection of channels of protection such as police stations and community health facilities (IOM, 2013).

In contrast, tourists, business travellers, religious pilgrims, etc. are not considered as international migrants since their stay in South Africa is limited and have a valid visa which extend the reason for their visit.

In this study migrant refers to an individual who is not a South African citizen, and a descendent from another country. The research will focus particularly on African cross border migrants from the Sub Saharan region.

- Youth

There is no universal consensus on the definition of youth. The term youth is a social construction, meaning different things to different people in different times, places and cultures. It can be defined as a stage of transition between childhood and adulthood which is a part of the life course perspective (Jones, 2002).

There are large variations on the age range for defining the youth concept which provide different age definitions from international and national platforms and institutions. The United Nation defines the term youth as “*men and women between the ages of 15 and 24 years*”. However the definitions of youth vary according to countries and cultures. The South African National Youth Policy (NYP) (2009) defines youth as the cohort of “*men and women between the ages of 14 years and 35 years*”. This definition was aged defined due to the historical context of South Africa that denied the youth educational and economically development.

This research targets youth between the ages of 18 – 25 years, which is more in line with international definition of youth than specified in the NYP (2009). In addition, preventative strategies to reduce the uptake of HIV infection are crucial as this cohort represents the future economic group of a country, and are at the moment exposed to higher sexual risk behaviour and a low uptake of condom use.

- Migrant Youth

Migrant youth is defined as men and women between the ages of 18 and 24 years (or up to 35 years as South African Youth Policy stated), who have relocated from their birth country and residing in another host country. In general, reasons youth and young adults migrate are often associated with crucial life transitions such as employment, education, family formation, as well as the consequence of conflict and persecution within their native countries (Henning &

Lattes, 2011). However, in context of the African cross border migrant, a significant number of young people cross the border unaccompanied by parents and relatives, escaping from war or poverty stricken areas to a more economical viable neighbouring country, such as South Africa (Henning & Lattes, 2011).

For the purpose of this study, a migrant youth is defined as a person aged 18-25 years who was not born in South Africa and is currently residing in South Africa. In addition the term includes young people who came to South Africa as refugees. However this study will focus on African descended migrant youth living in the Western Cape.

- HIV/AIDS

The Human Immunodeficiency Virus (HIV) has become a global health issue in the 1980s. The first cases of disease detection occurred in Congo approximately in the 1920s, with the virus transmission from monkeys to humans (Avert, 2015). The HIV virus compromises the immune system which is the human body's natural defence against illnesses. People infected with the HIV virus are susceptible to infections and diseases due to their decreased strength in their immune system's ability to fight off bacterial and virological infections.

There are various HIV-strains which are classified into different types, and various sub-types. The most common HIV type found in the world is the HIV-1 and HIV-2 and mainly prevalent in Western Africa, and parts of India and Europe (Avert, 2015). HIV is primarily transmitted through unprotected sexual intercourse (which include anal or oral sex), hypo-dermic needles (used by drug addicts) contaminated blood transfusions and mother-to-child transmission during pregnancy, birth process, or breastfeeding. The life expectancy of a HIV infected person is approximately 10 years to 15 years before developing AIDS, a consequences of the immune system severely compromised (Avert, 2015).

AIDS is the acronym for Acquired Immune Deficiency Syndrome which is also known as the “advanced stage of HIV infection” or “late stage of HIV”. The CD4 count of an HIV infected person is clinically monitored and if it decreases below 200 cells per millilitre of blood, the person is recognised to have AIDS. This stage is a complicated stage with a wide range of health conditions which include pneumonia, tuberculosis, thrush, fungal infections and skin lesions caused by Kaposi Sarcoma. There is also the increased risk of life threatening diseases which include various types of cancers and brain illnesses (Avert, 2015).

The UNAIDS report on the Global HIV/AIDS Epidemiology conceded that AIDS related deaths have accumulated to thirty four (34) million people from its onset to mid- 2014 (UNAIDS, 2015). Even though, significant scientific advancement in the field of understanding HIV, prevention strategies and antiretroviral treatments, the cure for HIV and AIDS is still not found. Despite the challenges, significant scientific developments have occurred within the last 10 years, showing considerable strides towards a cure. The mass education and strategic programmes has reduced the HIV prevalence rates within a number of countries and thus ensure that HIV infections show reduction in populations.

The success of lobbying for anti-retroviral prophylaxis and the significant reduction in pricing for developing countries, provided the opportunity that more HIV infected people have access to treatment, which ultimately prolong life expectancy and provide a higher quality of life. A significant number of people, approximately 15.8 million HIV positive individuals have access to affordable antiretroviral therapy (ART) worldwide (UNAIDS, 2015).

- Condoms

Condoms are used as a dual protection against pregnancy and sexual transmitted infections such as HIV, syphilis and gonorrhoea. It is manufactured using latex or lamb skin products and is deemed a “useful” barrier device. Condoms are manufactured for males and females,

however the male condoms are more easily accessible and freely distributed. Condoms are used as a mean to practice safer sex and decrease the risk of HIV transmission with an infected person.

Even though treatments are available to slow down the progress of HIV and great scientific breakthroughs to treat AIDS related diseases, prevention still remains the best mode of fighting the HIV epidemic. Condoms have been widely recognised and recommended by international platforms such as the United Nations Joint Programme on AIDS (UNAIDS), as an important measure to reduce the risk of HIV infection and prevention of re-infection of HIV infected individuals.

- Condom Use

The effectiveness of condom use as a viable method of preventing heterosexual transmission of HIV is largely based on the consistent use of condoms. It is imperative to consistently use condoms, translating to using a condom every time sexual intercourse occurs, complying 100 percent the use of condoms. This ensures the level of sexual risk for sexual transmitted infections such as HIV is reduced and shows a protective measure. Consistent use of condoms has shown a level of 87% protection when compared with those who are not using or inconsistently using condoms (Davis & Weller, 1999).

- High risk sexual behaviour

Risky sexual behaviour can be identified as sexual intercourse without the use of a condom, multiple sexual partners and at risk for sexual transmitted infections such as HIV (Kapadia, Latka, Strathdee, Mackesy-Amiti, Hudson, Thiede & Garfein, 2011). Predictors of risky sexual behaviour were strongly associated with alcohol/ drug use, sexual risk history and type of partnership (new, regular or irregular) (Parks & Ya-Ping, 2009). Safer sexual practices or

condom use decreased with the length of the relationship as studies has shown that women would use condoms with new or casual partners however a decrease of condom use is observed with more regular or steady relationship status (Macaluso, Demand, Artz & Hook, 2000; Kapadia et al, 2011; Parks & Ya-Ping, 2011). Increased sexual risk is largely based on multiple partners, a sense of low risk of sexual transmitted infections which include HIV, unprotected sex, and no contraceptive methods which leads to unplanned pregnancies.

- Condom use Intention.

Fishbein and Ajzen (1975) define the concept intentions “*represents an individual’s personal prospect in his or her willingness to perform a behaviour*”. In 1991, Ajzen has deepened this meaning of intention as follows “*intentions are expected to capture the motivational factors that impact on behaviour*”. Intentions are thus driven by a person’s motivation to perform a specific behaviour (Ajzen, 2002). They are determined to a large extent by three conceptually independent factors which Ajzen has based his theory of TPB, namely: attitudes, subjective norms and perceived behavioural control.

It reviews the attitude towards condoms use ( positive and negative evaluation of condoms and the use of condoms; subjective norms is the social factor which interpret the perceived social pressure to perform or not perform the behaviour - in essence how society view condom use and particularly their views of young people’s use of condoms. The third determinant of intentions, perceived behaviour control refers to people’s self- reflection on their ability or capacity to perform that behaviour, in this case their ability to use condoms effectively and consistently. According to the TPB model there is an increased intention to use condoms when the person’s attitude and subjective norms becomes more positively inclined (Bilic, 2005).

- Attitudes towards condom:

Collins (2011) defines attitude as “*a settled way of thinking or feeling about someone or something, which is usually reflected in a person’s behaviour*”. Attitudes towards using a condom are thus a significant predictor which influences the behaviour and intentions of using a condom during sexual intercourse. Attitudes regarding condoms and condom usage are largely determined by people’s perceptions and views regarding condoms. A positive perception of condom usage are strongly associated with knowledge of condoms, safe sexual practice and risk reduction perception and are most likely to negotiate and use condoms during sexual intercourse (Haque & Soonthorndhada, 2009). A negative perception of condom use is strongly associated with lack of trust and illicit sex especially within a long term relationship such as marital relationships, condom use is largely limited or frequently used (Haque & Soonthorndhada, 2009).

- Socio-cultural factors of condom use

Condom use in HIV prevention have been hindered by various factors which include social, cultural and economic factors. In Sub-Saharan Africa the knowledge of condoms are high and the effective measure tool to decrease the spread of HIV infection and pregnancy, however influential factors that deter the use of context is based on socially, culturally and context boundaries ( Mgabo, 2009). Several studies had indicated that there is an association between socio-cultural factors and condom use and healthy sexual choices (Lugella et al, 2004) Socio-cultural factors highlighted in studies include the following: culture, peers, family, religious background, knowledge, values, norms, belief system, and social economic situation.

Socio-cultural factors predispose women to HIV/AIDS infection, particularly in low-resource settings such as Sub-Saharan Africa. Women are more likely to be vulnerable to the disease due to inequality and access to education. Cultural beliefs have increased women’s risks and

restricted their decision regarding risky behaviour. Cultural practices such as early marriage and adolescent pregnancy force young women to drop out of school at early age. This results to their dependency on their sexual counterpart and husbands for survival. Women have limited resources to negotiate safer sexual practices with their partners, who in African culture can have multiple partners and external relationships. Men refuses to use condoms and cited cultural reasons for their refusal (Iwara, & Alonge, 2014). Preston-Whyte (1999) highlighted that common socio-cultural barriers place a risk on sexual behaviour and a vulnerability and susceptibility to HIV infection conversion, these are critical topics and requires much needed research opportunities. The Joint United Nations Program on HIV/AIDS emphasised the need to address the sociocultural behaviours and values of communities that expose individuals to HIV risk behaviours. This is an important approach to review sociocultural determinants in specific population cohort groups as it will lead to effective HIV/AIDS intervention strategies (UNAIDS, 2015)

- Planned Behaviour Theory

The Theory of Planned Behaviour (TPB) is considered to be one of the most influential theories for the prediction of different types of behaviour particular beneficial for risky health behaviour (Bilic, 2005). The central theme is to predict behaviour and understand causes that influences set behaviours. TPB illustrates the intentional pathway to behaviour and denotes the factors, which determines a person's decision to follow a particular behaviour. This theory is one of the most frequently used in explaining condom use behaviour (Ajzen, 1991; Boer & Westhoff, 2006). A study conducted by Boer and Mashamba (2005) indicted that social cognitions based on the Planned Behaviour theory are able to predict intended condom use in non- western cultures. This is quite an interesting factor as limited research is done within the scope of this particular issue and thus requires a theoretical perspective which can be evaluated against a

reputable and successful theory which will provide a ‘weight’ in measuring the outcome of this research dissertation.

- Acculturation

The concept of acculturation, was introduced in the fields of anthropology and sociology in the early 20<sup>th</sup> century. Its main focus is to explain dynamics involved when people from diverse cultural backgrounds come into long term contact with one another. Berry’s concept of acculturation, is based on two independent phenomena which is rooted in the process of acculturation of migrants, namely: the maintenance of heritage, culture and identity; and involvement with or identification with aspects of their societies of settlement (Berry, 1980). It thus investigate the transitional process of moving from their cultural heritage and way of life to adopt certain aspects of their new receiving country’s culture and social identities as a means of survival, over the course of time.

## **1.9 Structure of the Research Report**

The structure of the report will be as follows with a brief description of each chapter.

- Chapter 1: Introduction

This Chapter provides the introduction of the research project that was conducted. This chapter reviews the background of the research problem, the statement of the problem and the significance of the research, main assumptions, research objectives and clarification of the key concepts.

- Chapter 2: Literature Review

The chapter provides scholar reviews and research around the central topic which provide evidence of current debates and critical analyses and challenges. It provides a framework for

discussion on the history of migrants in South Africa, provide context on Migrant Youth and Health and Condom Use, Determinants to condom use and Socio cultural influences on condom use in young migrants. It highlights the theoretical frameworks used in the study. It will in addition, discuss the legislative frameworks, as well as the programmatic and policy responses in relation to the Migrants and Health on international, national and regional platforms.

- In chapter 3: Methodology

This chapter focus on the research design, sampling process, data collection procedure and tools as well as the data analysis methods utilised. The chapter will provide an overview of the ethical consideration and the researcher's reflexivity. It will conclude with a brief discussion on the limitations of the study.

- Chapter 4: Presentation and analysis of the findings

This chapter present the data obtained and provide the outlines of the research findings. Findings will be presented based on the data analysis process used in the methodology section. The findings will be compared with other literature and a brief discussion will emerged. Quotations will be used to illustrate and support particular findings and provide context.

- Chapter 5: Conclusions And Recommendations

The chapter draws conclusions from findings of the study. It will streamline with the objectives of the study and ensure that the research questions were answered. Recommendations are highlighted and focus on strategic interventions which could assist migrant youth in terms of their sexual health, government's appropriate strategic programmes reforms, as well as for future research opportunities.

## **CHAPTER TWO: LITERATURE REVIEW**

### **INTRODUCTION**

This chapter examines current debates and scholar literature on migration, health, young adults intentions and behaviours on condom use and the impact that socio-cultural factors have on their decision making process. The literature review included sources in books; journal articles; web based scholarly articles and legislative documents. The legislative framework includes policy guidelines on migration, youth migration and HIV management. It will conclude with the theoretical paradigms on the theory of Planned Behaviour (TBP) and the Theory of Acculturation which underpins the study.

#### **2.1. The History of Migration in South Africa**

Migration from African descent played a significant role in the development process of South Africa since the 19<sup>th</sup> century which marked the period of labour migration. The Apartheid era in South Africa has been known for their cheap labour practices and their immigration policy of Africans were regulated with cheap, foreign labour within the Southern Borders of Africa (Chereni, 2013).

The Colonial, Apartheid government has successfully established key priority economic nodes such as the mining industries which produced gold, diamonds and other rich minerals and a functioning agricultural sector (Chereni, 2013). The migration policy made provisions for black Africans to immigrate to South Africa as cheap labour force to ensure constant reserves for the mining industries and the agricultural sector. African countries such as Lesotho, Mozambique, Swaziland, Botswana and Malawi provided much needed labour reserves.

Historically, labour migration dominated the movements of populations in Southern Africa, and majority of unskilled or semi-skilled male workers were recruited mainly for South African

mines (Chereni, 2013). However mine workers could not migrate with their families and could not obtain South African citizenship due to the Apartheid laws. South Africa was perceived by other African countries as a temporary settlement, employment prospects and a better quality of life.

