Sexual health in relation to religious beliefs: perceptions of young women living in Khayelitsha

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Declaration

I, Shehani Perera, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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Dedication

This thesis is dedicated to my mother, Renuka, my father, Thusitha, my brother Lahiru and Aurélien, my partner and best friend. Without any of you, none of this would have been possible.

Abstract

Relatively little is known about the relationship between sexual health and religion as it is experienced by youth transitioning to adulthood in contexts of uncertainty and socio-economic deprivation. This thesis considers this issue in three parts. Part A, the research protocol, presents a protocol for a study exploring the experiences and perceptions of the relationship between sexual health and religion among young women living in Khayelitsha. Part B is a structured literature review that provides an overview of literature pertaining to the conceptualisation of sexual health, factors influencing sexual health, different perspectives on sex and sexuality, the relationship between sexual health and religion, the transition to adulthood and the gaps identified in the literature. Part C is a journal "ready" manuscript that makes the argument that young people navigating uncertainty and dealing with the complexities of transitioning to adulthood may perceive religion and the church to play the role of a custodian in sexual health issues, however, expectations of the church are difficult to live up to and sit in tension with socio-economic realities. The findings explore how this tension is experienced and how sexual health decision-making unfolds in this context. The exploration of perceptions regarding the partnership between religious organisations and public health facilities offering sexual health services reveals a need for religious organisations to provide support to youth as they transition to adulthood and for public health to be embedded in every aspect of youth life: neighbourhoods, schools and recreational spaces. It is hoped that the findings in this study contribute to the improvement of sexual health interventions being provided in South Africa.

Acknowledgements

To begin with, I would like to acknowledge my supervisor, Dr. Alison Swartz, for her guidance and personal, academic and financial support. Without her encouragement or mentorship, I would not have made it through these two very long years. I would also like to thank all the young women that I was privileged to have worked with this year. Your determination and courage have been inspiring. Finally, I would like to thank my family, without whom none of this would have been possible, and Aurélien Pradier, for all his love, support and encouragement.

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PART A: RESEARCH PROTOCOL

Section One: Introduction

In this section, the background and context for the study titled *'Sexual health in relation to religious beliefs: perceptions of young women living in Khayelitsha'* will be presented. The purpose of the study, its rationale and significance as well aims, objectives and research questions will also be detailed.

1. Background and context

Sexual health is defined by the World Health Organisation (WHO) (1975 as cited in Edwards and Coleman, 2004, p.190) as the "integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love". Sexual health issues such as sexual violence, rape and sexual coercion, unintended pregnancies, STIs and HIV/AIDS greatly diminish the sexual health of young people both male and female. In fact, according to the United Nations AIDS report published in 2018, HIV/AIDS alone affects nearly 45% of those living in eastern and southern Africa. In South Africa, it has been estimated that 20.6% of adults aged between 15-49 are HIV-positive (Human Sciences Research Council (HSRC), 2018). This accounts for nearly one-fifth of all women of reproductive age (15-49 years) and 5.5% among women between 15- 24 years (HSRC, 2018). Especially within the latter age group, HIV is rapidly spreading, particularly because of this population's increased likelihood to HIV-transmission (Moodley, 2017). Various factors lend themselves to the prominence of sexual health-related issues. Researchers have found that among young people between the ages of 15 and 24, the use of substances, socio-economic deprivation and gender inequalities increase their susceptibility to HIV-infection and other sexual health problems (Moodley, 2017). One study found that among university students, campus culture instigated risky sexual behaviour and in

another study, religious affiliation with Pentecostalism was found to significantly reduce extra- and pre-marital sex among members (Mutinta & Govender, 2012; Garner, 2000).

While religion, and sexual health may not be obvious partners, a number of studies around the world have investigated various aspects of religiosity, faith, and spirituality in relation to HIV (Takyi, 2003), maternal and child health (Ha et al., 2014), adolescent sexual behaviours (Osafo et al., 2014), and sexual initiation and condom use (Agha et al., 2006) - among others. Within the South African context, various scholars have contributed to local literature in the field. These include aspects related to religion and sexual practices (Burchardt, 2011; Moodley, 2017); sexuality, reproduction, and HIV/AIDS (Mantell et al., 2011); the influence of faith-based organisations (FBOs) on different aspects of HIV-prevention and treatment (Keikelame et al., 2010) and young people's sexuality and sexual partnerships (Eriksson et al., 2014; Harrison et al., 2008). However, a number of gaps and limitations that exist in the available literature call for further research to be undertaken to fully understand how religion, faith, and spirituality influence sexual and reproductive health.

The first issue is the lack of research investigating the impact of contemporary youth culture on the sexual culture of young people. Burchardt (2011, p.671) recognizes that many studies fail to depict the sexual culture that shapes young people's sexual lives and perceptions and tend to emphasize instead, the notion that religious communities are "totalities whose believers have no social existence outside of them." The socio-cultural context and economic circumstances governing young people's decision-making and contemporary youth culture consisting of nightlife characterised by "parties, music, dance, alcohol consumption, the collective smoking of marihuana" and material consumption, dating and the different ways in which youth transition into adulthood, is therefore crucial to examine as a backdrop amidst

the more nuanced sexual interactions and sexual health issues that take place (Burchardt, 2011, p. 679).

Secondly, there is a dearth of literature looking at romantic relationships, sexual partnerships, marriage, fertility desires and motherhood as integral areas of sexual health and their relationship to religious and/or faith beliefs. Within many types of African societies, fertility "was and still is valued above all other human endowments, in all strata" (Fortes, 1978 as cited in Nattabi et al., 2012, p. 2). The importance of pro-natalist attitudes in sub-Saharan Africa contributes to a great deal of pressure for women to have children regardless of HIV-status or other sexual health issues. Men are just as pressured to have children as fatherhood, like motherhood, are often associated with social status within African communities (Mantell et al., 2011; Nattabi et al., 2012). Parenthood, is itself, considered an important social and cultural marker in sub-Saharan Africa, and some authors argue that in the context of socio-economic deprivation, sexual relationships can be used to build social capital and "in the absence of other accepted markers of transition to adulthood...early fertility, though clearly a public health problem, can become a solution to social circumstances" as parenthood may build self-esteem and develop a sense of responsibility for others (Hollows & Larsen as cited in Nattabi et al., 2012; Mantell et al., 2011; Swartz et al., 2018: 152). Thus, further research could explore how motherhood, fertility desires and sexual partnerships are shaped by religious and/or faith beliefs held by at-risk populations.

Lastly, there is a gap in the literature of research exploring the perceptions of young people themselves on the topic of how they perceive their sexual health, its relationship to their religious and/or faith beliefs and how they themselves experience the partnership between public health and FBOs in promoting sexual health. It would be worthwhile to examine whether young people perceive the incorporation of religion in sexual health programmes to

be useful in improving their sexual health outcomes and explore why they hold these beliefs and how they think sexual health interventions can be improved.

2. Purpose of the study

In light of the above-mentioned gaps found in the literature, the purpose of this study is to explore the perceptions of young women living in Khayelitsha about sexual health and its relationship to individual religious beliefs and the role that religious organisations play in their lives.

3. Rationale and significance

The rationale behind the purpose of this study is three-fold. Firstly, the study's focus on women is due to the higher prevalence of HIV among women (23%) in comparison to men (13%) in South Africa (National Department of Health (NDoH), 2016). Furthermore, while men are less likely to engage in help-seeking behaviours, women face additional sexual health issues such as domestic violence and further, have lower earnings and rates of employment (NDoH, 2016). Given that HIV-prevalence increases with lower household wealth among young people, young women in the lowest wealth quintile are at high-risk of becoming HIV-infected (NDoH, 2016). Therefore, more research investigating the forces that influence young women's sexual health and behavior is required to improve sexual health outcomes (Harrison et al., 2015). As 80% of the country identifies as being affiliated with some religion, it is considered to be an important influencing factor to incorporate when investigating how sexual behaviours are shaped and had thus been incorporated into the study (StatsSA, 2011).

Secondly, the study intends to shed light on how contemporary youth culture influences the sexual culture of young people living in a township setting where risk of HIV-infection and STIs is found to be high (Ngixa, 2012). By understanding the intricacies of the interplay between youth culture and sexual health, risky sexual behaviours will be illuminated, making

public health specialists more aware of the types of factors that young people deal with in terms of their sexual lives. It is crucial that sexual health clinicians and other health-workers are knowledgeable about how religion may have an impact on sexual health (Spadt et al., 2014; StatsSA, 2011). According to Spadt and colleagues (2014), religious awareness can improve the therapeutic alliance between patients and clinicians and can positively impact treatment-compliance - both of which are necessary for improving the quality of the South African health system (Coovadia et al., 2009). In Khayelitsha, where many public health facilities offering sexual health services exist to serve the community, having guidelines and policies that enhance religious awareness is therefore, an important component of health-service delivery. These guidelines/policies can only be produced once there is enough information on how sexual health is related to religion and is therefore, a significant reason for conducting this study.

Thirdly, by understanding fertility intentions, parenthood desires and how young people form sexual relationships, more knowledge about what safe-sex strategies are used and required will be identified to best assist and facilitate the reproductive and sexual rights of young South African women. It can be argued that religion, as well as sexual health services, both cater to individual well-being and self-care (Gaydos et al., 2010). More so, religion and sexual-health affect people on an individual, couple, community and national level and each domain can be intervened at to improve health and well-being. Gaydos and colleagues (2010) also note that faith communities are a space in which intergenerational groups of community members can meet on a regular basis, which means that there is a possibility of shifting social norms that are transgenerational. In the context of South Africa, where stigma and gender inequality are the main drivers of the HIV-epidemic, and where nearly 80% of the population identify as Christian, harmful gender norms and stigmatisation must be tackled in religious spaces by providing tailored sexual health information to young people who can then

disseminate these in their communities (UNAIDS, 2008 as cited in Keikelame et al., 2010; Coovadia et al., 2009; StatsSA, 2011). Enhancing the well-being of each individual translates to more productive, resilient communities. In the emerging field of religion and sexual health therefore, there are "both synergistic and antagonistic" features of the relationship, that can be examined to improve the lives of young people from various levels of intervention (Gaydos et al., 2010: 475).

4. Aims, objectives and research questions

4.1 Aim

The aim of the study is to explore the perceptions of young women living in Khayelitsha on how their religious and/or faith beliefs shape their sexual lives and influence their decisions related to sexual health.

4.2 Objectives

The objectives of the study are:

1. To understand how young women experience the relationship between sexual health and religion within the context of uncertainty and socio-economic deprivation
2. To examine how the transition to adulthood and navigating uncertainty influences the relationship between sexual health and religion
3. To examine how contemporary youth culture plays a role in influencing the relationship between sexual health and religion
4. To gain insight into how young women perceive the partnership between religious organisations and sexual health services offered by public health facilities in promoting sexual health

4.3 Research questions

The primary research question is: How is the relationship between sexual health and religion experienced by young women living in Khayelitsha?

The secondary research questions are:

1. How is the relationship between sexual health and religion influenced by the transition to adulthood in contexts of uncertainty and socio-economic deprivation?
2. How does contemporary youth culture and poverty in Khayelitsha influence young women's sexual lives and their commitments to their religious and/or faith beliefs?
3. How does sexual health decision-making unfold within the context of uncertainty, socio-economic deprivation and contemporary youth culture?
4. How do young women perceive the partnership between health facilities offering sexual health services and religious organisations in promoting sexual health, and how do they think it can be improved?

5. Concept Clarification

5.1 Sexual health

Sexual health is the "integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love" (World Health Organisation [WHO], 1975 as cited in Edwards and Coleman, 2004, p. 190). In this study, sexual health will be examined as: 1) the capacity to enjoy and control sexual behaviour; 2) freedom from fear, shame, guilt and other psychological factors inhibiting sexual fulfillment and 3) freedom from any organic diseases that interfere with sexual functioning (Mace, Bannerman and Burton, 1974 as cited in Edwards & Coleman, 2004, p.189).

