

**REPRODUCTIVE DECISION-MAKING IN THE ERA OF HIGH LEVELS OF  
UNWANTED PREGNANCY AND HIV/AIDS AMONG YOUNG PEOPLE: A CASE  
STUDY OF NELSON MANDELA DRIVE CAMPUS IN  
THE EASTERN CAPE**

By

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## Declaration

Submitted in fulfillment / partial fulfillment of the requirements for the degree of  
Masters, in the Graduate Programme in Population Studies,  
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Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in the graduate Programme in Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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## **Abstract**

Young people are faced with high levels of HIV/AIDS and unwanted pregnancy in South Africa. In this context it is important to understand the reproductive decision-making process with regard to these sexual risks. The study draws on in-depth interviews conducted with 20 Black students aged 18 to 24 years at the Walter Sisulu University. The study found that there was a high level of awareness of unwanted pregnancy and HIV/AIDS. However, many young people engaged in risky sexual behaviours. Differing gender roles seemed to significantly promote risky sex and discouraged shared decision-making. The study suggests that men often dominated the decision-making process. In addition, partner coercion was prevalent, and it negatively affected the health choices of young people. Other factors that were barriers to adopting prevention strategies included the negative attitudes of health providers and limited communication between parents and children and also, between sexual partners. Young people were afraid to freely discuss sexual issues and preferred actions to avoid antagonizing partners who might suspect infidelity, lack of commitment and HIV infection. Some young people also expressed concern that contraceptives were not safe. Young people emphasized the negative repercussions of HIV/AIDS and unwanted pregnancy and the importance of creating greater awareness of the risks and adopting prevention strategies. However, the study findings point to the need for health promotion interventions to go beyond risk awareness and incorporate the cultural, social and economic contextual factors in which the behaviour takes place.

## **List of Acronyms**

AIDS	Acquired Immune Deficiency Syndrome
DHS	Demographic and Health Surveys
HIV	Human-Immunodeficiency Virus
FP	Family Planning
PLWHIV	People Living With HIV
STI	Sexually Transmitted Infection

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## **Chapter One**

### **Introduction**

#### **1.1. Background**

Youth usually refers to people between the ages of 10 and 24 years (Nugent, 2005). This covers a wide range of experiences and transitions that include an early phase (between ages 10 and 14), a middle phase (between 15 and 20), and a later phase (between 21 and 24) (Nugent, 2005). Youth often come face-face with numerous health risks along their path to adulthood, many of which affect the length and quality of their lives. Presently the greatest risk for the youth is HIV/AIDS, which is afflicting them, especially young women. This is especially severe in some regions of the developing world. In addition, early sexual activity, unwanted pregnancies and early childbearing may have long term effects on their quality of life (Nugent, 2005). HIV/AIDS and unwanted or unplanned pregnancies are some of the major causes of morbidity and mortality among young people in sub-Saharan Africa (Nugent, 2005).

#### **1.2. HIV and AIDS**

The Human Immunodeficiency Virus (HIV) is a retrovirus that almost inevitably results in Acquired Immune Deficiency Syndrome (AIDS). It is a relatively newly acquired condition and is only in its third decade of public existence. Despite being relatively new, the epidemic has killed millions of people, making it one of the devastating epidemics in the recorded history. Globally, the total number of people living with HIV was approximately 33.2 million by 2007. Close to 2.5 million people got infected in 2007. Young people in the age range of 15 to 24 years accounted for half of all new cases of HIV around the world. By the end of 2007 AIDS epidemic had claimed 2.1 million people (UNAIDS, 2008). Sub-Saharan Africa contributes just over 10% of the world's population, but accounts for more than 60% of all people living with HIV (22.5 million). In sub-Saharan Africa, among young people aged 15–24 years, 4.6% of women and 1.7% of men were living with HIV in 2005 (UNAIDS, 2008; WHO 2005).



Southern Africa remains the epicenter of the global AIDS epidemic. South Africa has one of the highest levels of HIV prevalence in the world. Almost 28% of South Africa's 45 million people have been affected by the virus that causes AIDS (UNAIDS, 2004). An estimated 21.5% of the adult population aged 18 to 64 years lives with virus and about 600 people die of HIV-related illnesses each day. Current statistics show that 15 to 24 year olds are presently the age group most susceptible to HIV, both nationally and internationally (UNAIDS, 2004). Among young people, the HIV prevalence rate is 12.5% (Dorrington et al., 2006).

In a number of communities, research has indicated that young women are more likely to be HIV-infected than young men. In South Africa, among women aged 20–24 years, almost one in three was found to be infected with HIV (Department of Health South Africa, 2005). The high prevalence rate of HIV/AIDS in South Africa poses one of the most serious threats to the health and well-being of young people (UNAIDS, 2005). HIV/AIDS affects family situations, economic circumstances and prospects, the well-being of the youth. It also affects their social behaviour as they negotiate sexual and intimate behaviour in this age of AIDS.

Reproductive health problems including HIV and AIDS contribute to high levels of morbidity and mortality experienced by young people. Parker (2003) argues that HIV mostly affects younger people. According to Parker (2003) about half of all adults who acquire HIV become infected before they turn 25 years of age. He also noted that, over 50% of all young people die before their 35 birthday. In other words, AIDS primarily strikes people who were infected as adolescents or young adults—shifting the usual pattern of deaths in developing countries (very young or very old age) and distorting the age structure in some countries (Ashford, 2006). HIV and AIDS have had other socio-economic repercussions on young people.

Socially, HIV positive people face prejudice and discrimination in many areas of life including employment, housing as well as other social relationships. In South Africa, a

study in 2002 revealed that only one third of respondents who had revealed their HIV positive status met with a positive response in their communities. Findings in this regard show that one in ten said that they had been met with outright hostility and rejection (Pembrey, 2006). Households experience the immediate impact of HIV/AIDS, because they are the main caregivers for the sick and inevitably suffer AIDS-related financial hardships. During the long period of illness caused by HIV/AIDS, the loss of income and cost of caring for a dying family member can impoverish a household. The epidemic cripples health systems especially in developing countries such as those in Africa, where systems may have been weak already before the epidemic struck (Ashford, 2006). Ashford (2006) also notes that the expenses associated with treating AIDS and AIDS related 'opportunistic infections' have been rising. Allocating resources and funds to HIV/AIDS can divert attention from other health concerns as public funds for health care becomes scarce. As a result, the costs associated with HIV prevention and treatments are increasingly borne by the private sector, households and individuals.

Economically, the HIV/AIDS pandemic has an impact on labour supply, through increased mortality and morbidity (Dixon, McDonald and Roberts, 2002). This is compounded by the loss of skills in key areas of the labour market. A study by the Food and Agriculture Organization (FAO) found that in the 10 African countries most severely affected by HIV/AIDS, the agricultural workforce would decline between 10% and 26% by 2020 (Dixon, McDonald and Roberts, 2002). In South Africa, Dixon, McDonald and Roberts, (2002) indicated that 60% of the labour force aged between 30 and 44 in mining sector would decline to 10% in 15 years time. Furthermore, the long period of illness associated with AIDS reduces labour productivity. For instance, the annual costs associated with sickness and reduced productivity ranged from \$17 to \$300 in Kenya's car manufacturing firm and Uganda's Railway Corporation, respectively (Dixon, McDonald and Roberts, 2002). Also, a study conducted in Kenya, Malawi, Tanzania, and Zambia found that slow growth in agricultural production due to HIV/AIDS could result in growing food insecurity by 2010 (Ashford, 2006). Economic stability is therefore compromised as economic units suffer through reduced profits, reduced competitiveness and falling of revenue from taxes in the face of HIV/AIDS.

However, Ashford (2006) asserts that the longer-term impact may be made more serious by the effects of lower investments in the younger generation (education, nutrition and health).

### **1.3. Unwanted pregnancy**

Globally, about 80 million pregnancies each year are unintended and more than one-half result in induced abortion (Mesce and Sines, 2006). Kaufman, De wet and Stadler (2001) also assert that although lifetime fertility has fallen close to below replacement level, fertility rates among young people have remained high in South Africa. The South African Demographic and Health Survey of 1998 (SADHS) revealed the rise in the proportion of teenage pregnancies from 2.4% to 35.1% with each additional year of age and majority of these pregnancies are neither planned nor wanted (Swartz, 2003). Furthermore, a study conducted among young people in Kwazulu-Natal revealed that nearly half had had their first sexual experience by the age 16 years. Almost half of sexually active women included in that study had been pregnant before, and most of those pregnancies were unwanted or unplanned (Manzini, 2001). Early childbearing is associated with a number of adverse socio-economic and health consequences.

Nugent (2005) notes that deaths and illness related to pregnancy, as well as other reproductive health problems are harmful to young women's health and ability to function normally, especially in low-income countries. An estimated 529,000 girls and women die from pregnancy-related causes each year, almost all of them in the developing world (Mesce and Sines, 2006). About 68,000 of the pregnancy related deaths are due to unsafe abortion and most unwanted pregnancies end in abortion. In Africa, 60% of women who have unsafe abortions are under the age of 25 years. In countries where abortion is illegal and unsafe, unintended pregnancy is a major contributor to maternal morbidity and mortality. Worldwide, abortion is estimated to have caused 400,000 of the 700,000 deaths resulting from unintended pregnancies between 1995 and 2000 (Santelli et al., 2003). However, despite its legal status in some countries, abortion is resisted on

moral and religious grounds and access to safe, legal abortion continues to be constrained. As a result, many young people opt for illegal abortions.

Santelli et al., (2003) reports that young women suffer complications from childbirth, including pre-term and obstructed labour, infections, anemia, and other complications. Burgard (2004) notes that one of the factors that could influence a mother's use of pregnancy related care is the wantedness of the pregnancy at the time it occurred; unwanted pregnancies may be less likely to receive timely and adequate care (Oropesa, Landale, Inkley and Gorman, 2000 cited in Burgard, 2004). According to Santelli (2003), women who carry an unwanted pregnancy to term are more likely to smoke, receive delayed prenatal care and have low birth weight infants. Weller, Eberstein and Bailey (1987) also note that many women may try to conceal or deny an unintended pregnancy. Thus, it is likely that an unwanted pregnancy compromises the health of the mother and her foetus.

In most developing countries, children born to young mothers face poor survival prospects and higher chances of serious illness and disability. For example, in Mali, nearly one in five children born to adolescent mothers dies before their first birthday (Population Reference Bureau, 2001). Sines, Tinker and Ruben, (2006) note that almost one quarter of newborns in developing countries are born with low birth weight, largely due to their young mothers' poor health and nutritional status. In addition, low-weight infants are about three times more likely than normal birth weight infants to experience lifelong disabilities such as mental retardation, cerebral palsy, and autism (Population Reference Bureau, 2001). Additionally, children born unwanted are more likely to have a variety of social and psychological problems. In the United States of America, a long-term study of children born between 1961 and 1963 found that being 'born unwanted' carried a risk of negative psychosocial development, especially for only children who had no siblings (Russo et al., 1992).

In several societies, an unwanted pregnancy means the end of formal education for a girl, because the prospective mother is expected to care for her child. In South Africa, where teenage unwanted pregnancies is common, Swartz (2003) observes that the father of the

child rarely takes responsibility for the financial, emotional and practical support of the child. In a study conducted in Soweto, Kaufman, de Wet and Stadler (2001) found that male partners shy away from the responsibility of taking care of a pregnant partner and later a child they have fathered. Unless the parents of the girl provide support, their pregnant daughter often leaves school, thus ending her opportunities for development, making her vulnerable to poverty, exploitative sexual relationships and violence as well as low self-esteem (Swartz, 2003). Therefore, it is important, as Varga (1997) states that in every sexual relationship, negotiation and decision-making are essential elements of preventing risky sexual practices that could lead to HIV infection and unwanted pregnancy.

#### **1.4. Decision-making**

Varga (1997) defines sexual decision-making as decisions, preferences and resolutions made by an individual regarding the conditions under which sexual intercourse occurs, whereas sexual negotiation includes the verbal and non-verbal interaction and dynamic between partners in deciding how and when intercourse will take place. Until relatively recently, much work with young people in developing countries has centered on the prevention of pregnancy and sexually transmitted infections (STIs) including HIV and AIDS, rather than the promotion of sexual health. It is vital to shift the focus towards multi-dimensional and rights-orientated conceptions of sexual health (Dixon-Mueller, 1993). Such conceptions, among many, include reproductive decision-making. After all, the 1994 International Conference on Population and Development (ICPD) in Cairo greatly recognized and emphasized the importance of shared reproductive decision-making.

##### **1.4.1. Benefits of reproductive decision-making**

The benefits of investing in the sexual and reproductive health of young people in general and reproductive decision-making in particular are physical, economic, social and psychological.

Efforts made to help couples talk about sexual issues and share responsibility for their reproductive health decisions can produce potentially life-saving changes in the sexual behaviour of people, especially the young. According to Family Health International (2002), helping couples to communicate about sex is increasingly viewed as essential to HIV/AIDS prevention strategies. Young people aged 15-24 represent 25% of the world's population (Jejeebhoy, 2006). Thus, appropriate communication between partners about sexual matters is likely to prevent risky behaviour of a significant proportion of the world's population. Furthermore, young people face significant risks related to sexual and reproductive health and many of them lack the knowledge and power to make informed sexual and reproductive choices (Jejeebhoy, 2006). Shared reproductive decision-making is a key intervention for protecting the health of young people against STIs (including HIV/AIDS) and unwanted pregnancy (WHO, 2005). In addition, reproductive decision-making is a basic human right for every one.

The rights-based approach to sexuality and reproductive health adopted at the International Conference of Population and Development (ICPD) of 1994 in Cairo assumes that health is a basic human right (Kumar, 2003). The basic elements of this approach include sexual and reproductive rights, gender equity and equality as well as client-centered sexual and reproductive health care. According to the reproductive rights approach, an individual has the right to exercise control over his or her own body, sexuality and reproduction (Kumar, 2003, 2003). Additionally, all individuals have the right to decide on accessing, choosing and enjoying the benefits of scientific progress in the selection of family planning methods (WHO, 2005).

Facilitating communication between partners with regard to sexual matters helps them agree upon and meet their reproductive goals (FHI, 2002). In diverse settings, spousal communication has been consistently associated with greater contraceptive use. For example, in Ghana, women who had discussed contraceptives with their husbands were twice as more likely to be current users of contraceptives than those who had not (Bawah, 2002).

Besides, medical advantages, reproductive decision-making on contraceptive use contribute to a range of development goals. Delaying motherhood through the use of contraceptive services is likely to be an important factor that contributes towards women's achievement of higher education as a goal. Women of all ages report that using contraception to time births and avoid unintended pregnancies improves their personal well-being and status in the household (UNFPA, 2004). Qualitative research in different countries shows that contraceptive use reduces stress about the risk of unplanned pregnancies and improves relationships between partners (UNFPA, 2004). For example, in Bolivia, women using contraceptives demonstrate greater self-esteem than those who do not. Also, in the Philippines, contraceptive users report greater overall satisfaction with their lives than nonusers (UNFPA, 2004). Also, choices of protecting and improving health, access to contraceptive services and maternal health services increase productivity in the home and the labour force, resulting in personal, household and societal economic benefits (UNFPA, 2004). Additionally, the decision to seek contraception services is also associated with opportunities to screen women for gender based violence and also offer counseling opportunities to such women (UNFPA, 2004).

It is against this backdrop that this study sets out to interrogate reproductive decision-making among young people in the Eastern Cape.

### **1.5. The aim of the study**

The overall aim of this study is to shed more insights into reproductive decision-making among young people in the era of high levels of unwanted pregnancy and HIV/AIDS.

### **1.6. The significance of the study**

Rwenge (2000) observes that the majority of African women do not use modern contraceptive methods. Rwenge (2000) further points out that consequently there is high risk of maternal and infant mortality resulting from early pregnancy. In addition, induced abortion often carried out in unsafe circumstances, short inter-pregnancy intervals, and

high and prolonged fertility are other risks. Despite these risks, little research has been done to determine the factors affecting sexual behaviour, especially with young people (Rwenge, 2000). A few studies that have been done have been essentially quantitative and descriptive (Rwenge, 2000). Since this study is qualitative, it hopes to investigate in more detail some of the factors influencing the decisions made by young people with regard to their sexual behaviour. Additionally, it hopes to investigate and analyze how young people perceive the risks involved in sexual relationships and how such perceptions influence shared decision-making. Finally, the study hopes to examine some of the factors facilitating and inhibiting shared decision-making with regard to the prevention of HIV/AIDS and unwanted pregnancy.