During the democratic South Africa of 1994 patterns of immigration has changed and immigration from neighbouring countries shifted from recruitment of a labour force system to formalise and adoption of the universal (global) standard and definitions of migration and migration procedures. The abolishment of Apartheid provided South Africans the opportunity for internal migration in search of working opportunities and better quality of life. Cross border labour force migrants became absolute or minimum as South Africa battle to provide employment for 80% of the black population who were denied employment opportunities (Araoye, 2015).

Currently South Africa migration population is estimated between 2 million and 3 million with an unspecified number of illegal migrants. The number of African migrants in South Africa is not easily accessible due to the irregular migration and the inadequate data collection systems (IOM, 2013). The total number of cross border migrants residing in South Africa was estimated at more than 2 million people with an unspecified number of undocumented migrants. The National Strategic Plan for HIV, STI and TB estimate that approximately 3 percent of people living in South Africa are cross border migrants (NSP, 2012). According to Statistics SA (2013) approximately 66 percent of people granted permanent residence permits in South Africa in 2012 were from African countries, with 46 percent of total permanent residence permits were from South African Development Community (SADC) countries. The largest number of people granted permanent residence was from Zimbabwe (42.6%) from the leading 10 African countries. Followed with Democratic Republic of Congo (DRC) (12.9%), Nigeria with 10.3% and Lesotho with 4.7%. Migrant youth accompanies their parents and relatives to South Africa,

however there is a significant number of youth crossing the borders without their parents or relatives accompanying them (IOM, 2013).

South Africa is recently challenged by Xenophobia attacks- the tensions between poor Black South Africans and migrants residing within poor communities. Frequent occurrences and sporadic instigation of xenophobic violence occurred over the past decade, notably in 2008, sixty-two people died and more than 150,000 displaced (The Guardian, 2015). Renewed xenophobic attacks and tensions escalated again with violence in the townships in Durban and Johannesburg in the earlier period of 2015. Migrants are distrustful and fearful as approximately more than 3500 migrants were resettled in transit camps within these provinces and a proportion of migrants have opted to be transported back to their home countries (The Guardian, 2015). However with government intervention with a process of re-integration of migrants back into South African society, with a process of resettling migrants back into their communities and engagement with dialogue to South Africans residing in these poor communities to accept migrants back, stability and peace were once again restored (The Guardian, 2015).

## **2.2. The South African Legislation and Policy Reforms**

The Migration Management in South Africa is guided by the Refugees Act of 1998 and the Immigration Act of 2002 (amended in 2004) and has been integrated in several key policy documents with regard to the safety and health of migrants, regardless of their migration status.

The Constitution of South Africa (1996) is extremely progressive and promotes human rights and human dignity as the highest order, and deemed crucial to be legislative as such. This is clearly marked and noted within the Refugees Act of 1998 primarily esteem refugees as “human beings with rights” and protected by the state. This is translated with providing refugees the same human rights and protection as any other South African citizen. In this

regard, refugees are not placed in refugee camps but integrated within the social fabric of South African communities. It can be concluded thus that South Africa has legislated the rights of refugees in a very progressive manner and within a rights based approach, which provide safety and stability.

The Refugees Act of 1998 defines thus the refugee, grants procedural process for application for status determination and sets out the accompanying rights for refugees. According to section 27, “a refugee should enjoy the full legal protection, which includes the rights set out in Chapter 2 of the Constitution, the bill of rights, which preserves the right of all people living in South Africa”. In addition, it reaffirms the democratic values of “human dignity, equality and freedom” and the right to reside and settle in South Africa.

South Africa has rejected encampment policies for refugees as indicated earlier. This resulted the settling of refugees amongst the local communities as part of their integrated, rights based approach. Refugees (legally defined) have same constitutional rights of access to education, health care and employment as South African constituents have. The National Development Plan (NDP) envisioned if migration properly managed, migrants could play a significant role in filling the gaps in the labour market and could positively contribute to South Africa’s development (IOM, 2013). However, due to the minimum effort to educate South Africans about refugee documents and rights, refugees are severely prejudiced and discriminated against. Refugees are still struggling to have access to the most basic services such as health care, placement of unaccompanied minors, accessing education institutions or finding employment which is necessary for successful integration (Khan, 2007).

The South African Immigration Act (Act 13 of 2002) provides “the regulations of admission of persons to, their residence in and their departure from the Republic of South Africa”. It issues temporary and permanent permits for admission of foreigners to South Africa. It ensures

that “the entry and departure of all persons at ports of entry are efficiently facilitated, administered and managed”. It ensures that the immigration laws are effectively and efficiently enforced. However, due to illegal entry into the country from unauthorised cross border entry points, South Africa has a major challenge to control and manage immigration monitoring systems. It is thus unsure of the number of illegal migrants in South Africa, as earlier eluded.

South Africa has a progressive and human rights approach to the management of migrants, however due to the high influx of illegal migrants in the country, this task has become challenged and highly bureaucratic in the administrative systems. The challenge is the administrative procedures and mismanagement (corruption) of the Immigration’s Department which is tied up in red tape, bureaucracy and stringent regulations that delay the process of providing the necessary permits and documentations for legal migrant status. A high number of migrants are still waiting the finalising of their legal migrant document process, which has been prolonged for months. This place migrants at a vulnerable place as they do not have access to legal employment opportunities, no opportunity to access education systems or health care facilities as they are deemed as illegal migrants in the country. They are forced into cheap and exploitative labour markets and companies, more vulnerable for migrant women as they are forced into prostitution and sexual exploitation.

The Immigration Act of 2002, in addition focuses on the exclusions and exemptions of prohibited persons and further affirms the category of foreigners who do not qualify for a temporary or permanent residence permit. The following exclude foreigners: namely, a) those infected with infectious diseases as prescribed from time to time, belong in the category of prohibited persons. This stipulation is in direct contrasts of the South African constitution which affirms the right to access of health care services to everyone within its borders, including sexual and reproductive health care. However, this pull factor of universal health care place a major pressure on the existing overburden health care system of South Africa. As

currently assessed at border municipalities the high influx of foreigners have negatively impacted due to high numbers of people accessing health care facilities which ultimately lead to insufficient stock for ARVs and other medical supplies. This places a tremendous pressure on provincial governments as their budget allocations cannot match the need for medical supplies and medical care as it is overextended by the influx of illegal foreigners (MSF, 2013).

### **2.3 Migrant Health Management in South Africa**

This section will highlight these key policy documents which will include the Constitution of South Africa and The National Strategic Plan on HIV, STIs and TB which provide the rights of migrants and migrant youth to health care and argue for key national programmatic response to the health needs of migrant youth.

The Constitution of South Africa (1996) decrees that “health is a fundamental human right” and it is critical for development and achievement of the Millennium Development Goals (MDGs). South Africa’s national and provincial departments made concerted efforts to develop progressive policies and programmes to ensure that health continues to be a fundamental “human right” to all its constituencies including migrants with legal or illegal status. However, in reality, many migrants do not access health care facilities due to questions regarding official documentation which could result in deportation if documents are not available. Other negative events such as recent xenophobic violence, insensitive health care workers, and social exclusion heighten the mistrust and avert migrants from seeking medical care within the public health care system (Munyewende, Rispel, Harris & Chersich, 2011).

These current experiences deepen with regard to migrant youths (as the challenges for youth in general) and highlight barriers to attend sexual and reproductive services due to stigma and added factor of immigration status. This highlights the need for a broader policy discourse on migrant rights and health care access in South Africa, with special reference to the migrant

youth (Munyewende et al, 2011). This requires more urgent reform and more protective measures in place which ensure that migrants can safely access the health care system and receive medical care and prevention mediums such as health counselling and health education.

South Africa was lauded for their efforts in reducing the HIV incidence through its progressive policies and programmes, with special focus on the youth creating safe health spaces such as the implementation of youth friendly services, in order to mitigate stigma and long term costs. However programmes excluded the migrant youth as no concerted effort of inclusive programmes has been initiated. This is a critical point for the current agenda of government, which focus increasingly on inclusive development, yet many young migrants experience multifaceted exclusion (Munyewende et al, 2011).

The National Strategic Plan (NSP) for HIV, STI and TB (2012-2016) is the strategic guide of the National Department of Health (NDOH) for the national response to HIV, STIs and TB within a five year period. It is designed to make available goals and strategies for the country's approach to these communicable diseases from the period of 2012 to 2016. The NSP acts as a guide towards strategic and sector implementation plan of provincial departments. The NSP is located within the constitutional framework of South Africa and the broader development plans of government. These include the Medium-Term Strategic Framework (MTSF) and Programme of Action, which commit to ensuring “a long and healthy live for all South Africans” and “equality and non-discrimination against marginalised groups”. The NSP for 2007-2011 which was an inclusive plan embraced non South African citizens by providing refugees, asylum seekers and foreign migrants the “right to equal access to interventions for HIV prevention, treatment and support” (NDOH, 2007).

The intention of the National Strategic Plan 2012 to 2016 is to reduce new HIV infections incidence by 50% and decrease the effect of HIV and AIDS & TB on individuals, families,

communities and society by enhancing access to appropriate treatment, care and support. The strategic objectives of the NSP includes 4 principles: namely, i) addressing social and structural barriers to HIV, STI, and TB prevention, care and impact; ii) preventing new HIV, STI and TB infections; iii) sustaining health and wellness; iv) increasing the protection of human rights and improving access to justice.

The NSP recognises migration as one of the key structural drivers of the epidemic, and migrants / refugees and youth are included as the key populations at risk in the NSP (NDOH, 2012). These key populations will be targeted with specific interventions to reduce the risk of HIV, STIs and TB. It highlights the right to HIV prevention, treatment and support.

The NSP recognises the paucity of research literature on migrants and HIV infection which can guide policy development and initiate strategic programmatic response. This will highlight the right of prevention, treatment and support of migrants and particular migrant youth. Key central issues such as understanding acculturation and socio-cultural factors and behavioural determinants towards condom usage are crucial to respond effectively to this key population group.

#### **2.4 The health of Migrant Youth**

This study is based on two central concepts of migration and health. Studies globally have indicated a strong association of higher rate of HIV infection among migrant population when compared with the general population of a country (Musariri, 2012). The most common factor in these settings is the low use of condoms, especially within the young migrant cohorts. However, diverse forms of migration (i.e. legal/illegal, temporary/ permanent) play an important role as the impact of health outcomes are reflected differently. Equally important is the gender characteristic, as gender is a significant differential in the process of migration and

in condom use. In addition, various determinants and factors place a major role in the low rate of condom usage especially linked with their particular migration status.

The health of young migrants' remains poorly understood, since they are not often included in national health surveillance and epidemiological studies. In addition, lack of standardisation in definitions and health indicators across countries makes it difficult to compare the health situations of young migrants globally (Gushulak, Weekers, MacPherson, 2009). Youth migrations' health vulnerabilities do not only stem from health sector policies and practices but due to the lack of streamlining all sector policies relating to migrant youth. In addition, restrictive migration policies tend to drive migration underground and due to a lack of protection mechanisms lead to dangerous working and living conditions. Furthermore, it highlights their degree of vulnerability within society and lead to stigma and risk taking especially with their health.

## **2.5 Sexual Risk Behaviour of Migrant Youth**

A common thread in earlier studies endeavour to understanding the factors influencing sexual health risk and condom use practices of young people, focused on the knowledge-attitude-behaviour nexus which describes the characteristics of the individual or internal factors (Marston & King, 2006). However, recent studies indicated that the knowledge of condom usage and HIV risk does not always translate to practices of safer sex (McMillan & Worth, 2010).

On the contrary, external factors such as contextual, structural and socio-economic factors plays a major role in migrant youth vulnerability and sexual health risks. Other factors include gender inequality, relationship type and partnership characteristics, education levels, poverty, income, family practices and socio-cultural influences on the sexual health of young people (McMillan & Worth, 2010). In addition due to their migration status the adoption of risky

sexual behaviours in urban areas is further heighten with an increased exposure to commercial sex industry, drugs and alcohol, and different peer networks (Sudhinaraset, et al, 2012).

## **2.6 Socio-Cultural Determinants of Condom Usage in Migrant Youth**

Knowledge of sexual risk behaviour and safe healthy sexual choices such as consistent condom use are easy measuring variables, yet other factors such as social and cultural dynamics influences young migrants with regard to their sexual behaviour and intentions of using condoms or not. Social and cultural factors, thus has a major influence on young migrants sexual behaviours and decision making processes with regard to condom usage.

Migration in itself contribute to the socio-cultural complexity as migrants tend to develop migrant cultures and identities, meaning migrants have a strong linkage to their social, ethnic and cultural identities and based on these social values and norms, makes decisions on their sexual behaviours (Coast, 2006).

The findings of international research into factors influencing young people's sexual behaviour consistently identify the importance of social and contextual factors. Mberu (2009) indicated the social environment plays a significant role for migrant youth, and include friends and peers, family members, sexual partners, school/ tertiary institutions, the community as well as cultural, religious and youth serving institutions.

Mberu (2009) ascertained that the impact of peers on reproductive and sexual behaviour of young people are strong and thus should be explored as it is predictive of condom use or non-condom use. Social and cultural forces strongly shape young people's sexual behaviour and explain to a large degree why HIV prevention programmes which focus on free distribution and of condoms and condom use education - which are important - often are ineffective to change behaviours (Marston & King, 2006).

## **2.7 Gender, Migrant Youth and Condom Use**

Condom use within migrant communities is a complex issue guided by various factors and circumstances, yet gender differentiation provide another level of complexity. It should be noted that factors influencing condom use are different between men and women. In many of studies conducted, women's HIV rates are higher than the men's rates (Halli, Moses, Blanchard, 2007). Women are more vulnerable and susceptible biologically, economically and culturally than men (Huggens, Hoffman & Dworking, 2010).

The migration experience and the conditions which accompany the migration of labourers especially women, such as poverty, poor housing and lack of stable social support systems are critical issues. (Musariri, 2012). It can be noted that gender based power relations play a significant role in the use of condoms. Women face unique obstacles and challenges to accessing and fulfilling their sexual and reproductive health rights, and support services, more when they are migrants. In South Africa, studies shows an association between migrants and condom use and indicated migrant as an independent risk factor for HIV infection among men to have multiple partners and non-condom usage. Similar results were shown in a study among migrant urban women in Carleton, South Africa (Musariri, 2012).

In many countries, particularly in Africa, greater vulnerability to HIV infection has been partly attributed to women's lack of power to negotiate safer sex (Musririri, 2012). Pettifor, Measham, Rees and Padian (2004) conducted a study on the association between sexual power, consistent condom use and consequently the risk of HIV infection among 15 to 24 year old women in South Africa. They found that women with low relationship control were 2.10 times more likely to use condoms inconsistently, and experiencing forced sex were 5.77 times more likely to use condoms inconsistently.

## **2.8 Theoretical Framework**

The Theoretical Framework highlights the theories which will underpin the thesis process. Planned Behaviour Theory and Acculturation Theory provide a significant insight to social cultural intentions and behaviour and provide a guide to understanding these factors within the migrant and condom usage contexts.

