

**ASSESSING KNOWLEDGE, ATTITUDES AND PRACTICES OF BOYS AND  
YOUNG MEN WITH REGARD TO THE PREVENTION OF PREGNANCY  
AND HIV INFECTION**

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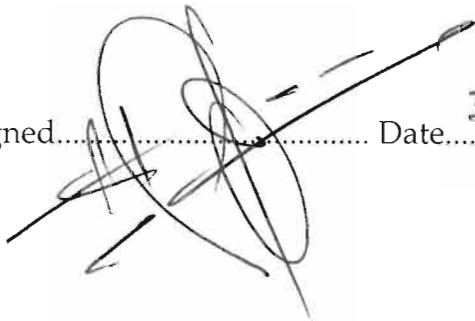
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**April 2006**

## Declaration

This dissertation represents the original work of the author and it has never been submitted for any degree or examination in any university. Full acknowledgement is given for all the sources referred to in this thesis.

Signed..... Date. 31 July 2006

A large, stylized handwritten signature in black ink, consisting of several overlapping loops and a long horizontal stroke extending to the right, crossing over the date.

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## **Abstract**

This paper focuses on boys and young men's attitudes, knowledge and practices with regard to pregnancy and HIV infection. The objective of the study is to ascertain how boys and young men perceive the risks of pregnancy and HIV infection. The study further investigates the strategies which the sexually active respondents considered as appropriate, practical and effective in coping with these risks.

The study was based on the secondary data which was extracted from the transitions to adulthood survey conducted in KwaZulu Natal during 2001. The analysis was restricted to young men aged 14 to 24 years. The major findings from the study revealed that young men did not perceive themselves at risk of HIV infection.

Overall, respondents were fairly knowledgeable about HIV/AIDS and knew where to access condoms, how HIV is contracted or transmitted etc. Findings also indicated that many respondents regarded pregnancy as a matter of great concern. Many respondents perceived pregnancy as highly problematic and were concerned to protect themselves against this risk. The major finding for this study revealed that the majority of sexually active young men used condoms for preventing both pregnancy and HIV/AIDS; while some also used various contraceptive methods to prevent pregnancy. A major factor promoting consistent condom use was the perception of pregnancy as highly problematic.

## **Glossary of Terms**

AIDS	Acquired Immunodeficiency Syndrome
CEAs	Census Enumeration Areas
SADHS	South Africa Demographic and Health Survey
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
RAT	Reasoned Action Theory
RHO	Reproductive Health Outlook
SLT	Social Learning Theory
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Programme on HIV/ AIDS
WHO	World Health Organization

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# Chapter One

## Introduction

### 1.1. Background to the Study

The prevention of unwanted pregnancies and HIV/AIDS are important priority areas in sexual and reproductive health. In its entirety sexual and reproductive health encompasses sexual behaviour, sexually transmitted infections (STIs), HIV/AIDS, family planning, abortion-related matters, pregnancy, childbirth, post-partum care, breastfeeding, maternal, infant nutrition and infertility services (Becker, 1996). Traditionally, men have been restricted from participating in sexual and reproductive health matters as these aspects were regarded as the responsibility of women (Adamchak et al., 2004). In the past decade however, there has been an increasing recognition of the need to involve men in sexual and reproductive health. This study looks broadly at the sexual and reproductive health behaviour of men. The involvement of men in sexual and reproductive health may not only benefit women and children but also equip men with broader knowledge about sexual and reproductive health matters.

Although there is no existing commonly agreed upon definition of sexual and reproductive health care for men (Alan Guttmacher Institute, 2002); Becker (1996: 291) defines male involvement in sexual and reproductive health as meeting “the rights of men...to be informed and to have access to safe, effective, affordable and acceptable methods of family planning”. The concept of male involvement was firmly entrenched at the 1994 International Conference of Population and Development which placed emphasis on meeting the reproductive health needs of men and women. In 1995, the Fourth World Conference in Women in Beijing

also formally accepted the role of men in ensuring greater gender equality and better reproductive health for men and women (Maharaj, 2000).

Maharaj (2000) argues that various aspects concerning STI/HIV and unwanted pregnancy prevention largely depend on men's cooperation with their partners. In many societies, men are the dominant decision makers with regards to such aspects as the desired number of children, birth spacing and limiting (Adamchak et al., 2004; Maharaj, 2001). As a result, excluding men from sexual and reproductive health matters will not serve any good purpose in ensuring good reproductive health outcomes. Instead, equipping young men with information will help them overcome peer pressure, enable them to make informed and positive decisions, take responsibility for their actions, and communicate effectively with their partners about personal and sexual matters (Alan Guttmacher Institute, 2002).

The advent of the HIV/AIDS pandemic has further increased the importance for men to support their partners in sexual and reproductive health matters (Varga, 2001). Some studies indicate that many men are responsible for the spread of STI/HIV infection because they are more likely to have multiple sexual partners (Sonfield, 2004). Nevertheless, there are many aspects which need to be explored through the involvement of men in sexual and reproductive health. For example, men have their own personal needs and challenges. Therefore, male involvement may help men access and use reproductive health care services more effectively (WHO, 2004). Thus, men need to be adequately informed about sexual and reproductive health matters. These skills would enable them to refrain from overlooking the seriousness of STIs for example, and as a result promptly seek proper medical treatment. They will recognize the importance of family planning and therefore be more likely to accept the methods of family planning and prevent unwanted pregnancy. As a result, it is important to

determine the role that men play in reproductive health. The purpose of this dissertation is to try and fill this gap in the research by focusing on boys and young men.