### **1.7. Organisation of the dissertation**

This dissertation is divided into seven chapters. The first chapter provides a brief background to the study. The second chapter reviews relevant literature on reproductive decision-making among young people. The third chapter examines the conceptual framework, followed by the fourth chapter which explains the methodology employed in the study. Chapter five outlines the main findings of the interviews with the young people. Chapter seven draws conclusions and presents recommendations.



## **Chapter Two**

### **Literature Review**

#### **2.1. Introduction**

This chapter reviews existing literature on reproductive decision-making with a particular focus on young people. It covers negotiation and decision-making dynamics; gender based violence and coercion; perception of risk of HIV infection and/or unwanted pregnancy; partner communication as well as male involvement.

#### **2.2. Sexual negotiation and decision-making**

In a study conducted in Kwazulu-Natal, Varga (1999) argues that both sexes face 'similar constraints' when attempting to negotiate the terms and conditions of sexual relations. Avoidance of direct communication, unspoken assumptions about appropriate sexual conduct and male dominance in most aspects of the decision-making process characterised partner dynamics (Varga, 1999). Although the study found that males dominated in sexual decision-making, both sexes viewed unprotected sex as an integral part of a serious love relationship. For instance, both sexes associated condom use with inappropriate promiscuous sexual practices and lack of trust in relationships. Additionally, women viewed the fulfillment of family and gender roles through pregnancy and childbearing as a significant element of the relationship (Varga, 1997).

In many cultures, sexual negotiation is limited by gender norms which dictate that girls and women should remain poorly informed about sex and reproduction, whereas young men should be more knowledgeable, often seen as an indication of their sexual experience (Gupta, Weiss and Mane, 1996, cited in Rivers and Aggleton, 1998). Female ignorance of sexual matters is often viewed as a sign of purity and innocence, while having 'too much' knowledge about sex is a sign of 'easy virtue' (Gupta, Weiss and Mane, 1996, cited in Rivers and Aggleton, 1998). For example, as evidenced in social settings as diverse as Thailand and Guatemala, young women's views suggest that being

knowledgeable about sex would compromise how they appeared to other people (Rivers and Aggleton, 1998). Also, in many settings, fear of rejection and stigmatization by partners prevent women from exerting an influence on condom use (Worth, 1989 cited in Varga, 1997). For example, in a study conducted in KwaZulu-Natal, Maharaj (2001) found that those who wished to protect against unwanted pregnancy and the risk of HIV infection were not in position to negotiate safer sex for fear of physical violence, desertion and economic hardship. Additionally, in diverse settings of Costa Rica, Indonesia, Mexico, and Senegal, studies found that the most common reasons married women cited for not negotiating female condom use with their husbands were fear of violence, withdrawal of economic support, or suspicions of infidelity (FHI, 2002). Thus, the odds that these women may engage in risk taking sexual behaviours are high.

For men, several studies indicate that a strong desire for children hinders the use of preventive measures (Bankole and Singh, 1998 cited in Bawah et al. 1999). In high-fertility settings, "pronatalist norms equate a desire to bear children with fidelity and commitment to a relationship. Thus, attempts to discuss family planning may well raise doubts and jealousy (FHI, 2002). For example, in a study conducted in Uganda, it was found that negotiation on limiting childbearing could raise suspicions of infidelity or imply that a man wants to have children outside marriage. Hence the expressed reluctance to use condoms within married relationships (FHI, 2002). Additionally, male opposition to open discussion over reproductive health matters was estimated to account for approximately 15% of unmet need for contraception overall, and it led women who used family planning to rely on less effective traditional methods that might be more easily concealed (FHI, 2002). In South Africa, the work by Preston-Whyte and Zondi (1992) highlighted the importance of fertility in African communities as presenting a barrier to the practice of safer sex. For example, in Kwazulu-Natal, research shows that rural boys (18%) and urban boys (6%) would be proud to be fathers because fatherhood is associated with being strong and manly (Varga, 2003). Additionally, other African studies such as the one conducted by Nzioka (1998) in Kenya, and the other by Ampofo (2001) in Ghana found that adolescent boys view fatherhood as a marker of manhood and

sexual prowess (cited in Varga, 2003). Thus, the desire to practice safer sex is minimized among the young people.

In most developing societies, various studies have indicated the domination of men with regard to reproductive decision-making, especially when partners do not believe in shared responsibility for safe sex practices. In Freetown in Sierra Leone, a study revealed that 59% of university students believed that it is the man who is responsible for bringing up issues of safer sex (Gage, 1998). In Swaziland, both male and female adolescents believed that boys had a 'natural right' to make more demands in sexual relationships (Gage, 1998). In Thailand, condom use was considered a man's prerogative. In this setting, the education of male partners was associated with condom use (Gage, 1998). The acceptability of multiple partners for males appears to be well established by the time they reach adolescence. For example, in Zimbabwe, secondary school male students reported having more than one girlfriend as desirable, but that their girlfriend should not have other boyfriends (Blanc, 2001). Also, a study on young female factory workers in Thailand indicated that they generally accepted male infidelity, but not vice-versa (Blanc, 2001).

### **2.3. Gender Based Violence**

Violence and coercion are major barriers to negotiating safer sexual practices. Between one-fifth and one-half of all girls and young women around the world report that their first sexual encounter was forced (Hallman, 2004). In many cultures, the patriarchal systems undermine young women, making them vulnerable to the risk of unwanted pregnancy and STIs including HIV/AIDS (Gage, 1998). Gender norms condone multiple sexual partners for boys while girls face social sanctions if they appear to be sexually active or get pregnant. Social norms contribute to a perception that controlling women is a sign of masculinity (Creel, Sass and Yinger, 2004). Patriarchy reduces women to sex objects, whereas men are considered as success objects. Additionally, men are socialized to be self-reliant, whereas women are not. This invulnerability associated with masculinity prevents men from protecting themselves from infection and encourages the

denial of risk (Gupta et al., 2000). For example, in 2003, a study in South Africa found that 10% of females aged 15-24 years were forced to have sex (Andersson, 2005). Andersson (2005) further observed that, in South Africa, male's control over women has contributed to extremely high rates of rape or attempted rape. Studies conducted in three provinces revealed that 2% of such cases could be attributed to such a social practice (Andersson, 2005).

Young people's desire to conform to the normative behaviours of peers plays a significant role in their sexual behaviour. In a study conducted in Kenya by Idele-Akwara (2002) it became clear that men compete to outnumber one another in number of sexual partners. Sexual pressure was used to force or coerce girls to have sex with them. That particular study further revealed that it was men who played the leading role in deciding when, where and how sexual intercourse took place (Idele-Akwara, 2002). In South Africa, research on Black youth indicate that both girls and boys tend to experience considerable same-sex pressure to be sexually active and engage in unprotected sex. Boys' engagement in sex is a desire to prove manliness and earn peer status and admiration on the one hand. On the other hand, young women desire to be sexually experienced as a symbol of maturity (Eaton et al., 2002). Based on the findings of that research, it is more likely that young people engage in risky sexual behaviour before they get married due to peer pressure.

In some societies, violence against women is acceptable. In KwaZulu-Natal, South Africa, for instance, a study conducted by Varga (1999) reported that both men and women accepted and generally saw coercive sex as 'male mandate'. Young women described physical coercion in a sexual relationship as being normal and a sign of love from a partner. This concurs with the study by MacPhail and Campbell (2001) which found that if young women do not willingly provide sex, their boyfriends would demand it as proof of their love. Additionally, Jewkes et al. (2006) reported that one-third of young South African girls experience sexual initiation by force. Among Xhosa youth in South Africa violence was accepted as an inevitable part of the relationship and reinforced by female peers who indicated that 'submission was the appropriate response'

(Wood and Jewkes, 1997:23). Harrison, Smit and Meyer (2001:68) highlight the high prevalence of male violence against females, where young women described the 'ideal' partner as 'one who will not beat me'. In other countries such as Nigeria, research found that 57% of male students; and 74% of out-of-school male apprentices, as well as 37% of female students and 43% of out-of-school female apprentices agreed that a man has the right to have sex with a woman he provides for financially (Finger et al., 2004:2). The Navrongo project in Ghana indicated that 51% of female and 43% of male respondents justified physical violence against a wife who decided to use contraception without the husband's consent; 43% of female and 33% of male justified physical violence against a wife who decided not to have sex (Bawah et al., 1999). A study in Uganda revealed that young girls think that rape is justifiable in cases of detoothering (Luke 2003). Given such findings of research, it is more likely that most women do not negotiate or they leave the decision-making to their male partners.

Gender based power relations can have direct influence on the partners' ability to make decisions related to their health (Blanc, 2001). Blanc (2001) noted that gender-based violence is a vital manifestation of unequal power in sexual relationships. Other investigators in the area of gender based power relations concur with this argument. Power disparities based on economics and age make young women more vulnerable to coercive and exploitative sexual practices, especially when faced with pressure from the kin to earn an income (Gage, 1998). The results from demographic and health surveys in five sub Saharan Africa countries illustrate this point very well. The studies show that the prevalence of transactional sex among unmarried women aged 15–19 at that time stood at 13% in Zimbabwe, 21% in Kenya, 26% in Mali, 31% in Uganda, and 38% in Zambia (Hallman, 2004). Hallman (2004) points out that the overwhelming motivation behind transactional sex is believed to be economic opportunity. Also evidence coming from a study conducted in South Africa shows that poverty and lack of parental resources are primary reasons for young women to engage in transactional sex (Hallman, 2004). In these sexual encounters, condom use is consistently lower. For example, Kaufman and Stavrou (2002) found that money and gifts influenced African girls, young girls in particular, not to suggest condom use in KwaZulu-Natal. There is empirical evidence

suggesting that physical abuse, attempted and actual rapes within the relationships is more common among those who are economically disadvantaged in South Africa (Whitefield, 1999 cited in Hallman, 2004). Thus, it is not surprising that Gupta et al. (2000) observe that the economic vulnerability of women makes them more likely to transact sex, less likely to succeed in negotiating protection, and less likely to leave a relationship that they perceive to be risky.

Research evidence links beliefs about HIV infection and sexual violence and how these two affect reproductive decision-making. Andersson (2005) reports that in South Africa, young respondents in the Centro de Investigación de Enfermedades Tropicales (CIET) study who had suffered forced sex were very much more likely to believe they were HIV positive, yet less likely to go for testing. The youth who had endured forced sex were also more likely to admit they would spread the virus if infected (Andersson, 2005). Forced sex is not the only cause of HIV infection; but the attitudes and mindset that underline the act of forced sex, the disrespect for the rights of others such as failure to disclose one's HIV status, all have a negative influence on reproductive decision-making. In other words, young people who endure forced sex are less likely to decide on taking an HIV test or practicing safer sex in their subsequent sexual encounters. In Uganda, a multivariate analysis of the effect of violence on reproductive decision-making indicated that wives who had experienced violence in a relationship were significantly less likely to use contraception (Gage, 1998 cited in Blanc, 2001). Additionally, in Kinshasa, a study found 97% of 238 women infected with HIV unwilling to reveal their HIV status to partners because of fear of divorce, physical harm public scorn (Rutenberg, Biddlecom and Kaona (2000).

#### **2.4. Perceived risks of pregnancy and of HIV/AIDS**

Youth often make sexual and reproductive health decisions based on their perceptions of costs and benefits incurred when they engage in risky sexual behaviour. Risky sexual behaviours can result in unwanted pregnancy and/or STIs including HIV and AIDS.

### **2.4.1. Unwanted pregnancy**

Gage (1998) noted that if pregnancy is seen in negative terms, it becomes a reason for people to avoid casual sexual activity. In a study conducted among the youth in the Mbale district of Uganda, Hulton, Cullen and Khalokho (2000) reported that health risks to the young mother and her infant including the risks of undergoing an abortion for a mistimed pregnancy were the major concerns among females. On the contrary, males were not concerned to any degree with the risks of pregnancy to a young woman or her child because they were not directly affected by an unwanted pregnancy (Hulton, Cullen and Khalokho, 2000). Thus, the chances of males taking any precaution to protect their partners from a mistimed pregnancy are low. Furthermore, in a study conducted among 2,067 sexually active youth aged 15–24 in KwaZulu-Natal, Maharaj (2006) notes that young people who considered a pregnancy highly problematic were more likely to decide on condom use than their counterparts who would view a pregnancy as no problem. Fifty nine percent of participants reported having used a condom at last intercourse, 64% of them cited protection against both HIV infection and unwanted pregnancy as the main reason (Maharaj, 2006). It must be noted that there are other factors like the socio-economic consequences of a mistimed pregnancy that may influence reproductive health choices young people make.

The perceptions of the socio-economic repercussions as a result of unwanted pregnancies determine the reproductive choices of young people. For example, in their study conducted in Uganda, Hulton, Cullen and Khalokho (2000) found that school regulations force young girls to discontinue school if found pregnant out of wedlock. In such an instance, childbearing might lead to probable future economic hardships. Apart from that, some parents might interpret their investment in girls' education as a waste. These factors influence directly the decisions young girls may make throughout their schooling life (Hulton, Cullen and Khalokho, 2000). Additionally, using data from the South African Demographic and Health Survey conducted in the late 1980's, Kaufman, De wet and Stadler (2001) found that increasing proportions of women who begin their childbearing as teenagers delay a second birth by at least four years. The educational opportunity is

likely to be a contributing factor for the delay of subsequent births (Kaufman, De wet and Stadler, 2001). For example, in 1993, about 34% of all girls younger than 24 who had a child as teenagers were currently attending secondary school. Thus, it is likely that young women consider practicing safer sex to prevent a pregnancy that could compromise their quality of life. In a situation where proving fertile takes precedence, however, girls engage in risky sexual behaviours for recognition in society. After all, Preston-Whyte and Zondi (1992) observed that families value both the children and the demonstrated fertility of girls.

#### **2.4.2. HIV and AIDS**

The degree to which young people perceive themselves to be at risk of HIV/AIDS and/or unwanted pregnancy will influence their reproductive choices. It is assumed that because of HIV and AIDS, most individuals are motivated to decide on condom use (Gage 1998). Varga (1997) points out that varied perceptions of risk affects individual decisions about the circumstances under which sexual intercourse occurs. AIDS has a long incubation period and its symptoms are often difficult to distinguish from those of other illnesses. This creates false impression that some people are healthy even when they are HIV positive. It is likely, thus, that several young people make risky sexual behaviour choices as a result of such an ignorant belief about HIV.

Furthermore, the aspect of trust in relationships is likely to determine how people perceive themselves to be at risk of HIV infection. In a study conducted in Zambia, Rutenberg, Biddlecom and Kaona (2000) found that more than a half of men and women felt they were not at any risk of HIV infection because sexual partners in stable relationships trusted each other to be faithful. Probably, partners who are in stable relationships perceive a lower risk of HIV infection, and thus, are not motivated to use protection during sexual intercourse. Additionally, Luke (2003) point out that in most sub Saharan African societies, men appear to be unconcerned with reproductive health risks to themselves or to their partners. As they become aware of the dangers of HIV/AIDS, they increasingly seek young girls (virgins) in the belief that young girls are unlikely to



be infected with HIV/AIDS. Often girls' older partners avoid using protection and argue that there is no risk involved in having sexual relations with young girls (Luke, 2003). Therefore, it is more likely that young women lack the ability to negotiate and eventually make safe reproductive health choices. Also, the perceptions of HIV risk among the youth can be reflected in the link between gender ideals and risk taking behaviour. For example, in the study conducted by Varga (2003) in KwaZulu-Natal, it was reported that a girl gains respect by being sexually available to her partner, granting him exclusive sexual decision-making authority. In addition, that study suggested that for girls, showing coyness and resistance to a partner's sexual advances, being sexually faithful to him and avoiding pregnancy would keep their relationship intact. However, Varga (2003) found that avoiding pregnancy does not necessarily translate into use of female contraception. This is so, because contraceptive use is viewed as inappropriate and reflecting loose morals, yet young women are expected not to fall pregnant. This belief therefore is likely to compromise the reproductive choices of young women.

## **2.5. Partner communication**

Research shows that communication between partners on reproductive health is low in many developing countries and that gender-based power inequities contribute to a lack of communication (Blanc, 2001). Several studies in sub Saharan Africa reveal that women and men are familiar with contraception and they generally approve of family planning, however, spousal communication on contraceptive matters is rare (Agadjanian, 2002). In Maputo, of the 269 men and 923 women surveyed in 1997, only 5.5% and 6.1% of men and women respectively had ever discussed family planning with their spouse (Agadjanian, 2002). In a study conducted in Kwazulu-Natal, evidence shows that discussion between men and women about sex was not appropriate. Culturally defined gender roles, which re-enforce male dominance and female submissiveness, influences sexual and reproductive decision-making and significantly limits communication between partners on sexual matters (Maharaj, 2001).