### **The Theory of Planned Behaviour**

The Theory of Planned Behaviour (TPB), is a theory which predicts deliberate behaviour, as behaviour can be deliberative and planned. The TPB was proposed by Icek Ajzen in 1985 as an extension of the theory of reasoned action and is one of the most predictive persuasion theories (Ajzen, 1985). Since its inception the model was widely used in various social psychology studies for explaining and changing health related behaviours for example, exercising, using condoms for AIDS prevention, using illegal drugs, wearing a safety helmet, and many more described in several literature reviews about campaigns, educative programmes and other fields. It is thus a powerful and predictive model for explaining human behaviour (Durmaz, 2011) In addition, it provides reasons why advertising campaigns who provide information is not working, implying that the increasing knowledge alone does not help to change behaviour very much (Ajzen & Sexton, 1999).

The rationale of the theory is based on the assumption that human beings action is based on rational and systematic use of information available to them (Ajzen & Madden, 1985). The theory contended that people reassess certain factors before deciding to engage or not engage in a behaviour (intent factor). The theory holds that intention, excluding unforeseen circumstances that limit individual control, will help predict future behaviour

According to TPB postulates 3 conceptually independent determinants of intention. The first is of a personal factor termed “attitude towards the behaviour” which refers to the degree to which a person has a favourable or unfavourable evaluation of the behaviour in question. The second prediction of intention is social factor, termed “subjective norms”. It refers to the perceived social pressure to perform or not to perform the behaviour. A third antecedent of intention is the degree of “perceived behavioural control” which refers to the perceived ease or difficulty of performing a behaviour. It takes into account past experiences as well as anticipated obstacles and impediments. Azen & Madden (1985) findings indicated that perception of control, like attitude towards the behaviour and subjective norms can have an important impact on a person’s behavioural motivation.

Durmaz (2011) ascertains that a particular behaviour will be expressed depending on several factors, which include the following notions. The strength of the intention (motivation) of an individual to perform that particular behaviour under consideration depends on the degree of favourableness of the attitude towards the behaviour, on when people believe that those they respected most would expect them to perform the behaviour or are themselves performing the behaviour (subjective norm). However other variables such as demographics, socio-cultural and structural can influence an individual’s behaviour. Furthermore, the main concepts prior to intention describe above, namely attitude, subjective norm and perceived behavioural control influences each other too. For example, the social norms within a community influence a person’s attitude towards informing and eventually affecting his/her intention to perform or not perform this behaviour.

TPB have been successfully used to predict and explain a wide range of health behaviours and intentions including smoking, drinking, health services utilization, breastfeeding and substance use among others. Bennet and Bozionelos (2000) provides an overview of 20 studies focused on the theory of planned behaviour in predicting condom use. They review included factors

that may influence attitudes, social norms or perceived behavioural control to either influence intentions of behaviour. Their key conclusions included the usefulness of the theory to predict both intentions to use condoms and condom use; that attitudes are more powerful predictive than social norms, and that efficacy judgements appear to be more influential than other perceived control factors.

This theory is thus a useful theoretical perspective to understand the determinants of socio-cultural implications of young African migrants on condom use. It will provide an in-depth analysis of young African migrants' intent on using condoms by examining their attitude, social norms and perceived behavioural control of condoms and condom usage. In addition, it will also answer the question the degree of influence of social cultural influences have on their decisions to use or not use a condom.

### **Acculturation Theory**

The classical definition of acculturation was first introduced by Redfield, Linton and Herskovits, as acculturation “comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups” (Berry, 1997).

Acculturation is thus the process by which migrants adopt the values, beliefs, attitudes and behaviours of the receiving culture (Du & Li, 2013). A great impact on acculturation is inherently based on dually adopting the culture of the receiving country and maintaining of heritage culture. In essence, individual level factors (such as gender, motivation, coping skills) combine with the level of sociocultural influences will determine whether an individual will easily adapt or resist the dominant receiving country's culture (Du & Li, 2013). Researchers have recommended two conceptual models to interpret migrants' adherence or adaptation to heritage and receiving cultures: namely unidimensional and bi-dimensional models (Du & Li,

2013). The unidimensional model considers the acculturation process as a one dimensional process where there is an adoption from one's heritage culture to the receiving culture. In contrast, the bi-dimensional model postulates that acculturation includes two independent dimensions, namely maintaining of the heritage culture and adaptation to the receiving culture. Meaning migrants retain their ethnic culture in conjunction with the acculturation to the receiving culture.

Berry, Phinney, Sam and Vedder (2006) assert that it is important to review the impact that acculturation process have on youth migrants and subsequently make inferences or predictions on their intentions and behaviour based on cultural factors and influences. Several studies have engaged with migrant adults however neglected the influence and impact that acculturation has on youth migrants. Recent research provide great understanding of acculturation on youth in various minority cultures in the developed countries (Du & Li, 2013), however less is known on the impact of acculturation on African societies and cultures intertwining with other African cultures and societies. For case in point, understanding African migrants living in a more developed and multicultural society such as South Africa.

Acculturation was used in various health research studies to determine the impact that acculturation had on health lifestyle choices. Substantial number of studies have documented a relationship between acculturation and health (Du & Li, 2013). Research highlighted importance of acculturation as a variable in health research (Hunt, Screider and Comer, 2004). They ascertained that the concept of acculturation levels predicted or explained health inequalities rooted in a behaviour which posits that culturally based knowledge, attitudes and beliefs cause people to make behavioural choices that result in the observed health patterns.

In essences this concept presumes individuals choose or rejects behaviours based on their cultural beliefs and that such choices are in prime factor affecting their health. In contrast, some

researchers believe that the results of poor health outcome and behaviour is based on the deterioration of cultural, social and familial norms and other environmental and external stressors (such as discrimination, language barriers) that make migrants susceptible for high risk behaviour (Du & Li, 2013). Furthermore, cultural norm theorists ascertain that due to unidimensional acculturation that migrants adopt the norms and values of the receiving culture and learn and display behaviours that are common or dominant in that culture (Du & Li, 2013).

These points are crucial in understanding health choices young African migrants living in South Africa are making and the influences of acculturations in their intentions and behaviour in making health choices such as safe sex choices and condom usage. It becomes crucial to understand, for this particular research project, how acculturation has impacted on the social and cultural norms of the migrant youth by adopting or rejecting social and cultural norms of the receiving country such as South Africa in their decision making process in their intent to using or not using condoms. It serves the underpinning question whether migrant youth living in South Africa is following a similar pattern of decision making process as other young South African youths have made.

## **2.9 Conclusion**

In conclusion of this chapter, South Africa has excellent policy and legislation frameworks that protects the rights and lives of migrant youth. It has a strong right based approach to the protection and safe guard of migrants, even though different policies relating to migrant youth are not in sync. However, there is the underlying discourse to protect and prevent the spread of sexually transmitted diseases such as HIV. Literature has shown how determinants such as sociocultural factors influence the use of condoms and the need for more extensive research in this field. The chapter concluded with the theoretical underpinnings guiding this study based on The Theory of Planned Behaviour and theory of Acculturation.

## **CHAPTER THREE: METHODOLOGY**

### **INTRODUCTION**

Research is an important instrument which contributes to knowledge production, providing an understanding of how the world and its inhabitants function. Just like any other instrument, there are required stipulations and techniques on which research has to be carried out and certain skills necessary to obtain information. Underpinning these techniques and skills are various perspectives, concepts and approaches that the researcher needs to understand and take into consideration when conducting research as this will inform procedures to be followed.

The main aim of the study was to examine the social and cultural contexts of youth migrants that influence or impact on their intentions and behaviours towards condom use. Wyn and White (1997) asserted that the realities of young people are not just about obtaining the correct research instrument, but it is also crucial to select the most appropriate research approach. In light of this reasoning, it was crucial for the researcher to apply the methodology that will provide the participants' voices to be heard. The research process must as far as possible, be systematic, controlled, rigorous, valid and verifiable, empirical and critical to have meaning in relation to the research context (De Vos, Strydom, Schulze and Patel, 2011).

Research methodology refers to “the methods, techniques, tools, processes and procedures employed in the process of implementing the research design or research plan as well as the underlying principles and assumptions that underpin their use” (Babbie & Mouton, 2007). It is essential that research projects shows a clear path of their methodology to be applied.

This Chapter will outline, explain and justify the research design, sampling process and procedure, data collection procedure, tools and apparatus use in this particular research project. In addition, it will highlight the data analysis method, data verification and ethical

considerations applied in this study. In conclusion this chapter conclude with the section on the limitations of the study and how these were dealt with to avoid biases and pitfalls.

### **3.1 Research Design**

Research design refers to “a strategic plan or structured framework for undertaking the research” which ensures time lines and research objectives are met (De Vos, 2005). Babbie & Mouton (2007) defined a design as a “plan or blueprint of how you intend conducting the research.” The choice of the research design is determined by the research questions. Since the research questions for this study seek to explore by describing migrant youths’ understanding of socio-cultural factors of condom use and predicting their behaviour, a qualitative exploratory approach is the most appropriate research design to attain the research’s objectives.

According to De Vos et al (2005) qualitative research can be defined as a “multi perspective approach to social interaction, aimed at making sense of, interpreting or reconstructing interaction in terms of the meanings that subjects attach to it”. The core of qualitative research is the subjective meaning and context people give to their lives, much richer understanding of the underlying social and behavioural dynamics. This study adopted this approach to attempt to gain in-depth knowledge of the migrant youths’ subjective realities, which was central to this study.

The qualitative approach is grounded in an interpretive paradigm which provide the assumption that people have multiple realities based on their physical and social experiences. Thus their interpretation and perception of the world is largely based on their learned experiences based on their physical and social contexts. It is based on the ontological and epistemological views that knowledge is socially constructed and that all knowledge is relative, contextual and subject to different interpretations (Seedat, Duncan, Lazarus, 2001).

### **3.2 Population and Sampling**

The research population is the total of all the persons, subjects, objects or members that “conform to a set of specifications or possess the attributes in which the researcher is interested (De Vos, 2005; Strydom, 2005)”. In this study all migrant youth from Sub-Saharan African countries, living in the Western Cape for more than a year, are defined as the research population. However as it is not feasible to interview the entire population, an appropriate and strategic sampling method was utilised to ensure appropriate selection of participants in this study.

De Vos et al (2005) stated that the sampling process involves selecting a particular case because it possesses certain characteristics that are of significance to the study under discussion. The selection of the participants of the study was based on their aged between 18 and 25 years; single or unmarried; and living in the Western Cape for more than a year. The sample size of the study consists of 20 participants, ten males and ten females to provide a gender perspective and analysis. The study is a qualitative explorative in nature and the sample size of the study is feasible, consistent with exploring the depth of responses and thus feasible for analysis.

According to Mason (2002) sampling method should be feasible and ethical and ascribed to the specifications of the required sampling method. For this study, a purposive sampling method was selected as the most appropriate method. Marshall (1996) argues that this sampling technique provide a ‘variation’ approach as within the target population varied characteristics are identified and a sample is drawn which matched the identified characteristics pertaining to the study specifics.

The researcher employed snowball sampling, as one of the types of purposive sampling, as a method to obtain the desired number of participants. It is also a suitable for populations who are hard to reach or “hidden” population (Strydom, 2011). This technique involved participants

recommending ideal potential candidates for the study. Snowballing technique was used to enquire from participants about other migrant youth who will be willing to be participate within the study.

### **3.3 Gaining Entry and Selection of Participants**

The most challenging aspect in conducting research successfully is the ability to gain access to the world of the potential participants (Feldman, Bell & Berger, 2003). The researcher visited Migrant Non-Governmental Organisations (NGOs) to obtain an access point into the world of the migrant youth in Cape Town. The researcher was provided with a list of 10 potential participants which was followed up and obtained permission to discuss the study. In addition the researcher enquired from migrant students from the University of Cape Town (UCT) and the University of Western Cape (UWC) if they are interested in the study and obtained permission to conduct an interview with them at a scheduled time. From the pool of potential participants I have enquired if they knew any potential participants whom I can interview. The sites were purposefully selected as they portrayed the mixture of migrant youth of both genders and age cohort applicable for this study. The researcher scheduled a convenient time with the participants for interviews. The fieldwork phase was conducted over a period of a year from September 2015 to October 2016.

### **3.4 Data Collection Approach**

Creswell (2007) defines data collection as “a series of interrelated activities aimed at gathering good information to answer emerging research questions”. Kothari (2004) regards questionnaires, interviews and direct observation as the most important data collecting tools. De Vos et al (2005) ascertain that in qualitative research, interviewing is the most common method used in the data collection process. In depth face to face interview method was used to be

engaging with respondents and sufficient probing to fully contextualise their responses and meanings.

Semi structured face to face interviews was conducted which are applicable to the exploration of the topic. First, socio-demographic and socio-economic characteristics of young migrant adults participated in this study were asked before each interview. The following items were asked or noted: name, gender, age, marital status, education level and duration in South Africa. Using interviews the researcher investigated the subjective interpretation of topics related to the socio-cultural impact on condom use behaviour. Because attitude is within the context of this study the most important determinant is predicting behaviour. To understand attitude towards informing on BCS, it is important to understand the behavioural beliefs and perceptions on several single behaviours before making predictions. Using semi-structured interviews, the qualities and meanings of the respondents' experiences and their social organisation related to this topic can be explored (Gubruim and Holstein, 2001). It is a valuable research method for exploring "data on understandings, opinions, what people remember doing, attitudes, feelings and the like, that people have in common (Arksey and Knight, 1999).

According to De Vos (2005), semi structured interviews are a "set of predetermined questions that can be used as an appropriate instrument to engage the participant and designate the narrative terrain." Khotari (2004) define an interview schedule as "a set of questions written to guide interviews". Since the research will be qualitative research the interview schedule allowed the participants to narrate their experiences and perceptions. With the assistance of the supervisor, the researcher designed the schedule in such a manner that simple, introductory questions that allowed the participant to ease into the interview are asked first. The questions became more detailed and specific as the interview proceeded, to gain the trust of the participant and ended with concluding remarks. All questions was drafted in English, easier to understand and without leading questions. The majority of the questions was open ended

questions to allow the respondents to give an in depth expression of their experiences and opinions. The schedule divided into sections and related questions on the same objective was grouped together (Appendix A and Appedix B).

The data collection apparatus was a tape recorder to record the interview and allow the researcher to focus on the participant and exploring the topic, noting the non-verbal cues and be more present and observant during the interview process.

The interview schedule was piloted, to ensure that the questions are valid and relevant. Changes to the interview schedule were made, with consultation with the research supervisor, to ensure that the interview schedule is valid and standardized.

The participants were informed about the purpose of the study and the time variations of the interviews ranged between 20-40 minutes for each interview with room for questions asked by the participants. Interviews were conducted at participants' homes, work offices or other external settings which were comfortable to them.

Each participant was informed about the interview will be voice-recorded (with permission) using a digital recording device. This was for ensuring accuracy of their experiences and personal reflections. Although the respondent's identity was known to the researcher, the participants were informed that their responses were anonymous and were ensured of privacy. After the informed consent by the participants, the interviews were conducted. No incentive was available for the interview, however some respondents decline the interviews for this particular reason. Information from the respondents and during the interview was treated confidentially.