5.2 Religion

Religion is understood to be "about transcending worldly desires, material attachment, and bodily urges, focusing on 'higher things', principally the divine that is incorruptible and sacred" (Yip, 2010: 667). The concept of religion will be explored in this study in two ways: 1) with regards to individual religious beliefs and 2) the role that religious organisations play in young womens' lives.

Section Two: Literature Review

In this section, a brief literature review for the study titled 'Sexual health in relation to religious beliefs: perceptions of young women living in Khayelitsha' will be presented. During the review, five key themes emerged from the literature: 1) the concept of sexual health; 2) sexual health issues in South Africa; 3) factors influence sexual health; 4) the relationship between sexual health and religion and 5) the transition to adulthood period.

1. On 'sexual health'

The definition of sexual health, since its earliest conception in 1975 by the WHO, has continuously evolved, adapting to the political and social landscapes in which it is embedded (Edwards and Coleman, 2004). It states: "Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love' (WHO, 1975 as cited in Edwards and Coleman, 2004: 190). The new millennium began to see a shift in the conceptual understanding of sexual health as being fluid to becoming a measurable outcome. In 2000, reproductive health was made a distinctive component falling under the broader term of sexual health and is defined by the WHO (2010) as health concerning 'the reproductive processes, functions and systems at all stages of life' (Edwards & Coleman, 2004; Chou et al., 2015). Measurable indicators of sexual health, sexual rights, the role of the community in influencing sexual health and the dissemination of information and services have become more tangible since 2001, informing much of the recent understandings around sexual health (Edwards & Coleman, 2004; Chou et al., 2015; Southern, 2018).

2. Sexual health issues in South Africa

The HIV-epidemic is one of South Africa's major public health problems (Coovadia et al., 2009; Harrison et al., 2015). According to the most recent HIV-related statistics, 20.6 % of

the entire population and one-fifth of all women of reproductive age (15-49 years) are HIV-positive (HSRC, 2018). While the Western Cape has the lowest provincial infection rate of 5.3%, the number of people with HIV/AIDS has doubled between 2005 and 2008 due to the low rate of condom use (StatsSA, 2011). The rate of sexual violence in South Africa is also among the highest in the world - in 2016, nearly 52,000 sexual crimes were reported to the South African Police Service (SAPS) 2016). Similarly, Abrahams and colleagues (2013, p.3) found that although intimate partner violence had declined in 2009 in comparison to 1999, the 2009 rate was still "five times higher than the global prevalence of this crime". In another study, 46 253 rapes were reported to the police in 2014 - although it is estimated that this is only a fraction of the actual number of rapes that occurred (Institute of Security Studies, 2014; Vetten, 2014 as cited in Cooper et al., 2015). Rape and violence increase the risk of HIV-transmission among women as they are unable to time and control their sexual and reproductive behaviour (Coovadia et al., 2009).

3. Factors that influence sexual health

In South Africa, the legacy of apartheid and its interaction with other social factors exacerbate the prominence of sexual health-related issues (Mmari & Sabherwal, 2013; Coovadia et al., 2009). There are various factors that have been found to influence sexual health. Gender is one of the most prominent factors (Harrison et al., 2015; Marston & King, 2006). Age-disparate relationships (Harrison et al., 2015; Harling et al., 2015), the “sugar daddy” phenomenon (Toska et al., 2015), gender-based violence and womens’ social and economic vulnerability in relation to sexual health have been well-documented in existing literature (Harrison et al., 2015; Jewkes, Levin & Penn-Kekana, 2002).

Age-disparate relationships are said to contribute to HIV-infection because young women lack power in these types of relationships to negotiate with partners when making decisions about their sexual health (Harrison et al., 2015). However, some studies have found

that age-disparate relationships may not predict HIV-acquisition as women have control over the formation and dissolution of relationships (Luke, 2005 as cited in Harling et al., 2015). Nevertheless age-disparate relationships can be problematic because they may involve a transactional sex-aspect which places women at greater risk of infection (Harrison et al., 2015).

Condom-use is influenced by the stigmatisation of using condoms in long-term committed relationships and may incite accusals of infidelity which can lead to domestic abuse or other forms of sexual violence (Harrison et al., 2015). Condom-use is also influenced by the consumption of alcohol. Increased alcohol consumption has been seen to lead to a decrease in condom-use (Pitpitan et al., 2012 as cited in Harrison et al., 2015). In addition to this, young people between the ages of 18 and 25 are more at-risk of HIV-infection because of their engagement in sexual risk-taking behaviours and experimentation with substances (Myer et al., 2009 as cited in Harrison et al., 2015). Sexual assault and rape are also more common among women that are under the age of 18 years old (Harrison et al., 2015).

With regards to HIV-testing and counselling, studies show that there is a universal awareness of sexual health service facilities in South Africa but few individuals get tested due to issues of stigmatisation, accessibility, affordability and the lack of social support systems (Denison et al., 2009 as cited in Harrison et al., 2015).

Other factors that influence susceptibility to sexual ill-health include culture and religion (Moodley, 2017). For example, Mutinta and Govender's (2012) study found that among university students, campus culture promoted risky sexual behaviour and in another study, Garner (2000) found that religious affiliation with Pentecostalism was found to significantly reduce extra- and pre-marital sex among members. The relationship between religion and sexual health will be explored in more detail in the following section.

4. The relationship between sexual health and religion

4.1 Around the world

Various studies conducted in other parts of the world have examined the role of religion, spirituality, and faith in relation to sexual or reproductive health. In the United States, research suggests that women are more likely to report higher levels of religiousness than men and there is a high level of agreement that religiousness and faith are related to sexual health (Holt et al., 2006; McCree et al., 2003). One study exploring the perceptions of the religion-health connection among African Americans in the Southeast, found that the 'divine healing typology' is ascribed to the role of a higher power (i.e. God) which, when incorporated with social support, mental health and other factors can contribute to overall well-being (Holt et al., 2006). In other studies, marital status and family size were found to be important factors that women considered in sexual health decision-making (Romo et al., 2004). Among Hispanic and Mexican-American women, higher levels of religiosity were associated with less contraceptive use (Amaro, 1988; Hine & Graves, 1998 as cited in Romo et al., 2004). In contrast to the United States' high levels of religiosity, Western European women are much less likely to declare affiliation to any religion (Frejka & Westoff, 2008 as cited in Moreau et al., 2013). However, even in secular States such as France, religiosity and religious affiliation have been found to shape sexual behaviour and contraceptive use (Moreau et al., 2013).

In Africa, most countries above the Saharan desert are Islamic, while below the Sahara, Christianity is the predominant religion (Encyclopaedia, 2003). Studies have investigated the association between religious affiliation and knowledge of HIV and protective behaviours in Ghana (Takyi, 2003) and parents' perceptions on how religion influences adolescents' sexual behaviours (Osafo et al., 2014). Takyi's (2003) study found that religious affiliation had a significant effect on the knowledge of HIV but did not find any association with changes in specific protective behaviours, such as the use of condoms. Among parents, Osafo and

colleagues (2014) found that existing moral mechanisms were found to regulate sexual behaviour, with religion being viewed as providing an alternative moral system when parents perceived lapses within the traditional methods of moral regulation. In Zambia, Agha and colleagues' (2006) study on the effects of religious affiliation on sexual initiation and condom use, found that young women affiliated with religions that excommunicate members on the basis of engaging in premarital sex were less likely to use condoms during first sex, but more likely to delay sexual intercourse. In much of the sub-Saharan literature, the theme of sexual socialisation in African communities is made salient, with some scholars arguing that religion exerts more influence on sexual socialisation than the State or society (Ha et al., 2014; Takyi, 2003; Anarfi & Owusu, 2011 as cited in Osafo et al., 2014).

4.2 In South Africa

Studies on religion and sexual health in South Africa have been conducted in relation to pentecostal moralism (Burchardt, 2011), sexual practices, sexual partnerships and sexuality (Harrison et al., 2008; Eriksson et al., 2014; Moodley, 2017), conservatism vs. secularism (Mantell et al., 2011), FBOs (Keikelame et al., 2010) and social determinants of risk behaviour (Mutinta & Govender, 2012)- among others. Coovadia and colleagues (2009) trace current public health challenges to South Africa's historical roots, identifying some of the main causes to be racial segregation, migrant labour and the failure to provide equal resources to every racial group. Consequently, violence, gangsterism and hyper-sexualised masculinities increase the vulnerability of young women to HIV-infection and gender-based violence (Morell, 1998 as cited in Coovadia et al., 2009). It is therefore, a well-established fact that young women are more likely than men to be infected with HIV, primarily because of the 'dynamic of hypervulnerability' which refer to gender inequalities and socio-economic vulnerabilities that put women at greater risk (Leclerc-Madlala, 2009 as cited in Harrison et al., 2015; Jewkes et al., 2010; Dunkle et al., 2004 as cited in Coovadia et al., 2009).

According to Coovadia and colleagues (2009: 822), South African perspectives on sex can be linked back to two competing discourses: one, that sex is solely for procreation and not a matter to be discussed with young people, and second, the 'traditional... idea that sex is a normal, healthy, and essential feature of life for all ages, and something about which there should be openness and communication'. The socialisation of young people occurring within this dichotomy opens itself up to much potential research. In one study, Moodley (2017) found that young people felt as though religion was once an important factor shaping their sexual lives, but has since, become less important. An emergent theme was the notion that 'religious institutions have given up' and that religious leaders often 'conveyed negative and confusing messages concerning condom use' and therefore, students felt they could compartmentalise religion from sex (Moodley, 2017: 1528). In other studies, sex with non-spouses or non-cohabiting partners was an increasingly common trend, which brought to light the dilemma of 'showing respect' in religious settings versus faithfulness and multiple concurrent relationships (Mantell et al., 2011; Burchardt, 2011: 680). In fact, studies have shown a great deal of interest in the perspectives and influence of FBOs/leaders on HIV, stigma, and the dissemination of sexual health information concerning condom and contraceptive use, abortion, premarital sex and adultery (Keikelame et al., 2010; Eriksson et al., 2014). There is agreement within the literature that faith communities "fail to fully address the needs of young people" and thus, these needs should be explored in more depth (Eriksson et al., 2014: 1673).

5. The transition to adulthood

The developmental period between the ages of 18 and 25 are referred to as the transition to adulthood period (Harrison et al., 2015). This period is characterised by the sequence of first acquiring educational qualifications, then gaining employment and finally, getting married and having children (Honwana, 2014). However, for many youths living in contexts where there are a lack of socioeconomic opportunities, uncertainty and poverty the transition to

adulthood is severely inhibited (Harrison et al., 2015; Swartz et al., 2018). Instead, these youth go through a period of 'waithood' which refers to the period between childhood and adulthood that is lengthened by their circumstances (Honwana, 2014). While waithood can be challenging, young people have found creative ways in which to express their sense of adultness, independence and empowered agency (Graham, 2016; Swartz et al., 2018). In Khayelitsha, early fertility, parenthood and gaining respectability have been found to be alternative markers in the transition to adulthood (Swartz et al., 2018; Sennott & Mojola, 2017).

Section Three: Methodology

1. Research design

This study will employ a qualitative, exploratory study design. Exploratory study designs are generally used to ascertain the nature of a problem rather than generate conclusive evidence or answers (De Vos et al., 2011). Instead, exploratory research typically investigates issues that have been little studied before. While there have been a few studies looking at various aspects of sexuality in Khayelitsha, evidence suggests that no studies have explored sexual health and its relationship to religious and/or faith beliefs among young women in the transition to adulthood period. This study design has the potential to bridge the gap in knowledge of how the relationship between sexual health and religion is experienced, what tensions exist and how these are expressed and what young women think of the partnership between religion and public health. While one study has looked at the erotic geographies and sexual practices of Pentecostal youth in Khayelitsha (Burchardt, 2011), no evidence suggests that a similar study exploring sexual health, a bifaceted conceptualisation of religion, the transition to adulthood and contemporary youth culture has been conducted before, with this specific population, in this chosen setting. The use of this study design will facilitate SP in

gathering novel insights about young women's perspectives about how their sexual health and sexual lives are influenced by religion.