## **1.2. Why Focus on Boys and Young Men**

Men, and young men in particular, have a greater risk of engaging in risk-taking behaviours (including sexual risk-taking) that jeopardize their own health (World Health Organization [WHO], 2000). In many parts of Africa, studies show that the age of sexual debut is declining (Varga, 2001; Meekers and Klein, 2002). Furthermore, boys are more likely to engage in sexual activity at an earlier age than girls. In a study conducted in Botswana, four out of every ten males were sexually experienced in comparison to one out of every seven females (Meekers and Klein, 2002). In many societies women are expected to demonstrate limited sexual experience whilst men are stigmatized if they are not able to demonstrate sexual experience (Varga, 2001; Wood et al., 1998). Young men in many parts of the world also face enormous pressure and encouragement to engage in risk-taking behaviour (WHO, 2000). In many societies men are likely to equate masculinity with having STIs, multiple sexual partners, and practicing unsafe sex (Varga, 2000). All of these factors may increase one's exposure to pregnancy and HIV infection.

Despite the decline in the total fertility rate in South Africa, the levels of teenage childbearing are still relatively high in the country. More than 30% of young women in South Africa have had their first child by age 19 (Kaufman et al., 2001). It can also be noted that those women who give birth during their teenage years often only have a few additional children later on in their childbearing life time. The 1999 South Africa Demographic and Health Survey states that 48% and 33% of the 15 to 19 year olds and the 20 to 24 year olds respectively show an interest

in delaying childbearing by at least two years. The survey reveals that 12.9% of the 15 to 19 year old women and 32.3% of the 20 to 24 year olds wanted no more children (SADHS, 1999).

The high levels of HIV infection among young people is also a matter of grave concern. Men and women become infected with HIV at different ages. In Sub-Saharan Africa the majority of people infected with HIV and dying of AIDS are female. In South Africa, HIV prevalence among young women is 12% compared to 6% among young men (Doherty and Colvin, 2004). The level of HIV prevalence is also closely linked to the levels of STI infections. A study of health facilities in six provinces in South Africa found that more than 10% of STI clients were under the age of 18 years. The majority of the STIs clients were men (Ramkissoo et al., 2004).

Given their critical role in preventing unwanted pregnancy and HIV infection, boys and young men have not been comparatively the focus of a great deal of research (Varga, 2000; WHO, 2000). Boys and young men, especially in sub-Saharan Africa, are one of the least studied cohorts in the HIV/AIDS literature (Tillotson and Maharaj, 2001). What is clear is that most of what is known about men comes from studies amongst women. Tillotson and Maharaj (2001) argue that research has thus far concentrated on issues of sexual negotiation, male dominance and chauvinism in order to show that women often engage in unprotected sex because of the resistance or abuse they receive from their male partners. There is a need therefore to better understand the knowledge, attitudes and behaviour of boys and young men and their role in preventing unwanted pregnancy and HIV infection.

### **1.3. Overall Objective**

The overall objective of this study is to explore the knowledge, attitudes and behaviour of young men with regard to pregnancy and HIV/ AIDS.

#### **1.3.1 Specific Objectives**

The specific objectives are:

- To determine the perceptions of young men with regard to pregnancy and HIV infection.
- To investigate the methods used by sexually active boys and young men to prevent pregnancy and HIV infection.
- To explore opportunities and constraints to adopt safer sexual behaviour with particular focus on partner communication.

### **1.4. Main Research Questions**

This study attempts to answer the following research questions:

- Do boys and young men perceive themselves at risk of an unwanted pregnancy and HIV infection?
- Is there any communication between partners about pregnancy and/or HIV/ AIDS prevention measures?
- What method(s) (if any) are sexually active boys and young men using to prevent pregnancy and HIV infection?
- What are some of the barriers boys and young men face in protecting themselves against pregnancy and HIV infection?

In order to address these objectives the study relies on secondary data from the second wave of the Transitions to Adulthood survey. The survey was conducted in the province of KwaZulu Natal in 2001.

## **1.5 Hypothesis**

Based on the conceptual framework and the aims of the study, the following two hypotheses are suggested:

- Men are knowledgeable about methods used for preventing pregnancy and HIV infection.
- Men use condoms to protect against the risks of pregnancy and HIV infection.

## **1.6 Definition of young people**

According to UNICEF, UNAIDS and WHO (2002), young people are defined as people aged between 15 and 24 years. However, for purposes of this study young people will be referred to as those aged between 14 and 24 years.

## **1.7 Organization of the Dissertation**

This dissertation is organized into seven chapters. Chapter one has provided the background information and the objective(s) of the study. Chapter two reviews the literature from other studies which have a similar content with the current study. Chapter three outlines theories pertinent to this study, as well as the proposed conceptual framework for the study. Chapter four describes the methodology which was used in the study and the methods used for analysing the data. The limitations of this study are discussed in chapter four as well. Chapter five outlines the main findings of the study while chapter six provides a

discussion of the main findings. The last chapter briefly concludes the entire discussion with recommendations from the study.