### **3.5 Data Analysis**

According to De Vos et al (2005) data analysis is “the process of bringing order, structure and meaning to the mass of collected data”. This research project analysed the data collected, using an adaptation of Tesch’s approach to data analysis (De Vos et al, 2005). The main key to this approach is the “labelling” of data and developing coherent and logical themes and categories. The interviews recorded were transcribed verbatim for data integrity. Each transcribe was individually analysed.

The analysis phase, included the labelling of text to understand the underlying meanings in relation to the objectives of the study. The text was coded and a coding framework was created to make sense of the data. The coding framework was used to draw conclusion and interpreted as the findings of the study. Quotes were used to provide context for the themes, categories and subcategories which were analysed. The researcher gave her critical commentary in relation to the findings of the study and compare with other study findings in order to provide critical context as to the reasons for similar or different finding outcomes.

### **3.6 Data Verification**

Morse et al (2002) defined rigour as “researchers’ adoption of verification strategies and self-correcting mechanisms, at each stage during the research process to work towards reliability and validity in the analysis of quality data”. In the 1970s and 1980s the apparent lack of methodological rigour in qualitative research was debated by social scientists. In response to debate Lincoln and Guba (1985) developed new criteria for assessing rigour or validity of the data, wiz data verification systems. The following concepts were deemed as appropriate for evaluating qualitative research, namely: credibility, transferability, dependability and conformability.

Credibility refers to how respondents were accurately described and identified. This is shown with the respondents' profile, which give accurate description of the participants. In addition, the study has developed a conceptual framework which served as a lens through which data analysis was conducted. A theoretical framework consisting of relevant theories which address objectives of this study and formed part of the literature review. Practically a tape recorder was used to ensure that there is referential adequacy (Babbie & Mouton, 2007).

The second construct is transferability which links to the concept of generalisability and was used to counter challenge by referring back to the original theoretical concepts and models as this stated the theoretical parameters of the research. The purposeful sampling approach also allows for a maximum range of specific information to be obtained thus aiding the "transferability".

The third construct of dependability provides the idea that the study can be repeated with the same or similar respondents, within the same environment, and can be concluded that the findings would be similar (Babbie & Mouton, 2007). Therefore since there can be no validity without reliability, thus, there should be no question around dependability.

The final construct is conformability refers to the degree by which the findings are gained as a result of inquiry and not based on the researchers' biases. An audit trail can be conducted to investigate any biases that might have occurred.

### **3.7 Ethical Considerations**

Halai (2006) stated that "sound research is a moral and ethical endeavour and should be ensured that the interest of those participating in a research project is not harmed as a result of the research study being undertaken". Numerous researchers acknowledged that ethics are the cornerstone in conducting effective and meaningful research (Best & Kahn, 2006; Field &

Behrman, 2004; Trimble & Fisher, 2006). Ethical research practice is grounded in the moral principles of respect for persons, beneficence, and justice (Marshall & Rossman, 2011).

Ethical conduct within research has become a highly pre-requisition to ensure the protection of human subjects' participation within research projects. The first international code of research ethics were established in 1947 and known as the Nuremberg Code, which set out the basic principles to be observed with engagement with human subjects in research (NIH, 2015). The Nuremberg Code introduced voluntary consent of human subjects to be inducted in research as an "absolute essential". It makes provision of protecting human subjects in clinical trials and requires no physical and mental suffering and physical harm during their participation within a study. The degree of risk to human subjects should never exceed the humanitarian importance of the problem. Risk to participants should be limited and minimise through thorough preparations. Subjects should be at liberty to withdrawn from the study and continue to be treated fairly and provided with the current standard of care services. Thus no discrimination against subjects who refuse to participate or withdrawn prematurely from a study. Thus the Nuremberg Code has set directives to ensure and safeguard human subjects in research as prior to the code of conduct, human subjects were exposed to numerous violations of human rights, gross injustice and harmful risks due to their participation within clinical studies, as in the cases of the Nazi Medical War Crimes (1939-1945) and The Syphilis Study at Tuskegee (1930s – 1972) (NIH, 2015).

Followed the infamous Syphilis Study at Tuskegee, the United States Congress established the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research in 1974 to established the ethical principles to guide research projects in relations to their involvement with human subjects. The Belmont Report was drafted which highlighted the following three principles as crucial to ethical conduct of research with human subjects, namely: 1) Respect for persons; 2) Beneficence and; 3) Justice.

- 1) *Respect for persons*: The Belmont Report define as follows: “To respect autonomy is to give weight to the autonomous person’s considered opinions and choices while refraining from obscuring his or her actions...”. It captures the notion that we do not use the people who participate in our study as a means to an end and that we respect their privacy, their anonymity, and their right to participate – or not – which is freely consented to (NIH, 2015; Marshall & Rossman, 2011).
- 2) *Beneficence*: The Belmont Report express Beneficence as follows: “Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being.” The general expression of Beneficence could be articulated as “do no harm” which means that the researcher does whatever he/she reasonably can to ensure that participants are not harm by participating in the study (NIH, 2015).
- 3) *Justice*: The Belmont Report define Justice as follows: “the principle of justice gives rise to moral requirements that there be fair procedures and outcomes in the selection of research subjects” (NIH, 2015). It translates the idea that the selection of participants is based on the fair distribution of benefits and burdens to the population who participate in the research. It thus takes a considered effort or evaluation of who benefits and does not benefit from the research and ensure that risk/benefit is shared across diverse populations (Marshall & Rossman, 2011).

Davids and Dodd (2002) highlighted in Marshall and Rossman (2011) that “ethical conduct is more than just a set of principles or abstract rules that sit as an overarching entity guiding researchers”, ethics exists in our practical engagement, our action and doing research. Ethics are a process, flexible and responsive to change. It ultimately responds to the idea that human subjects’ protection against harm and their human rights and dignity are uphold, which exceed scientific investigation and advancement.

The Belmont principle of respect for persons is essentially subjected for all human subjects participating within a research to provide a voluntary informed consent which provide consent and willingness to participate in a research project. The informed consent is deeply imbedded in voluntary process of no coercion of research staff; have the ability of human subjects to comprehend the information and understanding the research projects and their participation in the study; coupled with disclosure of any foreseeable risks and benefits to participating in the research. Finally understanding the conditions of participating, including the right to refuse or withdrawn with no penalties.

Followed are the steps that was taken in this research to ensure that the ethical considerations were uphold and was formalised with the design of the informed consent.

#### *The Informed consent*

Blanche, Durrheim and Painter (2006) defines the informed consent as, “the process of seeking the explicit and uncoerced agreement from subjects to participate in a research project, based on their full understanding of the procedures involved and their likely effects”. The informed consent is a written document, disclosing all aspects of the study, with the signature of the respondent, indicating their understanding of the informed consent and agreement to participate in the study. The informed consent assures the review boards and ethics committee that participants were fully informed about the purpose of the study, that their participation is voluntary, that they understood the extent of their commitment to the study, their identities will be protected and there are minimal risks associated with participating. This full disclosure was made at the first point of contact between the researcher and the respondent.

The following concepts was highlighted in the informed consent process,

- Privacy

Privacy, in this context means being “free from unsanctioned intrusion” (NIH, 2015). To ensure the privacy of participants, interviews were conducted within Migrant Organisations or at their residential homes where respondents were recruited from. Private space for interviews was negotiated and, with prior arrangements with respondents a set time for the interview was scheduled. This ensured that their privacy was maintained during the interview process. Interviews conducted outside of the organisation and where the participant felt more comfortable the researcher ensure that the space is private.

- Anonymity and Confidentiality

Anonymity and confidentiality is to ensure that the privacy of the patient is uphold and refer largely to the data collected from the patient that the identifiable information of the participant is omitted, unless the participant provide consent to disclosure information.

The researcher assured the participants about the degree of confidentiality in the information that was gathered from them. To maintain their anonymity a pseudo name was selected by the respondent. The pseudo name was used during the interview and recording of the interview. During the transcribing and write up of findings the pseudo names was used to ensure confidentiality. The storing of research recordings and data are locked in a secure encrypted file on the researcher’s personal computer.

- Voluntary Participation

Voluntary Participation refers to the participant’s freedom to choose whether he or she wants to participate in the study. Participants were made aware that they can withdraw from the study at any time. Participants were informed they can decline answering questions if need be.

### **3.8 Limitations**

Qualitative research methodology was utilised and has its own unique limitations of subjective interpretative errors. The researcher's own biases and subjective opinions could be influenced in the interview process, interpretations and analysis phase. The researcher was aware of these biases and attempted to eliminate biases during the analysis phase. The purposive sampling technique brings its own limitations, for instance the sample can be skewed due to the biases of selection of participants based on convenience and availability (Marshall, 1996).

In terms of the data collection, the research quality is largely dependent on the skill of the researcher. This includes their ability to ensure the participant is comfortable, ensure building of trust, participant is engaging within the interview space and discussions. The quality is also largely dependent on the ability of the researcher to probe sufficiently and detect crucial non-verbal cues. According to De Vos (2005) there are various pitfalls that can be encountered in an interview such as interruptions, which can disrupt the respondents' thoughts, thus the researcher selected an interview space which are quiet and secluded.

Face to face interview technique, could limit true reflection from participants. They might want to reflect answers that the interviewee wanted them to say. In some cases participants did ask how to respond to questions, the researcher has reminded them of only conveying their views and perceptions, and that the interview is value free or non-judgmental, reminding them of that there is no right or wrong answer. The researcher ensured that the participants are comfortable, relaxed by engaging and reflecting back what the participant's was saying.

Social Desirable bias in self reporting of condom use behaviour is a factor that the researcher has taken into account, however cannot verify or validate this phenomena.

### **3.9 Reflexivity**

Reflexivity is deemed essential, as the researcher is the primary “instrument” of data collection and analysis within the qualitative inquiry (Khotari, 2004). According to De Vos (2005), “reflexivity is achieved through detachment, internal dialogue and constant scrutiny of the researcher and conscious through the process through which social constructs and questions can be interpreted of the field experiences”. Thus the researcher becomes part of the research process and their reflective analytical perceptions are valuable.

In the qualitative paradigm the researcher biases and subjective feelings can impact on the research activities and ultimately the research outcome (Khotari, 2004). Consequently, the researcher should be conscious of these feelings and biases prior to entering the field. My experience within the qualitative research field, are extensive with 10 years experiences in field work, which have groomed me to be conscious of biases and power relations within the interview process. Language, age and ethnic background can also play significant factors in the interview process and requires extensive experience to level the field in order for these factors not to interfere with the research interview dynamics.

### **3.10 Conclusion**

This chapter has outline the research design, sampling process, data collection phase, tools and methods used in this research project. The chapter, in addition described the analysis method, data verification and ethical considerations applied in this study. It has highlighted the limitations of the study and the particular methodology used. The researcher’s reflectivity has provided the reasoned actions to minimise the limitation not to influence the study negatively.

## CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS

### INTRODUCTION

This chapter discuss the research findings with aligning with the five research objectives. The Profile of Respondents provide a descriptive account of the unique variables and a framework for analysis. Section one shown in table 1 provides the profiling of the 20 participants in the study. The profile included variables such as country of origin, gender, age, relationship status, education level, permit type, and years stayed in South Africa. Additionally, the framework of analysis represent in table 2, consists of themes, categories and sub categories formulated from the reading and analysing the interview transcripts. The method was adopted and modified based on Tesch's (1990) framework discussed in chapter 3.

**Table 1 Profile of Respondents**

Respondent (R)	Country of Origin	Gender	Age (Years)	Relationship Status	Education Level	Permit Type	Years of Stay in SA
1	Zimbabwe	Female	21	Single	Graduate	Study	3 years
2	Nigeria	Female	25	Single	Graduate	Study	3 years
3	Zimbabwe	Female	23	Single	Grade 10	Refugee	2 years
4	Zimbabwe	Male	25	Single	Graduate	Study	5 years
5	Zimbabwe	Male	25	Single	Graduate	Study	4 years
6	Malawi	Male	24	Single	Graduate	Work	3 years
7	Nigeria	Male	24	Single	Graduate	Study	4 years
8	Nigeria	Male	23	Single	Graduate	Study	3 years
9	Congo	Female	22	Single	Post Matric	Asylum	9 years
10	Cameroon	Female	22	Single	Post Matric	Asylum	3 years
11	Congo	Female	24	Single	Post Matric	Asylum	4 years
12	Malawi	Male	23	Single	Graduate	Study	3 years
13	Malawi	Male	22	Single	Graduate	Study	3 years
14	Malawi	Male	21	Single	Graduate	Study	3 years
15	Zimbabwe	Female	24	Single	Post Matric	Refugee	3 years
16	Zimbabwe	Female	23	Single	Post Matric	Refugee	2 years
17	Nigeria	Male	20	Single	Graduate	Study	3 years
18	Congo	Female	20	Single	Graduate	Study	3 years
19	Nigeria	Male	25	Single	Graduate	Study	2 years
20	Kenya	Female	24	Single	Post Matric	Refugee	2 years

#### **4.1 Socio-demographic profile of participants**

Illustrated in Table 1, the total number of respondents in the study was 20 migrant youth, with an evenly gender distribution of 10 females and 10 males. The sample were drawn from respondents from Sub-Saharan Africa, notably from Zimbabwe (6), Nigeria (5), Congo (3), Cameroon (1), Kenya (1) and Malawi (4). Migrant youth were eligible to participate in the study if they were between the ages of 18 and 25 years. The African adolescent's mean age was 23 years with a range of 20 to 25 years.

Respondents were recruited from different locations in Cape Town, which included an informal settlement in Khayelitsha, University of Cape Town (UCT), and University of Western Cape (UWC), a refugee skills development centre in Athlone and Cape Town. This provided a mixture of diverse backgrounds, education levels, socio-economic status and permit type. In terms of permit type, 12 respondents hold study permits, 3 asylum status and 5 are illegal migrants. According to the participants' years of residing in South Africa, the years varied between 2 to 5 years, with one respondent living in South Africa for 9 years. All of the respondents are single in contrast of being married, however 6 are cohabiting, 6 are single, and 4 are in a relationship but not co-habiting and 4 are single with casual relationships. Education level varied between grade 10, post Matric and Graduate levels.

#### **4.2 Framework for analysis**

The framework of analysis was developed using the main research questions as well as from the information received from the interviews conducted and the general themes were developed from these findings. Categories were identified under each theme to facilitate the analysis process. Sub Categories were identified under the category field to explore context and meaning.