2. Population and sampling

2.1 Population

In this study, the research population will be composed of young women living in Khayelitsha township, Cape Town. Inclusion criteria will include being female, residing in Khayelitsha and being between the ages of 18 and 25 years. This age range falls within the period of transitioning to adulthood, which is considered to increase the risk of HIV-infection (Myer et al., 2009 as cited in Harrison et al., 2015). Furthermore, this study will focus exclusively on young women rather than men because the greater burden of sexual health issues is carried by women (HSRC, 2018; Harrison et al., 2015). Exclusion criteria will include not being from Khayelitsha and being under the age of 18 or above the age of 25.

2.2 Sampling

The sampling method used in this study will be purposive sampling and snowballing sampling, if necessary. These methods will be used to isolate for the specific characteristics required to fulfil the study's aim and research questions (De Vos et al., 2011). The sample number of the study is intended to be between 10 and 12 participants for semi-structured interviews and 5-6 participants in each of the 2-3 focus groups.

2.3 Recruitment

Study participants will be recruited from two different networks. The first, is Dr. Alison Swartz's (study supervisor) existing network of young people living in Town Two. Dr. Swartz has conducted extensive ethnographic research within Town Two and has created strong personal and professional ties with many of the community members.

The second network from which participants will be recruited is a Khayelitsha-based psycho-social programme teaching business, self-development and IT skills to young women.

One of Dr. Alison Swartz's Master of Public Health students is the programme manager of the programme and both she and her employment supervisors granted SP and AS permission to present the study's information to the women in the programme and obtain their consent if willing to participate.

Potential participants will explicitly have to give their permission to participate either verbally or through written consent. This will be obtained through visits made to both Town Two and the programme. We will then explain the study's objectives to potential participants and let them know that we would like to conduct some research about religion, sexual health and youth culture in the coming months. We will then hand out the participant information sheet (Appendix E) and informed consent forms (Appendices C and D). Individuals will then be asked to take their time to read through the information sheet and consent form and to think about whether they would like to be involved. During the next visit, individuals will be asked whether they have any questions they would like answered and after clarifying all points, can sign the consent forms. Matters of consent will also be explained before the start of each individual interview. Participation will thus be kept strictly on a voluntary basis.

2.4 Study setting: Khayelitsha

Khayelitsha means 'Our New Home' in the language of isiXhosa and is an informal settlement in Cape Town, South Africa (Ngixa, 2012). According to StatsSA (2011), Khayelitsha has a population of approximately 400 000 and is considered to be the fastest-growing township in South Africa. It was established in 1985 due to the implementation of the *Group Areas Act 1950* which sought to racially segregate the South African population (Ngixa, 2012). There are a number of health clinics that offer youth-friendly services to address the health needs of young people aged between 12 and 25 years (Patten et al., 2013). Services include: "HIV testing and counselling, enrolment on ART, diagnosis and treatment of sexually transmitted infections, family planning services, termination of pregnancy services and general care" (Patten et al., 2013: 2).

3. Data collection approach

Data for this study will be collected using ethnographic field notes, focus group discussions and semi-structured, one-on-one interviews. Semi-structured interviews are typically conducted to capture a nuanced picture of the participants' beliefs, perspectives and opinions, and in this study, will be related to the questions of sexual health, its relationship to religion and the expression of the relationship in the context of uncertainty and socio-economic deprivation (De Vos et al., 2011). Gaydos and colleagues (2010) comment that qualitative methods of data collection such as interviews and ethnography are the most appropriate methods of data collection for religion-related studies. Thus, ethnographic field notes will also be kept during the entire period of data collection.

Individual interviews will be conducted with 10-12 participants on religious beliefs, sexual relationships, fertility desires, motherhood, sexual health and contemporary youth culture. The interview schedule provided in Appendix A will be conducted in English. All interviews will be audio-recorded with the consent of participants, transcribed, and uploaded onto DEDOOSE 8.2.14 software- a web-based application for analysing qualitative and mixed-methods data. The data collection period is intended to end in mid/end of July 2019.

Two to three focus group discussions based on the 'River of Life' activity will be conducted with 5-6 participants in each focus group. The 'River of Life' activity seeks to explore life histories from birth into the future (Pienaar et al., 2011). The activity will be used to gain insight into experiences of transitioning to adulthood as a young person living in Khayelitsha and how participants position themselves in relation to different social systems such as religious organisations, schools, their families, youth culture and the health care system in their community. The focus group schedule is provided in Appendix B.

4. Data management: Use and protection of research data

Field notes will be written after each field visit to the research community and these as well as transcribed interviews and audio-recordings will be uploaded onto password protected computers. All files will be appropriately labelled in order to make retrieval manageable (dates, interviewee information etc.). SP will transcribe and anonymise the data before transcribing into Microsoft Word format for analysis and uploading onto DEDOOSE software on a password protected-computer. Back-up copies of all the files will be made and a master copy will be safely secured on a password protected computer (De Vos et al., 2011). Signed consent forms will be kept securely in a locked cupboard which only AS and SP will have access to. On completion of the proposed research study, the data will not be destroyed. Data will be stored on a password-protected computer for 5 years. Data will be used for research purposes and for public dissemination at the end of the study. A knowledge dissemination event will take place with the participants after the study's write-up. Participant permission for further use of their data will be obtained using informed consent forms if necessary.

5. Data analysis

The data collected for this study will first be transcribed and then uploaded onto the DEDOOSE web-based qualitative and mixed-methods analysis application. Braun and Clarke's (2006 as cited in Maguire and Delahunt, 2017) six-step framework for thematic analysis will then be used to systematically analyse the data.

The six steps are as follows:

1. Familiarise with the data: SP will read and re-read the transcripts. Notes will be taken during this reading process to form the initial preliminary analysis.
2. Generate initial codes: The data will be organised in a meaningful and systematic way. Theoretical thematic analysis will be employed, rather than an inductive

approach as specific research questions are sought to be addressed through this research (Maguire and Delahunt, 2017).

3. Search for themes: Patterns in the data will then be identified
4. Review themes: These emergent themes will then be reviewed by both SP and Dr. Alison Swartz which will ensure rigour at this stage of the research
5. Define and name themes: The themes will then be defined and organised in a coherent and meaningful way
6. Produce the report: A report will then be written in the form of a journal "ready" manuscript and submitted as part of the Master of Public Health thesis component.

Thematic analysis is "the process of identifying patterns of themes within qualitative data" (Maguire and Delahunt, 2017: 3352). The primary aim of thematic analysis is to identify emergent themes and patterns in the data and then to use them to answer a question or to generate meaningful insights about an issue (Maguire and Delahunt, 2017). Rather than merely organising and summarising the data, thematic analysis goes further to analyse the key themes and make sense of them. There are two levels of themes that have been identified by Braun and Clarke (2006 as cited in Maguire and Delahunt). The first, is the semantic level at which meanings of the data remain on the surface and no further meaning is extracted. The second, is the latent level where deeper meanings and "underlying ideas, assumption, and conceptualisations- and ideologies" are formed (Braun and Clarke, 2006: 6 as cited in Maguire and Delahunt, 2017: 3353).

6. Data verification

Data verification will be conducted with reference to the four following criteria proposed by Lincoln and Guba (1999 as cited in De Vos et al., 2011):

1. Credibility/authenticity- the identification and accurate description of the subject
2. Transferability- transferability of the research findings to another context or case

3. Dependability- the logical, accurate documentation and auditing of the data collected;
4. Confirmability- the potential of the findings to be confirmed by future research

Reflexivity

Reflexivity is the process of "introspection on the role of subjectivity in the research process" (Palagnas et al., 2017: 427). The primary researcher is a young female, aged 25, who is not South African and from a Sri Lankan culture. The researcher does not speak fluent isiXhosa, which is the primary language spoken in the study setting. This could impact the quality of the data collected as all interviews will be conducted in English. The researcher is also of a similar age to the participants which could facilitate discussions about sexual and reproductive health, dating and sexuality. SP is not affiliated with any religion or faith group and will be mindful of this fact when discussing religious and/or faith beliefs with the participants to not let her own views or opinions obstruct data collection. SP will try to ensure, at all times, that she will be self-aware, respectful and sensitive to the culture and religious beliefs of the participants in order to ensure that any differences of view do not hinder or impede on the quality of the data collected.

7. Ethical considerations

Voluntary Participation

Participation in this study, will at all times be voluntary. The young women aforementioned from both Town Two and the programme will be informed face-to-face about the study's aims and objectives before being asked whether they would like to participate. Two copies of the informed consent forms (Appendix C and D) will be handed out and read together (both by participants and researchers), after which the participants will be able to ask any questions. Participants will then sign both the consent forms and give the researcher one copy and keep the other. Thereafter, interested individuals will be asked to write down their names and contact details and then contacted at a later date to participate in scheduled individual

interviews which will be voluntary, regardless of whether or not they signed up to participate.

A factor that may increase the vulnerability of participants might be the discussion of sexual and reproductive health. Discussing negative health conditions or negative sexual experiences may produce some discomfort to some women. Additionally, as the women live in an impoverished township settlement and are unemployed, there may be various social and economic issues that surface during the interviews that may be difficult to speak about. In order to ensure the comfort and well-being of the participants, debriefing measures will be put into place after every interview. Contact details of mental health professionals have also been listed in Appendix F. Participants will be referred to these if any mental health-related or any other relevant social issues emerge.

Confidentiality and anonymity

Throughout data collection, all participant-identifiers will be removed as data does not have to remain linked to specific participants. Only views, perspectives and experiences will be analysed. Confidentiality and anonymity will therefore be ensured by the removal of these identifiers and if participants wish, pseudonyms will be used during write-up.

Ethics approval

Ethical approval for this study will be sought from the University of Cape Town's Health Science Faculty's Human Research and Ethics Committee (HREC) and the University of Cape Town's School of Public Health and Family Medicine. This study is a sub-study of a larger study titled "Uncertainty, sexual partnerships and the transition into adulthood in Khayelitsha" which has already obtained ethics approval from the University of Cape Town's Health Science Faculty's (HREC) and the University of Cape Town's School of Public Health and Family Medicine. The HREC reference number for this study is **321/2018.**

Risks

Overall, participation in this study is anticipated to be of moderate-risk. The resurfacing of unpleasant or negative life/sexual experiences may be one potential harm that could befall the participants as a result of participating in this research study. In order to ameliorate this harm, when individual interviews will be conducted, participants can ask to skip any uncomfortable questions or terminate the interview at any time. Additionally, if the participant requires psychological support, a referral for counselling will be made to one of the mental health professionals listed in Appendix F. SP is also currently a registered Social Worker (REG NO. 1047782 [01 April 2019- 31 March 2020] and has the necessary training and appropriate skills to identify and effectively refer participants that may require additional support. SP has experience working and training at SHAWCO Du Noon Clinic, ASTRA Jewish Sheltered Employment Centre and Timour Hall Primary School as a Social Worker. She has also volunteered with Cape Mental Health as a psycho-social group facilitator. No other physical, professional or legal risks are anticipated.

Benefits

The benefits of the proposed research for participants is anticipated to include deeper self-awareness of how their religious and/or faith beliefs influence sexual and reproductive health decision-making. Participation in this research study will also give participants the opportunity to contribute to the generation of knowledge that will be used to further improve public health interventions targeted at this specific population, within this context.

8. Study period and time-frame

Research Activity	**Intended Time-line**
1. Protocol submission	April 2019
2. Literature review submission to AS	June 2019
3. Data collection	May-July 2019
4. Data Analysis	June-August 2019
5. Journal "ready" manuscript	August 2019
6. Draft submission to AS and final write-up	mid-August 2019
7. Submission	1st September 2019

9. Write-up and dissemination

The final version of this mini-thesis will, upon completion, be submitted in partial fulfillment for the Master in Public Health degree (Social and Behavioural Sciences track) offered at the University of Cape Town. Part C, the journal "ready" manuscript will also be submitted to a chosen peer-reviewed journal (*Journal of Religion and Health* or *Culture, Health and Sexuality*) for publication at a later period.