Studies show that couples may avoid communication about STIs, HIV and family planning (FP) for several reasons. When either men or women broach the subject with their partners, especially in settings of high HIV prevalence, they risk being accused of having extramarital partners, being promiscuous, or being infected (Blanc et al., 1996; Varga, 1997; Fapohunda and Rutenberg, 1999 cited in Blanc, 2001). Thus, much of the communication about reproductive and sexual matters tends to be indirect or nonverbal because of the obstacles to verbal discussion (Blanc, 2001). Avoidance of direct discussions on this subject manifests itself in other ways too. For example, in Mali some women deduced their husbands' attitudes from the fact that they turned off the television or got annoyed when family planning campaigns were shown (Castle et al., 1999 cited in Blanc, 2001). In Kenya, some of the nonverbal strategies women use to initiate or reject sex with their partner included cooking meals, preparing a bath for the partner, and putting children to bed early. For men, strategies to initiate or reject sex included bringing a gift home, giving compliments, and using a pet name (Balmer et al., 1995 cited in Blanc, 2001).

### **2.5.1. Spousal perceptions of the attitudes of partner**

Little research has been conducted on women's perception of their partners' attitudes to contraception. In South Africa, Klugman (1993) pointed out that many women still perceive their partners as disapproving of contraception. Because of this perception, women are hesitant to make the decision to practice contraception or to reveal to their partners that they are using contraception. In addition, women are uncomfortable with contraceptive services as they fear the side effects. Thus, it is more likely that women will avoid using available modern contraceptive methods. Additionally, conventional wisdom has it that contraception provides an opportunity for women to become promiscuous. Several men still feel that contraception use leads to loss of control over their partners' sexual life (Klugman, 1993). For instance, in many settings, including Egypt, Guatemala, India, Philippines and Nepal, women's perception that their partners have negative attitudes towards family planning is a dominant factor discouraging their use of contraceptives (Casterline, Sathar and Haque, 2001). In a study conducted in

Kenya, Lasee and Becker (1997) point out that the woman's perception of her partner's attitude is an important predictor of contraception practice. The odds of her using contraception was 4.5 times higher if the wife believed that her partner approved of family planning than if she thought that he did not. In a study conducted in Maputo, Agadjanian (2002) found that men are against family planning because they believe that it encourages prostitution. Therefore, it is more likely that women would rather have unprotected sex than face the stigma associated with contraceptive use.

### **2.5.2. Agreement between partners with regard to family planning**

Agreement or disagreement between partners about family planning may affect unmet need for contraception. In Uganda, Wolf, Blanc and Ssebuliba (2000) noted that disagreement between partners adversely affects unmet needs because people tend to rely on traditional forms of family planning, such as periodic abstinence that can be potentially concealed. In addition, the same authors observed that for all contraceptive methods combined (traditional and modern); partner opposition appears to reduce contraceptive use by roughly one quarter for both men and women. Although several studies focusing on couple's reproductive and contraceptive decisions tend to find considerable disagreement between couples, Agadjanian (2002) argues that gendered communication could facilitate constructive negotiation of reproductive and contraceptive goals with their partners. For example, in Kenya, Lasee and Becker (1997) point out that 44% of the couples who frequently discussed family planning practiced contraception compared with 35% of those who occasionally discussed it. Only 13% percent of those who never discussed FP practiced contraception. Additionally, negative reactions as a result of raising issues of sexual and reproductive health from either partner may be changing for the better. For example, in Dar es Salaam, a study of HIV testing experiences found that, of the 69% of women who disclosed their HIV test results to their partners, fewer than 10% experienced negative reactions, such as being blamed for the results or being physically assaulted (Mbwambo et al., 2001, cited in Blanc, 2001).

## **2.6. Male involvement in reproductive decision-making**

Most of the focus of reproductive health programmes has been entirely on women and often men are ignored. The reason for this has been that it is women who get pregnant and it is for them that modern contraception has been designed (Maharaj, 2001). In addition, Salway (1994) observes that reproductive health programmes tend to be hindered by the relative scarcity of information about men's knowledge, attitudes and practices regarding family planning. This dearth of information about men explains the likelihood of more emphasis being focused only on women's health programmes.

Research has often assumed that women's reports on contraception represent their partners' views, but evidence indicates that women's reports do not often represent the couple (Salway, 1994). A study conducted in Maputo revealed that men and women share fertility related perceptions and concerns, though they may express them differently (Agadjanian, 2002). In South Africa, Kunene et al. (2004) point out that it is increasingly becoming evident that every pregnancy is facing an element of risk, because men as partners and decision-makers are not informed about reproductive health issues. Therefore, excluding men from such issues is a mistake, for it takes a couple to make reproductive decisions.

Wegner et al. (1998) observe that men who are educated about reproductive health issues are more likely to be supportive of their partner's decision to use contraception. Men's involvement and support is essential if women are to practice safe sex, avoid unwanted pregnancy or make better health care decisions. Men's roles in contraception are noted by Joesoef, Baghman and Utono (1988) in a study in Indonesia where the attitude of husbands towards family planning is the most important determinant of contraceptive use among urban women. The results from predominantly Muslim countries about the control of men with regard to contraceptive decision-making becomes a mirror for other societies where traditional female gender roles mean that women have little say in sexual matters and lack the status to influence their partner's behaviour (Kamal, 2000). Kamal (2000) found that in many cases, women who are non-users of contraceptives attribute it to

husband's disapproval as an excuse for being a non-user in the future. In Ghana the attitudes and education of the male partner greatly influenced the reproductive choices of his spouse (Ezeh, 1996 cited in Maharaj, 2001). In South Africa, a study conducted in a rural and urban area found that a large proportion of women felt they had no right to insist that their partners use condoms (Maharaj, 2001). Therefore, it is less likely that young women are able to make healthy reproductive choices.

## **2.7. Socio-cultural norms and religious beliefs**

Socio-cultural norms and religious beliefs influence reproductive health choices including contraceptive use (Creel, Sass and Yinger, 2002). A study conducted in Pakistan found that 76% of husbands and 66% of wives feared that God would become angry if they practiced contraception (Creel, Sass and Yinger, 2002). In some societies, the use of contraceptives may challenge cultural beliefs. In some societies, women believe that it is healthy to menstruate every month and thus refuse to use contraceptive methods that often results in irregular bleeding, spotting, or amenorrhea. For example, in Cambodia, local beliefs concerning fertility, conception and balance of bodily elements, rather than modern reproductive physiology significantly influences women's perceptions of how modern methods prevent pregnancy and cause side effects (Sadana and Snow, 1999).

In some societies, culture significantly influences the reproductive choices of some young people. For example, in the Vientiane Municipality of Lao, a considerable minority of respondents in the study argued against the provision of contraceptive supplies to unmarried youth as a general principle, and unmarried young women in particular. They justified this on the grounds that it was wrong to use contraceptives according to Lao culture and custom, which disapproves of premarital sexual activity that is believed to encourage the consumption of alcohol, sex and the spread of disease (Sychareun, 2004). Additionally, a study on condom use and sexual risk taking behaviours in South Africa shows that condoms are seen as a threat to masculinity and pleasure and often are viewed as necessary for only those infected with HIV or STIs (MacPhail and Campbell, 2001).

Given such findings of research, it is less likely that young people would choose to use contraceptives including condoms.

Furthermore, health workers seem reluctant to promote condom use, possibly because of their own negative attitudes towards condoms or to condom-users (for example, associating condoms with promiscuity, infidelity and sickness) (Reddy et al., 2000). As a result of this, the chances of using condoms are dramatically reduced. For example, in South Africa, Nicholas (1998) found that over 48% of the South African tertiary students in the study had never used condoms, and many more admitted to not using contraception during their first sexual intercourse.

Some studies, however, differ from the above-mentioned study. For example, Buga, Amoko and Ncayiyana (1996) found that 62% of sexually active boys in a rural school in Transkei had used condoms and nearly a third reported enjoying using it. However, condom use was lower among females, only about 19.4% of females reported using condoms and thus teenage pregnancy rate was 31%. Additionally, a recent national study in South Africa, showed that the levels of condom use (57.1% for males and 46.1% for females) were higher than in similar studies completed previously (Shisana and Simbayi, 2003). However, there was a downward trend of condom use among both youth and adults who have had more than three sexual partners (Shisana and Simbayi, 2003). Thus, it is likely that having many sexual partners adversely affects the reproductive choices of young people.

## **2.8. Summary**

This literature review has identified a number of factors that influence reproductive decision-making in the era of high rates of HIV/AIDS and unwanted pregnancies in different contexts. Some of these factors impact positively on reproductive decision-making process, while others impact negatively. These factors are likely to vary from one context to the next. Several studies seem to suggest that the following factors play an important role in the health seeking behaviour or lack of it among the youth: ability to

negotiate and make reproductive decisions, the degree of perceived risk of HIV/AIDS and unwanted pregnancy, perception of attitudes of partners, partner communication, coercion and violence, male involvement, socio-cultural norms and religious beliefs.

## **Chapter Three**

### **Conceptual Framework**

#### **3.1. Introduction**

Since the earliest research on the link between perception and behaviour in the 1930s and because of the growing importance of behaviour prediction in the development of effective health promotion, a variety of social cognitive models were developed in an attempt to explain how knowledge, attitudes, values and beliefs interact with one another to bring about eventual behaviour change (Aitken, 2002). Some of the prevalent robust models will be outlined in an effort to create a theoretical framework that will guide this study

#### **3.2. Theoretical models of behavioural change**

Over the past decade, the majority of HIV-related articles have focused on social cognitive models. Numerous studies have shown that the above models are the most effective and valuable theoretical tools in predicting HIV-preventive behaviours and can provide ‘theoretical guidance on psychological changes likely to result in HIV-preventive behaviour change’ (Aitken, 2005:27). The most commonly used models are the health belief model, theory of reasoned action, theory of planned behaviour and social learning/cognitive theory.

##### ***Health Belief Model***

This model is a simplistic, rational-cognitive model of health promoting behaviour. Central to the health belief model are the following tenets: perceived susceptibility (e.g. subjective evaluation of HIV risk); perceived severity (e.g. seriousness of HIV risk); perceived benefits (e.g. of condom use); perceived barriers (e.g. cost, embarrassment and inconvenience); internal or external quest to actions (e.g. media campaigns); likelihood to action (e.g. when perceived benefits outweigh the barriers); demographic, psychological and structural variables (e.g. gender, ethnicity, social class, peers etc) (Aitken 2005).



The model assumes that health is a highly valued goal for individuals (du Plessis et al., 1993), and that individuals are rational decision-makers (Airhihenbuwa and Obregon, 2000). These assumptions, however, have been clearly identified as false (Airhihenbuwa and Obregon, 2000; du Plessis et al., 1993). The model neglects to account for the influence of cognitions, intention formation and other forms of social and affective control (Sheeran and Abraham, 1995 cited in Aitken, 2005). It is likely that applying this model alone may not guide this study.

### ***Social Cognitive Learning Model***

The social cognitive model was developed by Bandura. It stresses that behaviour change requires social and cognitive skills instead of deliberate conscious decision-making as emphasized by the health belief model (Airhihenbuwa and Obregon, 2000, cited in Aitken, 2005). Aitken (2005) also noted that this model advocates effective instilling of beliefs in individuals so that they may believe they have the ability to change their mind and handle the situation effectively. The expectation that one can successfully complete the behaviour is theorized to be an important predictor of whether one attempts the behaviour. While this theory seems to provide a better explanation than the health belief model, it falsely assumes that the audience is rational by nature; making rational actions that are compliant with health promoting behaviours (Richter and Swart-Kruger, 1995 cited in Aitken, 2005). Other theories were developed to take care of this assumption.

### ***Theory of Reasoned Action***

This theory was developed by Fishbein and Ajzen. The theory of reasoned action assumes that, 'an individual's behaviour is a function of the intention to perform that behaviour' (du Plessis *et al.*, 1993:12 cited in Aitken, 2005). Thus, the individual's intention to perform the behaviour is the direct, immediate determinant of the act (Ajzen, 1988). The two determinants that behavioural intentions depend on are: (1) personal attitudes (positive or negative evaluation of performing the behaviour and the consequences attached), and (2) subjective norms or social influences (Aitken, 2005).

Individual's attitudes are derived from his or her beliefs about the possible consequences of the action in light of his or her evaluations of these consequences. The subjective norm component is the direct acknowledgement of social influences on intentions. Abraham et al. 1998 noted in Aitken, (2005) that the influence includes, the degree to which specific others are expected to approve or disapprove of the required action. This model, however, neglects the importance of underlying beliefs that the presence of certain situational factors influence perceived behavioural control.

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

This theory was developed by Ajzen, and it is a successor to the theory of reasoned behaviour. It is more accurately regarded as the theory of the proximal determinants of behaviour (Conner and Sparks, 1995:127) and it lends itself well to an extensive range of behaviours. According to this theory, an individual's attitude towards the behaviour, subjective norms and the degree of perceived behavioural control are determinants of intention (Ajzen, 1988 cited in Aitken, 2005). The degree of perceived behavioural control is closely related to 'self efficacy' (Aitken, 2005). This theory hypothesizes that the intention to act is higher when the person's attitude towards the behaviour is positive and when that person believes that significant others approve of the decision to act (Abraham et al., 1998 cited in Aitken, 2005). A person with high self-efficacy sets high goals, exerts greater effort, perseveres for longer despite obstacles or errors, and is less prone to anxiety self-doubt when performing the required action.

There is an assumption, however, that all of the above determinants of intention are influenced by underlying beliefs (Montano et al., 2001 cited in Aitken, 2005). For example, in the light of a person's motivation to conform, subjective norms are determined by his or her belief that certain other individuals think she or he should or should not behave. The attitude is determined by the person's belief that the proposed behaviour will result in particular consequences. Perceived behavioural control is influenced by the belief that, when it is favourable to behave, certain situational actors will be present (Aitken, 2005). The inclusion of perceived behavioural control is a

significant contribution to the predictions of the intentions to use condoms and actual condom use (Conner and Sparks, 1995).

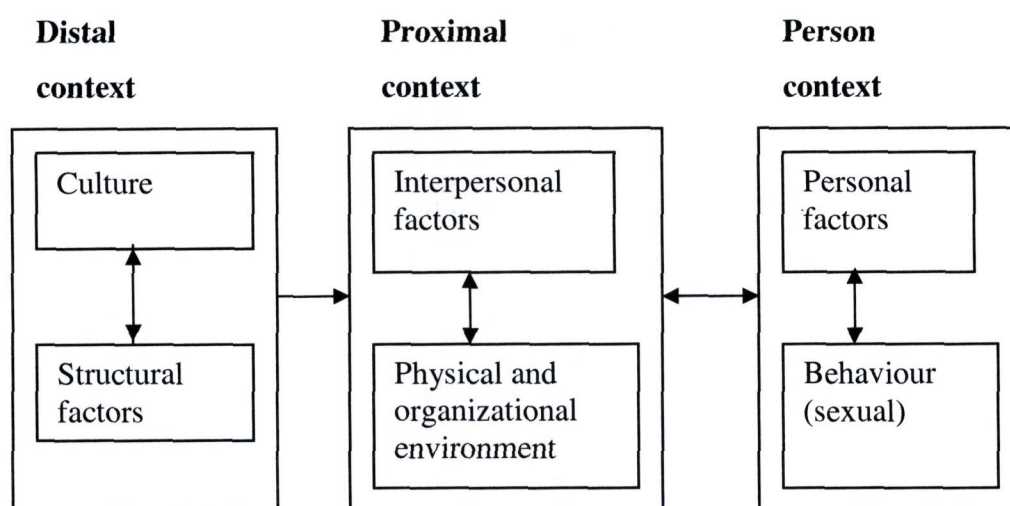
### **3.3. Critiques of Social Cognitive Models**

These models mainly deal with factors within the triad: behavioural, personal and interpersonal factors. They have been found to be valid and useful within contexts in which they were designed. One critique of these models, however, is that they neglect distal aspects of society and cultural context. According to Harrison, Smit and Meyer (2000) HIV prevention programmes can be made more effective in the South Africa context if they target more risky groups. Interventions should be well-designed, appropriate and evaluated, (they should include cognitive and behavioural aspects). Moreover, the messages need to be appropriate and culturally relevant. Finally, interventions and other prevention programmes need to be combined and linked with health services. Considering the above aspects and South Africa's unique cultural heritage in relation to Western contexts, one can presume that a model that considers culture and context would be appropriate for South Africa. Numerous studies have shown that models are culture-specific (Eaton et al, 2002). Attitudes, perceived norms and self-efficacy are all functions of underlying cultural beliefs (Eaton et al., 2002).