The analysis of this research project was based on the Tesch's model of analysis (De Vos, 1998) to study the qualitative interviews. Similar thoughts were group together and given

labels. These labels were condensed into the categories below. Groups of categories were then headed under themes that mirror the objectives. The framework of discussion included 4 themes, with categories and subcategories, as illustrated by Table 2 as follows:

**Table 2: Framework for analysis**

<b>Themes</b>	<b>Categories</b>	<b>Sub-Categories</b>
1. Migrant youth experience of using condoms	Knowledge about the use of condoms.	Condom Use Behaviour Dual protection knowledge
	Usage of condoms- reasons	Relationship status Length of time in relationship Pregnancy prevention Not trusting partner
	Experiences of using condoms	<b>Positive experiences</b> -dual protection against STI and pregnancy -free & easily accessible in public spaces  <b>Negative experiences</b> -not 100% reliable/ malfunction -lessens pleasure experiences (importance of satisfying sexual needs) not comfortable to use
2.Socio-Cultural factors determine the intentions of condom use	People Influence the use of condoms	Social network positively encourage the use of condoms friends & peers sexual partner Health experts / nurses at clinic Media resources (news, tv, magazines, HIV intervention programmes) Educational institution (schools, varsity and colleges)
		Cultural networks–discourage the use of condoms Parents and family values cultural & religious networks
3. The association between cultural values and intentions to condom use	Traditional norms on sexual behaviour	Traditional marriage values (sex before marriage prohibited) Cultural views on pregnancy
4.The association between gender and condom use intentions and behaviours	Traditional Gender roles	Gendered norms within sexual relationships Gendered expectations of condom use

### **4.3 Migrant Youth experience of using condoms**

The study explored the experiences of migrant youth in terms of using condoms during sexual conduct, the measurable variables included the following: history of using condoms during sexual intercourse; the frequency of using condoms; the type of main sexual partner and relation to using condoms, and the subjective experiences of using condoms.

#### **History of Condom Use**

The history of condom use was measured against first debut of sexual activity and measured the proportion of the participants who used condoms at their first sexual debut. In addition it evaluated how decisions were made on using or not using a condom during sexual intercourse. Followed were given their account of their last sexual act whether they used a condom or not and the rationale on the decision taken.

#### **First Sexual Debut**

All participants interviewed, except one, had sexual intercourse. Their account of the first sexual debut ranges between the ages of 16 years and 20 years and with the exception of one participant, which is still a virgin at the age of 21 years.

Participants' encounters of first sexual intercourse were consistent with literature focused on African countries, which have a mean of 17 years, a median of 18 years and a modal of 24 years in a study focus on Nigerian youth (Ataman & Odaman, 2015). According to a study focusing on Sub Saharan African youth, analysing national survey data from 24 countries in Sub-Saharan Africa (SSA) a high proportion of adolescents between the ages of 15 and 19 years were sexually active (Doyle, Mavedzenge, Plummer & Ross, 2012). Significantly, it reported that females with higher education will delay sexual debut to later, due to educational

aspirations and delayed marital arrangements. However more are engaged in sexual activities with multiple partners than those with lower education levels (Doyle et al, 2012).

In South Africa, sexual debut ranged between 16 and 20 years, with a median age of sexual debut for females at 16 years and 15 years for males (Richter, Mabaso, Ramjith & Norris, 2015). It is consistent with the reasoning of delayed sexual debut due to educational aspirations and a high proportion of participants completed secondary education levels. This is coherent with the findings within this study.

Most of participants did not use condoms at their first sexual experience, due to their inexperience and ‘it just happened’ responses. Only in one instance the sexual partner used condoms based on previous experiences with sexual activities.

*The first time I had sex I was in Form 4 ... I was 18 years old ... the person I was with was also a virgin so we were thinking very little of using a condom that day. (female, 22 years old).*

Decision making process in first sexual activity was largely made by the male partner and the female was subdue to the gendered cultural roles in relationships (which will be explained later). Women assigned the decision to use condoms to their sexual partners, who in most cases had previous experiences with sexual activities. As a female (22 years old) recounted: “*I was 19 years old, for me it was my first time but the person I was with was already experienced and he was using a condom*”. In other responses, the partner did not use a condom and the respondent trusted the partner to ensure their safety. Females in the study recounted at their first sexual act, their male sexual partners who requested sexual acts should ensure their safety as love and trust are strongly associated with agreement to sexual debut activity. Males in the other hand do not have condoms in their possession at first sexual encounter occurred.

## Account of last sexual conduct

The question relating to “the last time you had sex, did you use a condom”, most respondents asserted that they indeed did not use condoms. The response is closely associated with the type of sexual partner and the length of the relationship. Responses such as “*I have a steady girlfriend (Male, 25 years)*” and “*we been dating for a long time now (Female, 23 years)*”.

Most participants who did not use condoms were in a long term relationship oppose to those who had casual relationships. This is consistent with literature as young migrants are more willing to use condoms with casual sexual partners and beginning of relationships but the frequency decrease with the length of the relationship (Higgins & Smith, 2016).

Two respondents, Amy and Mildred admitted that with their partners they had HIV test done at the beginning of their relationships and thus forego the use of condoms.

*Because, my partner was tested you see. We had to go for the HIV test and we were free to do our thing that we wanted to do. (Female, 22 years)*

*The day he asked me for sex I said no. You can't have sex with me because I don't know your status. And then we go for HIV test and he was negative and I was negative. That's why we had sex together. That's why I said there is no need for us to use condoms. We are fit, that's why. (Female, 23 years)*

However Amy later admitted that she is not sure whether her partner is faithful especially when he works away from home. They did not re-engage the topic of HIV testing when she had a suspicion of infidelity. Mildred on the other hand is an unemployed migrant, solely dependent on her partner for financial support and admitted to make all decisions in their home with regard to the household, groceries and even in the bedroom.

## **Knowledge of condom use**

Condoms are the most viable method to prevent HIV infection, and thus knowledge of condom use and HIV should be crucial predictors to intention to use condoms and translated into positive condom use behaviour. In this study, the knowledge of condom use was strongly associated with dual protection against unplanned pregnancy and sexual transmitted infections such as HIV. However knowledge does not always translate into behavioural changes (McMillan & Worth, 2010).

Inconsistent use of condoms were highlighted by most participants and was based on relationship status, length in a relationship, pregnancy prevention and trust dynamics in the partnership. Respondents with casual relationship are more likely to use condoms than those within long term relationships.

A high frequency of condom use were associated at the beginning of the relationship but became less frequent with the duration of the relationship. However an increase will be noticed if participants do not trust their faithfulness of their sexual partner during the relationship.

*“ he (partner) works away for long periods and I’m uncomfortable what he did when he was away from me, so I can’t just work on him like that without a condom ” (Female, 24 years).*

A high proportion of the women on the study did not use reproductive methods such as contraceptive pills and devices but solely rely on the use of condoms as a measure to prevent pregnancy.

*I don’t want babies just yet, so that’s one of the biggest motivation for me. I try to stay safe as I’m in a long term exclusive relationship and, so for me the biggest challenge is hmmm, I’m not good at calculating my safe periods and so I have to ensure I’m safe (Female, 25 year old).*

## **Experiences of condom use**

Evaluating the positive and negative experiences of condom use, respondents had mixture of reasons for using condoms. Positive experiences were strongly associated with preventing pregnancy and sexual transmitted infections. Negative connotations included condoms are not 100% reliable and safe due to the fact it might break and if incorrectly used can lead to pregnancy or infection of HIV and other sexual infectious diseases.

Another contributor to the positive experience to condoms are the fact that it is easily accessible and freely available in public spaces, such as public toilets, clinics, at university public spaces, etc. In addition it is cheaply available for purchase at pharmacies and all shop outlets.

*I can say where every I go one sees them, at a train station you meet a box with condoms and stuff like that, you go to public toilets and you find them there and in school they gave us so many of them (Female, 23 years) .*

The South African Children's Act (2007) provided children from the age of 12 the right to access condoms and contraceptive methods. It provided the space for children over the age of 12 to access condom distribution centres such as government clinics and schools to distribute condoms freely to young adults. This was an effort by government to reduce HIV infections and teenage pregnancies.

However, young men largely described that condoms are not pleasant to use and hinders the pleasure experience associated with sex. Men were more likely to acknowledge that condoms interfere with sexual pleasure than women would acknowledge. Women did not have an issue with using condoms but some admitted experiencing pain during sex. Both genders agreed that the positive elements outweighs the negative experience of using condoms which is prevention

of pregnancy and STIs. Despite this positive affirmation of the function of condoms, yet very few respondents use condoms on a consistent basis.

#### **4.4 Socio-Cultural factors determine the intentions of condom use**

The influence of socio-cultural factors plays a significant role in determining the intentions and behaviours towards condom use among migrant youth residing in South Africa. Factors that were explored in this study included the following: peers, partner, family, culture, religious background, knowledge, values, norms and belief systems.

##### **Partner, Peers and Family**

The results indicated that perceived support from condom use from the respondents most valued person has a positive effect on the frequency of condom use with casual partners. Within this study, partners support and peers advocacy increase the intention to use condoms. These are listed high on the respondents' choices, yet a significant number of respondents deemed their own knowledge regarding the effectiveness and safety measures of condoms use determined their intentions to use condoms and ultimately had a higher frequency of using condoms. Fishbein and Ajzen (1980), attests that individual's behaviour is formed by elements such as personality, beliefs, values, behaviours and motivations.

Sources of condom use and healthy sexual behaviour were extracted from health experts such as nurses at clinics, media resources which included news broadcasts, television programmes and talk shows, print media such as newspapers and magazines. HIV intervention programmes and educational institutions such as schools, universities and colleges with formal and informal curriculum courses or seminars were sources of condom use knowledge production. It is within the external sources that young migrants educate themselves about healthy sexual behaviours.

The results show that respondents' parents, culture and religious affiliation have an impact on the attitude of migrant youth's perception of condom use. Respondents all indicated that their parents did not talk to them about safe sex or condom use as the context of sex is only valued and supported as part of the institution of marriage which is framed by cultural and religious traditions. Communication of sex before marriage is a taboo and thus the issue of condom use in premarital state is condemned.

*My parents will never talk to me about using condoms first of all .... It is something that is very private and if your parent is talking to you about condoms it is almost as if they are saying to you yes go and have sex and make sure you use a condom. So sex is something that is prohibited as a young person especially if you are not married. So if you are young and having sex, you make sure your parents does not know that you are sexually active, Because today you can't be in a relationship and not having sex, so it is just one of those things (female, 24 years).*

Literature confirms that parent-child communication regarding safe sex is a huge barrier as parents are concern these messages will translate as positive reinforcements to become sexually active (Valezquez, 2014). Parents thus reinforce family values which ensure that sex should be in the confinement of marriage and sexual conduct outside marriage is prohibited and against moral standards.

The following quote demonstrate the impact that strong family moral and values holds for the migrant adolescent and the measures they will take to ensure that their parents do not know their sexual activity. Pregnancy is seen as a results of sexual conduct which is restricted for those who are not married. Especially those who are in South Africa on study purposes and families in their respective countries still supporting them financially. Thus adolescents 'hide' their sexual activities and use condoms to decrease the risk of unplanned pregnancy.

*You dont want to imbarress your parents and come home with a pregnancy instead of certificates from school... It is the pregnancy part that is challenging that we need to hide, that pushes you to use condoms (female, 22 years).*

Those with educational aspirations are more likely to have intentions to use condoms than those who are not in educational institutions, and thus still financially dependent on their family back home.

### **Culture and Religion**

African Migrant youth faces challenges in their construction of their identity due to strong ties to cultural and religious networks, their assimilation into the current environment and their development of self with the transition from child into adulthood (Renzaho, Dhingra & Georgeou, 2017).

The respondents in this study are all Christians and follow the doctrine of Christianity which is ‘very conservative’ and ‘rigid’ in its approach to sex education and sexual health for premarital young adolescents. Premarital sex is deemed and labelled as ‘sinful’ nature and going against the doctrine of the Church.

Sex is only valid and considered in the context of marriage and thus discussions of condom use is not applicable and bear no reference to unmarried young people.

*I would say, to my understanding – that is family and religious leaders, hmm condom use, it is something that actually are related to premarital sex and immoral behaviours to some extent. Although we know that condoms are good, it is something that is not encouraged to use. Ja it is seen as hmmm it has a lot of negativity attached to it, you know. That is what I would say it is definitely not something that are openly accepted by anyone (Female, 20 years).*

Cultural values are consistent with these views as certain rights of passage or cultural traditions/customs should be followed when two people become intimate, protocols which include marriage negotiations and customary marriages such as Lobola and traditional weddings.

*I think, I'm talking now from my background and country of origin. Ja there is that high moral standard and a bit of conservativeness, around certain things, anything related to sexual things, sexuality in general (Female, 25 years)*

Strong opinions of these statements were raised from respondents originating from rural areas and those in urban areas highlighted these sentiments but acknowledge that these cultural ideologies are not as stringent as in rural areas. However, cultural ideologies remains fairly intact when discussing adolescent sex education and sexual health issues.

#### **4.5 The association between cultural values and intentions to condom use**

The impact of traditional norms on sexual behaviour focused primarily on virginity and the delay of early sexual initiation until marriage. HIV policy and program responses to HIV prevention included traditional African norms as a means to reduce the risk of HIV infections. These are particularly more effective in rural areas in Sub-Saharan Africa, as the distribution of condoms are very low compared to government expenditure in urban areas (Molla, Berhane, Lindtjorn, 2008). However due to the increase of higher educational aspirations of young people coupled with delayed marital status, these programmes needs to be adjusted as earlier debut of sexual activities increases amongst young African adolescents (Molla, Berhane, Lindtjorn, 2008).

In this study, cultural values have a significant impact on the intentions of participants to use condoms more frequently, especially those on study visas extending their education in South

Africa. The use of condoms is not directly based on the idea of HIV risk perception but more intensely on violating cultural norms which ‘brings shame to the family’. The individual is not solely held responsible for violating cultural standards, but the family as a whole is responsible for the misdemeanour of premarital pregnancies. This is illustrated by the following statement:

*I think people from my society, I think might use condoms, because usually when they fall pregnant like before marriage, it seen as, errr , shame the family , so if you tend to use a condom , you use it with the intent of avoiding such labels , avoiding to bring shame on the family (Female, 21 years).*

Labelling of ‘shame’ is directly interpreted as family socialisation and the values/ norms parents have instilled in their children. Parents did not ‘*train their children that’s why they are falling pregnant*’ (Female, 21 years) are common believe systems when cultural and religious norms are violated, and these cultural values are upheld strongly within the African cultural societies. Rules and expectations of behaviour within cultural and social groupings are deeply imbedded within the psyche of individuals associated with the particular groups. Violating these rules results in painful shaming and exclusion based on stigma.

Marriage is the cultural institution that contains sexual activities which safe guard against labels such as immoral, loose woman, shaming family and multiple sex partners. These cultural values protects family pride and family stature within the broader society.

The intense pressure to uphold these cultural values of virginity and marriage is clearly tangible in the response of the only respondent that was still a virgin in this study, her response as follows:

*my culture, it’s something that is procedural, like first of all, you go with your boyfriend when you want to get married, to be introduced and then you get*

*married, it doesn't matter if you have intercourse after that , but you mustn't do that before marriage, so as a cultural perspective, it contains me or restricts me from indulging in sexual activities because, they are expected , my parents and society, they are expecting me to do that sexual activity after I get married, so certain procedures need to follow (Female, 21 years).*

These cultural values and messaging of sexual safety and the risk of HIV infection is limited and only considered within the confinements of marriage. It is in direct contrast with the ideology of the young migrant who have premarital sex and finding possible pathways to ensure their sexual safety is ensured by considering the use of condoms. However it becomes a challenging route of discovery if they are not efficiently guided by their family structure and societal cultural institutions. The isolation of 'hiding' their sexual activities impair their rationale to make good decisive decisions regarding negotiating the use of condoms, the use of contraceptives in general and engaging with their partners to ensure safer sexual conduct.