## **Chapter Two**

### **Literature Review**

#### **2.1 Introduction**

This chapter will review existing literature on the sexual and reproductive behaviours of young people with particular focus on boys and young men. The complexity of investigating the factors influencing sexual and reproductive health behaviour and practices among young people is described in the following statement by Magnani et al. (2001:62) that: "in a given setting, a multitude of correlates exists, each having a small impact on sexual behaviour, rather than a few correlates, each having a large impact."

#### **2.2 Age at First Sexual Intercourse**

A number of studies show that young people are becoming sexually active at a much earlier age (Manzini, 2001; Hartell, 2005). Out of a sample of 796 young women, it was discovered that approximately half had already had their first sexual experience by the age of 16 years (Manzini, 2001). In a study conducted in the Eastern Cape, South Africa, Hartell (2005) found that although both boys and girls started their sexual debut at approximately the same age, the onset of sexual intercourse was much earlier for boys. A study conducted in Bangladesh also revealed that boys were more likely to be sexually active than girls. The study found that 38% of adolescent males living in rural areas were sexually active by the age of 18 years in comparison with only 6% of females (Pachauri and Santhya, 2002). In their study, Bradner et al. (2000) also observe that men aged 20 years and above have higher odds of being sexually active than younger men.



Often the ages from which youth start their sexual debut differs substantially with regards to gender. Boys are more likely than girls to begin their sexual debut at an earlier age. According to Kaufman et al. (2004), young men have higher odds of being sexually experienced than young women. African men were four times more likely to have engaged in sexual activity than White men during the year preceding the survey; while Indian men were the least likely to have engaged in sexual activity. In addition, African boys from the urban areas in KwaZulu Natal had slight higher odds of engaging in sexual relations than boys from rural areas. Normally young people initiate sex on the basis of certain social aspects such as: exposure to television, religious involvement and educational standard (Kaufman et al., 2004).

### **2.3 Frequency of Sexual Intercourse**

A study conducted in KwaZulu Natal by Jackson and Harrison (1999) found that many young men considered sex as equivalent to life and felt that it was necessary from a young age. In her study in KwaZulu Natal, Varga (1999) found that for many young people having many sexual partners was not only acceptable but desirable, and the consequences of being without a girlfriend have been observed as obstacles to safe behavior. However, in their study in KwaZulu Natal, Tillotson and Maharaj (2001) found that while some respondents felt that they would receive fame in the township, most felt that multiple sexual partners in the face of the threat of HIV/AIDS is dangerous and indeed stupid. Peer pressure placed on young men to prove their virility is a major contributing factor to their early sexual debut (Wood et al., 1998). Although sexual debut may begin at quite an early age amongst males, the frequency of sexual activity increases with age (Bradner et al., 2000). Adults aged 25 to 49 years reported higher levels of sexual frequency than younger people and people older than 50

years. Only seven out of ten sexually active young people reported having sex four or less times per month (Shisana et al., 2002).

## **2.4 Multiple Sexual Partners**

Multiple sexual partners have been identified as a major contributing factor to the continual spread of STIs and HIV/AIDS (Bauni and Jarabi, 2000). Although both males and females may have access to multiple sexual partners, men often have higher odds of practicing this behavior. Young males are generally more likely to have multiple sexual partners in comparison to females. A study of South African youth conducted by Simbayi et al. (2004) found that 23.9% of young men and 7.8% of young women had more than one sexual partner. Kaufman et al. (2004) compared the numbers of sexual partners that boys and girls had in KwaZulu Natal. According to this study, only 27% of the boys reported having a single partner in comparison to 40% of girls. Furthermore, among those youth who had two and more partners, only 2% were girls whilst 18% were boys.

According to Wood et al. (1998), the Xhosas assign different roles to men and women. Within a sexual relationship, women are expected to be submissive whilst men are expected to dominate, and women who have had many sexual partners are referred to as 'whores' (slang word used for a woman who has multiple sexual partners) (Wood et al., 1998). In many societies, men are rewarded for having many sexual partners. In a study conducted in KwaZulu Natal, Varga (1999) observed that it is socially expected and accepted of men to have multiple sexual partners. Furthermore, Messersmith et al. (2000) revealed that some of the reported reasons that men gave for having multiple sexual partners were: the desire for sexual variety, physical need, need for companionship, peer pressure, and troubles within their primary relationship(s).

Additionally, Simbayi et al. (2004) found that one of the major factors contributing to the large proportion of young people reporting multiple sexual partners was the lack of self-esteem. Hulton et al. (2000) argue that young men lack responsibility for their behaviour which creates a serious obstacle to improved reproductive health outcomes.

Simbayi et al. (2004) found that the high level of poverty in South Africa is another factor contributing to the high incidence of unsafe sexual behaviour. In this accord, Maharaj (2001) argues that women who struggle to make a living often engage in risky sexual practices since they often lack power and autonomy to negotiate safer sex. Additionally, poverty would sometimes lead to women engaging in transactional unprotected sex i.e. sex for obtaining money and material goods such as clothing and/or food (ibid). In addition, as the level of education increases the number of sexual partners may also increase. Hollander (2003) observed that students in grade 12 had 1.5 more sexual partners than students in grade 9 and the use of condoms was not a regular practice.