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PART B: STRUCTURED LITERATURE REVIEW

1. Introduction

The objectives of this literature review are to one, summarise and interpret contemporary literature focusing on sexual health and its relationship to religion and two, to present any gaps in the existing literature. A few key themes emerged in the review: 1) the evolving nature of the concept of sexual health; 2) the myriad of factors influencing sexual health; 3) the different perspectives on sex and sexuality in South Africa ; 4) the relationship between sexual health and religion and 5) the transition to adulthood. Critical examination of the gaps in these emerging themes point towards the need for future research that explores the *lived experience* of sexual health in relation to individual religious beliefs, the role that religious organisations play and how sexual health decision-making unfolds in relation to discourses on sexuality.

Search strategy

In order to find the most relevant literature, key terms such as “sexual health”, “religion”, “Afric*”, “sub-Saharan Afric*”, “South Africa”, “faith-based” and “khayelitsha” were entered into databases such as SCOPUS, PubMed, MEDLINE, Google Scholar and EBSCOhost using Boolean phrases.

2. On ‘sexual health’

Since 1975, the definition of sexual health has continued to evolve and is said to be fluid, dependent on time and space and shaped by historical events such as “the 1960s sexual revolution, the ongoing struggle over reproductive rights and abortion, the maturation of the gay rights movement, overpopulation concerns, and the devastating international impact of HIV/AIDS” (Edwards & Coleman, 2004: 189). Originally, it referred to the “integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively

enriching and that enhance personality, communication and love" (World Health Organisation [WHO], 1975 as cited in Edwards & Coleman, 2004: 190). Newer definitions of sexual health have come to encompass the knowledge of sexuality, self-awareness, self-acceptance, the ability to be intimate and communicate sexual needs and desires with a sexual partner, to be able to obtain sexual fulfillment, set healthy sexual boundaries and be free from diseases that interfere with sexual functioning (Robinson et al., 2002).

The term 'sexual health' is also used interchangeably with 'reproductive health'. However, it is important to note that sexual health and reproductive health, while appearing to be the same, are in fact, quite different from each other. The WHO (2010) defines reproductive health as health concerning 'the reproductive processes, functions and systems at all stages of life' and thus, there is a general consensus in the literature that 'reproductive health' falls under the broader umbrella of sexual health (as cited in Edwards & Coleman, 2004).

While there is a considerable amount of literature on the theoretical and conceptual understandings of 'sexual health', what is lacking however, is literature that goes beyond theoretical conceptualisation and explores the term in its practical application in lived experience. In South Africa, young women carry the greatest burden of sexual health disease and thus, it would be useful to explore how sexual health is experienced and understood by this at-risk population (Beksinska et al., 2014). Health promotion strategies can then address any issues in understanding and improve upon sexual health literacy.

3. Factors influencing sexual health

Various factors affect sexual health. In the past 15 years, factors influencing young women's sexual and reproductive health (Siebold, 2011); sexual behaviour (Pettifor et al., 2005; Marston & King, 2006; Eaton, Flisher & Aaro, 2003); sexual violence (Petersen, Bhana & McKay, 2005; Coovadia et al., 2009); timing of first sexual intercourse (Tenkorang &

Maticka-Tyndale, 2009); domestic violence (Jewkes, Levin & Penn-Kekana, 2002) and the social determinants of health (Rao et al., 2012) (to name a few) have been explored more specifically. Mmari and Sabherwal's (2013) literature review on the risk and protective factors of adolescent sexual and reproductive health in developing countries found that between 2003 and 2010, the most published articles focused on condom use and sexual initiation, followed by pregnancy and childbearing, HIV, contraception, number of sexual partners, STIs and sexual coercion. Overall, risk factors for sexual and reproductive health among adolescents were identified as being unmarried, unemployed, consuming alcohol, having peers who had had sex, place of residence, early sexual debut orphan status and forced sex with a sexual partner and biological risk factors (Mmari & Sabherwal, 2013; Harrison et al., 2015). Protective factors were greater educational attainment and being able to discuss reproductive health issues with partners (Mmari & Sabherwal, 2013).

In South Africa, young women, in comparison to their male counterparts, carry a greater burden of sexual health disease with nearly one-fifth of all women of reproductive age (15-49 years) being identified as HIV-positive (StatsSA, 2011). Gender-related contextual factors such as age-disparate relationships may precipitate gender-based violence and limited condom-use negotiation which has been extensively covered in the literature (Harrison et al., 2015; Marston & King, 2006; Pettifor et al., 2005). However, some scholars contend that age-disparate relationships do not predict HIV- acquisition and suggest that this may be due to women having more power over the formation and dissolution of relationships and because they may be selective of partners to avoid risk of infection (Harling et al., 2015). Women's socio-economic vulnerability also places them at higher risk of experiencing domestic abuse, sexual assault and rape (Harrison et al., 2015; Jewkes, Levin & Penn-Kekana, 2002; Cooper et al., 2015).

The rate of sexual violence in South Africa is amongst one of highest in the world - in 2016, nearly 52 000 sexual crimes were reported to the South African Police Service

(SAPS)- although the actual number is believed to be higher (SAPS, 2016). Marston and King's (2006) study revealed that girls were told to keep quiet about sexual coercion and violence occurring in their relationships. These gender inequalities and economic vulnerability shaping the context of HIV-risk among women are referred to as the 'dynamics of hypervulnerability' (Leclerc-Madlala, 2009 as cited in Harrison et al., 2015).

Additionally, risk of HIV-infection and other sexually transmitted infections (STIs) is also highest among women transitioning to adulthood between the ages 18 and 25 (Harrison et al., 2015). This is due to greater substance use, experimentation and sexual risk-taking behaviour during this period (Myer et al., 2009 as cited in Harrison et al., 2015). Studies show that alcohol use increases during the transition to adulthood, which coincides with the decreased use of condoms as alcohol consumption increases (Pitpitan et al., 2012 as cited in Harrison et al., 2015). The use of condoms is stigmatised in long-term, committed relationships and is associated with inviting accusals of infidelity (Marston & King, 2006; Heeren et al., 2007 as cited in Harrison et al., 2015).

4. The different perspectives on sex and sexuality

Trinitapoli (2006) notes that religion and spirituality are central to African social and cultural life and therefore, have a strong bearing on sexual behaviour and health outcomes. In South Africa, Christian missionaries in the 19th Century brought about the separation of sexuality as a set of 'practices and knowledge' from 'concepts of kinship and reproduction' (Delius & Glasner, 2002 as cited in Burchardt, 2013: 497). Thus, there are now two competing discourses on human sexuality. One, is rooted in religious (Christian) discourse and asserts that "sex is for procreation within marriage and not a topic for discussion with young people" (Coovadia et al., 2009: 822). However, South Africa's history of forced removals and the growing mining industry and migrant labour system does not ensure the guarantee of fidelity or monogamy and thus, the notion that sexual activity is purely for reproduction within the

union of marriage does not hold in the face of these social issues (Mantell et al., 2011; Coovadia et al., 2009).

The other view is the traditional African perspective that "sex is normal, healthy and [an] essential feature of life for all ages, and something about which there should be openness and communication"(Delius & Glaser, 2002; Jewkes, Penn-Kekana & Rose-Junius, 2005 as cited in Coovadia et al., 2009: 822). Studies have found that in reality, matters of sex are discussed among peers or learnt through media due to numerous barriers in parent-adolescent and intergenerational communication on issues related to sexuality and sexual health such as embarrassment, culture and religious beliefs (Coetzee et al., 2014; Motsomi et al., 2016; Fearon et al., 2015). Thus, the impact that religion and culture have on sexual health is an important component of gaining deeper understanding about sexual health issues.

5. The relationship between religion and sexual health

The impact that religion has had on various aspects of sexual health have been well-documented. Moodley's (2017) study among college students in Cape Town found that there was a large need for more open communication about youth sexual health by religious institutions and that there was a general perception that religion did not have the ability to make any significant impact to changing sexual health behaviours. However, authors such as Leclerc-Madlala (2000) argue that discarding religion may make youth more susceptible to HIV-infection and others such as Forman (1998) and Puffer and colleagues (2012) advise that partnerships between public health and religious institutions be encouraged in order to improve youth sexual health (as cited in Moodley, 2017).

In South Africa, studies concerning religion and sexual health have explored pentecostal moralism and sexual practices (Burchardt, 2011), sexual partnerships and sexuality (Harrison, Cleland & Frohlich, 2008; Eriksson et al., 2014; Moodley, 2017), conservatism vs. secularism (Mantell et al., 2011), faith-based organisations (FBOs)

(Keikelame et al., 2010) and the social determinants of risky sexual behaviour (Mutinta & Govender, 2012) - to name a few. Religion and sexual health are generally discussed or investigated within the context of HIV (Garner, 2000), HIV-related stigma (Keikelame et al., 2010), HIV-prevention (Mutinta & Govender, 2012; Eriksson et al., 2014), HIV-treatment (Medved-Kendrick, 2017) and HIV-risk (Harrison, Cleland & Frohlich, 2008) -reflecting the impact HIV has had in the region.

During the early years of the HIV-epidemic, religious involvement in the health sector was considered detrimental as some religious groups perceived AIDS to be a punishment for the sin of human sexual promiscuity and thus, opposed prevention efforts such as the promotion of condom-use and sex education (Balogun, 2010; Shaw & El-Bassel, 2014). More recently however, FBOs have become major players in HIV-prevention partnerships, with Christian organisations spearheading faith-based responses to the epidemic (Shaw & El-Bassel, 2014; Balogun, 2010).

However, the partnership between FBOs and public health is not without its drawbacks. Casale and colleagues' (2010: 140) study exploring the dilemmas and tensions facing faith-based organisations when promoting HIV-prevention programmes found that the "moral dichotomisation of right and wrong" when religious institutions deliver sexual health messages can silence or stigmatise those who have behaved 'badly' or 'wrongly'. Keikelame and colleagues (2010) note that this stigmatisation and discrimination can hinder testing for STIs/HIV and prevent individuals from knowing their status and obtaining life-saving treatment.

Another major barrier to collaboration between FBOs and public health is conflict over prevention strategies (Olowu, 2015). The main source of conflict is over which prevention effort is promoted: FBOs favour abstinence and faithfulness, while secular officials prefer methods proven to be effective such as condom-use and contraception (Olowu, 2015). Consequentially, mixed messages about condom use are delivered, in which

the primary sexual health message from FBOs is to abstain from premarital sex and to use condoms and contraceptives from health organisations (Eriksson et al., 2014; Olowu, 2015; Amoateng et al., 2014). This contradiction is referred to in the literature as the 'condoms versus abstinence discourse' (Casale et al., 2010). However, Mbotho, Cilliers and Akintola (2011) found that among university students at the University of KwaZulu-Natal, the message of abstinence gave them the opportunity to fulfil their spiritual obligations to God but also, to avoid emotional hurt and any physical costs of having sexual intercourse.

Secularism has also had an effect on the relationship between religion and sexual health. Before 1994, South Africa was a society based on racial segregation and Christian values and had a history of international isolation however, after the demise of apartheid, it became part of the global economy and had to learn to adhere to the modernist values of economic freedom and secularism (Vorster, 2013). Since the 1990s, South Africans have been faced with an explosion of information caused by the media, internet, and mobile phone industries (Vorster, 2013). This exposure to cultural variation has shifted discourses, transformed values and norms and allowed for freedom of choice between beliefs (Vorster, 2013). Some studies suggest that secularism may be one reason for the perception of religion having a lessening effect on sexual behaviour (Moodley, 2017). Other studies suggest that neither secularism nor religious practice appear to play a significant role in influencing sexual behaviour, regardless of the strength of religious commitments, as these commitments themselves are constantly shifting, reflecting the nature of insecure socio-economic situations and experimentation with self-expression (Burchardt, 2011). The transition to adulthood is seen as a period of greater self-experimentation among youth.