Cultural taboo of sex education for premarital adolescence place young migrant Africans at a vulnerable place in their phase of transition to adulthood. Inconsistent use of condoms and inconsistent use of contraceptives were closely associated with those adolescents who have to hide their sexual activity from their family.

Peers become a crucial source of information regarding the use of condoms and general discussion of sex education. Individually young people have to source their own sex education via media platforms as means of knowledge production, removed from the opportunity to discuss more in-depth and intimate intricacies of sexual relationships and sexual healthy living.

The intention to use condoms was largely driven by cultural taboos, stigma around premarital sex and teenage pregnancy. However these negative connotations regarding condom use deter or prohibit young migrant youth to access condoms even though they easily available at public spaces or cheaply available at all shop outlets and pharmacy outlets.

#### **4.6 The linkages between gender and condom use intentions and behaviours**

Within this study setting, there is a significant difference between gender and condom use intentions and behaviours. Power relations in sexual relationships plays a crucial role and gendered approaches to safer sexual conduct are skewed and challenges the negotiation of condom use. A woman in a sexual relationship is more likely to be challenged to negotiate the use of condoms than a man in a sexual relationship. This is largely influenced by the traditional gender norms and gendered roles within a sexual relationship (Teitelman, Bohinski, & Tuttle, 2010).

##### **Traditional gender norms**

Teitelman et al (2010), depicts that sexual gender norms plays an important factor within a sexual relationship. They highlighted the following as common trends in their study with women discussing their relationships and sexual gendered norms, namely: expectations of sex, partner non-monogamy and non-condom use. It reduces the young women's sexual relationship power and increase sexual inequality which disadvantage them in negotiating for safer sexual practices.

Similar trends emerged from this study, this normative expectation that sex is used as a mechanism to ensure partner's faithfulness and satisfactions are fulfilled within the relationship. Sex placed a high value in the relationship and a means for women to retain their partners and increase their faithfulness and loyalty in the relationship.

Followed is an extract from a participant discussing the importance to ensure her partner is faithful and the means she undertook to ensure that he remains loyal:

*I mean he is a man, South Africa is a country where women are everywhere and a temptation might come that he could not resist. So I need to make sure that he doesn't look around (Female, 22 years).*

Most of the female participants acknowledges that infidelity or the opportunity for their partner to be unfaithful is present, and some have suspected their sexual partners to be unfaithful. They understood from a normative perspective that their male partners could cheat as cultural beliefs provided the expectations that men can have multiple partners and or additional casual relationships.

*I don't know what he does when he is not with me, if he is sleeping around with other women, you know South Africa has become a dangerous place for our young people, sex is everywhere, you walk down the street you find sex, you go to the club you find sex... Sex has become careless and we don't respect sex anymore (Female, 24 years).*

The greatest challenge in the study for females participants were the challenge to negotiate condom use with partners as most of the partners do not like the idea of using condoms. It becomes an issue of contention when the female distrust or suspect their partner of infidelity or 'cheating'. The risk of contracting sexual transmitted infections are a great concern and thus opt to use condoms or if partner do not want to use condoms the option for HIV test were highlighted. However the participant with a lower education level than Matric acknowledges the fact that negotiating condom use with her partner is limited as her partner is the sole breadwinner and thus leave all decision making processes in his hands. Most of the female

participant with higher than Matric education level felt that they have to some degree a sense of autonomy and control and a more equal relationship with their partners.

### **Gendered expectation of condom use**

The challenge for young migrants are not to access condoms as they are freely available at public spaces and cheaply available at shopping malls and pharmacy outlets. The freedom to buy or take condoms are major challenges for young people as the fear of stigma, labelling, self-conviction (shame, sin) deter young migrants to access condom distribution places or independently buy condoms. The pressure of societal perception of condom usage with regard to young people are negatively associated and negative connotations regarding condom use. Christian values prohibits sex before marriage and deemed as a 'sin' to engage in sexual activities. The implication to request condoms from public spaces or private outlets is deemed to high due to fear of stigma and self-conviction that young migrants do not freely obtain condoms.

Several young females in this study, vocalised that they would never buy condoms and expect their male partners to obtain condoms.

*I don't buy condoms but from my knowledge and experiences I know that it is freely available. Ahh my partner does the buying of condoms, I don't think I will be able to ... a lady purchase a condom openly might be considered to be someone that's loose, so many bad things are attached to it , so for me I'm not even free to go buy, that is one of my biggest hindrance, in that instances ... It's for a guy acceptable, for a man maybe, but even for him (boyfriend)it is not that easy to buy it (Female, 25 years).*

The expectation is very high for the male in the relationship to purchase or have condoms readily available. However, male participants described how difficult it is to freely buy or take

condoms from public and private distribution outlets. They are reluctant to obtain condoms and buying is usually difficult and *'hide or snuck them in between other groceries, but to buy it separately is not done without ease'* (Male, 25 years).

The expectation to use condoms are strongly evident with these young people, yet their ambivalence is in conflict with social norms or sexual scripting with regards to use of condoms. Female respondents acknowledge that their male counterparts should be in possession of condoms, which place responsibility with males. Females believed that socially it is not acceptable for a lady or female to have condoms as it will come across that they are sexually experienced and have multiple partners or "loose" women. Even though they would want to use condoms it prohibited them from having condoms in their possessions.

Similarly, males in this study, have ambivalent feelings regarding negotiating condom use with their female partners, as similar issues of mistrust and multiple partners were raised. The challenge of obtaining condoms and societal negative views on condoms, minimise their intention to use condoms and negotiate about the use of condoms.

#### **4.7 Predicting Intention to use condoms**

The Theory of Planned Behaviour (TPB) is a predictive model for explain human behaviour (Durmaz, 2011). The theory is based on the idea that human's actions is based on rational and systematic use of information available to them (Ajzen & Madden, 1985). Within this study, we will evaluate the TPB theory as a measure to understand socio-cultural determinants influencing migrant youth's intention and behaviour towards condom use. TPB is grounded in the following concepts of attitudes, subjective norms and perceived behaviour control and to some degree influence intentions of behaviour. This theory is a useful theory to understand the determinants of socio-cultural perspective of young migrants on condom use.

According to Nurmala (2009) who reviewed six publications addressing the TPB theory in predicting condom use behaviour, concluded that TPB as a theory provides a strong predictive power for condom use behaviour. Within this study, a positive attitude towards condom use, coupled with a positive reinforcement from partners and peers with a greater confidence to negotiate condom use, shows an increased intention to use condoms. However with regard to socio-cultural factors, a stronger sense of intention to use condoms is noticed with participants who have parental pride and career goals as predictive measures. It is also observed in participants who see themselves as equals within the relationship and can make decisions regarding safer sexual conducts.

On the other hand, the intention to use condoms is less in participants who have negative attitudes towards condoms, conflictual messaging of society, cultural and religious networks towards condom use. In addition, those who see themselves less in control of making decisions about sexual safety within a cultural context of gendered roles within relationships.

#### **4.8 Acculturation and condom use**

Acculturation is the process whereby migrants infuse ideologies of receiving countries to their cultural ideologies (Berry, 2003). It is a cultural and psychological adjustment due to contact between two or more cultural groups and their individual members (Berry, 2005).

The study evaluated acculturation and condom use with variables such as 'length of stay in South Africa' and 'perceptions changed now living in South Africa'. The length of stay in South Africa ranged between 2 years and 9 years, with the highest frequency of stay were 3 years (11 participants).

Participants compared their views on sexual issues from their native country to their experiences living in South Africa. The general consensus of participants is the idea that

premarital sex is accepted more fairly in South Africa than in their native country. Followed is an insert from Trevor who lived in a rural area in Zimbabwe and migrated to urban area in Cape Town.

*I think one thing migrating does is kind of weans you away from the people who knows you like your mother/father , those people who make more about having sex and what not. So you come to a country such as South Africa, it is very liberal , and not interested or care about what you do - it kind of gives you abit more freedom, ..... So I dont know if its coming to South Africa or just being away from home with out the supervision of your care givers ..... but you know if you were still living at home you would not bring a girl home, cause you mother would probably freck out. especially if she knows the girl is sleeping here or i'm sleeping at her place.*

This is quite an interesting observation by a male participant (25 years), questioning whether his liberal notions of sex is based on the acceptable culture of South Africa of premarital sex or whether it is the idea of distance between social and cultural ideologies of his rural native community. However he later in the interview reflected:

*we no longer as cultural as we used to be.... Perhaps when I go home again I might become more cultural but here where I'm now they are more liberal and so we become more liberal”.*

In contrast a female participant (22 years), oppose the South African culture of views on premarital sex or sex in general that results in at-risk for young people for sexually transmitted infections.

*South Africa somehow has become dangerous for our young people . . . Sex has become careless we dont respect sex anymore. If you walk down the street, you find sex, you enter the club, you find sex . . . its so easy to get sick, because when you having all that sexual intercourses with different partners you not protecting yourself.*

Sexual partners are too easily obtainable and a high proportion of young migrants indicated not to have sexual relationships with South African counterparts as they are too

intend on having multiple sexual partners and not always using a condom. They feel they will be more at risk of HIV infection being with a South African than being in a sexual relationship with their native people. South African young people take risk and have unprotected sex. A female (24 years) narrated:

*“I would not date someone from South Africa, I’m really scared”.*

The positive contribution of living in South Africa is the freedom to obtain condoms and the multiple distribution sites make it easily accessible, unlike their countries of origin. Participants feel a greater sense to freely obtain condoms yet various socio-cultural factors prohibit them from feeling at ease to obtain those condoms. A female (25 years) recounted her experience as follows:

*It (condoms) is well promoted in South Africa and easily accessible than my country ... There is some reluctance from my boyfriend to buy condoms ... you can be stigmatised from just buying a condom, that’s a little bit of societal norms that exists ... I think it’s an issue.... That is why I won’t buy them.*

Even though acculturation has occurred with regard to the freedom to have sexual intercourse with who one chooses to, the idea of multiple partners and frequently inconsistent use of condoms are frowned upon. In this sense, migrant youth’s sexual behaviour in South Africa has changed and a much more awareness of the use of condoms as risky sexual behaviour is frequent within the South African youth population. In conclusion, acculturation did not occur within these migrant youth to some large extent as socio-cultural values are remain evident in their thought processors. A possible explanation is the duration of stay in South Africa might be too short to make a feasible analysis, and thus no general assumptions could be inferred.

## **4.9 Conclusion**

This chapter discussed the finding of the research study based on the data collection process and the data analysis framework that was employed. The research findings resonates with other research studies in similar settings, however there is a paucity in literature regarding African migrant youth residing on the continent of Africa.

## **CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS**

### **INTRODUCTION**

The main aim of the study was to examine the social and cultural contexts of young migrants that influence or impact on their intentions and behaviours towards condom use. In-depth interviews were conducted with twenty migrant youth from Sub Saharan African countries living in South Africa, special reference to the Western Cape.

This chapter presents the conclusion and recommendation of the research study. It will draw conclusion from each objective of this study and propose recommendations which will ultimately provide appropriate strategic guidelines for HIV programmes directed to African migrant youth residing within South Africa.

#### **5.1 Conclusions**

The main conclusions are drawn from the research findings and are presented in relation to the objectives of the study.

The findings indicated that condom use amongst migrant youth residing in South Africa are inconsistent and largely based on relationship type, length of relationship and the degree of trust in the relationship. First sexual debut were between the ages of 16 years and 20 years and showed consistency with South African youth first sexual debut account. However a high proportion of the migrant youth debut later (age 18 years) due to higher educational aspirations and delayed marital arrangements. The use of condoms at first sexual debut was very low and this was due to inexperience and unplanned moment of sexual intercourse.

Migrant youth in this study with a higher education level of tertiary training have a good understanding of the function of condoms and reasons for condom use as measures to prevent pregnancy, method of contraceptives and ultimately safety against sexual transmitted diseases

such as HIV. However, knowledge does not translate to practice as most of respondents did not use condoms consistently, even when they suspect their partners of not being faithful.

The use of condoms peaked at the beginning of relationships or with casual multiple partners and decrease within relationships and the length of relationships. Female respondents did indicate that with trusting barriers they would insist on negotiating the use of condoms. However male partners have negative experiences of using condoms and is strongly associated with lessening the pleasure of sex and intimacy. They also question the effectiveness of condoms as the possibility of breakage is high and could lead to pregnancies and at risk for HIV infection. Females responses of negative experiences with condom use are largely due to painful experience during sex but ultimately the decision to use condoms are largely left in the hands of the male sexual partner.

Females who do use condoms in this study narrated it as their only method of contraceptives as alternative methods of contraceptives have negative side effects such as weight gain. Men who do use condoms in this study reasoned to delay pregnancy and due to their studies are not ready to be fathers.

The study findings also showed linkages between condom use intentions and behaviour with social cultural factors. Migrants' intentions to use condoms are hugely influence with the attitudes and values of social and cultural networks. A positive association with condom use shows more likely that migrant youth will use condoms. However a negative association with condoms use by social and cultural networks shows a decline in intentions to use condoms.

Partners and peer groups showed a significant influence on the migrant youth's intentions to use condoms and ultimately use condoms. Respondents listed their own knowledge and attitudes regarding condom use as a measure of intention. External sources such as health

experts, educational institutions, and social and printed media platforms are viewed as mediums to educate migrant youth on safer sexual practices.

Parents, culture and religious affiliations and networks have a negative impact on migrant youth's intentions and behaviour towards condom use. Safe sex talks are taboo and in direct contrast with cultural values regarding marriage and sexual conduct. Christian doctrines are conservative and rigid toward sex education and sexual health for premarital young migrants.

There is a significant barrier between migrant youth and parents, cultural values and religious doctrine. Migrant youth hide their sexual activities and have positive intentions to use condoms as a strong predictor. However, due to the lack of support from immediate family it is a challenge to navigate their decisions on safer sex practices as certain cultural values deter them from using condoms, especially with gendered roles in sexual relationships.

Cultural values had a significant impact on the intention to use condoms among these migrant youth. Even though it seems there is a positive association between cultural values and the intention of using condoms, there is great concern for stigma, isolation and labelling when premarital sex and the use of condoms becomes evident. Cultural taboo of sex education for premarital migrant youth place them at risk for unsafe sexual practices. The notion that condom use are the most common use of contraceptives and the use of other contraceptives were pushed to the side speaks to the fact that sexual conduct should be in secret and hidden from other elders within society at large, thus the use of clinics were not an option for these young migrants.