## **2.5 Sexually Transmitted Infections (STIs)**

Unprotected sexual practices increase the risk of STIs (Bradner et al., 2000). Studies show that the majority of young people are aware of STIs (Hulton et al., 2000). A study conducted on adolescents in Uganda found that young people were able to mention at least one STI other than HIV/AIDS during interviews (ibid). Many studies associate STIs with the risk of HIV/AIDS (Sloan et al., 2000; Bauni and Jarabi, 2000).

STIs are highly prevalent in many populations. Sloan et al. (2000) postulate that the prevalence of gonorrhea and chlamydial infection is highest among young people in sub-Saharan Africa. Africa is recognized as one of the continents with

the highest incidences of chlamydial infections ranging from 4 to 7% among women and 3 to 5% among men. Similarly, gonorrhea ranges from 1 to 3% among women and 1 to 2% among men (ibid). In a study conducted in Kenya, Bauni and Jarabi (2000) found that for every 10 people there were 3 to 7 STI sufferers. In general, boys are more likely than girls to report an STI (ibid). In Nigeria, Messersmith et al. (2000) found that gonorrhea and syphilis were the most commonly reported STIs. However, genital warts, trichomoniasis, chlamydia and candidiasis were also prevalent amongst young people (ibid).

Studies have found that there is a great deal of reluctance among men to visit health facilities for STI treatment (Bauni and Jarabi, 2000). In their study in Kenya, Bauni and Jarabi (2000) found that some women expressed the suspicion that men might be treating STIs without their knowledge. Frequent sexual behaviour, multiple sexual partners and non-use of condoms are leading factors contributing to increased STI prevalence (Marcell et al., 2003).

## **2.6 Awareness of HIV/AIDS**

Most studies show that the awareness of HIV/AIDS is high (Smith, 2004; Simbayi et al., 2004). The South Africa Demographic and Health Survey (1999) found that 95.1% and 97.6% of the 15-19 and 20-24 year old women respectively reported that they had heard of AIDS. Most respondents mentioned a number of sources of information regarding HIV/AIDS including the media, health practitioners, friends and relatives (SADHS, 1999). There also appears to be an awareness of the routes of HIV transmission (Osirike, 1998; Smith, 2004). With regard to protection against the risk of HIV infection, a number of measures are mentioned including abstinence, condom use and faithfulness to one sexual partner (Smith, 2004). In her review, Hartell (2005) observed that: in general, South African adolescents are well aware of HIV and AIDS. However, although

most of the young people in KwaZulu Natal acknowledged the severity of HIV/AIDS, few were particularly knowledgeable regarding the factors that impacted on the transmission of HIV/AIDS (ibid).

A study conducted by the Human Sciences Research Council in 2004 revealed that young people in South Africa were not only aware of HIV/AIDS, but were also undergoing HIV/AIDS tests in order to determine their own status. The study found that 15.9% of young men and 20.5% of young women had undertaken an HIV test. In addition, 12.3% of young men and 18.4% of young women were aware of their own HIV status (Simbayi et al., 2004).

Osirike (1998) points out that in spite of their high level of knowledge about HIV/AIDS, a large number of youth do not know anyone with HIV/AIDS as only 2.3% of them claimed to have seen someone with HIV/AIDS. Those respondents who claimed to know someone with HIV/AIDS were not sure as to whether those sufferers were medically certified, and the majority of young people claimed that they had obtained their information about HIV/AIDS from the media (ibid).

Many studies show that young people often do not regard themselves as being at a high risk of contracting HIV/AIDS (Kaufman et al., 2004; Hulton et al., 2000). For example, in a study conducted in Nigeria, Smith (2004) found that when asked about their personal risk of acquiring HIV/AIDS, only about 11% of the young men perceived themselves to be at high risk of acquiring HIV/AIDS. Approximately 4 to 7% of respondents perceived themselves to be at moderate risk while between 20% and 26% perceived themselves to be at low risk of acquiring HIV/AIDS. In contrast, in a study conducted in South Africa, Stadler and Hlongwa (2002) found a high level of awareness of the risk of HIV/AIDS but



revealed that young people often felt unable to effectively control their sexual behaviors.

## **2.7. Condom Use**

Most studies show that awareness of condoms is high (Harrison et al., 2001; SADHS, 1999; MacPhail and Campbell, 2001). Condoms are perceived as an important method of protection against HIV infection and STIs. Studies have found that young men are confident about their ability to prevent HIV/AIDS with the use of condoms (Hulton et al., 2000). Hulton et al. (2000) observed that condoms were the sole method of contraception that male respondents mentioned during survey interviews. However, while young people are aware of the means to protect against STIs and other risks, few of them practice safe sex. A study among young people in Cape Town revealed that 80% of students admitted that their use of preventive method(s) against HIV was poor in spite of their awareness of HIV/AIDS (Hartell, 2005).

In South Africa, condom use is higher among young people than older people. Some studies have found condom use among youth to be as high as 40% (Harrison et al., 2001; Kaufman et al., 2004; Simbayi et al., 2004). In a study conducted in KwaZuluNatal, Kaufman et al. (2004) found that rates of condom use were relatively high, with almost 49% of boys and 46% of girls reporting use at last sexual intercourse. This study also found that Indian boys were more likely to use condoms than White boys, whilst White boys were more likely to use condoms in comparison to African boys from both rural and urban areas. In addition, the study found a strong association between condom use and involvement in sport, parent's education and employment opportunities. According to Kaufman et al. (2004), boys who participate in sports have higher odds of using condoms than those who do not, and boys who live in households

with an educated adult(s) are more likely to use condoms than boys from households without any educated individual(s). The study also found that employment opportunities at the community level tend to increase condom use. Earning potential had a strong positive effect on condom use among both young men and women (ibid).