In order to understand sexual behaviour in South Africa, there is a need to consider the interactive aspects of factors at three inter-related levels: personal, proximal and distal context. Personal factors refer to individual factors and include knowledge and beliefs about a health behaviour, the importance of perceptions about the seriousness of a health threat, one's personal vulnerability to the threat and one's perceived ability to reduce one's risk, expectations that one can successfully complete a health behaviour (Ajzen, 1988; Bandura, 1991), a person's intentions (Fishbein et al., 1994 cited in FHI, 1996) and self-esteem. The proximal context refers to interpersonal and environmental factors (Eaton et al., 2002). Four interpersonal factors emerged as major determinants of sexual behaviour: communication, gender imbalances, peer pressure, parent-child interaction. Eaton et al. (2002) added that with regard to physical and organizational environment there are three other factors that emerge as determinants of behaviour: accessibility to

condoms, media and place of residence (Eaton et al., 2002). The distal context includes structural and cultural factors (Eaton et al., 2002). Culture comprises traditions, norms, the social discourse within a society, shared beliefs and values, and variations in such factors across segments of the population. Structural factors include legal, political, economic or organizational elements of society. It is important to note that the three inter-related levels mentioned above are reciprocally related (Eaton et al., 2002), and their interaction significantly influence sexual behaviours adopted by specific segments of population.

**Figure.1.** Framework for organizing the relationship between sexual behaviour, personal factors and the proximal and distal contexts.



Source: Eaton et al. (2002).

### 3.4. Summary

The personal, proximal and distal contexts interact to facilitate or inhibit sexual behaviour change. Despite the obvious contextual limitations of social cognitive theories, the first three models (the health belief model, social learning model and theory of reasoned action) guide the understanding of person factors and social influence. The theory of planned behaviour is a substantially integrative and well corroborated model and is the only model which recognizes that people may not be under complete (perceived) control over their behaviour (Ajzen, 1988). Thus, it will guide the study in accounting for contextual and cultural factors as major determinants of behaviour.

## **Chapter Four**

### **Methodology**

#### **4.1. Introduction**

This chapter starts by examining the setting of the study. It provides a description of the area in which the study was conducted. This study draws on qualitative in-depth interviews conducted with twenty students aged 18-24 years old at Walter Sisulu University. The qualitative data provides detailed descriptions of the personal and private experiences of young people.

#### **4.2. Study Context**

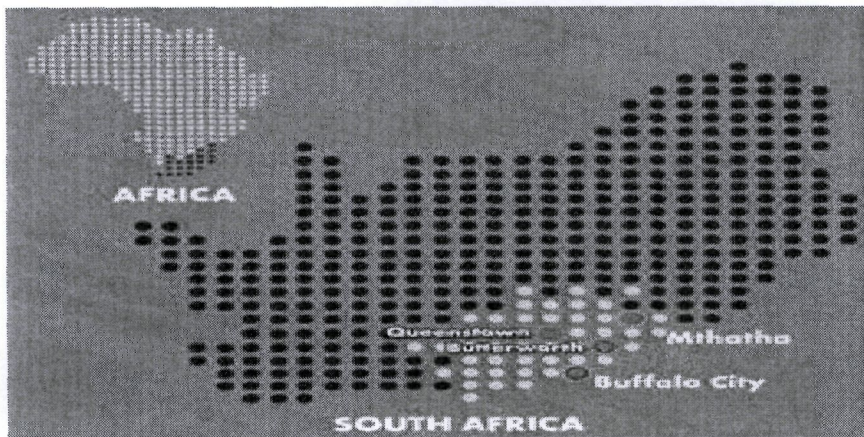
The study area is the former University of Transkei which is located in the Eastern Cape. This province was formed in 1994 out of the independent homelands of Transkei and Ciskei as well as the eastern portion of the Cape Province. This province is the traditional home of the Xhosa (Department of Health, 2005). The Eastern Cape Province is the second largest province in South Africa, with a total population of 6,503,201 residing on 169,580 square kilometers of land (Department of Health, 2005). The population is predominantly Black (87.5%) and most of the people reside in former homelands where there is poor infrastructure (Department of Health, 2005).

The majority, 63.4% of the Black population live in rural areas as compared to 36.6% residing in urban areas (Department of Health, 2005). At 55.7%, youth unemployment rate in Eastern Cape was the highest nationally (Statistics South, 2001). The Eastern Cape Province has the third highest proportion, 16.4% of HIV infections among the youth, compared to 10.4% of HIV infections nationally. With regard to teenage pregnancy and repeated pregnancy rates, the province occupies the fourth position (14.8%) and third position nationally respectively (Dorrington et al., 2006).

Mthatha campus is located in the OR Tambo district whose seat is Mthatha. The majority of the population, 1 676 463 people in this district, speak Xhosa (Statistics South Africa, 2001). Mthatha campus covers the former University of Transkei, which is situated on

the outskirts of the city of Mthatha on Nelson Mandela drive, and it is the main campus of Walter Sisulu University. Walter Sisulu University covers an area of approximately 1000 kilometers in the Eastern Cape, making it accessible to students in a vast expanse of the underdeveloped eastern half of the Province, home to over 4.5 million people. Walter Sisulu University has over 20,000 students (Krishanlal-Gopal, 2007). Mthatha campus is one of the delivery sites of the Walter Sisulu University. Other delivery sites include Buffalo City, Butterworth and Queenstown.

Figure: a map showing the delivery sites of Walter Sisulu University.



Source:<http://www.wsu.ac.za/aboutus/delivery>

### **4.3. Qualitative Research Methods**

The study was qualitative in nature. Straus and Corbin (1996) describe qualitative methods as a method of data collection that uses non-mathematical procedures in the process of data collection and interpretation. Qualitative research is concerned with how the social world is interpreted, understood, experienced, or produced (Ulin, Robinson and McNeill, 2002).

Qualitative research values natural settings as one of its principles. This action helps researchers to understand the lived experiences of people. Furthermore, it enables the exploration of a phenomenon in the light of related social, cultural, political, and physical environments of the people being studied (Ulin, Robinson and McNeill, 2002). Qualitative research also generates knowledge of social events and processes by understanding what they mean to people, exploring and documenting how people interact with each other and how they interpret and interact with the world around them.

In qualitative research, listening, interpreting and responding to the participant make a researcher a key instrument for absorbing information and also influencing how it is got (Ulin, Robinson and McNeill, 2002). In this respect, the research process becomes flexible, emergent and iterative. There is constant interplay between design and discovery and findings emerge continuously as a researcher constantly observes how participants respond to the topic under investigation and examines information for a fresh understanding that could lead to a change in technique, questions, or changing and taking a new direction altogether (Ulin, Robinson and McNeill, 2002). In this respect, the researcher work together with participants to explore and find answers.

Qualitative methods, using in-depth interviewing approaches, produce contextual or holistic explanations for a smaller number of cases, with an emphasis on the meaning rather than the frequency of social phenomena (Simmons and Elias, 1994). Waitzkin (1991) points out that quantification alone does not address the complexities, context, or underlying themes of discourse. It is only through 'an in-depth interpretive analysis' that these can be understood adequately. The way people talk about their lives is important.

The language they use and the connections they make reveal the world that they see and in which they act. However, a greater skill is needed as well as much closer association of senior researchers with the day-to-day research process in the field than is typically needed in conducting surveys (Simmons and Elias, 1994).

Similarly, qualitative approaches such as direct observation in the field and in clinics have been employed to understand more fully the nature of the interaction between workers and their clients (Simmons and Elias, 1994). Additionally, these approaches provide an opportunity for people to reveal their feelings, the complexity or intensity of their feelings about family planning and other reproductive health services. Such feelings are likely to differ from the more cursory appraisals possible in survey research (Simmons and Elias, 1994).

#### **4.4. In-depth Interviews**

Any person-to-person interaction between two or more individuals with a specific purpose in mind is called an interview (Shuang and Monoar, 2005). This method is appropriate because it is flexible and gives the interviewees opportunity to say all they want about the issues under investigation (Cohen and Marion, 1994). With regard to in-depth interviews, there is an exchange between one interviewer and one respondent usually guided by a few broad topics. The interviewer and participant are collaborators, 'working together to achieve the shared goal of understanding' (Ulin, Robinson and McNeill, 2002). In a relaxed and comfortable setting, the interviews generate empirical data by enabling participants to talk freely about their lives (Ulin, Robinson and McNeill, 2002; Simmons and Elias, 1994). In addition, in-depth interviews are flexible and give the interviewees an opportunity to say all they want about the issues under investigation (Cohen and Marion, 1994). Such interviews involve long and deep conversation about a topic in question; the interviewer is able to explore respondents' feelings, thoughts and experiences. Maykut and Morehouse (1994) argue that such prolonged discussions allow the competent interviewer to establish rapport with the interviewee and to foster a climate of trust.



Qualitative research is associated with various challenges. Ulin, Robinson and McNeill, (2002) assert that qualitative research generally requires flexible research methods, careful interviewer training, and recognizing the limitations of results from small samples. However, results from small qualitative samples cannot be generalized. They, thus, need to be supplemented with quantitative research methodologies which may not be applicable to every setting. In conducting research, some interviewers and moderators find it difficult to probe beneath the surface, hence rich information may be lost if data collectors miss opportunities to probe significant comments (Ulin, Robinson and McNeill, 2002). Lastly, qualitative analysis is complex and hence undertaking a full scale qualitative study can be a very lengthy and tedious process (Hayes, 2000).

The study conducted in-depth interviews with twenty Black university students aged 18-24 years. This is because young Black Africans are experiencing higher rates of HIV infection and unwanted pregnancies than any other race and age groups in South Africa (Dorrington, 2006). Both male and female students participated in the interviews to ensure that their views are represented in order to develop a rich and comprehensive understanding of the phenomena under study (Yin, 1994). The purposive sampling technique was used to select the sample. De Vos (1998:317) “states that a purposive study is whereby information rich participants with depth and breadth of experience and who share commonalities are identified”. The selection of university students aged 18-24 years for the sample yielded knowledge that is valuable to the proposed study. University life styles expose young people to new cultures, most of which tend to involve risky sexual behaviours. Moreover, being young is a time of discovery, rousing feelings and investigation of new behaviours. In addition, it was feasible for the researcher to focus on university students because they could easily be reached. An interview guide was used to make sure that relevant topics for this particular study are adequately covered in order to fully understand the experiences of respondents.

Firstly, ethical approval to conduct the study was obtained from the Faculty of Humanities, Development and Social Sciences at the University of KwaZulu-Natal. Furthermore, for easy access to Mthatha campus, permission to conduct the research was

sought and obtained from the Walter Sisulu University Management office in Mathata Eastern Cape.

The researcher sought permission from the relevant lecturers to talk to students at the beginning of a lecture. It is at this time that a researcher made an appointment to meet respondents (students) during their free time. As the researcher met each individual respondent, she sought consent by asking if he or she would be willing to participate in the study. Upon agreement, the respondent would be given a consent form to sign, after which permission would be sought to tape-record the interview. Respondents who agreed to be interviewed signed consent forms and all the interviews were tape-recorded. Participants were given the assurance that their responses would be kept strictly confidential to protect them from any physical or psychological harm as a result of participating in the study.

In data collection phase, 20 in-depth interviews were conducted at Mthatha campus and each interview lasted for about 30-40 minutes. Of these, 10 interviews were conducted with male students and 10 interviews with female students. All interviews were conducted by a researcher, assisted by a translator. English was the main medium of communication during the interview, but, if a respondent felt comfortable expressing him or herself in the local language (Xhosa), the study used the translator who was fluent in both languages. This enabled respondents to feel comfortable to share their experiences in Xhosa. The participation rate turned out to be high and only a few individuals refused to participate citing time, being shy and 'what do i gain from this interview' as the main constraints to participation.

The study employed two research assistants: about 50% of male respondents preferred a male research assistant during the interviews because they felt free to share their experience with him. On the other hand, female respondents who were fluent in English preferred to share with the female researcher. A few (3) female students felt free to share the experiences with the research assistant in Xhosa. The interviews were conducted from August to October 2007. Lastly, the researcher informed the respondents that the study is

not just part of the requirement for her Masters degree, but its results would fill gaps that may exist with information on sexual behaviour and the reproductive health of university students.

#### **4.5. Data Analysis**

Interviews with participants were tape-recorded and later transcribed by the researcher. Interviews that were expressed in Xhosa language were translated into English by the research assistant. The researcher spent more time reading the transcripts and developing themes covered in the interview guide. The results were illustrated by relying mainly on the transcripts.

The study made use of thematic analysis. According to Hayes (2000), thematic analysis involves identifying particular themes which occur in the material. Themes may emerge from the data as it is being analysed, taking the form of recurrent statements, attributions or assumptions which people make. Themes may also have been determined before the analysis began, and the analysis may consist of identifying statements which relate to them. This type of thematic analysis is theory driven, and allows the researcher to use this kind of qualitative analysis to test specific hypotheses and ideas. Themes are recurrent ideas or topics which can be detected in the material being analysed, and appear on more than one occasion in a particular set of data. This method is said to be original, and probably the most straightforward method of all the different qualitative techniques. Thematic qualitative analysis involves the researcher searching diligently through the data in order to identify these themes. Consequently, thematic qualitative analysis is almost always a long and tedious process (Hayes, 2000). According to Hayes (2000) the process involved in thematic qualitative analysis begins with the preparation of the data. This is done in such a way that the researcher can return to them over and over again. With regard to interviews, it almost always means transcribing them so that the researcher can use the transcripts of the results. Once the data has been prepared, one can begin to identify themes. With inductive thematic analysis, themes emerge from the data collected (Hayes, 2000).

After the data preparation stage, the second stage consists of reading carefully through all the data, and writing down any items of interest or other information which seem to be relevant to the topic under study. This activity is applied separately for each transcript. At this level, the themes have not yet emerged. In this case, the researcher is looking at specific items of information that seem to be relevant to the topic in question. The third stage is the 'sorting stage' because it involves sorting the data. At this point, themes begin to emerge. Items which appear to be dealing with similar topics are put together. For instance, if the investigator is using paper records, or electronic system, the piles which develop represent the beginning of themes which will change to the final form as the analysis proceeds. The investigator takes each pile separately and examines it to see exactly what each theme is and later gives it a provisional name. Then, the investigator takes the themes, one at a time, and goes through each of the transcripts carefully again to identify anything relevant to the theme which is being explored at that particular time. Once this stage ends, the investigator is in a position to take each theme and construct its final analytical form. It has three parts (a) a name, or label for the theme, (b) a definition of the theme, (c) the third part is the data which are relevant to the theme. Hayes (2000) notes that in case of the interview data, this stage will consist of quotations.

#### **4.6. Limitations of the study**

Some respondents initially felt shy and embarrassed when asked about their sexual experiences; and this could have limited free discussion about important aspects of their sexual life. Catania et al. (1990:340) reported that most African cultures are characterised by limited discussions about sexual matters between the 'old people and the young, because such discussions are considered very sensitive. Therefore, some respondents may feel "intensely embarrassed or threatened when asked to reveal what they do, think, and feel during their sexual encounters".

In-depth interviews require creating natural involvement, encouraging conversational competence and showing understanding (Ulin et al., 2002). In this study, interviews were conducted at a time when students had no lectures or tutorials. However, towards the end of an interview some students would excuse themselves in order to attend lectures or

tutorials. This interrupted the flow of the discussion; hence researchers could not satisfactorily explore all areas of the topic from such interviewees due to time constraints.

Gathering information on sexual and HIV/AIDS matters is subject to “measurement error” and “participation bias” (Catania et al., 1990: 340). In trying to avoid respondent participation bias, the interviewers were very careful not to indicate any negative or positive judgment about the respondent. Also, the researchers made sure of this by informing the interviewees over and over again that the information reported will be kept confidential and later destroyed. Lastly, the study covered a limited geographical scope, thus generalisation of results to the whole Eastern Cape Province or to the entire South Africa should be taken with caution.

## **Chapter Five**

### **Results**

#### **5.1. Introduction**

This chapter presents the findings from a qualitative study of university students in the Eastern Cape Province. It explores reproductive decision-making in the era of high levels of unwanted pregnancy and HIV/AIDS. The socio-economic and demographic profile of the study participants is also described. Other sub-themes include: awareness of sexual risks, barriers to preventing sexual risks, risk perceptions, and communication on sexual matters.

#### **5.2. Sample Characteristics**

The study population consisted of a young and highly educated sample. The sample was selected by age and sex. It consisted of 10 females and 10 males. They were all Black South Africans aged between 18-24 years. The average age of the sample was 21 years. The majority of the respondents were not married. Only one female respondent was married. Most of them were unemployed and therefore do not earn an income from any job, except for two males who reported earning some income from part-time jobs. On average, respondents get an allowance of approximately R428 a month from parents or guardians. Most of them live with parents in rural areas during holidays. The vast majority of respondents were Christians.