Gender plays a significant role in socio-cultural contexts and provides variations within the reasons for intentions and behaviours towards condom use in sexual relationships. Power relations have an immense influence on the male/female connotation within the relationship. Traditional gender norms and values place women at a less powerful position and at risk for non-condom use and ensuring pleasure of sex of their male partners. Condom decisions are

largely decided by the male partner, yet female partners with higher education levels and older than 23 years, shows a positive contribution of being in a position to negotiate condom use, even though it might not be successful on all occasions.

Gendered expectations of condom use place more emphasis on the males to be in possession of condoms, and culturally it is expected of them to have condoms when they are not married to safeguard females from pregnancy- and bringing shame on family. The expectation to use condoms are strongly evident in the narratives of these young people, however they are reluctant due to social norms and sexual scripting regarding the use of condoms. Both genders are reluctant to raise the issue of condom use due to labelling of mistrust, promiscuous and unfaithfulness, which is derived from social norms and cultural values.

## **5.2 Recommendations**

There is a need to targeted and redesign messages promoting condom use amongst migrant youth residing in urban areas such as Cape Town. The reason is based on the rationale that the contexts of migrant youth are completely different from those in their country of origin.

Socially, religious and culturally sensitive programming should be incorporated within the HIV and Sexual Risk intervention programmes, which will ensure stigmatised issues such as premarital sexual conduct, early sexual debut, HIV risk behaviour, teen contraceptive use become mainstream within society and service deliveries which are accessible to migrants.

The social realities of migrant youth these days are outside of the scope of any social and cultural ideologies as youth delay marriage due to purse of higher education. Cultural and religious institutions should review their ideologies as currently value systems does not apply to some extent to the migrant youth who is of age to have sexual experience, yet not married. Safer sexual conduct and sex education should be revisited for these premarital migrant youth,

as cultural and religious contexts plays a pivotal role in their decisiveness regarding life decisions.

Based on the findings, it is evident that there are some areas that requires some further investigation. The sample size of this study is limited to twenty participants and cannot make inference on the cohort of migrant youths living in Cape Town or South Africa. A more focused and rigorous investigation into socio-cultural determinants of condom use in the migrant youth population will provide a more detailed analysis of factors that hinders condom use intentions and behaviour.

## REFERENCES

- Ajzen, I. & Sexton, J. (1999). Depth of processing, belief, congruence, and attitude-behaviour correspondence. In Chaiken, S. & Trope, Y. (Eds). *Dual process theories in social psychology*, 117- 138. New York: Guilford.
- Araoye, A. (2015) *South Africa, the Global Immigration Crisis and the Challenge of African Solidarity*. *The Thinker*, 65 (3), Retrieved from <http://www.thethinker.co.za/resources/65%20araoye.pdf>
- Arksey, H., & Knight, P.T. (1999). *Interviewing for Social Scientists: An Introductory Resource with Examples*. London: SAGE Publications.
- Ataman, J.E. & Odaman, O.M. (2015). *Youth sexuality and youth at first sexual intercourse in Edo central, Nigeria*. *Annals of Biomedical Sciences*, 14 (1), 51-59.
- Avert. (2015). *HIV transmission and Prevention*. Retrieved September 2015 from AVERT.org: <http://www.avert.org/>.
- Azjen, I. & Madden, T.J. (1985). *Prediction of Goal-Directed Behavior: Attitudes, Intentions, and Perceived Behavioural Control*. *Journal of Experimental Social Psychology*, 22, 453-474.
- Azjen, I. (2002). *Perceived behavioural control, self-efficacy, locus of control and the theory of planned behaviour*. *Journal of Applied Social Psychology*, 32, 665- 683. Doi:10.1111/j.1559-1816.2002.tb00236.x.
- Azjen, I. (1985). From intentions to actions: A theory of planned behaviour. In J. Kuhl & J. Beckman (Eds.) *Action control from cognition to behaviour*. Heidelberg: Springer.
- Azjen, I. (1991). *The theory of planned behaviour*. *Organizational Behaviour and Human Decision Processes*, 50, 179 -211.
- Babbie, E. & Mouton, J. (2007). *The practice of social research*. Cape Town: Oxford University Press.

- Bam, K., Thapa, R., Newman, M.S., Bhatt, L.P. & Bhatta, S. K. (2013). *Sexual Behaviour and Condom Use among Seasonal Dalit Migrant Laborers to India from Far West, Nepal: A Qualitative Study*. Plos One Journal, 8 (9), 1-10. Doi: 10.1371/journal.pone.0074903.
- Bekker, L.G. & Hosek, S. (2015). *HIV and Adolescents: focus on young key populations*. Journal of the International AIDS Society. 18(1), 1- 07. Doi: 10.7448/IAS.18.2.20027.
- Bennet, P. & Bozionelos, G. (2000). *The Theory of planned behaviour as predictor of condom use: A narrative review*. Psychology Health & Medicine, 5, 307-326. Doi: 10.1080/713690195.
- Berry, J. W. (1980). Acculturation as varieties of adaptation. In A. M. Padilla (ed.), *Acculturation: Theory, models and some new findings*. Westview: Boulder.
- Berry, J.W. (1997). *Immigration, Acculturation and Adaption*. Journal of Applied Psychology, 46 (1), 5-68. Doi: 10.1111/j.1464-0597.1997.tb01087.x.
- Berry, J.W. (2005). Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations. 29, 697-712. Doi:10.1016/j.ijintrel.2005.07.013.
- Berry, J.W., Phinney, J.S., Sam, D.L., & Vedder, P. (2006). *Immigrant Youth: Acculturation, Identity and Adaptation*. Journal of Applied Psychology, 55 (3) 303-332.
- Best, J. W. & Kahn, J. V. (2006). *Research in education*. USA: Pearson.
- Bilic, B. (2005). *The theory of Planned Behaviour and Health Behaviours: Critical Analysis of Methodological and Theoretical Issues*. Hellenic Journal of Psychology, 2, 243-259.
- Boer, H. & Westhoff, Y. (2006). *The Role of Positive and Negative Signaling Communication by Strong and Weak Ties in the Shaping of Safe Sex Subjective Norms of Adolescents in South Africa*. Communication Theory 16 (1), 75-90. Doi:10.1111/j.1468-2885.2006.00006.x.
- Boer, H. & Mashamba, M. (2005). *Psychosocial correlates of HIV protection motivation among black adolescents in Venda, South Africa*. AIDS Educ Prev. 17 (6) 590- 602. Doi: 10.1521/aeap.2005.17.6.590.

- Carmack, C. & Lewis-Moss, R. (2009). *Examining the Theory of Planned Behaviour Applied to Condom Use: The Effect-Indicator vs. Causal-Indicator Models*. *J Prim Prev*. 30(6), 659-676. Doi: 10.1007/s10935-009-0199-3.
- Chereni, A. (2014). *A Methodological Approach and Conceptual Tools for Studying Migrant Belongings in African Cities: A Case of Zimbabweans in Johannesburg*. *Forum: Qualitative Social Research*, 15 (1).
- Coast, E. (2006). *Local understanding of, and responses to, HIV: Rural-urban migrants in Tanzania*. *Social Science & Medicine*, 63, pp. 1000-1010.
- Collins (2011). *English Dictionary and Thesaurus*. 11<sup>th</sup> Revised Edition. United Kingdom: Collins Publisher.
- Creswell, J.W (2007). *Qualitative inquiry and research design: Choosing Amongst Five Approaches*. Second Edition. Thousand Oaks: Sage Publishers.
- Davis, K.R., & Weller, S.C. (1999). *The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV*. *Family Planning Perspectives*, 31 (6), 272-279. Doi: <https://doi.org/10.1363/3127299>.
- De Vos, A.S. (2005) *Research at Grassroots: For the Social Sciences and Human Sciences Professionals*. Pretoria: Van Schaik Publishers.
- De Vos, A.S., Strydom, H., Schulze, P. & Patel, L. (2011). The science and the profession. In De Vos, H., Fouché, C.B. & Delpont, C.S., *Research at the grassroots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.
- De Vos, H., Fouché, C.B. & Delpont, C.S. (2005). *Research at the grassroots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.
- Doyle, A.M., Mavedzenge, S.N., Plummer, M.L & Ross, D.A. (2012). *The sexual behaviour of adolescents in Sub-Saharan Africa: patterns and trends from national surveys*. *Tropical*

Medicine and International Health. Volume 12, No 7, pp 798-807. Doi: 10.1111/j.1365-3156.2012.03005.x.

Du, H., & Li, X., (2015) *Acculturation and HIV related sexual behaviours among international migrants: a systematic review and meta- analysis*. Health Psychology Review, 9 (1) 103 - 122. Doi: 10.1080/17437199.2013.840952.

Durmaz, M. (2011). *Young Adult migrants' role in stimulating participation in breast cancer screening of older female family members*. Free University, Amsterdam. (MA thesis).

Feldman, M., Bell, J. & Berger, M. (2003). *Gaining access: a practical and theoretical guide for qualitative researchers*. California: Alta Mira Press.

Field, M. J. & Behrman, R. E. (2004). *Ethical conduct of clinical research involving children*. Washington, D.C: National Academy of Sciences.

Fishbein, M. & Ajzen, I. (1980), *Understanding attitudes and predicting social behaviour*. Englewood Cliffs, NJ: Prentice-Hall.

Fishbein, M. & Ajzen, I (1975) *Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Research*. Massachusetts: Addison- Wesley.

Gubruim, J.F & Holstein, J.A. (2001) *Handbook of Interview Research: Context and Method*. Sage Publications. Thousand Oaks.

Gushulak, B.D., Weekers, J., & MacPherson, D.W. (2010) *Migrants and emerging public health issues in a globalised world: threats, risks and challenges, an evidence-based framework*. Emerg Health Threats Journal. 2, (10). Doi: 10.3134/ehjt.09.010.

Halai, A. (2006). Ethics in Qualitative research: Issues and Challenges. Plenary Address: *Multi-Disciplinary Qualitative Research in Developing Countries*, Aka Khan University, Karachi, November 2006: Edqual Working Paper No.4: Pakistan.

Halli, S., Moses, S. & Blanchard, J., (2007). *Migration and HIV transmission in rural South India: an ethnographic study*. Cult Health Sex, 9 (3) (85-94). Doi:10.1080/13691050600963898.

- Haque, M.R. & Soonthorndhada, A. (2009). *Risk Perception and Condom-use among Thai Youths: Findings from Kanchanaburi Demographic Surveillance System Site in Thailand*. Journal of Health Population Nutrition, 27 (6), 772-783.
- Harttgen, K. & Klasen, S. (2008). *Well-being of Migrant Children and Migrant Youth in Europe*. Ibero America Institute for Economic Research (IAI) Discussion Papers. Germany.
- Hennie, S. & Lattes, P. (2011). *International Migration in a globalised world: The role of Youth*. 2011 Global Migration Group Symposium. New York.
- Higgins, J.A., Hoffman, S. & Dworkin, S.L. (2010). *Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS*. Am J Public Health. Vol 100 (3), 435-445. Doi: 10.2105/AJPH.2009.159723.
- Higgins, J.A. & Smith, N.K. (2016). *The Sexual Acceptability of Contraception: Reviewing the Literature and Building a New Concept*. Journal Sex Res. 3 (53), 417-456. Doi: 10.1080/00224499.2015.1134425.
- Hunt, L.M., Schneider, S. & Comer, B. (2004). *Should "acculturation" be a variable in health research? A critical review of research on US Hispanics*. Social Science & Medicine, 59, 973-986. Doi: 10.1016/j.socscimed.2003.12.009
- International Organisation for Migration (2013). *World Migration Report: Migrant Well Being and Development*. Switzerland.
- Iwara, F. & Alonge, A. (2014). *Sociocultural and economic factors influencing the use of HIV/AIDS information by women in Ugep, Cross River State, Nigeria*. Library Philosophy and Practice, 1141 (7).
- John-Langba, J. (2007). *The relationship of sexual and gender-based violence to sexual risk behaviour among refugee women in Sub-Saharan Africa*. World Health Population. 9(2), 26-37.
- Jones, G. (2002). *The Youth Divide: Diverging paths to Adulthood*. York: Joseph Rowntree Foundation.

- Kapadia, F., Latka, M.H., Wu, Y., Strathdee, S.A., Mackesy-Amiti, M.E., Hudson, S.M., Thiede, H. & Garfein, R.S. (2011). *Longitudinal Determinants of Consistent Condom Use by Partner Type Among Young Injection Drug Users: The Role of Personal And Partner Characteristics*. *AIDS Behav*, 15, 1309-1318. Doi: 10.1007/s10461-009-9569-3.
- Khan, F. (2007). *Local Integration: The preferred durable solution*. Prepared for UNHCRs 2007 Annual Consultations with NGOs. Geneva, Switzerland, 26<sup>th</sup> September 2007.
- Kirpitchenko, L. & Mansouri, F. (2014) *Social Engagement among Migrant Youth: Attitudes and Meanings*. *Social Inclusion*, 2, 17-27.
- Kondowe, C. (2014). Exploring the circumstances and experiences of youth immigrants when establishing and running a successful informal micro-business. University of Western Cape (MA thesis).
- Kothari, C.R. (2004). *Research Methodology: Methods and Techniques. Second Revised Edition*. New Delhi: New Age Publishers.
- Landau, L.R. & Segatti, A.W (2009). *Human Development Impacts of Migration: South Africa Case Study*. Human Development Research Paper (HDRP) Series, 05.
- Lincoln, Y.S. & Guba, E.G. (1985) *Naturalistic Inquiry*. Newbury Park: Sage Publication.
- Lugella, J., Emmelin, M., Mutembei, A., Sima, M., Kwesigabo, G., Killewo, J. & Dahlgren, L. (2004). *Social, Cultural and Sexual Behavioural Determinants of observed decline in HIV Infection trends” Lessons from the Kagera Region, Tanzania*. *Soc Sci Med*, 59 (1), 185-98. Doi:10.1016/j.socscimed.2003.10.033.
- Macaluso, M., Demand, M.J., Artz, L.M. & Hook. E.W. (2000). *Partner Type and Condom Use*. *AIDS* 2000, 14 (5), 537-546.
- Magadi, M.A. (2013). Migration as a risk factor for HIV infection among youths in sub-Saharan Africa: evidence from the DHS. In Jaurez, F. (Ed) *Youth Migration and transitions to adulthood in developing countries*. Los Angeles: Sage Publication.