Although condoms may be used during last sexual intercourse, in general adolescents are not practicing safe sex on a consistent basis (Hartell, 2005). For example, Smith (2004) reveals that youth reported abstinence and condom use as preventive methods against the risks of pregnancy, STIs and HIV, however, only between about 40 to 42% of young people reported using condoms consistently in their current sexual relationships (Smith, 2004). The inconsistent use of condoms is of major concern and is likely to contribute to the increase in HIV/AIDS and unintended pregnancy.

The high level of inconsistent condom use amongst African boys and young men in KwaZulu Natal often stems from the fact that the practice of safe sex is hampered by particular social, cultural and peer pressures (Varga, 2003). These boys and young men are pressured into not using condoms in order to prove their status as men and therefore these rules and pressures often dictate their sexual practices (ibid). Findings from recent surveys indicate that 50 to 60% of sexually active youth in South Africa are not using condoms (Stadler and Hlongwa, 2002). The main reason for their non-use of condoms may be that young men often associate condoms with lack of trust in the sexual relationship (ibid). As a result, young men often do not practice safe sex with their steady partners but rather use them when having sexual intercourse with their casual partners (Harrison et al., 2001).

The perception of risk of HIV/AIDS is another contributing factor to condom use. This can be further supported by studies that show that young people who perceive themselves to be at low risk often engage in unprotected sex (Harrison et al., 2001; Varga, 2003; Kaufman et al., 2004). In a study conducted by Harrison et al. (2001) it was found that some young people were completely opposed to the idea of condom use because they perceived no risk of HIV infection, thus indicating the relationship between perceived risk of contracting HIV and condom use.

According to Smith (2004), young people globally and not just in South Africa are not practicing safe sex on a consistent basis either. In Nigeria, for example, young men believe that “if they choose partners of good moral character and if their relationships are founded on love, they face little risk of acquiring HIV infection” (Smith, 2004: 228). As a result, they do not see the necessity for condom use. They are aware of the need for consistent condom use when practicing sex with casual and short term partners or when sexual activity is based on something else and not love (ibid). In Lebanon, Kulczycki (2004) found that men do not use condoms consistently. The study found inconsistent condom use as well as high discontinuation rates.

## **2.8 Barriers to Condom Use**

Hulton et al. (2000) points out that in some settings lack of knowledge about condoms and its importance is another barrier to its use. For example, in Uganda, it was clear that some young men “had never seen a condom, or they had questions indicating that they had never used one or did not use it regularly” (Hulton et al., 2000).



There is also evidence that suggests that young people perceive condom use as interfering with sexual pleasure, as a result this impacts on whether or not a condom will be used during sexual intercourse (Sunmola, 2001). Hulton et al. (2000) revealed that male respondents perceived condom use as reducing sensitivity and pleasure during sexual intercourse. According to Kulczycki (2004) 'encumbering beliefs' about condoms also reduce their use. For example, the belief that condoms are ineffective and may lead to adverse effects can reduce their use during sexual intercourse. Furthermore, socio-religious beliefs prevalent in some societies may deter condom use (Kulczycki, 2004). Other barriers to condom use include their lack of availability and access to facilities providing them. Many communities in South Africa do not have access to clinics, hospitals, and/or shops and as a result they do not have easy access to condoms. (Tillotson and Maharaj, 2001).

A strong emphasis on fertility may also act as a deterrent to condom use. In many societies there are often social pressures from peers, sexual partners and sometimes relatives regarding the importance of reproduction and this pressure often impacts on the practice of unsafe sexual intercourse (Hulton et al., 2000). In Nigeria, children are seen as sustaining lineage, and as a result condoms are not acceptable as they are a form of birth control (Smith, 2004). Some young people find it difficult to negotiate condom use with their partners for a number of reasons including fear of conflict within the relationship, social stigma ascribed to condom use, threat of violence and so forth. A study conducted in Nigeria found that introducing condom use in a sexual relationship was very difficult as it would imply that one did not trust his partner and/or that his sexual behaviour was unfaithful and risky (Smith, 2004). Such attitudes negatively impact on condom use. "Some men stated that when a woman requests condom use... she is demonstrating that she is too experienced" (Smith, 2004: 230). Men often do not regard such women as good and trustworthy sexual partners.

Sometimes women lack power in their sexual relationships; as a result, they do not stand any chance of suggesting the use of condoms during sexual intercourse (Hulton et al., 2000). Hulton et al. (2000) also indicate the unacceptability of preventive methods as another barrier to condom use. A study in Uganda found that men regarded any contraceptive method as the responsibility of women, and therefore did not bother communicating or using condoms during their relationships (Hulton et al., 2000). Also, because condom use is associated more with HIV prevention, the Ugandan young men reported that insisting on its use would result in the dissolution of the sexual relationship (ibid). The lack of ability to negotiate condom use clearly signifies an improper partner communication which is a very important segment of the sexual and reproductive health sphere.