#### **5.3. Awareness of HIV/AIDS and unwanted pregnancy**

The study respondents had heard about HIV/AIDS and unwanted pregnancy. Many of the respondents pointed to the high level of HIV infections and unwanted pregnancy among young people on campus.

*“There are so many girls who are pregnant at this school. As for HIV, in our psychology class, we learnt that by 2004, about 50% of the students had HIV/AIDS” (IDI #3, male).*

The respondents argued that younger men and women are most at risk of pregnancy and HIV infection because they are more experimental in their lifestyles. Young people are therefore more likely to engage in unprotected sexual intercourse. Most respondents knew that unprotected sexual intercourse increases the risk of HIV infection and pregnancy.

*“You get HIV when you have sex without a condom. You can also get HIV in accidents when the blood of a sick person mixes with yours, also sharing contaminated instruments when tattooing. Sometimes it is from mother-to-baby but it can be treated by antiretroviral drugs” (IDI # 4, female).*

*“If you don’t use a condom or pill or injection you will become pregnant” (IDI #1, female).*

The study indicated that awareness of pregnancy and HIV/AIDS is fairly high among young people. The respondents reported obtaining information from various sources including health centers, media, and peers. It is obvious that the type of information people acquire from the different sources is likely to influence their attitudes and sexual behaviours differently.

The respondents reported that health workers provide information on HIV, pregnancy and contraceptives when young people approach them.

*“Health care providers at the campus clinic and the Mthatha General hospital in the Nelson Mandela academic hospital teach us how HIV is transmitted, prevented and other pregnancy related issues. They get us tested if we want and later counsel us, and then give us some booklets” (IDI #2, male).*

Respondents identified the media, especially television programs such as LoveLife, Komanani and others, as leaving lasting impressions in people’s minds. They created awareness of the risk of unprotected sexual intercourse including HIV/AIDS and

unwanted pregnancy. The print media also educates people about sexual risks and the protective strategies that could avert these risks.

*“I get information from my sisters, from the TV, the radio and magazines and library books (IDI #2, female).”*

Most respondents also reported that they obtain information from their peers. They often talk openly to their peers about sex. However, they are more likely to discuss their sexual experiences and only occasionally talk about preventive measures. Most respondents especially females admitted that HIV/AIDS related issues are rarely discussed unless they are with very close friends. For most young people, especially females, HIV is the last thing on their minds and many consider it a private matter. In addition, some consider themselves at no risk of HIV infection and therefore feel that it is not necessary to discuss it.

*“We talk about exciting things mostly. We only talk about the pleasure you get when you are playing sex, how many boyfriends we have. We have too many things to talk about. But we never talk about HIV/STDs. It is the last thing on our mind” (IDI #7, female).*

*“I don’t think we need to talk about HIV because the thing is for those people with it. But what I normally say to friends is that I will never get tested because I don’t want to know my status” (IDI #5, male).*

A few of the respondents also mentioned other sources of information about pregnancy and HIV/AIDS including students counseling services and religious organizations. Most respondents felt that they could not discuss sexual matters with their parents. They felt that culturally it is disrespectful to talk to parents about sex. Some parents feel that any discussion on sexual issues with children may encourage them to engage in sexual intercourse. Some respondents said that at times they had discussed sexual issues with their parents but the conversation was usually one sided. The child is usually lectured by



the parent about the risks associated with sexual behaviour and the importance of abstaining from sexual activities.

*“It is not allowed to discuss with parents about all these sexual issues like girlfriends or boyfriends, HIV and AIDS and STIs. If you talk about these things, parents would look at you as a spoilt child” (IDI #8, male).*

*“Parents discourage me from having sexual relationships. They do not like someone who likes women; they always say it is not safe. As for having a child, my parents never want me to have a child” (IDI #7, male).*

#### **5.4. Strategies to prevent HIV/AIDS and unwanted pregnancy**

The respondents mentioned that condoms are most commonly used for preventing HIV/AIDS and unwanted pregnancy. However, only 40% of female and 20% of male respondents reported using condoms regularly. A few respondents also mentioned using hormonal contraceptive methods to prevent pregnancy but these methods do not provide protection against disease.

*“I and my partner, besides the condoms, we are not using any other contraceptive method. At some point she was using injections but we saw that we are preventing pregnancy only but not STIs like HIV” (IDI #1, male).*

Respondents mentioned zero-grazing as another protective measure common among them. Most females and males said that they were faithful to their partners. They felt that there was little risk of HIV infection because they were faithful to each other, but there was a possibility of pregnancy. Some respondents also argued that avoiding multiple sexual partnerships was a good risk reduction strategy.

*“Me and my boyfriend, we don’t use condoms because we trust each other. He does not sleep around, I don’t sleep around. We are clean of HIV, but I am now pregnant” (IDI #8, female).*

*“I don’t have many girls because I cannot concentrate on my studies and also give each of them attention” (IDI #6, male).*

Most respondents identified abstinence as the safest method for preventing unwanted pregnancy and HIV/AIDS. However, they felt that abstinence was difficult to sustain. Few male and female respondents reported that they abstained from sex. Many respondents explained that religion was an important reason for abstaining from sexual intercourse. These respondents pointed out that their religion condemns premarital sex and because they want to honor their faith they abstain from sexual intercourse. However, some respondents stated that they abstain from sex in order to protect against unwanted pregnancy and HIV/AIDS.

*“When one has started having sex, it is difficult to abstain. But abstaining is very safe (IDI #2, male).*

*“I am saved (a born again Christian), so I am not allowed to have sex. We are not allowed to even date, I do not date. I also abstain because I do not want to get HIV and have an unplanned baby” (IDI #2, female).*

### **5.5. Barriers to preventing HIV/AIDS and unwanted pregnancy**

Many of the respondents admitted that they did not take any measures to protect against the risk of pregnancy and/or HIV/AIDS. The respondents stated that at a certain age some young women engage in unprotected sex to prove that they are fertile. They succumb to pressure from their friends to conceive in order to prove their maturity, especially if friends of the same age group already have babies. In addition, some young women feel the pressure to bear a child in order to ensure that their partner does not abandon them. Some expressed concern that their partner may abandon them if they insisted on condoms and there was no child to keep them in the relationship.

*“For some girls, they see girls of their age having babies and feel the pressure to get a baby, and feel that they are old enough” (IDI #10, male).*

*“The boyfriends don’t want to use condoms. For some girls to have unprotected sex is to keep their man near you. If you don’t want to have unprotected sex, he goes to look for others who don’t want to have sex with a condom. (IDI #3, male).*

Some of the male respondents felt that it was their right to control their girlfriends. They felt that their culture gives them more control in the sexual relationship. They assert their dominance over women by not using condoms and making them pregnant. Women who refuse to have their children often have to face abandonment or rejection. In this way, men are able to force women to accept their personal preferences. As a result, women have limited ability to negotiate safer sexual behaviour because of the fear of abandonment.

*“I tend to make final decisions about sex because my own tradition and culture advise us (men) to take the lead (IDI #1, male).*

*“Some guys make a girl pregnant because they want to own her, my property, my territory, someone else must not interfere with my property” (IDI #2, male).*

Some of the respondents argued that there were many barriers to changing their behaviour. They point out that partner communication about HIV, pregnancy and contraceptives was important but, in most cases, free and open partner communication was limited. Often men dominated discussions on sexual matters. However, they acknowledge that there are some women who are more assertive and in those cases, shared decision-making about using a method of protection was more likely.

*“I wanted to avoid having an unplanned child and HIV. As I talked to her about it she was just listening. At first she did not want condoms, but as time went on she accepted” (IDI #6, male).*

Both male and female respondents argued that some young people, especially males, value multiple sexual partnerships and they prefer to engage in ‘skin-to skin’ sex. They have sex with multiple sexual partners but they do not use a condom. Sometimes young

people have many sexual partners to conform to group sexual norms in order to avoid feelings of alienation.

*“When most friends are doing it and you are not, you feel left out, or friends begin ignoring you because you are not going along with the group. So you just decide to do so that you can fit into the group” (IDI #8, female).*

Both male and female respondents also argue that some young people belong to groups that value stable partnerships but they do not use condoms. In these sexual relationships, the suggestion of condoms is likely to lead to accusations of infidelity and lack of trust in a partner.

*“We do not use condoms because we trust each other. He does not move around and I do not move around” (IDI # 8, female).*

Some respondents did not use any method of protection because they doubted the efficacy and effectiveness of the product. Some of the respondents questioned whether certain condom types were strong enough to prevent semen and vaginal fluids from mixing. There was some concern expressed about the quality of condoms that were distributed at public sector facilities. Many would prefer to buy condoms but they are much more expensive. In addition, some female respondents said that their partners told them that some condoms were not able to accommodate some male penises: some were too small and some were too large. As a result, they felt uncomfortable using them. Some respondents also reported that condoms made sex less pleasurable because it blocked the warmth of ‘skin-to-skin’ contact. Some respondents especially females were concerned that hormonal contraceptives were not a good method of prevention because they lead to side effects which could impact negatively on women’s bodies.

*“You will go in most halls of residences and find that lots of boxes are still filled with ‘choice condoms’ because some people will say I won’t use them because they are not safe, so you have to buy ‘lovers plus condoms’ and if you don’t have money to buy them, definitely you won’t use a condom” (IDI # 8 female).*

*“Some people say condoms are not good for them, like my boyfriend said he is too big for a condom (IDI #5, female).*

*“Condoms can be very tight; sometimes you don’t feel the pleasure of sex (IDI #8, male).*

*“Other people say that when you use a pill you become wet, it is better to use an injection, but it can also make you fat” (IDI #5, female).*

Furthermore, respondents said that condoms were at times forgotten or deliberately ignored in the heat of the moment. Sometimes the relationship progressed so quickly that they did not have time to think of condoms. Some males indicated that women were unpredictable especially if it was their first sexual encounter with a guy. A woman can easily change her mind if a guy detached himself from her even for a few minutes to grab a condom. As a result, some men do not use a condom because they do not want to jeopardize their sexual relationship.

*“When you are in the mood for sex I don’t think you think of a condom. It is when we miss and forget or ignore condoms” (IDI #4, male).*

*“As guys when you get a lady for the first time, she accepts to have sex and you try to put her in a mood for sex. By the time you go and grab a condom you find that she is out of the mood. Therefore what the guys does is that if the lady gets in the mood you grab that chance and have sex without wasting time going for condom. So you have sex without a condom but you put yourself at risk of AIDS” (IDI #9, male).*

Most respondents spoke of the high levels of poverty in the rural areas. Poverty sometimes encourages people to engage in particular sexual behaviours that they would not otherwise engage in. Many respondents felt that poverty was a major barrier to safer sexual practices. Some of the respondents explained that some young women from very humble backgrounds exchanged sex for money and gifts. But this practice was not reported among men. The items from men supplemented the little pocket money the girls

got from home and enabled them to conform to the campus lifestyles that they considered as fashionable. To insist on condom use meant putting a stop to the assistance these male partners provided. In these relationships, men were very powerful because they could determine the conditions under which the sexual act occurs.

*“For girls, they just want to get material things from men. Maybe they get a small amount of money from their parents, yet they want to have something nice at school, so they engage in sex as the guy wants it to get these stuff. I haven’t heard of men going for sugar mammas. I did not hear about that” (IDI # 3, male).*

Some respondents stated that young men do not take responsibility for preventing pregnancy. Men are seen as less concerned about pregnancy. Many men regard family planning as the responsibility of women because most methods are made for women. Moreover, they feel that female partners should be responsible for family planning because they fall pregnant. On the other hand, most respondents said that condom use is the responsibility of the man because they approach females for sex and condoms are worn by them. Most females said they feared to openly suggest condoms, because they were concerned about being labeled ‘whores’. They also did not want to suggest condom use because it might appear to the man that she was planning to have sex with him.

*“Usually, it becomes a girl’s duty to prevent a pregnancy. If the girl is pregnant, the boy can start looking for someone else (IDI #10, male).*

*“My first boyfriend did not accept it, but the second one wants condoms. I don’t think a girl needs a condom, it is always the guys, they are the ones who wear them” (IDI #6, female).*

*“A girl fears that people will think that she is sleeping around if she picks condoms. If you take condoms to your boyfriend, other guys usually say, what do you expect, you think we are gonna have sex? You feel uncomfortable. It is normally the guys who pick them” (IDI #4, male).*

Some respondents said that young men do not worry about making their partners pregnant since it is easy to deny responsibility for the pregnancy, especially if they hear that their girlfriend had previous sexual partners. Other males leave parenthood responsibilities entirely to their female partner, who then have to burden their parents with caring for the child. Men provide no financial, physical or emotional support for the child. Some men give their girlfriends money to force them to have an abortion while others are not even willing to pay for an abortion.

*“Some runaway saying, no that child is not mine, you had me and the other guys; so they just say the child is not mine” (IDI #9, male).*

*“In most cases the girl has to take the child to her grandmother to look after, with no support from the boy” (IDI #3, male).*

*“I don’t worry about pregnancy. I hear there is Marie Stopes. If someone gets pregnant then she will go to Marie Stopes and abort. I have to get R100 or R150 and give it her to go and abort. If I do not have money, its her business” (IDI #3, male).*

Many respondents pointed to the attitudes of health workers as a major barrier to adopting protective strategies. In general, respondents said that health workers have negative attitudes towards young people who go to them in relation to sexual matters. About half of the respondents said that health workers were rude to them, telling them that they were too young to be involved in sexual activities. The respondents argued that it is mainly females who face this wrath since they encounter many sexual problems and as a result, they need frequent medical attention. Men may obtain condoms at health facilities without having to interact with health workers. They only face the wrath of health workers if they contract a sexually transmitted infection and have to seek medical attention.

*“Whenever we go for contraceptives, they say why do you use these things, why don’t you just abstain? They don’t understand that we are doing it and nothing can change that. When you go there to test pregnancy, they shout at us. They say: why did not you use a condom?” (IDI #4, female).*

*“With boys, I don’t think there is any discrimination; they understand that boys are boys, so they have to get those condoms. But there is discrimination when it comes to “edrop” (sexually transmitted disease). You get it this month and then go to the clinic again with the same problem, they scold you and tell you that you are going to die because you don’t care about your life” (IDI # 2 male).*

Respondents said they responded to negative attitudes in two ways: Firstly, they stopped asking sensitive questions about sexual issues. Secondly, they would not go back to such health centers to get publicly embarrassed again and they would not take measures to protect themselves against the risk of pregnancy and/or HIV/AIDS.

*“You don’t ask again, you do not go back, or you change the clinic or you just forget about contraceptives/condoms. These black nurses are really, really very bad. You do not want that embarrassment again” (IDI # 8, female).*

## **5.6. Sexual Behaviour**

The proportion of respondents who reported ever having had sex was generally high. However, somewhat surprisingly, female respondents were more likely than male respondents to report ever having had sex. The age of first sexual intercourse was also low. The average age of first sexual intercourse was 13 years for females and 15 years for males.

*“Guys start getting girlfriends at 14 or 15 years old and immediately begin sexual intercourse. As for girls, they start as early as age 12 or 13. Because the government agreed that they can have sex and even get pregnant – it is freedom (IDI # 4, male).*



The respondents stated that young people face pressure from friends or relatives to be sexually active. About 90% of respondents argued that young people listen to conversations, learn and imitate the sexual behaviors of older peers and relatives.

*“When small boys sit with older boys and hear them talk about these things, they copy what they hear. Even young girls when they are sitting with their sisters or old friends talking about boyfriends to them it sounds like something good. Sometimes the boyfriends pressurize them to do these things” (IDI # 6 male).*

A few respondents spoke of the media especially television programmes that contain pornographic images as tempting young people to engage in sexual activity at a young age. According to respondents, when young people watch such programs, they get aroused and imitate this behaviour.

*“After 11:00 pm there are those pornographic movies on TV, so my young cousin (girl) was just watching. As she was watching it went to her mind and she thought of practicing sex... She does not know the result and this applies to most young boys and girls” (IDI # 8, female).*

The respondents felt that younger people are more likely than older people to have multiple partners. Most of the respondents said that young people aged 21 years or younger have many sexual partners. However, multiple sexual partnerships were not common among all the respondents. Few of the respondents stated that they had more than one sexual partner. Males were more likely than females to report having more than one sexual partner.

The reasons for multiple partnerships varied between males and females. Most respondents reported that this behavior was more acceptable for males than females. They said that young men with many girlfriends avoid peer ridicule and earn peer respect. This was because men with many girlfriends were considered to be ‘real men.’