6. The transition to adulthood

The transition to adulthood period refers to the period between 18 and 25 years and is generally seen as moving from schooling to employment and then to raising one's own

family (Honwana, 2014; Harrison et al., 2015). In many parts of the world, marriage, having children and taking responsibility for their development are seen as significant markers along the transition to adulthood (Juarez & Gayet, 2014). However, many studies have found that for youth facing a lack of employment opportunities, access to post-secondary schooling and other basic resources, the ability to become independent- 'to build, buy, or rent a house for themselves, support their relatives, get married, establish families and gain social recognition as adults'- is severely inhibited (Honwana, 2014: 28; Juarez & Gayet, 2014; Graham, 2016; Swartz, Colvin & Harrison, 2016; Sennott & Mojola, 2017). Honwana (2014) introduces the term 'waithood' which refers to the transitional period between adolescence and adulthood, which is oftentimes longer for youth that do not have the resources to become independent. The failure to do so is not ascribed to young people's capabilities but rather, to the failure of the State that does not provide the opportunities to study further or find gainful employment (Honwana, 2014). Some authors have identified that the absence of traditional markers of transitioning to adulthood have led to the emergence of alternatives. For women, Swartz and colleagues (2018: 152) suggest that "early fertility, though clearly a public health problem, can become a solution to social circumstances" as parenthood may build self-esteem and develop a sense of responsibility. Similarly, biological motherhood and respectability, which is performed through taking responsibility over domestic duties, can serve as important markers of womanhood (Sennott & Mojola, 2017).

In Khayelitsha, the transition to adulthood involves the navigation of uncertainty and a lack of opportunity however, while these are some of the many challenges that young people face, there is also a great capacity and potential to find creative means to express empowered agency (Swartz, Colvin & Harrison, 2016; Graham, 2016). The intersection between this creativity and agency culminate in success stories of performing well academically, being involved in community-development efforts or starting a small business of one's own (Swartz, Colvin & Harrison, 2016). Nevertheless, the majority of youth are

caught somewhere within the stage of ‘waithood’, which can often continue for long periods of time (Swartz, Colvin & Harrison, 2016). Thus, parenthood and intimate sexual relationships can exist as avenues into the transition to adulthood and play a central role in young people's lives (Swartz, Colvin & Harrison, 2018; Burchardt, 2011).

7. Gaps in the literature

From the review of this literature, what we know is that the theoretical and conceptual understanding of sexual health is located within landscapes that are influenced by socio-political and historical events (Edwards & Coleman, 2004). We also know that sexual health is an umbrella term encompassing various aspects related to sexual health such as sexual fulfillment, lack of disease, reproductive-health, healthy relationships and greater self-awareness (Robinson et al., 2002). There is also extensive literature pointing out the fact that young women are at greater risk of sexual health problems (StatsSA, 2011; Harrison et al., 2015). The partnership between faith-based organisations involved in sexual health interventions and health facilities offering sexual health services is also identified to be fraught with conflict (Casale et al., 2010; Eriksson et al., 2011; Olowu, 2015; Amoateng et al., 2014).

From this information, we can deduce that there are a number of gaps to which we require the answers. The first question is how the tensions in the relationship between sexual health and religion express themselves in communities that are at-risk and how these tensions are experienced. We also do not know how the relationship is experienced at the time of transitioning to adulthood, which is considered to be a time at which HIV-infection is considered particularly high (Dick & Ferguson, 2015 as cited in Harrison et al., 2015). The context of uncertainty and socio-economic deprivation in which this relationship is experienced is also under-studied, with respect to how it influences the experiences of individual religiosity and sexual health decision-making. While we also know that religion

and spirituality are considered a central focus in African culture, we do not know how contemporary *youth* culture plays a role in influencing the sexual health-religion relationship, at the time of transitioning to adulthood and when faced with socio-economic uncertainty. Greater insight is required into how young people make sense of the tensions in how public health interventions involving religious organisations are being delivered. Their perceptions of religious organisations' involvement in providing sexual health programmes and how they think it can be strengthened may also provide valuable insight into how we can better tailor health interventions to at-risk populations.

8. Conclusion

This literature review has provided an overview on the topic of sexual health and religion with particular attention to the South African context. the main themes discussed with the conceptual nature of sexual health factors influencing sexual health different perspectives of human sexuality the relationship between sexual health and religion and the transition to adulthood. the main gaps in the literature include a lack of exploration of the experience of tensions in the sexual health religion relationship how sexual health decision-making unfolds in light of these tensions and how the partnership between religious organisations and health facilities offering sexual health services is perceived.

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PART C: JOURNAL "READY" MANUSCRIPT

"You don't feel in control": the relationship between sexual health, religion and the transition to adulthood in a context of uncertainty

Shehani Perera[1] ·

Abstract South Africa continues to have the highest HIV-prevalence in the world, in addition to other sexual health-related issues. A vast majority of its population is also religiously affiliated with Christianity. This study sought to understand how young women living in Khayelitsha experience the relationship between sexual health and religion within the context of uncertainty and socio-economic deprivation. How their sexual health-decision making unfolds given the tensions that arise between religious expectations and socio-economic realities and how they perceive the partnership between religious organisations and public health facilities offering sexual health services was also explored. Data collection consisted of ethnographic field notes, 11 semi-structured interviews and 3 focus group discussions with 6 people in each group. Data were then analysed using a thematic analysis approach. The findings reveal that young women experience the tension between religious expectations and their socio-economic realities through the "moral dichotomisation of right and wrong" and that this, in addition to the 'dynamics of hypervulnerability' consisting of gender inequalities and economic vulnerability, leads to a sense of lacking control over sexual

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health decision-making. The call for church involvement in sexual health-related matters reveals a deeper desire for various forms of support as they transition to adulthood in the context of uncertainty and socio-economic marginalisation. The article argues that young people navigating uncertainty and dealing with the complexities of transitioning to adulthood may perceive religion and the church to play the role of a custodian in sexual health issues, however, expectations of the church are difficult to live up to and sit in tension with socio-economic realities. Thus, a division of duties between religious organisations and public health facilities should be established to strengthen sexual health promotion and prevention efforts.

Keywords Sexual health・Religion ・Sexual health decision-making・Youth・Transition to Adulthood

Introduction

Sexual health is the "integration of somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love" (World Health Organisation [WHO], 1975 as cited in Edwards & Coleman, 2004, p. 190). Sexual health promotion is intended to promote sexual fulfilment, control over sexual and reproductive behaviours and the use of health services to prevent disease (Mace, Bannerman & Burton as cited in Edwards & Coleman, 2004, p. 189).

A myriad of factors influence sexual health such as gender stereotypes, social expectations, the nature of sexual partnerships and stigmatisation- despite varying contexts (Marston & King, 2006; Pettifor et al., 2005). In South Africa, rape, sexual violence, unintended pregnancies and unsafe abortions occur against a backdrop of

historical apartheid policies and social issues related to poverty, unemployment, social isolation and conservative ideas about women's societal position (Jewkes, Levin & Penn-Kekana, 2002). Sex remains a controversial issue due to religious and cultural views on sexuality impacting the uptake of sexual health interventions.

Religion and spirituality are central to African social and cultural life and have a strong bearing on sexual behaviour and health outcomes (Trinitapoli, 2006). In South Africa, there are two competing discourses on human sexuality. One is rooted in religious (Christian) discourse and asserts that "sex is for procreation within marriage and not a topic for discussion with young people" (Coovadia et al., 2009: 822). However, South Africa's history of forced removals and the growing mining industry and migrant labour system do not ensure guarantees of fidelity or monogamy and thus, the notion that procreation should occur only within marriage does not hold in the face of these social issues (Mantell et al., 2011; Coovadia et al., 2009).

The other view is the traditional African perspective that "sex is normal, healthy and [an] essential feature of life for all ages, and something about which there should be openness and communication"(Delius & Glaser, 2002; Jewkes, Penn-Kekana & Rose-Junius, 2005 as cited in Coovadia et al., 2009: 822). Studies have found that in reality, there are numerous barriers to parent-adolescent communication on issues related to sex such as embarrassment, culture and religious beliefs (Motsomi et al., 2016; Coetzee et al., 2014; Burchardt, 2013). Instead, matters of sex are discussed among peers or learnt through media (Motsomi et al., 2016; Fearon et al., 2015).

Studies concerning sexual health and religion have explored pentecostal moralism and sexual practices (Burchardt, 2011), sexual partnerships and sexuality (Harrison et al., 2008; Eriksson et al., 2014; Moodley, 2017), conservatism vs.

secularism (Mantell et al., 2011), faith-based organisations (FBOs) (Keikelame et al., 2010) and social determinants of risky sexual behaviour (Mutinta & Govender, 2012).

These studies are generally discussed within the context of HIV, reflecting the impact the epidemic has had in the region (Garner, 2000; Keikelame et al., 2010; Mutinta & Govender, 2012; Eriksson et al., 2014; Medved-Kendrick, 2017; Harrison, Cleland & Frohlich, 2008; Burchardt, 2016). During the early years of the epidemic, religious involvement in the health sector was considered detrimental as some religious groups perceived AIDS to be a punishment for the sin of human sexual promiscuity (Balogun, 2010). There was high opposition to prevention efforts such as condom-use and sex education (Balogun, 2010; Shaw & El-Bassel, 2014). More recently, however, FBOs have become major players in HIV-prevention partnerships, with Christian organisations spearheading faith-based responses to the epidemic (Shaw & El-Bassel, 2014; Balogun, 2010; Ochillo, Teijlingen & Hind, 2017).

While some significant steps have been made, the partnership is rife with tensions and contradictions. One major source of conflict is over prevention strategies (Olowu, 2015). FBOs favour abstinence and faithfulness, while secular health officials advocate for methods such as condom-use (Olowu, 2015). Consequently, mixed sexual health messages - referred to in the literature as the 'condoms versus abstinence discourse' - are delivered (Olowu, 2015; Amoateng et al., 2014; Casale et al., 2010).

Additionally, Casale and colleagues' (2010, p. 140) study exploring the dilemmas and tensions facing FBOs when promoting HIV-prevention programmes found that the "moral dichotomisation of right and wrong" can silence or stigmatise those who are perceived to have behaved 'badly' or 'wrongly'. Keikelame and

colleagues (2010) note that this stigmatisation and discrimination can hinder testing for STIs/HIV and prevent individuals from knowing their status and obtaining life-saving treatment.

In order to gain a deeper understanding of these issues, this study explored the complex relationship between sexual health and religion in Khayelitsha, an impoverished township in Cape Town, South Africa, focusing on the experiences and perceptions of young women.

Khayelitsha means 'Our New Home' in isiXhosa, the main language spoken in the township, and was established as a result of apartheid racist geographical design (Ngixa, 2012). It is one of the largest townships in South Africa with a population of approximately 500 000 people and has one of the highest burdens of HIV-infection (Ngixa, 2012). While nearly 16% of the population is HIV-positive, the burden of disease is disproportionately borne by women (Garone et al., 2011; Ngxiza, 2012). Given that the vast majority of the population, 77%, identifies as being Christian, this study focuses on the relationship between Pentecostal Christianity and sexual health (Dinbabo et al., 2017).

Since Khayelitsha's establishment, there have been persistent interconnected challenges linked to socio-economic deprivation, high unemployment rates, inadequate infrastructure and a lack of economic opportunity (Ngixa, 2012). In many parts of the world, obtaining educational qualifications, employment, getting married and having children are seen as significant markers in the transition to adulthood (Juarez & Gayet, 2014). However, for youth in Khayelitsha, the ability to become independent- 'to build, buy, or rent a house for themselves, support their relatives, get married, establish families and gain social recognition as adults'- is severely inhibited (Honwana, 2014, p. 28; Swartz, Colvin & Harrison, 2016). Honwana (2014)

introduces the term ‘waithood’ to characterise the lengthened period between childhood and adulthood for youth unable to become independent. The failure to gain independence is not ascribed to young people’s capabilities but rather, to the failure of the State that is unable to provide educational or employment opportunities (Honwana, 2014).