- Marshall, C. & Rossman, G. (2011). *Designing Qualitative Research. Fifth Edition*. Thousand Oaks: Sage Publication.
- Marshall, M.N. (1996). *Sampling for qualitative research*. Family Practice, 13 (6), 522 – 525.
- Marston, C. & King, E. (2006) *Factors that shape young people's sexual behaviour: a systematic review*. Lancet. 368 (9547), 1581-1586. DOI:10.1016/S0140-6736(06)69662-1.
- Mason, J. (2002) *Qualitative Researching, 2<sup>nd</sup> Edition*. London: Sage Publications.
- Mberu, B.U. (2009). *Protection before the harm: The case of condom use at the onset of premarital sexual relationship among youths in Nigeria*. African Population Studies. 22 (1) 57-83.
- McMillan, K. & Worth, H. (2010). *The impact of socio-cultural context on young people's condom use: evidence from two Pacific Island countries*. Cult Health Sex. 13(3) 313-326. DOI:10.1080/13691058.2010.529945.
- Mececins Sans Frontieres (MSF). (2013) *Mobile care for Mobile populations in Musina, South Africa*. 15 November 2015.
- Mgabo, M. (2009). *Socio-Cultural Factors and Challenges on condom use among Fishing Communities in Tanzania. A case of Lukuba Island, Musoma Rural District*. Makerere University. (MA Thesis).
- Molla, M., Berhane, Y. & Lindtjorn, B. (2008). Traditional values of virginity and sexual behaviour in rural Ethiopian youth: results from a cross-sectional study. BMC Public Health, 8 (9), 1-10. Doi: 10.1186/1471-2458-8-9
- Morse, J.M., Barrett, M., Mayan, M., Olson, K. & Spiers, J. (2002) *Verification Strategies for Establishing Reliability and Validity in Qualitative Research*. International Journal of Qualitative Methods, 1(2), 1-19.
- Munyewende, P., Rispel, L.C., Harris, B., Chersich, M. (2011). *Exploring perceptions of HIV risk and health service access among Zimbabwean migrant women in Johannesburg: A gap in health*

- policy in South Africa?* Journal of Public Health Policy. 32 (1), 152-161.  
Doi:10.1057/jphp.2011.36.
- Musariri, L. (2012). *Determinants of Condom Use Among Migrant Farm Workers in Two South African Provinces*. University of Witwatersrand, Johannesburg. (MA Thesis).
- Nguyen, A. & Benet-Martinez, V. (2013). *Biculturalism and Adjustment: A Meta-Analysis*. Journal of Cross Cultural Psychology. 44, 122-159. Doi: 10.1177/0022022111435097
- Nurmala, I. (2009). *Determinants of Condom-Use Behaviour from Studies Using the Theory of Planned Behaviour: A Literature Review*. Indonesian Journal of Public Health, 6 (1), 1-10.
- Odimegwu, C. & Somefun, O. (2017) *Ethnicity, gender and risky sexual behaviour among Nigerian youth: an alternative explanation*. Reproductive Health. 14 (6), 01-15. Doi:10.1186/s12978-017-0284-7.
- Oyediran, K.A., Feyisetan, O.I. & Akpan, T. (2011) *Predictors of condom-use among young never-married males in Nigeria*. J. Health Popul Nutri. 29 (3), 273-285.
- Parks, K.A., Ya-Ping, H., Collins, R.L., Radloff, K.L. & King, L.P. (2009) *Predictors of Risky Sexual Behaviour with New and Regular Partners in a Sample of Women Bar Drinkers*. J. Stud Alcohol Drugs. 70 (2), 197-205.
- Pettifor, A.E., Measham, D.M., Rees, H.V. & Padian, N.S. (2004). *Sexual Power and HIV Risk, South Africa*. Emerg Infect Dis, 10 (11) 1996-2004.
- Pfarrwaller, E. & Suris, J.C. (2012) *Determinants of health in recently arrived young migrants and refugees: a review of the literature*. Italian Journal of Public Health, 9 (03). Doi: <http://dx.Doi.org/10.2427/7529>.
- Preston-Whyte, E. (1999) Reproductive health and the condom dilemma: identifying situational barriers to HIV protection in South Africa. In J. Caldwell (Ed.), *Resistances to Behavioural Change to Reduce HIV/AIDS Infection*, 139-155. Australia.

- Redfield, R., Linton, R. & Herskovits, M. J. (1936). *Memorandum for the study of acculturation*. American Anthropologist, 38, 149-152. Doi: 10.1525/aa.1936.38.1.02a00330.
- Renzaho, A., Dhingra, N., & Georgeou, N. (2017). *Youth as contested sites of culture: The intergenerational acculturation gap amongst new migrant communities- Parental and young adult perspectives*. Plos One. 12 (2) 1- 19. 10.1371/journal.pone.0170700.
- Republic of South Africa. (1994). *Constitution of South Africa*. Pretoria. Government Gazette.
- Republic of South Africa. (1998). *Refugees Act 130 of 1998*. Pretoria. Government Gazette.
- Republic of South Africa. (2002). *Immigration Act (Act 13 of 2002)*. Pretoria. Government Gazette.
- Republic of South Africa. (2004). *Immigration Act of 2002*. Pretoria. Government Gazette.
- Republic of South Africa. (2007). *The South African Children's Act*. Pretoria. Government Gazette.
- Republic of South Africa. (2009). *National Youth Development Act, 2008 (Act No. 54 of 2008)*. Pretoria. Government Gazette.
- Republic of South Africa (2012). *National Strategic Plan for HIV, STI and TB (2012-2016)*. Pretoria. Government Gazette.
- Republic of South Africa (2016). *Green Paper on International Migration in South Africa*. Pretoria. Government Gazette.
- Richter, L., Mabaso, M., Ramjith, J., & Norris, S.A. (2015) *Early sexual debut: Voluntary or coerced? From longitudinal data in South Africa-the Birth to Twenty Plus study*. S.Afr Med J. 105(4), 304-307.
- Rijks, B. (2014). *Health, Youth Migration and Development*. New York: UNICEF.
- Seedat, M., Duncan, N., & Lazarus, S. (Eds) (2001). *Community Psychology theory, method & practice*. Cape Town: Oxford University Press.
- Statistics South Africa. (2013). *Documented immigrants in South Africa*. Pretoria: Statistics South Africa.

- Strydom, H (2011) Participatory action research. In De Vos, A.S, Strydom, H., Fouche, C.B. & Delport, C.S. (Eds). *Research at grass roots: for the social sciences and human services professions*. Cape Town: Van Schaik Publishers.
- Sudhinaraset, M., Astone, N. & Blum, R.W. (2012). *Migration and Unprotected Sex in Shanghai, China: Correlates of Condom Use and Contraceptive Consistency across Migrant and Non-Migrant Youth*. *J Adolesc Health*, 50 (3), 68–S74. Doi: 10.1016/j.jadohealth.2011.12.007.
- Teitelman, A.M., Bohinski, J.M. & Tuttle, A.M. (2010). *Condom Coercion, Sexual Relationship Power, and Risk for HIV and Other Sexually Transmitted Infections Among Young Women Attending Urban Family Planning Clinics*. *Fam Viol Prev Health Pract*. 1 (10), 1-20.
- Terre Blanche, M., & Durrheim, K. & Painter, D. (2006). *Research in practice: Applied methods for the social sciences, 2nd edition*. Cape Town: UCT Press.
- Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in Practice: Applied methods for the social sciences, 2<sup>nd</sup> edition*. Cape Town: UCT Press.
- The Gardian Publication (2015). *Xenophobia in South Africa: “They beat my husband with sticks and took everything”*. Publication on 17 April 2015. Reviewed on 20 April 2015 [www.theguardian.com](http://www.theguardian.com).
- Trimble, J. E & Fisher, C. B. (2006). *Handbook of ethical research with Ethnocultural populations and communities*. Thousand Oaks: Sage Publications.
- UNAIDS (2011). *South Africa Epidemic Update*, viewed on 28 February 2016, from [www.unaids.org](http://www.unaids.org)
- UNAIDS, 2015. *AIDS by the Number*. Reviewed on 16 September 2016. [http://www.unaids.org/sites/default/files/media\\_asset/JC2571\\_AIDS\\_by\\_the\\_numbers\\_en\\_1.pdf](http://www.unaids.org/sites/default/files/media_asset/JC2571_AIDS_by_the_numbers_en_1.pdf)
- United Nation Department of Economic and Social Affairs, Population Division. (2013) *International Migration Report 2013*. New York.

- Valezquez, E.A. (2014) *Parent-Adolescent Communication about Sexual Topics, Cultural Factors, and Latino Adolescents' Sexual Behaviour and Condom Attitudes*. Virginia Commonwealth University, Virginia (MA Thesis).
- Vallerand, J.R., Pelletier, L.G., Deshaies, P., Cuerruer, J.P. & Mongeau, C. (1992). *Ajzen and Fishbein's Theory of Reasoned Action as Applied to Moral Behavior: A confirmatory Analysis*. *Journal of Personality and Social Psychology*, 62 (1), 98-109.
- World Health Organisation. (2010). *Social determinants of sexual and reproductive health: Informing future research and programme implementation*. Switzerland: World Health Organization.
- World Health Organisation. (2014). *Health for the World's Adolescents: A second chance in the second decade*. Switzerland: World Health Organization.
- World Health Organisation. (2016) Global Health Report: UNAIDS Report. Reviewed on 15 September 2016. <http://www.who.int/hiv/pub/arv/global-aids-update-2016-pub/en/>
- Wyn, J. & White, R. (1997). *Rethinking Youth*. London: Sage Publications.

## Appendix A: Consent form

### Consent Form to Participate in Research Study

<b>Project Title</b>	Socio- Cultural Factors Influencing the Condom use Intentions and Behaviours of Migrant Youth in the Western Cape, South Africa	
<b>Purpose</b>	The research project is part of the requirements for the degree of MSocSc at the University of Cape Town. This research project is being conducted by Raylene Titus and supervised by Dr. Johannes John-Langba of the University of Cape Town. The purpose of the study is to explore the socio-cultural factors that influence condom use intentions and behaviours of migrant youth in the Western Cape, South Africa. We are inviting you to participate in this study because you are a migrant between the ages of 18-25, and live in Cape Town.	
<b>Methods to be used</b>	One-on one interview. Our interview will be audio taped to help me accurately capture your insight in your own words. For the purpose of this study the tapes will only be heard by myself. If at any time you feel uncomfortable with the tape recorder, can stop the tape recorder and continue with interview.	
<b>Confidentiality</b>	The investigators promise to keep all the information confidential as required by law. To help protect your privacy and confidentiality, we will not ask for your full name, physical address or any other information that may identify you. The researcher will only take notes of your suggestion and comments and will use this information to make changes to the final draft of the survey. A pseudo name will be used to delink your information to the interview. This will ensure your anonymity and confidentiality.	
<b>Risks</b>	There are no known physical risks associated with participating in this research. It is possible that you feel uncomfortable answering some sensitive questions about sex.	
<b>Benefits</b>	This research is not designed to help you personally but the results may help the researchers learn more about what the sexual health services of migrant youths need. We hope to use this information to improve youth programs in South Africa.	
<b>Freedom to withdrawn</b>	Your participation in this research is completely voluntary. You may choose not to take part at all. You may stop participating any time.	
<b>Ask questions</b>	You are encouraged to ask questions or raise any concerns at any time regarding the nature of the study or the methods I am using. Please contact me any time at; <a href="mailto:raylene.titus@gmail.com">raylene.titus@gmail.com</a> or call at 021 9033527	
<b>Age of Subject and Consent</b>	your signature indicates that: you are at least 18 years of age; the research has been explained to you; your questions have been fully answered and; you freely and voluntarily choose to participate in this research project.	
<b>Signature and Date</b>	<b>Name of Respondent</b>	
	<b>Signature of Respondent</b>	
	<b>Date of signature</b>	
<b>Thumb Print</b>		

## Appendix B: Research Interview Schedule

### Socio- Cultural Factors Influencing the Condom use Intentions and Behaviours of Migrant Youth in the Western Cape, South Africa

#### Introduction

❖ Introduction

I am a Masters research student from the University of Cape Town. The aim of this study is to explore the socio-cultural factors that influence condom use Intentions and Behaviours amongst migrant youth in the Western Cape, South Africa.

❖ Thank respondent for participation in this interview.

❖ Ethical considerations

- Digital recording
- Confidentiality – link to choice of pseudonym – anonymity crucial
- Voluntary Participation
- Access to findings
- Referral if necessary

❖ No right or wrong answers

❖ Estimated time frame of interview : 25 -40 minutes

❖ Interview Plan: The interview is structured as follows with 5 different themes, namely:

- Section A: Personal Information
- Section B: Examine migrant youth experiences of condom use in South Africa
- Section C: Identify socio-cultural factors influencing the condom use intentions and behaviours of migrant youth
- Section D: Examine the influences of cultural believes on attitudes towards condom use
- Section E: Examine the gender dimension of condom use intentions and behaviour among migrant youth

❖ Closure of Interview: Thanking participant for participating in study, and provide the opportunity to ask questions before closing the interview.

## Section A: Personal Information

Pseudo Name: \_\_\_\_\_ Country of Origin: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Highest level of Education Completed: \_\_\_\_\_

## Section B: Examine migrant youth experiences of condom use in South Africa

*What experiences do youth migrants have with condom use in the Western Cape?*

1. How long have you been in South Africa? \_\_\_\_\_
2. Have you ever had sexual intercourse?  
(Probe: by sexual intercourse I mean vaginal, oral or anal intercourse)  
If yes, did you use condoms in your last sexual intercourse?  
(Was the person you had last sex with your primary partner or casual partner?)
3. Do you always use condoms during sexual intercourse? If yes, why or if No, why not?
4. Do have a main sexual partner? (Probe: Is the person South African or from you country or another country besides South africa or your country of origin ?)
5. What are your experiences of using condoms?  
(Probe: positive and negative experiences; un/pleasant feeling, reliability of condoms; availability of free condoms and cost of condoms, purchasing of condoms)

## Section C: Identify socio-cultural factors influencing the condom use intentions and behaviours of migrant youth

*What socio-cultural factors determine the intentions of youth migrants to use condoms during sexual intercourse?*

6. Who are the people you think that might influence your decision of condom use?  
(Probe: What will the people (for instance parents, siblings, partner, religious leaders and friends) think, if you are using condoms during sexual intercourse?)
7. Does your social and cultural background and interaction influence your decision to use condoms during sex?  
(Probe: Explain what is meant by social and cultural, probe how they influence e.g circumcision, transactional sex, alcohol and drugs, peer pressure etc.)

8. Do you think that living now in South Africa that your influences on condom usage have changed? (*who influences you now? South African/ global culture (westernisation), new social group, new friends?*)
9. Has living in South Africa influence your perceptions about condom use during sex? (Probe: How?)

**Section D: Examine the influences of cultural beliefs on attitudes towards condom use.**

What is the association between cultural values and intentions to condom use?

10. Do you think that your cultural beliefs impacts on your thinking on condom usage? (*Probe: what is your culture's view on condom usage, and do you live accordingly?*)
11. Does your cultural values guides you how to behave during sexual intercourse? (*Probe: The reason you are using/ not using condoms during sexual intercourse been influenced by your cultural background? or is it based on any other reason/s*)

**Section E: Examine the gender dimension of condom use intentions and behaviour among migrant youth**

*What is the association between gender and condom use intentions and behaviours among migrant youth?*

12. What are some of the challenges you encounter in negotiating the use of condom during sex? (Probe: How are these challenges related to your gender? Do you think it is possible for you to negotiate condom use with your partner?)
13. If your partner discuss or suggest using a condom, what would be your comment/ reaction?
14. Do you think you will use condoms the next time you have sex? Why/ why not?

**THANK YOU FOR PARTICIPATING IN THIS STUDY.**