*“Some of boys are having many girlfriends to show off. He will tell friends that I have a girlfriend at Intinga (hall of residence); I am having a girlfriend here and introduce each one to friends to impress them, and they want to be players, have some fun” (IDI # 9 male)*

Some respondents stated that young men go for many partners to avoid trusting any single partner. They said once a man gets involved in stable partnerships, he begins to trust his partner and abandons condom use. But when a guy has many girlfriends, condoms are used because he cannot trust any of them.

*“The reason for not having one girlfriend is that it is bad. I am running away of trusting. If you have a partner for more than three months you definitely trust her and you don’t use a condom or you use “choice type” the damaged condoms. But if you are meeting a new girlfriend you are not sure about her, so you have to prepare and buy better condoms preferable “lovers plus type”. I don’t have the heart of trusting one person (IDI # 9, male).*

Furthermore, respondents stated that partners who are away from each other for long periods of time often seek other partners to fill the loneliness in their lives. The other partners help to keep them company and also, fill the void that they are experiencing because of separation.

*“I have three girlfriends. One is working here, another one is in Durban doing internship, so the distance is too much for me, even in December and March short holidays she does not come, so I have to get someone else to keep me covered” (IDI # 3, male).*

Most respondents reported that partner misunderstandings were common among young people. Male respondents reported that, at times, girlfriends deny sex to boyfriends claiming to be busy or they lose interest in a partner when they are cheating with somebody else. On the other hand, respondents, especially females, reported that boyfriends are unreliable. They are unfaithful and can easily end the relationship. As a

result, young people get many partners to replace those who deny them sex or are likely to abandon them.

*“Most boys say that it is good to have many partners because if you want sex from one girl and she is busy, you can get another option. Also if your girlfriends cheat on you, you have somebody else to turn to” (IDI #6, male).*

*“When she is dumped by a boyfriend, to get rid off stress there must be another boyfriend” (IDI #2, female).*

*“Women are not comfortable about their position in a relationship. A girl may think she is being cheated on and end up having another boyfriend” (IDI #7 male).*

Firstly, most respondents reported that peer pressure especially same-sex pressure among women to get material goods motivated them to have multiple partners. They said that young women are under pressure to appear fashionable by owning items like televisions, refrigerators, microwaves, laptops and others. Those who have such items look down upon those who do not by labeling them ‘poor villagers’. Thus, young women opt for many partners who would provide such items in exchange for sex rather than face peer ridicule. Secondly, respondents’ spoke of turbulence in young people’s relationships as very common. For young women, boyfriends are never trustworthy; they often cheat on their girlfriends. For this reason, young girls opt for many male partners rather than face the pain of disappointment or abandonment.

*“Girls say I want to go out, go to town, go for dinner, get cosmetics, they want their rooms to look expensive, have computers in their rooms and all these demands” (IDI #7, female).*

### **5.7. Perception of risk of HIV/AIDS and unwanted pregnancy**

The respondents unanimously acknowledged that campus students are at high risk. They, however, used subjective measures of HIV or unwanted pregnancy risk, which varied from individual to individual.

The respondents broadly categorized their reasons for being at risk of HIV/AIDS and unwanted pregnancy into behavioural, economic and environmental factors. The respondents reported that unprotected sex and sex with multiple partners was common at campus. Students often engage in sex without regard for place and time. Respondents stated that many young people feel that they need to experiment with many partners and gain as much sexual experience as possible during their youth.

*“The obvious truth about relationships is that boys fool around, people fool around” (IDI #2, female).*

*“Some of these things you have to learn while you are still young because it becomes a problem when you are an adult. We need to experiment so that during marriage we know what to do” (IDI #3, male).*

In addition, respondents said that most young people especially males disapprove of condoms and they do not even try to find out their partners' HIV status. This behaviour is common in stable sexual relationship. Hence, they expose themselves to sexual risks in the name of trust because they are less likely to use a condom. As a result, they are at risk of not only HIV/AIDS but also unwanted pregnancy.

*“Most of the students with stable partners get pregnant and HIV, I would say 60% don't use condoms and make babies” (IDI #7, female).*

Most respondents perceived themselves at risk because some young women have sex with men in exchange for material gains. Respondents reported that the key decision makers, the men, do not use condoms regularly, especially if they begin to trust that the partner may be safe. To make matters worse, respondents said that women engaging in

transactional sex often lead a double life. They conceal their true sexual behaviour and befriend boys of their age especially campus boys as stable partners.

Some respondents felt at risk because some HIV positive people are deliberately infecting others. They stated that HIV positive people believe that their former sexual partners deliberately infected them and, therefore, vow not to die alone. Such an attitude compromises their decision to prevent unwanted pregnancies and HIV/AIDS.

*“Some people who are HIV infected are sleeping around with those who are not infected hence infecting them or making babies” (IDI #8, male).*

*“Normally the boys if they test HIV positive they tell themselves that I will not die alone, I will make sure that I will give it to each and every girl” (IDI #5, female).*

The respondents reported that most drug or alcohol users engage in sex, mainly during and after parties. Young people under the influence of alcohol or drugs are less likely to use condoms; but are more likely to engage in unprotected sex with many partners.

*“Most of the students take too much liquor and some do drugs, and when there are parties around campus, you find that people are not in their normal senses, they just do anything, sleep with girls without using condoms” (IDI #8, male).*

Perceptions of risk varied tremendously among respondents. Most respondents generally agreed that there was a high level of unwanted pregnancy and HIV/AIDS on campus. However, most respondents felt that they were not at risk of HIV/AIDS and unwanted pregnancy. Men and women in stable sexual relationships do not use any form of protection because they think they are not at risk. Often one year is enough to get familiar with a person, understand her or his behavior and earn their trust. Trust means that people stick to one partner and do not engage in sex with other people. Thus, they are seen as ‘clean’- which means that they are not HIV positive.

*“People tell themselves that I won’t get infected. I and my boyfriend made a decision not to use condoms because we trust each other; we have been together for over a year” (IDI #8, female).*

Some respondents said that quite often, relatives or best friends talk about how decent somebody is. In this regard, ‘decent’ means that a person is not promiscuous. Consequently, prospective partners trust that the person is HIV free regardless of how long they have known her or him. They pursue the person until they have sex with the person.

*“My uncle sometimes chooses a girl I must have a relationship with, saying that the girl you are going out with is from the outside, she is not good for you. Try the other one, she is clean and then I go for her” (IDI #2, male).*

Some (40%) respondents perceived no sexual risks including HIV, unless they contract it through other ways than sex. They insisted that they know enough about sexual risks and they consistently use condoms to avoid infection and pregnancy.

*“I am 100% sure that I am not at risk, because I told myself that I will never have sex without using condoms, but if it breaks it is a different story! However, there are many other ways of getting HIV, like getting involved in a car accident” (IDI #1, male).*

In addition, some respondents perceived a higher risk of pregnancy but not of HIV. They admitted that they had had lapses in condom use. They stated that their partners were young and not promiscuous, which meant that they were safe from HIV infection. And at the time, they had no problem with getting their partner pregnant.

*“The one schooling at Zamukulungisa, she was young (just 21 years old) and clean. We first started with using condoms but around about three to four months we left condoms; as a result she got pregnant. At the time she did not have a problem getting pregnant. I myself did not have a problem with it” (IDI #3, male).*

Furthermore, some respondents perceived no sexual risks. They stated that in their first sexual relationships, they were so young and lacked knowledgeable about condoms and sexual risks. Although they admitted that they had heard information about contraceptives from various sources, not everyone took it seriously.

*“In my first time relationships I never used a condom. At that time I had no idea about condom, by that time I was 18 years old” (IDI #7, female).*

Regarding abstinence, a few respondents perceived no risk of HIV/AIDS and/or unwanted pregnancy because they stopped engaging in sex. They, however, ignored the potential risk of HIV infection from past relationships. When asked whether they tested for HIV, most of them said no.

*“I am not at risk. After recovering from an STD from my second boyfriend, I do not plan to have sexual intercourse again” (IDI #7, female).*

### **5.8. Sexual decision-making**

Most respondents stated that males dominated the decisions about the timing of sexual intercourse. They said that male partners were adamant that sexual intercourse should occur as soon as one started a relationship in order to show commitment and love. In this regard, males blackmailed their female partners by accusing them of being unfaithful and not committed to the relationship. Some girls felt intimidated and, against their will, they succumbed to partners' sexual demands.

*“The girl might say I am not available at the time the boy wants it (sex), or why have sex at a particular time. But for the guys the sooner they have sex the better. If I had a girlfriend, surely sexual intercourse would be a sign of love and trust” (IDI #2, male).*

*“If I say I am not interested in sex today he gets angry because he thinks I have found a new boyfriend” (IDI #5, female).*

*“If I would say no to sex today he would think that I don’t love him, and that would hurt me and I would be forced to have sex with him” (IDI # 1, female).*

Most respondents stated that males did not get intimidated by females’ sexual demands. They said that if male partners did not want to have sex at a particular time, they stuck to their decision regardless of whether it hurt the girlfriends or not. In this respect, girlfriends were expected to respect their male partner’s decision.

*“I just tell her that I am fatigued. She puts a sad face, but I don’t care about that. If I am not in the mood, I am not in the mood” (IDI #4, male).*

Most female respondents felt that their boyfriend’s refusal to fulfill their sexual needs was some sort of punishment for them. In spite of this, they knew that they had to accept their male partner’s decision. Girlfriends who complained or insisted that their male partners meet their sexual needs risked being labeled whores.

*“As girls it is not easy for me to say, why don’t you want now, what happened, let’s make love now. You do not want to show that you are weak. But you feel like maybe there is something I have done and he is punishing me (IDI #6, female).*

There were some respondents who indicated that some women were able to decide on the timing of sex. The nature and duration of relationship placed them in a more powerful decision-making position. Female respondents who were in long and stable relationships which were characterized by openness and love stated that if either of partners did not want to engage in sex at a particular time, they both respected each others decisions. In their first sexual encounters with a man female partners were more likely to influence the timing of sex than in subsequent sexual encounters. They said that boyfriends were not yet assertive enough to dictate the timing of initial sex. She can refuse to have sex if she is not happy with the conditions of the sexual relationship.

*“I understand, because he too also understands. If I am not in the mood for sex he accepts it and likewise him” (IDI #4, female).*



*“If it is her first time with you she can leave without having sex anytime, anywhere, anyhow, but if you are familiar with each other, it is difficult for a girl to leave and deny you sex” (IDI #10, male).*

Many of the male respondents felt that the man should determine where sex takes place. The same reasoning was echoed by females. Most of them found it funny being asked where they had sex because it is common knowledge that this must be at the venue decided by the boyfriend: usually his house or room of residence.

*“We do not argue about venue. Because I believe that sexual intercourse should be done at a man’s place and that’s where we have it from” (IDI #6, female).*

With regard to initiating sex, all males and 70% of female respondents indicated that male partners were responsible for initiating sex. They said that since it is the men who initiate the relationship, they are therefore most likely to initiate sex. Girlfriends are expected to listen and obey.

*“Normally my boyfriend makes the decision for us to have sex. He would ask me to go to his home and I would go to his home. He does not say anything but you know that he wants to do that” (IDI # 5, female).*

*“It is me who makes the decision. I usually go to her first, not her coming to me for a relationship, so she must listen to what I tell her” (IDI #4, male).*

On the other hand, respondents indicated that female partners could initiate sex without being labeled whores, only if a couple had been together for a long period of time and have had sex several times. In this respect, male partners believe that their girlfriends learnt such a behavior from them, which once again reflects male dominance. In addition, respondents stated that females who initiate sex still are unable to convince male partners who do not want to engage in sex to yield to their sexual demands. Male partners still control the sexual decision-making process.

*“If you are meeting her for the first and second time and she tries to put you in a mood for sex, then you know she has been around, she does these things to other guys. I just deny her sex totally. But if I am meeting her for lets say the sixth time you may think that she is imitating me, and that’s ok” (IDI #9, male).*

*“It’s me who initiates. If I do not want to have sex I do not want and would not change my mind. But my first boyfriend he was the one who influenced me that we should have sex. My second boyfriend who is my current one also used to decide when we would have sex” (IDI #6, female).*

### **5.9. Partner communication**

The respondents spoke about partners preferring to communicate their sexual desires by use of actions rather than openly talking about them. They said that verbal communication makes them and their partners feel uncomfortable. In the initial stage of a relationship, most young people avoid asking questions about their partner’s sex life for fear of antagonizing their partner.

Most respondents, who reported having initiated sex, said they used indirect words like ‘I miss you’ and ‘come to my place’. Other cues used to suggest sex include kissing, touching and stripping. For partners, such expressions meant that the other partner was asking for sex. If male partners communicate their sexual desires in such a manner, their female partners are expected to understand and respond. For female partners, even the use of actions is done with caution to avoid being viewed as sexually vulnerable.

*“When we kiss she goes on and on, then I know what she wants” (IDI #6, male).*

*“When we are at his place, I start kissing him, taking off his clothes, touching his sensitive parts and then he would know what I want” (IDI # 6, female)*

*“I could not tell him that I want to have sex. I just tell him that I miss you, I am coming to your place, and then he would know what I want” (IDI #1, female).*

*Once a guy acts on it, then you feel free to go on, but when it is a girl it feels very uncomfortable. I do not want him to say I am not controlling myself” (IDI #8, female).*

Furthermore, partners said they use actions to express their refusal of sexual demands from the other partner. If women do not honor appointments made with partners to meet for sex or do not accept to be romanced by partners, it means that such women do not want to have sex. Males, on the other hand, refuse sex openly. They verbally refuse sex and may or may not give reasons.

*“She may say, I cannot do this (romance) or she may not come for that appointment which you made with her. Girls just disappear” (IDI #2, male).*

*I just tell her that I am not feeling like making love today” (IDI #6, male).*

Regarding condom use, respondents contradicted themselves, at times agreeing that they openly communicate, but later on denying it. More males than female respondents stated that they openly discussed condom use with partners to prevent HIV and unwanted pregnancy.

Several reasons emerged why some respondents especially females did not freely discuss condoms. Most females assumed that boyfriends were old enough and knowledgeable about sex and condoms. They expected and waited for boyfriends to start such discussions on condoms and sexual risks. They believed that boyfriends and not girlfriends should take precautions in order to prevent sexual risks. Female partners who suggest condom use or keep condoms are likely to find themselves abandoned by partners who may view such women as whores.

*“I don’t talk about condoms. My boyfriend was older than me, he knew all about sexual intercourse. So I thought he would protect me from diseases and pregnancy” (IDI #6, female).*

*“Normally when you go to sleepover at your boyfriend’s house you don’t ask for or bring condoms, you expect him to have condoms. One of reasons is that a girl fear that he will think that she is sleeping around. If you take condoms to your boyfriend, guys usually say, what do you expect, you think we are going to have sex? You feel uncomfortable” (IDI #5, female).*

Respondents stated that condoms are not freely discussed because they connote promiscuity. They felt that suggesting condom use might destabilize a relationship by introducing an element of mistrust and suggesting promiscuous sexual practices. Most people think that condoms should be used when having casual sex. In addition, other respondents stated that partners who introduce condoms may be suspected of being HIV positive or suspect their partners to be infected with HIV or they do not want to have their boyfriends’ child. Thus, some partners avoid condom-related discussions.

*“When I told my girlfriend about condoms, she did not want to use them because she thought that I do not trust her, she said you do not love me (IDI #1, male).*

*“He will think that I suspect him to be having AIDS or I do not want to have his child” (IDI #2, female).*

Furthermore, respondents said that young people mainly use cues to express their desires of condom use. They said that male partners place condoms where girlfriends can easily see them or may tell the girlfriends to pick up the condom. This is based on the assumption that female partners know the meaning of such cues and respond to them accordingly.

*“They (girls) obviously think we both want to use condoms, so I just get condoms and she sees them. If she has a problem with them then I would know it” (IDI #5, male).*

Regarding HIV and unwanted pregnancy, all respondents individually acknowledged the importance of discussing HIV and pregnancy related issues with partners. They stated

that partners who frequently communicated their fears of HIV/AIDS and unwanted pregnancy were more likely to use condoms regularly.

*“I wanted to avoid having an unplanned child and disease. As I talked to her about it she was just listening. At first she did not want condoms, but as time went on she accepted” (IDI #1, male).*

Respondents said that partners express their fears of HIV/AIDS and pregnancy to each other as a strategy of creating awareness of the dangers associated with unprotected sex. In addition, respondents said that couples who are in stable relationships express their fears to partners as a sign of love and honesty to them. They said that regardless of whether or not their partners gets offended, fears of HIV/AIDS and unwanted pregnancy should be communicated to the loved ones.