Despite these challenges, youth find creative means to express empowered agency (Swartz, Colvin & Harrison, 2016; Graham, 2016). The intersection between this creativity and agency culminate in success stories of performing well academically, being involved in community-development efforts or starting small businesses (Swartz, Colvin & Harrison, 2016). The majority, however, are caught somewhere within the stage of ‘waithood’ (Swartz, Colvin & Harrison, 2016).

The study’s objectives were, therefore, to understand how young women experience the relationship between sexual health and religion within the context of uncertainty and socio-economic deprivation and how they perceive the partnership between FBOs and public health facilities offering sexual health services. The concept of religion was explored in two ways: 1) with regards to individual beliefs and 2) the role that religious organisations play in their lives.

The article ultimately argues that young people navigating uncertainty and dealing with the complexities of transitioning to adulthood may perceive religion and the church to play the role of a custodian in sexual health issues, however, expectations of the church are difficult to live up to and sit in tension with socio-economic realities. The findings explore how this tension is experienced and how sexual health decision-making unfolds in this context. The exploration of perceptions regarding the partnership between FBOs and public health facilities offering sexual health services reveals a need for FBOs to provide support to youth as they transition

to adulthood and for public health to be embedded in every aspect of youth life: neighbourhoods, schools and recreational spaces.

Methodology

Study design and population

This study was part of a broader ethnographic study exploring uncertainty, sexual partnerships and the transition to adulthood among young people living in Khayelitsha. A qualitative, exploratory study design was used to gain an in-depth understanding of the relationship between sexual health and religion (De Vos et al., 2011). Young women living in Khayelitsha between the ages of 18 and 25 years were selected for this study. Many of the participants were unemployed and lived at home, while only a few were still at school or lived alone. Three of the participants had children and one was pregnant.

Recruitment and sampling

Participants were recruited from two different networks. Dr. Alison Swartz (AS), the supervisor of this study, has conducted extensive ethnographic research with young people living in Khayelitsha and introduced me to some of the young women she had already worked with. These members were approached, given information about the study and asked whether they would be willing to be involved. The second network through which participants were recruited was a Khayelitsha-based psycho-social project teaching business, self-development and entrepreneurial skills to young women. I provided all prospective members with information about the research-project and asked them if they would be willing to participate. Subsequently,

purposive and snowballing sampling were used to select participants. The sample for this study consisted of 11 participants for individual interviews and 6 participants in each of the focus group discussions.

Data Collection

Data for the study was collected between February and August 2019. Field notes were written during the first initial visits in order to ensure credibility through the triangulation of field notes, FGDs and individual interviews. FGDs were based on the 'River of Life' activity which seeks to explore life histories from birth into 5 years into the future and was conducted as a first exercise to gain insight how the women positioned themselves in relation to social systems such as FBOs, schools, their families and the community's health system (Pienaar et al., 2011). Eleven semi-structured interviews were later conducted.

Data Analysis

Braun and Clarke's (2006 as cited in Maguire & Delahunt, 2017) six-step framework for thematic analysis was used to guide the analysis of the data collected. Thematic analysis is "the process of identifying patterns of themes within qualitative data" (Maguire & Delahunt, 2017, p.3352). Data was first transcribed and uploaded onto DEDOOSE software. An audit trail was kept throughout data analysis to detail the process of coding the transcripts several times, grouping them into themes and revising them using an iterative process by both SP and AS. The research process and data analysis were reviewed by AS to ensure findings were consistent.

Findings

Three main themes emerged in the analysis of the data: 1) the "moral dichotomisation of right and wrong" experienced as the 'party girl' and the 'church girl'; 2) tensions between religious expectations and socio-economic realities; and 3) a desire for community support through church involvement.

Theme 1- 'The party girl vs. the church girl': the religious dichotomisation of 'right' and 'wrong'

Church services preach the gospel through the "moral dichotomisation of right and wrong". For many of the women interviewed, religious doctrine provides a framework for what is deemed 'right' and 'wrong' behaviour. One participant said:

> *Being Christian helps you avoid wrong things. It is a home where you are protected and taught the right way.*

The word "home" here, refers to the solace found in religious doctrine. For young people continuously in motion and striving to make ends meet in the period of 'waithood', adhering to religious values or being part of a religious community provides protection and a safe retreat when life becomes overwhelming. Religion also has a moralising effect. One woman said:

> *When you believe in something, you know that whenever you make a bad decision it [religion] comes into your mind to alert you that "This is not meant to happen, this is wrong." If I didn't believe in God, I would enjoy each and every wrong thing I do.*

Contemporary youth cultural activities often conflict with biblical canons and are, therefore, categorized as 'bad' in the dichotomous framework of Christian morality. In Khayelitsha, youth culture consists of "parties, music, dance, alcohol consumption [and] the collective smoking of marihuana" (Burchardt, 2011, p.679). The majority of participants I interviewed, despite their religious affiliation and intimate understanding of the requirements of Christian morality, confirmed that they often transgressed these rules, going to parties, bars and clubs; having boyfriends and premarital sex. However, despite the apparent statistical normality of their actions, the sense that they had 'broken the rules' led to profound feelings of shame and guilt. In fact, young women often seem uncomfortable facing their previous night's actions in the morning. Thus, one participant said:

> *[Young women] drink alcohol and dance, then meet someone who takes them home... But then, when you wake up, you just leave… just like that.*

The avoidance of facing the other person in the morning indicates a desire to maintain a certain sense of respectability and quickly escape the sobering realisation of having engaged in something deemed "immoral". In a sense, avoiding facing the other person is a way for these young women to avoid facing themselves. The split between being sexually promiscuous at night and 'respectable' during the day can be paralleled to religious dichotomies between right and wrong, darkness and light, heaven and hell. Psychologically, the participants I have interviewed develop multiple contradictory identities, trying to reconcile 'party girl' and 'church girl'. The young women that I interviewed feel torn between the collective pressure, particularly from parents and

clergy, as well as their personal aspirations to be ‘good’ and ‘respectable’ on the one hand, and the peer pressure and biological urge to engage in activities that contravene socio-religious norms. This complexity not only leads to psychological suffering, but also reinforces harmful stereotypes. The archetypes are used to deal with the tension that arises between the expectations placed on them by religion and their navigation of uncertainty and waithood. They are not only linked to what it means to be a good *Christian* woman, but also what it means to be ‘respectable’ in society. Theme 2 explores this notion further.

Theme 2- Sexual health decision-making unfolds amidst the tension between religious expectations and socio-economic realities

To be perceived as a good, respectable Christian woman, young women are expected to get married, have children and raise a family. One participant said:

> *I think religion plays a role because in the Bible even God says that “I’ve brought you into life so that you can reproduce life on earth.” So, I think [that is] the main reason I would never not want to have kids.*

Having children is considered a significant expression of religious commitment and devotion, but also gives life meaning and purpose. For women living in contexts lacking socio-economic opportunities, having children gives them a sense of purpose and responsibility. One participant said:

> *I would like to have [children] because I want to live for someone. It's what motivates me to live, to know my purpose in life. When you have a child, you have to get up in the morning and do something!*

Despite this, many women expressed that they would first like to establish themselves and be financially independent, or at least, independent from their parents, before getting married or having children. However, due to the socio-economic context that push women to use sexual relations to obtain basic needs and a contemporary youth culture that promotes premarital sexual encounters, young women may have children before marriage. Contraceptive measures are seen to contradict religious values. Thus, although *parenthood* is considered to be in accordance with religious values, having premarital sex, using contraceptives and potential abortions are not. This can cause women to feel as though they have "failed" if they do not live up to the expectation of being married first before becoming pregnant. One woman said:

> *I failed my religion by getting pregnant and disappointed a lot of people. It was an embarrassment to my family. My family are people that go to church and then I got pregnant out of wedlock. It was a big thing.*

While the "failure" that brings about "disappointment" and "embarrassment" was getting pregnant "out of wedlock", it is the public knowledge of having had premarital sex which brings the greatest shame. Thus, a woman's reproductive decisions are the concern of not only her or her family, but also of "a lot of [other] people" in their broader community. There is a sense, therefore, that women lack control in making sexual health decisions. One participant said:

> *Men believe that if you get married to them that they will be the head of the house. He is going to be the one to control everything, but only if you come together, and talk about such things [sexual health] ...it will be much better, it will make some harmony in the relationship.*

Women are limited in their sexual-health related decision-making because of community pressures and gender-dynamics within households (Jewkes & Morell, 2010). Social media, on the other hand, is used to control womens' socio-economic ranking:

> *Facebook and Instagram also play a role in the youth's lives. For instance, on Facebook people fake themselves, people want to meet a standard of living that they can't afford. They pretend to be the someone they are not because they want to be slay queens and buy clothes.*

Social media has made the lives of young people more transparent, and there is more pressure to "keep up" with the lifestyles they see. The term 'slay queen' refers to women from impoverished backgrounds who maintain a façade of opulence through the conspicuous consumption of branded clothing, expensive meals and frequenting exclusive clubs. Linked to the context of socio-economic uncertainty, conspicuous consumption becomes important for social ranking amongst peers. Men use environments such as bars to alert women of their wealth through extravagant displays of consumption. One participant explains:

Let's say we go to a club and this guy comes directly to me, out of all my friends he likes me and he says "Look here, I want you and I could buy all of your friends stuff but you must go home with me tonight."

The need to be materially provided for and a desire to move up the social hierarchy amongst peers, attracts women in these spaces to multiple partnerships based on transactional sex which places them at risk of sexual ill-health. The very gendered dynamic of being a 'good' woman or wife, and being a 'respectable' Christian therefore sits in tension with socio-economic realities that push women to behave in ways that might risk their sexual health. Due to this tension, young women call for some kind of *redemption* through the involvement of churches, clinics and parents in sexual health matters. Rather than judgement or social exclusion they require support.

Theme 3- The desire for church involvement in sexual health matters is a call for further community support

Many participants expressed their desire for church involvement in sexual health-related matters, however, when explaining how they envisioned this collaboration, they identified numerous practical barriers. Thus, many participants explained that the church favours abstinence over condom-use, which they argued was unrealistic and impractical. Further, participants noted that it is generally deemed inappropriate to ask for and receive sexual health advice at church. Of course, the two are related, as one participant explained in the following way:

> *They can't teach two things at the same place. They say we should not have sex, yet, they give us condoms... which are used to have sex. What are they saying we must do with them?*

As they perceived that two contradictory things could not be taught at the same place, many suggested a division of activity between churches and public health facilities. Churches were seen as most effective in supporting youth as they navigate uncertainty and transition to adulthood:

> *I think if [the church] had talks with the young kids, to tell them about how they grew up and if they shared their experiences, their stories; I think that would be better. If pastors offered support to kids that parents don't offer them, that would also be fine. And if they donated more, anything, clothes for example, anything that will make the young people feel good… Even food.*

The two dynamics at play here are 1) the desire to break the silence between generations and 'share' life experiences and 2) a desire for more support. In this case, material support in the form of food and clothing is being requested, however, many other participants spoke of emotional, psychological and spiritual support. Saying that pastors could offer support to individuals whose "parents don't offer" support, also reveals a call for more psycho-social and emotional support from parents. Public health facilities were perceived as being most effective when embedded within youth-spaces:

> *Constant pop ups maybe? A few months there would be a pop up and nurses in the parks [can teach] young people about sex. I think there should be more pop up clinics*

for young people. Maybe at the backyard of a school, maybe the backyard of a church, at the park, so that they can be encouraged to go get tested…[and] learn more about sexual health.

The reference to "pop ups" suggests that women expect the public health facilities do more preventative work, to come to them rather than asking them to come to clinics. This is particularly true because public health facilities offering sexual health services are frequently described as intimidating for young women seeking sexual health advice. Many expressed anxieties about having a bad experience with healthcare workers who might "shout" at or "judge" them for having had pre-marital sex. Further, many women explained that going to clinics could result in stigma and ostracisation. Women may thus avoid going to clinics to learn about sexual health altogether perpetuating the cycle of sexual ill-health. The solution suggested by the participants was to normalize sexual health related discussions though "pop-ups" in public spaces. This would not only eliminate the stigma currently associated with clinics, but also prioritize prevention over treatment.