## **2.9 Partner Communication**

One of the main objectives of involving men in sexual and reproductive health is "to promote gender equality in all spheres of life..., to engage and enable men to take responsibility for their sexual and reproductive behaviour and their social family roles" (RHO, 2004: 05). In order for this objective to be achieved there should be an efficient partner communication (Becker, 1996). Partner communication entails disclosure of personal feelings from one sexual partner to another. From the sexual and reproductive health point of view, partner communication includes talking about such aspects as: condom use, STIs, HIV/AIDS, contraception use and ideal number of children and so forth. According to Maman and Medly (2003), partner communication is particularly important during the HIV/AIDS era. True and honest partner communication may enhance trust in sexual relationships. Within the HIV/AIDS context, partner communication may help to motivate a sexual partner to seek an HIV

test, change one's behaviour and as a result contribute to the minimization of the HIV spread (Maman and Medly, 2003).

Maman and Medly (2003) argue that the proper management of HIV may be made easier via efficient partner communication. Thus "for example, women who disclose their status to partners may be more likely to participate in programmes for prevention of HIV transmission from mothers to their infants" (ibid: 07). Many studies indicate that men partake in risky sexual behaviours and therefore, according to Elwy et al. (2002), effective partner communication may contribute towards helping men change their sexual behaviours.

An investigation regarding communication between sexual partners indicated that men would rather talk to other males about STIs than they would to their own partners (Bott and Shah, 1997). In a study conducted in Thailand, Karra et al. (1997) found that 70% of males and 60% of females reported that they communicated about sexual matters with their sexual partners. This represents a relatively high level of partner communication. However, the study found that while most females knew that their partners had extra sexual partners, they could not (or found it very difficult to) initiate a conversation about extra sexual partners, condom use or to initiate sexual intercourse (ibid). In her study in KwaZulu Natal, Varga (1999) found that the relationship between young people was characterized by poor communication. Few discussed with their partners how or when sex would take place, and thus were not prepared for it when it happened. It also contributed to a lack of clarity about personal preferences and expectations.

## **2.10 Awareness of the Risk of Pregnancy**

Increasingly, unwanted pregnancy is seen as a major problem by young people. Early pregnancy is viewed negatively due to the perception that it leads to adverse long-term socio-economic and personal consequences (Varga, 2003). In South Africa, a number of studies report high levels of unwanted pregnancies among young people especially outside of marriage (Kaufman et al., 2001; Preston-Whyte and Zondi, 1992). Garenne et al. (2001) argue that the prevailing teenage pregnancy in South Africa may also be attributed to gender based violence. The findings of a study conducted among young pregnant women in South Africa found that "violence and coercive male behaviour, combined with young women's limited understanding of reproductive biology, directly affected their capacity to protect themselves against unwanted intercourse and pregnancy" (Garenne et al., 2001). The study found that one third of pregnant women reported that they had experienced forced sexual intercourse. According to early studies among young people in South Africa many girls placed a large emphasis on pregnancy. This was linked to the cultural value placed on fertility in African society (Preston-Whyte and Zondi, 1992). However, a number of recent studies show that young people do not necessarily want to fall pregnant at an early age and would prefer to delay childbearing (Kaufman et al., 2001; Varga, 2003).

Furthermore, a number of studies show that young men also want to postpone early childbearing (Kaufman et al., 2001; Varga, 2003). These studies reveal that one of the risks which young men are often fearful of is impregnating girls. Boys and young men who impregnate girls are often faced with the difficulty of social and economic issues such as feeding and clothing the child (Kaufman et al., 2001). Having a child is expensive and is likely to have major consequences especially if the young man comes from a poor family. Sometimes it may

contribute to the father of the child dropping-out of school in order to seek employment.

In a study conducted in KwaZulu Natal, Varga (2003) revealed that boys are fearful of impregnating girls for the following reasons: fear of school disruption, disappointing their parents, financial hardship that would sometimes lead to reduced employment prospects. Social exclusion is another factor which may contribute to young men being fearful of impregnating girls as the father of the child becomes socially isolated from his peers and left to deal with the situation alone. However, some boys want to be fathers because they feel that would prove their virility and the responsibility of caring for a child is seen as an indication of 'a real man'. However, Varga (2003:167) observes that "social pressure to demonstrate masculinity through accepting paternity is largely a rural phenomenon." In Uganda, Hulton et al. (2000) observe that there are strict norms which impact adversely on young men who make adolescent girls pregnant. Often young men have to pay financial charges for impregnating young women. Moreover, some men reported being imprisoned for impregnating girls under 18 years of age (ibid).

Hofferth and Moore (1979) argue that policy makers, parents and educators perceive premature childbearing as disrupting and accelerating the life span of the affected adolescent(s). In this regard, teenage pregnancy is seen as preempting the educational, vocational and social experiences of the teenagers (ibid). Beacon (1974) cited in Hofferth and Moore (1979: 02) argues that "if motherhood occurs very early in life, it is probable that a stress-engendering acceleration of role transitions will lead to ... social pathologies". The future economic state of the adolescent could be at risk following the early childbearing and this could apply to both male and female adolescents. Teenage parents could sometimes be obliged to secure their support means in order to cater for the fact

that they are now parents. An unintended pregnancy could force them into premature and unhappy marriages and low paying jobs (Hofferth and Moore, 1979).