*“I and my girl discuss HIV several times. If one gets HIV it means that both of us will be in danger. So it is our responsibility to make sure that we do not get sick” (IDI #1, male)*

*“We talk about HIV because I love her and do not think I would lie to her” (IDI #6, male).*

Regarding HIV status, most respondents said that it is not easy to reveal one's status. However, none of the males and only a few females said they would keep their HIV status a secret for fear of hurting their partners. Some female respondents felt that their HIV status is their own business, and hence, they do not have to reveal it to anybody especially boyfriends.

*“I think I would not tell him because I do not want him broken; HIV+ status is difficult to accept” (IDI #4, female).*

*“I do not think he pays for my medical expenses, I owe him no explanation” (IDI #3, female).*

There were respondents who stated that HIV infection was not something they can conceal forever. They would reveal their HIV status to their partner in order to encourage them to go for testing and get treatment if they were infected. But if they are not infected, then the HIV positive person should reveal their status to avoid infecting their partner.

*“To let my partner know my HIV status so that she can go for HIV testing and get treatment” (IDI #10, male).*

*“Yes, I have to, so that I don’t infect her” (IDI #2, female).*

In addition, other respondents said that they would reveal their HIV status to partners they love. Partners deserve to know each others status so that they can make decisions about their health and the future course of their relationship. Some males said they would convince their partners to go together for HIV testing so that they can know who to blame for their condition. Lastly, others especially females said they would reveal their status to avoid problems that may arise if the partner finds out at a later stage.

*“I would tell her my HIV status because our relationship is characterized by trust. If she feels that leaving me is the right thing to do, she can leave me (IDI #1, male).*

*“I would tell her so that she can get tested, and then I will say I got it from you because before I met you I was not sexually active” (IDI #7, male).*

*“I would tell him my HIV status. It would eventually come out if I do not, because he will start asking why I am not sleeping with him” (IDI #6, female).*

Respondents said that they would employ indirect strategies to express fears about HIV and unwanted pregnancy and also to reveal their HIV status in order to avoid being misinterpreted by partners.

Respondents stated that they would tell their boyfriends or girlfriends about particular people that they both know who are living with HIV/AIDS or have died of HIV/AIDS to

encourage the use of protection in their relationship. They also said partners mention the negative repercussions people face as a result of unwanted pregnancy (e.g. dropping out of school, stigma associated with teenage pregnancy and abortion) to encourage their partners to accept the use of contraception in their relationships.

*“We talked about ladies in our location that died of HIV. We said that if we do not use condoms we will get HIV as well. The pain is not good” (IDI #7, female).*

*“We were talking about his friend that has an unwanted baby, so I started asking him about it and he said they decided to have an abortion. So I said to him these are the disadvantages of not using a condom, so its better that we use condoms every time we have sex” (IDI #7, female).*

Furthermore, respondents said they also draw on the media to assist them in communicating with their partners their concerns about the risk of pregnancy and HIV/AIDS. They said that certain television and radio programs indicate the agony and pain people living with HIV/AIDS suffer. In addition, media programs at times show HIV-related stigma faced by relatives or friends of HIV positive people. The media also indicates the repercussions of unplanned pregnancies such as the pain of abortion.

*“I bring up the subject of HIV and other sexual matters, when the TV or radio is covering such topics then I turn around and say what about that? How do you think we should avoid it? In this manner I convey my concerns” (IDI #5, female).*

Lastly, respondents said that they introduce topics on HIV/AIDS and unwanted pregnancy by asking particular questions. They said that by asking particular questions on HIV/AIDS and unwanted pregnancy they are able to create a conducive environment for discussing their own fears and behaviours. They also ask questions around HIV status to gauge whether their partner is ready to know their HIV positive.

*“I ask jokingly that you know about HIV, unplanned pregnancy? What is your view about it? I may say I have got a friend who has an STI so what is your view about it? (IDI #2, male).*

*“I start by asking some questions. Like what would you do if something like this happens? I will wait to hear from her and then tell her that it is not easy” (IDI #1, male).*

Regarding HIV status, for female respondents, the strategies they employ to reveal their status seemed to be motivated by the fear of partners' reactions. Some said that if they ask their partner questions relating to their HIV status and their partner reacts in a scaring manner, then they would reveal their HIV status to them electronically. Others said that they would convince their partners to go for couple testing. It might be easier if it is the health care provider who reveals their HIV status rather than the girlfriend revealing it to him.

*“If I am HIV positive I would not tell him straight away I will ask him what can happen if he found out that I am HIV positive. If his response is scaring then I would send him an SMS” (IDI # 5, female).*

*“If it is HIV I would tell him that we should go and test together. From there, he would know our status” (IDI # 6, female).*

On the other hand, for male respondents, the strategies they said they would employ to reveal their HIV status to partners were straight forward. Most of them said that the thought of how their partners would react would not influence their decision to reveal their HIV status to them.

*“Immediately you come out of the clinic you phone and tell her that I went to the clinic and got tested and found this and that condition. If she wants she can leave me (IDI #7, male).*



*“I went to a bash and got drunk and had unprotected sex and I am now infected with HIV” (IDI # 8, male).*

### **5.10. Sexual Coercion**

All respondents reported abandonment as the most common coercive experience encountered by students especially females at the campus. Some of the respondents said they encountered actual abandonment. Most females said that their boyfriends were at times unfaithful and when confronted about their infidelity, some boyfriends physically assaulted them. Some male partners, however, abandoned girlfriends who no longer excited them sexually. Others abandoned girlfriends whom they could not control in search for obedient ones. The above reasons reflected male dominance which negatively affected decision-making.

*“I experienced partner abuse, like someone hitting you because you want to use a condom and he does not want it, my second boyfriend did that, and he was always cheating on me. He would call me and say I am sorry, but we eventually broke up” (IDI #6, female).*

*“I have got principles, if a girl does not want to play according to my principles we just break up. I must use a condom, I do not hide from her my other girlfriends, if a girl does not want that, we just breakup” (IDI #9, male).*

Respondents stated that young women at a socio-economic disadvantage were coerced into early sexual debut and unprotected sex by male partners who provided them with material goods and money. Although male partners provided such gifts as a form of appreciation, the reality was that they dictated the terms of the relationship. Failure to consent to their male partners' demands could mean losing out on the assistance they offered, yet for some females, such assistance was a necessity.

Furthermore, respondents reported blackmail as another coercive experience. They stated that some people blackmailed partners by doubting their commitment and love if they

refused to yield to their sexual demands. For most respondents, sex made a relationship solid and stable because it connoted love and commitment. Most respondents indicated that young people especially male partners did not tolerate the denial of sex in a relationship, unless it was with a new partner. As a result, some people engaged in sex against their will in order to prove their commitment to the relationship.

*“I want to prove that I am loyal to you, so you must prove that you are loyal to me too by making love to me. If boys do not succeed, the relationship is not worth keeping” (IDI #3, male).*

*“Eh! It pisses me off. Like these girls I have, if we already are having sex, and now she does not want to, she has to provide a good reason why. But to someone I have just met, I don’t have a problem if she refuses to have sex” (IDI #3, male).*

*“If she refuses to have sex, the guy normally gets angry, some guys attempt to beat that lady” (IDI #2, male).*

About 80% of male and 50% of female respondents admitted that forced unprotected sex was common at campus. It was mainly females who were victims of this behaviour. The perpetrators were mainly sexual partners and colleagues who paid rooms visits for academic and non-academic purposes. For some men, if a girl visited them or welcomed them in her room especially at night, it was an indication that she wanted to engage in sex. In this scenario, condoms are in most cases not available or are deliberately ignored. In addition, some respondents indicated that some male partners do not want to use condoms with their girlfriends and may physically force them to engage in unprotected sex.

*“it’s when you go to his place to visit or him visiting you in your room that he forces you to have sex without a condom” (IDI #5, female).*

*“The point is when he does not want to use condoms I cannot do anything about it. He forces me” (IDI #5, female).*

Regarding rape, respondents stated that rape was not common at campus, but a few cases had been reported. Rape occurred during room visits. This behavior normally occurred if girls dressed seductively. Some young women were raped when they walked alone at night. Others were raped when they accepted material goods from men and then tried to dodge their sexual demands. The perpetrators are mainly outsiders, colleagues and in some cases, sexual partners. The respondents said that in most of these sexual encounters condoms are not used.

*“A guy may visit a girl to her room, this lady may want to go or come out of bathroom with just a towel wrapped around her, this may lead to rape” (IDI #9, male).*

*“Some people who are party animals, they drink alcohol and the boy says you don’t just drink my alcohol, you must give something in return” (IDI #5, female).*

Most respondents did not condone rape. Some said rapists deserve punishment. Some respondents said that with so many women willing to consent to sex, there was no need for rape. But a few of them felt forced sex was at times justifiable especially if a woman was trying to avoid sex with a man who had given her money or gifts.

*“There are so many women who would willingly accept to have sex, so there is no need for rape” (IDI #4, male).*

*“I saw my friend getting arrested for rape, I would never do that” (IDI #3 male).*

*“I do not think a guy feels good if a lady is being given money, buying her clothes and other things, but when the guy wants to sleep with her she disagrees” (IDI #8, male).*

### **5.11. Summary**

This chapter summarized key findings of the study conducted among students of Nelson Mandela drive campus. Respondents’ knowledge, opinions, attitudes and beliefs, roles

and expectations on issues surrounding decision making in the era of high levels of HIV and unwanted pregnancies were explored. The areas covered included awareness of sexual risks, barriers of preventing them, sexual behaviors, risk perception, communication and decision making, and coercion.

## **Chapter Six**

### **Discussion of Findings**

This study has explored the process of reproductive decision-making among young people in the context of high levels of unwanted pregnancy and HIV/AIDS. The data for the study was collected using in-depth interviews with students aged 18 to 24 years old at the Walter Sisulu University. This chapter will provide a discussion based on these findings.

The findings of the study show that knowledge of HIV/AIDS and unwanted pregnancy is relatively high among respondents. This suggests that health promotion interventions have succeeded in creating awareness of the risks associated with unprotected sexual activity. Knowledge of HIV transmission and prevention was reportedly universal. Most respondents knew that HIV is mainly transmitted through unprotected sex, followed by blood transfusion, contaminated instruments and maternal transmission. In a study conducted by Mulindi et al. (1998) in Kenya, sexual activity was the major mode of HIV transmission accounting for 80% of infections (Longfield et al., 2002). In addition, the present study found that respondents identified condoms, abstinence and mutual faithfulness as providing protection against unwanted pregnancy and HIV/AIDS. Similar findings were noted by Idele-Akwara (2002) in a study conducted in Kenya which identified monogamy, fidelity and condom use as the best protection strategies.

Seemingly, however, awareness of high levels of sexual risks did not translate into safer sexual behaviours. A high prevalence of HIV/AIDS and unwanted pregnancy was reported among campus students. Respondents attributed this to the risky sexual behaviours of young people which included casual sex, multiple sexual partnerships and infidelity among stable partners. In these sexual encounters, condom use was not consistent. Similarly, in Kenya, Idele-Akwara (2002) noted that despite prevention campaigns conducted, HIV/AIDS prevalence rates had risen sharply in the adult population from 5% in 1990 to 14% in 2001. In addition, Idele-Akwara (2002) pointed

out that many studies in Kenya show a high prevalence of multiple and casual sexual partners, low perceived risk of HIV infection and inconsistent condom use.

The social context also influences the decision-making process among Xhosa youth. The students reported that they obtained information from a range of sources which impacted their choices. The media had a powerful influence on the sexual decision-making process. Young people watch pornography on television and often imitate the sexual acts they are exposed to in the media. In addition, most of the young peers listened, watched and imitated the sexual acts of old peers in order to earn respect and prove their maturity which led them to engage in risky behaviours. A review of studies of the sexual behaviour of young people found that males faced pressure to prove manliness and to have many partners (Eaton et al., 2002). In addition, females faced pressure of exclusion from group discussions by sexually experienced girls because they were considered children (Eaton et al., 2002).

Many respondents observed that the Xhosa culture teaches females to be submissive to their partners whereas males are taught to be forthright and assertive. Unsurprisingly, the study found that most females were faithful to their sexual partners and they desired to satisfy their partners sexually. Despite the fear that an unwanted pregnancy would interfere with future goals, some girls had born children to prove their maturity while others had bore children in order to keep partners whom they felt would abandon them if they did not have their children. Similar findings were documented among the Zulu people by Varga (2003) that a woman was expected to be sexually available to her partner. And a woman with many partners was labeled as a whore or *isifebe*. Varga (2003) also noted that, although high fertility among Zulu adolescent girls was at times viewed as a major setback, it was a central element of respectability and womanhood. In addition, the South African Demographic and Health Survey (1999) suggested that by age 19 about 30% of girls had been pregnant and nearly as many as 30% had given birth at least once.

On the other hand, the study found that most men had multiple partners, casual partners and sex without condoms to earn the respect of their peers. Although many male respondents said they were not ready to be fathers, at the time of interview, most of them were sexually active; some had fathered children as a means of controlling their partners to prove that they were real men. Studies suggest that women experience cultural constraints in negotiating safer sex, because men's high-risk sexual practices are generally acceptable (Varga, 2003). Varga (2003) also pointed out that among the Zulu people, men with many partners are viewed as successful or *isoka*.

Consistent use of condoms was not common especially the use of condoms available at public sector facilities which were seen as poor quality and not safe. The better quality condoms 'lovers plus' were expensive and less convenient to obtain. A study conducted in the Cameroon also found that the youth linked condom breakage problems to the poor quality of condoms available. Better quality condoms were sold in pharmacies or health centers, but they were less convenient to get and more expensive (Calves, 1999). In addition, condoms were reported to vary in size and some condoms could not properly fit certain sizes of penis. Thus they were considered uncomfortable to use. Therefore, it was not surprising that condoms were at times forgotten or deliberately ignored in the heat of romance. Similar findings were reported in the Cameroon which found that young people perceived sex with condoms as unnatural, artificial and too indirect and, preferred sex without condoms which they referred to as full contact (Calves, 1999).

Furthermore, condom use was viewed as the male's responsibility since condoms were worn by them. Thus females who introduced condoms in the relationship faced ridicule. Similarly, in the Cameroon, several derogatory terms (such as "passe-partout" which meant literally "goes everywhere", "occasion pressée", which meant literally prostitutes) were used to refer to girls who used and purchased condoms. Boys who carried condoms were seen as wise and responsible, careful and evolved (Calves, 1999). The present study, however, revealed that most males had negative attitudes towards condoms. A number of studies in Southern Africa suggest that condoms are not used consistently because they are seen as a threat to masculinity and pleasure (Calves, 1999).

This finding was similar to the study using data from the Kenyan Demographic and Health Survey. The survey indicated that 56% males and 32% females engaged in high levels of sexual activity and there was limited condom use (Longfield, et al., 2002). Despite high levels of sexual activity, only 10% of youth aged 15-19 and 6% of youth aged 20-24 reported using condoms in their last sex act.

The present study revealed that some people used drugs and alcohol to socialize, however, users got sexually stimulated, and unconsciously engaged in risky behaviours. In Eastern Europe, Takacs et al. (2006) documented similar findings. They found that although youth viewed substance use as an essential element of social activity it increased lust and decreased intentions to practice safer sex. The present study also indicated that some respondents argued that some HIV positive people unknowingly or deliberately transmitted the virus to others for revenge. Similarly, in Kenya, Idele-Akwara (2002) documented some HIV infected people unknowingly spreading the disease, while others spreading it deliberately in order not to die alone.

It was obvious that preventing pregnancy was viewed as the female's responsibility since they are the ones who fall pregnant. There were concerns that these methods prevented pregnancy but not disease; hence, most people preferred using condoms. Similarly, in a study conducted in South Africa, women who perceived themselves to be at greater risk of STIs protected themselves from disease as well as from pregnancy by using condoms with another method of contraception (Maharaj, 2006). Also, in the present study, a few women reported that they stopped using hormonal methods for fear of side effects. Similarly, in Cameroon, Calves (1999) documented that the youth in Andea region were reluctant to use contraceptives because they feared side effects.

Health providers were seen as a major barrier to obtaining a method of prevention. Many health providers blame young people for their health problems. Similarly, in a study conducted in Durban, Varga (2002) documented that girls opted for backstreet abortions because health care services were inaccessible to them in large part because health-care



providers had arrogant attitudes towards pregnant teenagers. In addition, case studies in Africa showed that adolescents who approach clinics for care were often berated, denied information or misinformed or turned away because staff objected to addressing their reproductive health concerns (Abdool Karim et al., 1992). In the present study, females were the main victims of blame compared to males. Most males felt that health providers expected them to engage in sexual experimentation; hence, they were less likely to be harassed unless they were diagnosed with STIs several times. In most cases young men who engage in risky sexual behaviour do so less from conscious choice than because that is the way men are expected to behave (Varga, 2001). Many young men grow up believing that their identity as men is defined by their sexual prowess (Varga, 2001; UNAIDS, 2004).