Discussion

This study explored the relationship between sexual health and religion among young women living in an impoverished South African township. I argue that for youth navigating the transition to adulthood in contexts of uncertainty, the church can play the role of custodian regarding sexual health matters. However, church expectations sit in tension with socio-economic realities and contemporary youth culture. While other studies have looked at the morality of transactional sex (van der Heijden &

Swartz, 2014) and the moralised discourse on gender and HIV (Mindry, Knight & van Rooyen, 2015), this study examined the lived experience of the "moral dichotomisation of 'right' and 'wrong'" and how sexual health decision-making unfolds given the tensions experienced (Casale et al., 2010, p.140). The archetypal "party girl" or "church girl" are borne out of contradictory discourses on womens' sexuality, their socio-economic vulnerability and their engagement in youth culture.

In order to understand the sexual behaviour of young women in contexts of socio-economic instability and vulnerability, it is important to note that adulthood is not only a biological or legal concept, but also socially constructed. As a social construct, adulthood is generally associated with financial independence, autonomous decision-making and a sense of personal responsibility (Arnett, 2004; Settersten, 2011). In addition to biological changes, therefore, the transition to adulthood is also marked by psycho-social and behavioural changes. Progressively, children are recognized as adults and experience themselves as adults because they comply with the social norms which define adulthood. In the context of extreme socio-economic instability and vulnerability, parenthood, womanhood, respectability and intimate sexual relationships have been found to exist as alternative modes of transition into adulthood (Swartz, Colvin & Harrison, 2018; Sennott & Mojola, 2017).

To this, one can add other activities that are reserved for adults, such as drinking alcohol, smoking, going to clubs and bars. Some studies have also found that 'partying' can be seen as a form of social and political participation (Riley, More & Griffin, 2010). For individuals unable to become adults through the attainment of financial independence and autonomy, sexual activity and activities such as drinking, smoking and partying are the only available way to distinguish themselves from children and to feel adult. Consequently, women living in contexts of socio-economic

instability may be prone to engaging excessively in activities - promiscuous sex and drinking in particular - that expose them to greater health risks. Most studies investigating sexual health among impoverished South African youth are centred around notions of economic vulnerability and the need to engage in transactional sex to fulfil basic resources and improve social status (Harrison et al., 2015).

The findings reveal that there is also a perceived sense of loss of control over sexual health decision-making and that this control lies not in the hands of women, but in the hands of their partners, family members, church and wider community. Greater self-empowerment, therefore, is required for women to regain a sense of control over their sexual health. Yet, the disempowering socio-economic realities they face, and the inhibition of their social and political participation requires that a more accessible mode of empowerment is available. This is, perhaps, the role that social media plays in their lives. For instance, the archetype of the 'slay queen' who maintains a façade of opulence, despite her socio-economic background, becomes a way in which young women can express their empowered agency and attain a higher social status amongst peers (Sennot & Mojola, 2017). The portrayal of being from a 'higher' class may also attract men of a similar class and allow young women to climb up the social hierarchy through their partner's social status. While there is acknowledgement that this lifestyle may be afforded though transactional sex or multiple relationships which increase the risk of sexual ill-health, there is also a collective, silent understanding that it is due to the difficulty of becoming self-sufficient given the circumstances.

Thus, many of the participants called for the involvement of churches in sexual health related issues. However, similar practical issues such as the contradictory 'abstinence vs condom use discourse' and the inappropriateness of learning about

sexual health from pastors were identified (Casale et al., 2010). The women suggested that church involvement could, instead, be enhanced if there was greater differentiation between sexual health-related activities offered by churches and those provided by public health facilities in their community. Churches were perceived to be better suited to provide support for youth as they transition to adulthood by providing material and emotional support. Given that women are at higher risk of sexual ill-health because of their engagement and/or reliance on transactional sex and multiple relations to fulfill their socio-economic needs, the church's potential function as a 'basic needs provider' may decrease the need for transactional sex and assist in promoting sexual health. Public health services were seen to be most effective when embedded in spaces frequented by youth such as recreational parks and schools. The disjuncture between the secularised nature of health services and the moralising nature of religion can be used to their advantage in this case. If recognised that both domains are working towards the same objectives, then health facilities can focus their efforts on providing secularised sexual health services to youth in neutral spaces to eliminate moralised judgement, while religious organisations provide various forms of support in accordance with the religious values of generosity and love. This may ease the tensions that young women experience due to these conflicts and allow them to gain more control over their lives and sexual health.

Limitations

This study may have been limited by the language barrier between SP and participants. Interviews were conducted in English which was not the primary language of the participants and might have influenced how they translated their perceptions. While

it was beneficial that SP was of a similar age to the participants which promoted openness in discussions about sex, sexual health and youth culture, the fact that SP is of Sri Lankan culture and Asian ethnicity may have influenced responses. Another limitation is that many of the participants were involved in a community-programmes and thus, their views might not be representative of other young women living in Khayelitsha who are uninvolved in similar programmes. Given the similarities in the "sexual health discourses" of most religions, many of the findings might well be transferable to other similar contexts. However, the relationship between sexual health, religious values and contemporary youth culture as described in this article, are unique to Khayelitsha, and thus, might not be generalisable.

Conclusion

The relationship between sexual health and religion is complicated by the tensions that arise between moralised religious dichotomies and the socio-economic realities of youth living in contexts of instability, poverty and uncertainty. The partnership between FBOs and public facilities offering sexual health services is also fraught with conflict. This study explored these tensions and complications within the context of socio-economic deprivation and contemporary youth culture in Khayelitsha. It contributes to a deeper understanding of how the tensions between sexual health and religion are expressed and experienced by young women and how these tensions influence their sexual health decision-making. When contemporary youth culture, coupled with the increasing occurrence of transactional sex and multiple relationships intersects with religious views on contraception and other prevention strategies, there is an increased risk of unintended pregnancies or HIV/STI- infection implying

increased sexual ill-health, social exclusion, mental health issues, and further economic vulnerability. The call for church involvement reveals that youth require positive role models who can support them and inspire hope for the future. While this study focused on the role of religious organisations, it is clear that community efforts involving parents, community members, schools, health services *and* religious organisations are required to support youth as they navigate uncertainty and the complexities of transitioning to adulthood in a context of uncertainty, instability and socio-economic deprivation.

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Compliance with Ethical Standards

Conflict of Interest The author declares that they have no conflicts of interest.

Ethical Considerations
All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Cape Town's (UCT) Health Science Faculty's Human Research and Ethics Committee (HREC) and UCT's School of Public Health and Family Medicine (HREC REF: 288/2019).

Informed Consent Informed consent was obtained from all the participants involved in this study.

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PART D: APPENDICES

Appendix A: Semi-structured Interview Schedule

*Consent procedure will occur immediately prior to the interview. All issues such as the freedom of the participant to choose not to respond to any questions or to opt-out of the study completely will be clarified before beginning the interview.

General

- Introductory comments about the study
- Please tell me a bit about yourself: your name, where you are from, where you live now, how old you are, if you work and if so what do you do, what your relationship status is, who you live with, if you have children, affiliation with any religion.

Religious/faith beliefs

- What role does religion play in your life, if any?
- When did you first encounter your religious beliefs or understandings? Were there any people in your life that played a role?
- What role does your faith (or absence of faith) play in making life decisions, if any?
- What types of religious and/or faith beliefs have you adopted in your life, if any? Could you tell me a bit more about that?
- Are there some religious beliefs or understandings that you prefer over others? What are some reasons for this?
- What types of religious beliefs or understandings have you left out? What are some reasons for this?

Relationships (Sexual partnerships), Marriage, fertility desires and motherhood

- What are some factors you consider when starting a relationship? Could you tell me more about why you chose to reflect on those factors?
- When choosing a sexual partner, do you take your religious and/or faith beliefs into consideration?
- How important is it that your partner has similar religious and/or faith beliefs? What are some reasons for this?
- Are you currently married? And if not, do you ever want to be married?
- How do you think your religious and/or faith beliefs have influenced your choice, if at all?
- Do you have any children? And if not, do you ever want to? Could you tell me a little bit more about that?
- How do you think your religious and/or faith beliefs have influenced your decisions, if at all?
- How do you define motherhood? How do your religious and/or faith beliefs perceive/regard motherhood?

Sexual health and partnership between PH & Religion

*First: an explanation of what is meant by sexual health. “Sexual health is the ability to enjoy and control sexual and reproductive behaviour, freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response, freedom from disease that interfere with sexual and reproductive functioning.”

- How would you define sexual health?
- From what I have explained about sexual health, do you feel you have the ability to control your sexual behaviour?
- Are there any areas where you feel your sexual health is being limited? Please tell me a little bit more about this.
- Have any religious and/or faith beliefs influenced your decisions about sexual health-related behaviours?

- How do you think sexual health-related interventions can be improved?
- Do you think incorporating religious and/or faith beliefs would make a difference? Please tell me a little bit more about why you think this.

Gender Issues & Contemporary Peer Culture

- Do you think that religion and faith plays a role in how men and women choose to behave sexually? Could you please tell me a little bit more about this?
- Do you think that the spread of HIV/AIDS and STIs is something that young people are taking into account when forming sexual partnerships?
- What types of things are part of the youth culture here in Khayelitsha?
- Do you think consumerism, going out to parties or nightclubs and the use of social media affects forming sexual relationships and young people's sexual behaviour? Please tell me more about this. (This question will also include what the participants say to the previous question).
- Do you think that religion and faith are important characteristics of youth culture here in Khayelitsha? Please tell me why you think so.

Concluding remarks

- We have come to the end of the interview. Thank you so much for the time that you have spent answering my questions.
- All the information that you have given me will be kept confidential. Only my supervisor and I will have access to it.
- I will also not use your name (unless you would like me to) if I use any of the information you have given me.
- We will also like to share the findings of the research with you- I will notify you at a later date of how we will do this.
- Is there anything you would like to add? Do you have any questions for me?

Appendix B: Focus Group Discussion Schedule

General

- Informed consent will occur immediately before any of the focus group discussions
- Introductory comments about the study
- Draw up mutually-agreed-upon confidentiality 'contract'
- Debrief after each session

Activity 1: The Transition to Adulthood: 'River of Life'

- Please spend some time drawing your 'River of Life' using these questions to guide you:

1. Relationships: Who are the various people who have accompanied you along your river's journey?
2. Who has most shaped you?
3. Faith: In what different ways have you understood faith across your life?
   Who or what was your faith to you at the different times depicted in your drawing?
   What caused you to feel closer to, or more distant from your faith at these different times?
   Have you faced any situations or experiences that changed your sense of God?
4. Challenges: In relation to your life's journey, what types of challenges might you, or people close to have faced?
   What is most challenging to young people your age?
   What do you associate with challenging experiences?
5. Values: What values, commitments/causes/principles were most important to you?
6. Goals: What purposes or goals have helped shape the flow of water in your river at a given time in your experience?

Activity 2: Follow-up & de-brief

1. What were some of your thoughts and/or feelings during this exercise?
2. What common themes did you hear?
3. How have friends, partners, church, community members, health clinics or any others played a role in your life?
4. How has religion and faith played a role in your lives?
5. How has this shaped your life and decisions about the future?

Closing

- Debrief
- Go over the consent procedure and reiterate confidentiality
- Are there any questions for me?

Appendix C : Informed Consent Form for Individual Interviews

Title: Sexual health in relation to religious beliefs: perceptions of young South African women living in Khayelitsha

Lead Researcher: Alison Swartz
Email: alison.swartz@uct.ac.za **Phone:** 021 406 6706

Student Researcher: Shehani Perera
Email: shehaniperera@hotmail.com **Phone:** 0607815587

Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Sciences. University of Cape Town **Email:** marc.blockman@uct.ac.za **Phone:** 021 406 6338

Purpose of Research: We are inviting you to participate in a study that aims to research the perceptions of sexual health and religious/faith beliefs among young women in Khayelitsha. In particular, we would like to ask questions about relationships, including those with romantic partners and children, reproductive and sexual health and faith and religious beliefs.