Furstenberg (1976) indicated that adolescents who experience an unintentional pregnancy often struggle as they realize that their life plans become different from those of other adolescents who have not had an unintended pregnancy. Early pregnancy is associated with the disruption of schooling, loss of economic opportunities, marital instability, difficulty in regulating family size and rearing existing children (ibid). Hofferth and Moore (1979) elaborate on this issue by also stating that teenage parents are often subject to social exclusion since they are set apart from their peers and are sometimes estranged from their own families (ibid).

## **2.11 Contraceptive Use**

In the past many adolescents did not use contraception in South Africa. The reasons for this included the high cultural emphasis placed on female fertility particularly in rural areas (Varga, 2003). Therefore, the nonuse of contraception, unprotected sex and high adolescent pregnancy have been (and continue to be) prevalent issues in South Africa (Varga, 2003). However, it is important to note that there has been an increase in awareness and use of contraceptive methods recently. In a study conducted in the former Transkei, Chimere-Dan (1996) found that a large proportion of young people knew and used contraceptives. Almost 91% of young people aged 15-19 years had heard about contraceptives and almost half of these were using a method of contraception. In addition, almost 95% of young people aged 20-24 years had heard of contraceptives and about 70% of them were using contraception. The findings from the 1998 South Africa Demographic and Health Survey also indicate that the contraceptive prevalence



rate is high among all sexually active women aged 15-24, with more than 60% reporting having used contraception (SADHS, 1999).

The majority of young women use injections as their first method of contraception (SADHS, 1999). This can further be supported by Ott et al. (2002) who also found that sexually active youth relied mainly on hormonal contraceptives and condoms, with the majority using the pill and injections as their contraceptive methods of choice. Many adolescents would even combine the use of a condom with a hormonal contraceptive (Ott et al. 2002). The study indicated that less than 10% of sexually active male and female youth were using a combination of two different types of contraceptives (ibid).

## **2.12 Barriers to Contraceptive Use**

The use of a method of contraception is also influenced by place of residence. A study of family planning in Kenya found that rural men were less likely to use a modern method of contraception compared with those living in urban areas (Nzioka, 2001). The high level of contraceptive use in urban areas is attributed to the information, education and communication programmes that are not successfully reaching rural areas. In addition, he argues that the low contraceptive use in rural area may be attributed to the lack of knowledge about a range of methods and their side effects.

In a study about contraceptive use, youth raised concerns that their parents were too conservative and still regarded them as too young. The parents did not discuss family planning and sexually related matters with them (Mfono, 1998). Due to this lack of communication, few adolescents were aware of the need for safety during their practice of sexual intercourse whilst the majority was not. According to the South African Demographic and Health Survey (1999), there

were a number of concerns from women (adolescents and young women) which impacted on their use of contraception. Some women claimed that they did not have sexual intercourse frequently; their partners were opposed to contraception; they did not know of any method of contraception and they feared side effects. In addition, some women felt it was an inconvenience to use contraception and that contraception interfered with their bodies (SADHS, 1999).

Often, boys assumed that their partners were using contraceptives because they still believed that contraceptive use was the female's responsibility (SADHS, 1999). Some boys were concerned however that, girls may discontinue contraceptive use because of beliefs arising from the use of contraception such as, gaining weight (Mfono, 1998). Furthermore, Franklin et al. (1997) posit that there is a lack of consistent information in sex education programmes. For example, "school based clinics appear to improve the general level of health care to students, no significant effects on sexual activity, contraceptive use, or pregnancy rates have been indicated consistently" (Franklin et al., 1997: 552). Gage (1998) asserts that youth are often subject to legal and social restrictions as a result of religious bodies, educational centers, family etc. These limit the amount of information regarding contraception and other related issues that youth are able to receive (Gage, 1998).

The threat of violence may also serve as a major barrier to negotiating contraception. Manzini (2001) found that almost a third of all young females interviewed stated that they were 'persuaded', 'tricked', 'forced' or 'raped' during the first time they had sexual intercourse. As a result, they are less likely to engage in protected sex by using a method of contraception. In their study, Harrison et al. (2001) observed that men exert considerable influence on the nature and timing of the sexual relationships. Women acceptance of male behaviour represents the acceptance of subtle forms of control over them. In their



study, Kaufman et al. (2001) observe that women who are financially independent may be better positioned to negotiate the conditions of their relationship and in particular whether to use contraception, and which methods to employ.

Studies indicated that some unmarried women were purposefully refraining from using contraception so that they could fall pregnant and secure their relationships further (Preston-Whyte and Zondi, 1992). Preston-Whyte and Zondi (1992) observed that young women in the rural KwaZulu Natal areas regarded childbearing as a symbol of success for a woman and that peer pressure was a driving force convincing young women to have children in order to prove their fertility. Many of these young women often believe that childbearing would increase their chances of marrying (Preston-Whyte and Zondi, 1992). However, some young women may not be using contraception because of misinformation or lack of information. For example, some young people believe that a single sexual encounter cannot result in pregnancy. Furthermore, some young girls do not use a method of contraception because of the lack of access to it. Preston-Whyte and Zondi (1992) point out that some parents refuse to allow their daughters to gain free access to clinics that provide contraception. They go on to argue that “the reasons range from moral considerations to a fear that contraception will encourage sexual freedom and experimentation, and in many cases, that will impair future fertility” (Preston-Whyte and Zondi, 1992: 236). Although parents do not want their children to use contraception sometimes, these girls often engage in unprotected sexual intercourse and become pregnant regardless.