As a result of the negative attitudes of health providers many young people's health decisions were compromised. Most of the youth were afraid to ask questions they considered sensitive. Others did not go back to the providers for medical help for fear of being embarrassed again. Thus, some youth reported having had unprotected sex. Similarly, Creel, Sass and Yinger, (2002) documented that adolescents who feel that health providers are unfriendly are not comfortable discussing their reproductive health needs with them.

Parent-child communication is seen as essential in ensuring good reproductive health outcomes (Eaton et al., 2002). However, only a few respondents reported discussing sexual matters with their partners. It was seen as disrespectful for children to discuss sexual issues with parents and parents viewed discussing sexual issues with children as encouraging promiscuity. In some situations however children listened as parents advised or warned them about sexual risks. Similar findings were documented in studies conducted elsewhere among young people in South Africa. A review of young people suggested that parents refuse to talk to children about sexual matters, and provide them with vague injunctions rather than information, and may even punish them for raising the subject (Eaton et al., 2002)

It was revealed that poverty is a common phenomenon among students. The study found that some females went for sex in exchange for material items to supplement the little pocket money they got from home in order to afford necessities. The results are consistent with other studies in sub Saharan Africa (Undie Chi-Chi and Benaya, 2006). In some parts of sub Saharan Africa, women and girls exchange sex for money in order to meet their basic needs (Undie Chi-Chi and Benaya, 2006). The present study revealed that gift giving by male partners as a form of appreciation justified coerced sexual intercourse if girlfriends attempted to dodge their sexual demands. Females engaged in sexual intercourse with many partners and without condoms in order to obtain the assistance men provided. Kaufman and Stavrou (2004) argue that gift giving has an insidious impact on the sexual behaviour and negotiation ability of girls, and, to a lesser degree, boys.

In this study, people acknowledged high levels of risky sexual behaviours and a need for behavioural change, however, individual accounts showed that they perceived little or no risk. Similarly, Naidoo, cited in Varga (1999) that 37% of Durban University students saw reason to change their sexual practices to avoid HIV/AIDS, but only 17% considered themselves at risk of HIV infection.

The likely factor for low or no self perceived risk of HIV/AIDS and pregnancy and unwillingness to openly incorporate it in their relationships was the belief that HIV/AIDS is linked with promiscuity and infidelity. Most respondents especially girls said they were faithful to their partners and felt no reason for regular condom use since they trusted their partners. Additionally, some partners especially males who got sexually involved with people labeled 'decent' or non-promiscuous by close friends or relatives were less likely to use condoms. Some men reported having many partners to prove that they were 'real men'. They viewed their sexual behaviour as normal. They thus perceived no self-risk of HIV/AIDS which they associated with promiscuous women. In the Cameroon, Meekers and Calves (1999) documented that among the youth, 60% males and 49% females who had not used a condom during the last intercourse said they trusted their partners. Furthermore, some people said they were young and ignorant about HIV and condoms,

and the little they knew about such sexual issues was never taken seriously since they perceived no sexual risk. In Kenya, Idele-Akwara (2002) documented that some people admitted to having been ignorant about AIDS because they were very young when they first had sexual intercourse.

Some respondents perceived no risk because they used condoms regularly. They, however, admitted having had lapses in usage in the past because they trusted their partners and some forgot or deliberately ignored condom use. In Kenya, Idele-Akwara (2002) observed that people used condoms regularly only with partners they did not trust. Someone in that particular study admitted to have had lapses in usage because the woman insisted on not using condoms. The present study also revealed that some people perceived no risk because they abstained from sex. They, however, often ignored that they could have contracted HIV from past relationships. Similarly, in Kenya, some unmarried people denied being at risk of HIV infection since they were not currently sexually active, although for some the risk of HIV infection from previous partners was often ignored, (Idele-Akwara, 2002).

In the present study, young men and not women initiated sexual intercourse. They determined the timing of the sexual act and the conditions under which sexual intercourse occurred. This dominating behaviour of men was generally seen as acceptable to both genders. If men made suggestions on sexual issues, partners respected their decision and not vice-versa. Similar findings were documented by Gage (1998) that 59% of university students of Freetown in Sierra Leone believed that it is the man's responsibility to bring up issues of safe sex. Also, in Swaziland, Gage (1998) observed that both adolescent boys and girls believed that boys had a 'natural right' to make more demands in sexual relationships. The present study, however, indicated that some females were able to influence sexual decisions only if they had been in a relationship for long period. However, some women also reported exerting more influence on their partners in the beginning of their sexual relationship. In circumstances where partners' views clashed over sexual issues, females were reportedly coerced into a state of powerlessness.

Similarly, a study conducted in KwaZulu-Natal by Varga (1997) reported that girls faced the threat of rejection or physical abuse if they broached the topic of sex to their partners.

Respondents suggested that open communication on sexual matters was limited. Both men and women used actions to communicate their desire for sex. Sometimes the refusal of the women to honor appointments made with partners to have sex or to be romanced meant they did not want to have sex. On the other hand, most men refused sex openly. Open communication was reported to be uncomfortable since it antagonized people's feelings. Similar findings were documented by Khan (2001) in a study conducted in Bangladesh. Khan (2001) found that physical touch (pushing, pulling or touching husband's body) was used by women to express their sexual desire. It was viewed as shameful to verbally communicate their desire for sexual intercourse.

In this study, most males discussed condom use freely whereas most females did not. Some people especially females assumed that their partners were sexually aware and experienced and it was therefore not necessary to suggest condom use. Also, it was men and not women who were responsible for taking precautions. Therefore, they expected and waited for male partners to initiate such discussions. In Thailand, Gage (1998) documented similar findings that condom use was considered a man's prerogative. Also, in Thailand and Guatemala, female ignorance of sexual matters was often viewed as a sign of purity and innocence, while having 'too much' knowledge about sex was a sign of 'easy virtue' (Rivers and Aggleton, 1998).

In addition, introducing condom use in a sexual relationship connoted promiscuity and generated antagonism in relationships. In stable partnerships, discussing condoms destabilized relationships since they introduced an element of distrust. Condoms were associated with promiscuous people and those they suspected to have HIV/AIDS. Similarly, in a study conducted on condom use and sexual behaviours in Southern Africa found that condoms were often viewed as necessary for only those infected with HIV or STDs (Varga, 2003). However, in some relationships partners used indirect, non-verbal strategies to convey their desire to use condoms. In this regard, male partners stored

condoms in places their partners could easily see them or told partners to pick condoms as cues for their intentions to use condoms.

In the study it was clear that most males worried about STIs whereas most females worried about unplanned pregnancy. The study revealed that the more they expressed fears about sexual risks the more likely they were to use condoms with their partners. In the Cameroon, Tchupo et al. (1996) noted that more girls (58.1%) than boys (35.7%) reported unwanted pregnancy and more boys (57.8%) than girls (32.8%) reported STIs as potential risks associated with sexual activity. Hence, most girls used condoms to prevent undesired pregnancy, whereas most boys used them to prevent STIs.

Open and free talk about HIV/AIDS and unwanted pregnancy has dire consequences in young people's relationships. In this respect, it was revealed that talking freely and openly about HIV/AIDS and pregnancy suggested that one partner violated the trust, commitment and intimacy of the relationship. In order to achieve peaceful discussions, therefore, partners communicated indirectly. They referred to events or stories outside their own relationships. For example, they made references to stories or events highlighted by the media. Also, they spoke about people living with HIV/AIDS and pregnant teenagers that they both knew. In Malawi, Zulu et al. (2002) noted that in order to avoid conflict, the discussions of HIV/AIDS risk and preventive strategies were often introduced with reference to stories and events relating to AIDS and irresponsible sexual behaviours outside the domestic sphere.

In their study in Kwazulu-Natal, Maharaj and Munthree (2007) observed that sexual coercion was a major barrier to adopting safer sexual behaviour. In the present study, females expressed concerns about being abandoned by partners who found new girlfriends. Male partners justified abandoning girlfriends on the grounds that they were no longer sexually exciting or they were disobedient. On the other hand, females justified abandonment of partners only on grounds that partners were unfaithful and were physically or/emotionally abusive to them. Similarly, in Kenya, Longfield et al. (2002) documented that in cross-generational relationships, older men "dumped" young partners

once their sexual needs were satisfied, whereas some young women abandoned older partners whom they could no longer depend on emotionally and financially for new partners. In Kenya, unmarried women abandoned partners whom they realized were double-dealing or had concurrent sexual partners (Idele-Akwara, 2002).

Sometimes men put women in situations where they are forced to give into their sexual demands. They visited female rooms or invited them in male rooms and forced them into unprotected sex, or raped them as they walked home alone at night. The distressing part was that the perpetrators were mainly stable sexual partners and colleagues or friends they were familiar with. Similarly in Kenya, Idele-Akwara (2002) noted that intercourse occurred in a place determined by the man, in most cases it was his house or a friend's house or an isolated field or place. The woman often ended up agreeing to have sex even if this was not in her mind in the first place.

Finally, a few cases of rape were reported during room visits especially at night, when girls moved alone at night and also, those women who accepted material items from men and then tried to dodge men's sexual demands. In this scenario, perpetrators were mainly acquaintances and in a few instances, strangers. Although most people did not condone rape, they felt that it was justified for girls who accepted material objects from men and tried to dodge their sexual demands. A study in a South Africa township found that rape was routine, and 60% of young African women reporting having had sex against their wishes (Hallman, 2004).

## **Chapter Seven**

### **Conclusion and Recommendations**

#### **7.1. Conclusion**

Several studies on risky sexual behaviours have shown that creating awareness of sexual risks and promoting preventative measures does not necessarily lead to behavioural change. HIV and teenage pregnancies have remained areas of concern in many countries of sub-Saharan Africa. A more contextual approach seemed appropriate to shed more insights into the reproductive decision-making with regard to preventing unwanted pregnancy and HIV/AIDS among young people.

In this study, despite high awareness about sexual risks, behavioural change seemed far from reality. The findings showed high prevalence of risky sexual behaviours among respondents. The different cultural expectations and standards seemed to give greater precedence to the sexual needs of men over women. In many sexual relationships, men wield more power over women. Men who engaged in risky sexual behaviours, fathered children and controlled their partners were respected whereas women were expected to be faithful to one partner, obey and satisfy all his sexual needs. As result, the different gender roles seemed to compromise young people's ability to engage in safer sex behaviours.

The media also had a powerful influence on young people. While the media has important educational messages to convey young people seemed to be lured more by the negative images that they view on television. Many watch pornography and they try to imitate the risky sexual behaviours they watch on television. Additionally, young people are also pressurised to engage in risky behaviours by their peers. However, peer pressure is not necessarily a negative influence (Eaton et al., 2002). Positive examples set by friends and role models may also promote safer sex behaviours. This suggests that appropriate attitudes towards safer sexual behaviours must be inculcated and encouraged in young people, so that they may exert massive influence on one another.

Furthermore, although parent-child interaction was reportedly significant in conveying HIV/AIDS and pregnancy prevention messages, it was viewed as inappropriate since it is seen as disrespect to parents and encouraging promiscuity. Unsurprisingly, therefore, this kind of interaction was rare. With regard to the provider-client interaction, the youth who sought medical help on sexual issues were reportedly ill-treated by providers. As a result, the youth avoided seeking help from providers whom they feared would humiliate them again. This played a role in promoting unsafe sexual behaviours among young people.

The condoms that were available at public sector facilities were considered poor quality and unsafe and as a result were less likely to be used. The Lover's Plus type of condoms which were considered good quality and safe were less convenient to get. In addition, there were concerns that condoms were either too small or too big to fit particular sizes of penises. It is not surprising therefore that condoms are rarely used and if they are used it is not consistent. Additionally, hormonal methods are criticised for only preventing pregnancy, but not disease. Many also expressed fear of side effects to the health of women. It is therefore not surprising that they decided not to continue using them.

The study found that many young people engage in high risk behaviour. Some people who used drugs and alcohol to socialise reportedly got stimulated sexually and unconsciously engaged in risky sexual behaviours. Additionally, HIV positive people unknowingly or deliberately transmitted the virus to others. However, most young people felt that they had little or no risk of HIV/AIDS and unwanted pregnancy.

Some people said they were in mutually monogamous relationships and they trusted their partners even though they acknowledged that some partners cheat. Other people trusted the judgment of close friends and relatives that potential partners were not promiscuous; they, however, acknowledged that their friends or relatives were not always right. For others, despite lapses in condom use in the past, they admitted using condoms regularly. Lastly, some perceived no risk because they were currently not sexually active. They often ignored their past sexual history.



In most sexual relationships, male partners dominated the decision-making process regarding sexual intercourse and condom use. It was however acknowledged that some female partners who were assertive enough, especially those who had been in stable relationships for a long period of time and those who engaged in sexual intercourse for the first time, were particularly influential in the decision-making process. Furthermore, findings pointed to the importance of discussing HIV/AIDS and pregnancy; however, for some partners especially females, some sexual matters were not freely discussed. Such discussions generated suspicions of HIV infection, infidelity and lack of trust. Respondents who freely discussed sexual risks focused mainly on adverse consequences to create awareness of their dangers. In some cases, communication was indirect rather than direct. Respondents asked questions, made references to events or stories relating to HIV/AIDS and pregnancy outside their own relationships to ensure harmonious discussions. Thus, the chances of making healthy reproductive choices are compromised by inadequate communication or ambiguous communication with regard to sexual matters. Also, fear of partner reaction led to females reportedly revealing their HIV status electronically to avoid confrontation. For males, however, their HIV status was reportedly revealed openly, regardless of partners' reaction. Knowing one's HIV status enables him or her to decide on future course of action.

In the context of coercion, experiences encountered by respondents reflected male dominance over female partners. Females abandoned unfaithful and abusive partners whereas males abandoned partners who were no longer sexually exciting and those they failed to control. Furthermore, women who accepted gifts from men were coerced into risky sexual demands of men who provided those gifts. Also, some females were blackmailed into sex to show that they were committed to their boyfriends. This coercive behaviour was reportedly routine and generally acceptable.

Forced unprotected sex and to a lesser extent rape of females, but not of males was reportedly prevalent. Although, most people did not condone forced sex, some people felt it was justified for females who accepted gifts from men; girlfriends who denied their

partners sex; and those who dressed seductively. Having discussed the findings, several recommendations were suggested.

## **7.2. Recommendations**

This study recognises that messages on abstinence, mutual monogamy and condoms have been tried and proven less successful. The study therefore pointed to the need for health promoting messages that incorporate the contexts in which reproductive decision-making takes place.

Both young men and women find themselves in a position of having to prove their masculinity and femininity. In some contexts, masculinity is associated with risky sexual behaviours and femininity is associated with passivity and obedience to male partners. There is therefore an urgent need to redefine cultural norms that set different standards for each gender. In this regard, open and free partner discussions need to be encouraged especially since the study found that verbal communication was limited. Additionally, partner coercion need to be addressed since it encouraged male dominance over females and discouraged shared decision-making. Shared decision-making is likely to promote positive reproductive health outcomes.

Furthermore, health promoting interventions need to train health providers to be more accommodative of youth's sexual issues since they were reported to be an appropriate source of information and care for the youth. Additionally, health promoting interventions should engage providers to ensure that they place more emphasis on training the youth on contraceptive methods and their side effects to enable them to make informed decisions.

Besides other sources of information, cell phones can also be utilized to transmit information about safer sexual practices, especially since most of the youth own cell phones and regularly use them. Also, counselling services and religious organizations that operate within the campus need to actively reach out to students. Campus societies

need to also go beyond transmitting prevention messages and incorporating skills to enable young people to negotiate safer sex since studies have shown that the ability to negotiate safer sex behaviour is dependent on shared decision-making to prevent sexual risk taking behaviour. Lastly, religious organizations need to develop a stronger presence at places where young people congregate especially since several studies show that youth with strong religious principles and values are less likely to engage in risky sexual behaviours.

Finally, findings pointed to the need to sensitise parents to the importance of communication about sexual issues, since it seemed likely to encourage preventative behaviours. In this regard, parents need to be sensitised on how and when to talk to children especially since parent-child interaction was reportedly uncomfortable and limited. Also, since parents were viewed as role models for the youth, they themselves need sensitization on behavioural change. If their behaviours changed, the youth would follow suit.

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