What is involved in participation? Are there any risks or benefits for me? Your participation in this research study is completely voluntary. If you choose to participate, we will have a discussion about your perceptions and beliefs as young women about reproductive and sexual health in relation to your religious/faith beliefs. Your responses will have no effect on your participation in the programme- our work has some similar goals but is also very different. All of us would like to better understand and support young women in Khayelitsha, but the programme has a slightly different focus to ours. Our goal is to conduct research on how religion and faith beliefs might influence sexual health. We value your opinions and personal experience because they will help us to increase our understanding of how young women in Khayelitsha are making decisions about sexual and reproductive health, and how they could be better supported. The programme is separate and provides you with business, IT and psycho-social skills.

If at any time you feel uncomfortable during the conversation, you can request to stop without any explanation. You can also refuse to answer certain questions or ask to move on to the next question without answering at any time. If you have questions or concerns, you are free to pause the conversation and ask for clarification. Following the discussion, you can also withdraw your answers at any time. If you are upset about any questions or feel stressed during or after the conversation, please let me know and we can refer you to a counsellor.

Confidentiality and disclosure of information: Any information obtained in this study will only be shared with your permission. Direct quotes or summaries of your words might be used but these will be anonymous and you will not be identified by name. If we need to refer to your words, we will use a fake name (pseudonym). We will only use your real name if you voluntarily request that we do so. In order to listen to the conversation in more detail later, we need to record the discussion. If you feel uncomfortable at any point, you can ask me to stop the tape. Any written or audio interviews will be stored on a password-protected computer.

Thank you so much for agreeing to participate in this study!

Consent: (Signature of participant) _____

(Name of participant) (Date)

Appendix D: Informed Consent Forms: Focus Group Discussions

Title: Sexual health in relation to religious beliefs: perceptions of young South African women living in Khayelitsha

Lead Researcher: Alison Swartz
Email: alison.swartz@uct.ac.za **Phone:** 021 406 6706

Student Researcher: Shehani Perera
Email: shehaniperera@hotmail.com **Phone:** 0607815587

Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Sciences. University of Cape Town
Email: marc.blockman@uct.ac.za **Phone:** 021 406 6338

Purpose of Research: We are inviting you to participate in a study that aims to research the perceptions of health and well-being among young women in Khayelitsha. In particular, we would like to ask questions about relationships, including those with romantic partners and children, reproductive and sexual health, faith and religious beliefs, and what your plans are for the future.

What is involved in participation? Are there any risks or benefits for me? Your participation in this research study is completely voluntary. If you choose to participate, we will have a discussion about your perceptions and beliefs as young women about reproductive and sexual health. Your responses will have no effect on your participation in the programme- our work has some similar goals but is also very different. All of us would like to better understand and support young women in Khayelitsha, but the programme has a slightly different focus to ours. We value your opinions and personal experience because they will help us to increase our understanding of how young women in Khayelitsha are making decisions about sexual and reproductive health, and how they could be better supported.

If at any time you feel uncomfortable during the conversation, you can request to stop without any explanation. You can also refuse to answer certain questions or ask to move on to the next question without answering at any time. If you have questions or concerns during your time with any members of the research team, you are free to pause the conversation and ask for clarification or let one of us know. Following the discussion or activity, you can also withdraw your answers at any time. If you are upset about any questions or feel stressed during or after the conversation, please let one of us know and we can refer you to a counsellor.

Confidentiality and disclosure of information: Because this discussion will happen in a group, we can't make absolutely sure that your confidentiality will be maintained. However, we will ensure that everyone participating knows that they should not talk about anything shared in the group with other people. Any information obtained in this study will only be shared with your permission. We may use direct quotes or summaries of your words but these will be anonymous and you will not be identified by name. If we need to refer to your words, we will use a fake name (pseudonym). We will only use your real name if you voluntarily request that we do so. In order to listen to the conversation in more detail later, we need to record the discussion. If you feel uncomfortable at any point, you can ask us to stop the tape. Any written or audio interviews will be stored on a password-protected computer.

Thank you so much for agreeing to participate in our study!

Consent:_____

(Signature of participant)

_____ (Name of participant) _____ (Date)

Appendix E: Participant General Information Sheet

Title: **Sexual health in relation to religious beliefs: perceptions of young South African women living in Khayelitsha**

Lead Researcher: Alison Swartz
Email: alison.swartz@uct.ac.za **Phone:** 021 406 6706

Student Researcher: Shehani Perera
Email: shehaniperera@hotmail.com **Phone:** 0607815587

Contact Information: Human Research Ethics Committee (HREC), Faculty of Health Sciences. University of Cape Town
Email: marc.blockman@uct.ac.za **Phone:** 021 406 6338

Before you decide on whether you would like to participate in this study, it is important that you understand why the research is being done and what it would involve for you. Please take time to read this information, and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask me.

What is the purpose of this study?
The purpose of this study is to research the perceptions of health and well-being among young women in Khayelitsha. In particular, we would like to ask questions about relationships, including those with romantic partners and children, reproductive and sexual health, faith and religious beliefs, and what your plans are for the future.

Why have I been invited?
Your opinions and personal experience are valued because they will help us to increase our understanding about how young women in Khayelitsha are making decisions about sexual and reproductive health, and how young women, between the ages of 18 and 25 can be better supported.

Do I have to take part? What will happen if I don't want to carry on with the study?
Your participation in this research study is completely voluntary. If you choose to participate, we will have a discussion about your perceptions and beliefs as young women about sexual health and your religion and/or faith beliefs. If you do not want to carry on with the study or feel uncomfortable at any point in time during the interview/focus group discussions, you are free to choose to drop-out of the study. Your participation, or decision to leave the study, will have no effect on your participation in the programme. Following the discussion or activity, you can also withdraw your answers at any time. If you are upset about any questions or feel stressed during or after the conversation, please let one of us know and we can refer you to a counsellor.

Are there any possible risks from taking part? Will the things I share be kept confidential?
The study does not have any serious disadvantages of risks that could occur from taking part. However, because some discussions will happen in a group setting, we cannot make absolutely sure that your confidentiality will be maintained. However, we will ensure that everyone participating knows that they should not talk about anything shared in the group with other people. Any information obtained in this study will only be shared with your permission. We may use direct quotes or summaries of your words but these will be anonymous and you will not be identified by name. If we need to refer to your words, we will use a fake name

(pseudonym). We will only use your real name if you voluntarily request that we do so. In order to listen to the conversation in more detail later, we need to record the discussion. If you feel uncomfortable at any point, you can ask us to stop the tape. Any written or audio interviews will be stored on a password-protected computer.

What are the possible benefits of taking part?
Your participation in this study may not have any direct benefits, however, your opinions and personal experiences will help us to increase our understanding about how young women in Khayelitsha perceive their sexual health in relation to their religious and/or faith beliefs, and how we could use this information to improve public health interventions.

Will I be reimbursed for taking part?
Unfortunately, you will not be reimbursed for taking part in this study. However, refreshments will be served at every focus group discussion session/interview.

What happens at the end of the study?
At the end of the study, the research findings may be published, presented at conferences and presented back to you. I will contact you when the findings have been finalised in order to relay what was found. The research being undertaken will also contribute to the fulfilment of an education requirement of my Master of Public Health degree. Please be reassured that you will not be identifiable from any report or publication.

Thank you for reading this information and for considering taking part.

Appendix F: Contact details of mental health organisations

1.Trauma Centre- For survivors of violence and torture

- **Address:** Cowley House, 126 Chapel Street, Woodstock, Cape Town, 7925
- **Phone:** +27 21 465 7373

2. Rape Crisis

- **Address:** 23 Trill Road, Observatory, Cape Town, 7925
- **Counselling lines:** 24hr Crisis line: 021 447 9762 **Khayelitsha: 021 361 9085

3. Simlela Centre

- **Address:** 89 Sulani Dr, Village 3 North, Cape Town, 7784
- **Phone:** 021 361, 0543

4. Township Parents and Children Counselling Centre

- **Address:** 4 Sipho Xulu St, Mandela Park, Khayelitsha, Cape Town, 7784
- **Phone:** 021 367 6012

5. Cape Mental Health

- **Address:** 22 Ivy Street, Observatory, Cape Town, 7935
- **Phone:** 021 447 9040

6. The South African Depression and Anxiety Group (SADAG)

- **Phone:** 080 045 6789

7. Philani
Address: Phaphani St, Ikwezi Park, Cape Town, 7784
Phone: 021 387 5124

Appendix G: Confirmation of formal ethics approval

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: sumeyah.arieffdien@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

03 July 2019

HREC REF: 288/2019

Dr A Swartz
School of Public Health & Family Medicine
Room 3.49, Falmouth Building
FHS

Dear Dr Swartz

PROJECT TITLE: SEXUAL HEALTH IN RELATION TO RELIGIOUS BELIEFS: PERCEPTIONS OF YOUNG SOUTH AFRICAN FEMALES LIVING IN KHAYELITSHA (SUB-STUDY LINKED TO 321/2008) (MASTERS CANDIDATE: MS S PERERA)

Thank you for your response letter dated 19 June 2019, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30 July 2020.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: Ms Shehani Perera will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

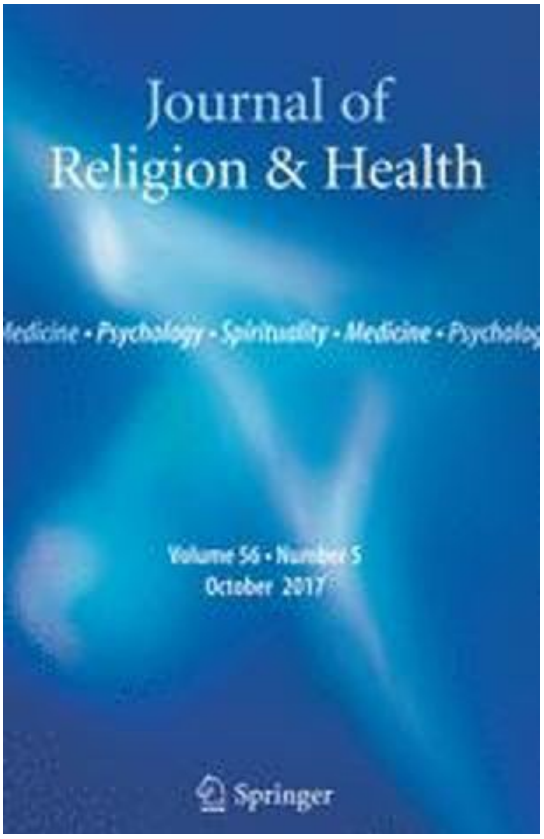
Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB0000[illegible]

Appendix H: Journal of Religion & Health- Instructions to Authors

Instructions to Contributors



Journal of Religion and Health

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2. Submit to the Editor-in-Chief of the Journal of Religion and Health an Authorization Form to be obtained from the Editor-in-Chief with the original signature of the author, indicating that the author has the permission of the subject(s) to publish his/her material and authorizing the Journal of Religion and Health to publish the article in compliance with HIPPA regulations regarding Protected Health Information. This form will also be signed by the Editor-in-Chief of the Journal of Religion and Health and the original form will be placed in a locked file under the auspices of the Editor-in-Chief in perpetuity. A copy of this form will be mailed to the author for his/her files in an envelope marked: “Personal and Confidential” .
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Plante, T. G., & Aldridge, A. (2005). Psychological patterns among Roman Catholic clergy accused of sexual misconduct. Pastoral Psychology, 54, 73–80.

Book

Levin, J. (2002). God, faith and health: Exploring the spirituality–healing connection. New York: Wiley.

Contribution to a Book

Cutler, D. L., Bigelow, D., Collins, V., Jackson, C., & Field, G. (2002). Why are severely mentally ill persons in jail and prison? In P. Backlar & D. L. Cutler (Eds.), Ethics in community mental health care: Commonplace concerns (pp. 137–154). New York: Kluwer Academic/Plenum Publishers.

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- A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

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- Research involving Human Participants and/or Animals
- Informed consent

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