### 2.13 Summary

This chapter has explored the experiences, attitudes and practices of young men in relation to various patterns of sexual and reproductive health. An in-depth review of such aspects as, first sexual experience, experiences of STIs, paternal experiences of young men are explored. In this regard, such variables as young men's residential area and their racial affiliation are reviewed as playing a leading role to the latter experiences. Also, young men's attitudes to condom use and practice of contraception at large are analysed; these sub-sections involve different levels that young men are subject to contraceptive and condom use. An exploration on the barriers pertinent to condom use and contraceptive use is also made. With regard to young men's practices, young men's risky sexual behaviour(s) is touched upon as well. The chapter also reviewed the importance of partner communication in relationships. Many studies reveal that youth are aware of the incidence of HIV/ AIDS and are also wary of impregnating girls but are not practicing safe sex.

## Chapter Three

### Theoretical Framework

#### 3.1 Introduction

This chapter outlines the conceptual framework of the study. This research is informed by the following theories, namely the health belief model, reasoned action theory, social learning theory and the AIDS risk reduction model. After reviewing these theories, the conceptual framework for this study will be discussed.

#### 3.2 Health Belief Model

The health belief model maintains that health behaviour is influenced by individual's socio-demographic characteristics, knowledge and attitudes (UNAIDS, 1999). The health belief model serves as an important "conceptual framework for understanding behaviour" (ibid). According to the model, individuals weigh the costs and benefits of a particular behaviour. In order for behavioural change to occur there needs to be:

- Perceived susceptibility to a particular health problem (e.g., "am I at risk for HIV?").
- Perceived seriousness of the condition (e.g., "how serious is AIDS; how hard would my life be if I got it?").
- Belief in effectiveness of the new behaviour (e.g., "condoms are effective against HIV transmission").
- Cues to action (e.g., "witnessing the death or illness of a close friend or relative due to AIDS").

- Perceived benefits of preventive action (e.g., “if I start using condoms, I can avoid HIV infection”).
- Barriers to taking action (e.g., “I don’t like using condoms”) (UNAIDS, 1999).

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

The theory of reasoned action links attitudes to voluntary, unconstrained, temporally proximate behaviours (Wright, 1998). Central to reasoned action theory is the influence that attitudes exert on one’s behaviour and vice versa. According to the reasoned action theory, attitudes are closely linked to a person’s evaluation of a given behaviour (Wright, 1998). The reasoned action theory, like the health belief model, has been used extensively to explain and predict a variety of human behaviours. The reasoned action theory assumes that people are rational entities and therefore consider the implications of their actions before they decide to engage in particular behaviours. Attitudes are a determining factor to undertaking a particular behaviour (UNAIDS, 1999). According to this theory, individuals consider the costs and benefits of engaging in a particular behaviour. If the perceived cost is greater, then the behaviour is less likely to occur. This theory stresses the determining role that personal intention plays in determining whether a specific behaviour will occur. Intention is a function of two major factors: the individual’s attitude towards performing that behaviour and perceived social norms about the behaviour (UNAIDS, 1999).

### **3.4 Social Learning Theory**

According to Bandura (1977), experience and observation affect human’s thoughts and the ultimate behaviour. “Social learning theory approaches the explanation of human behaviour in terms of a continuous reciprocal interaction

between cognitive, behavioural, and environmental determinants. Within the process of reciprocal determinism lies the opportunity for people to influence their destiny as well as the limits of self-direction" (Bandura, 1977: vii). Self-efficacy and outcome of expectancies are the focal principles of the social learning theory. Self-efficacy entails being adamant about implementing a certain behaviour; and outcome expectancies is about an optimistic belief that the embarked upon behaviour will fulfil the intended objective (UNAIDS, 1999: 07). According to Bandura (1977), observation is the crucial if not the major component of the social learning theory. "The capacity to learn by observation enables people to acquire large, integrated patterns of behaviour without having to form them gradually by tedious trial and error" (ibid: 12).

### **3.5 AIDS Risk Reduction Theory**

The AIDS risk reduction model is described as the route through which individuals pass on their way to changing behavior in response to the risk of acquiring HIV/ AIDS (UNAIDS, 1999). There are three stages which are central to the AIDS risk reduction model including behaviour labeling, commitment to change and taking of action. There are three key components to the first stage, *viz.*: knowledge of the sexual activities associated with HIV transmission, belief in personal susceptibility to contracting HIV and belief that having AIDS is undesirable. The second stage is the commitment to change which involves assessing the enjoyment that people perceive out of sexual intercourse (as the leading route of HIV transmission) and relate it to the risk of contracting HIV infection. For example, some people may perceive practicing unprotected sex as pleasurable and the possible pain from contracting HIV infection would not outweigh the pleasurable benefits of unprotected sex. Conversely, some people may be concerned about changes in their state of health and in their economic state if they contracted the virus and relate these changes to their overall

perceptions about HIV/AIDS. Some people may be faced with the challenge of unacceptability or stigma in their societies following their acquisition of HIV/AIDS. The commitment to change behaviour to reduce the risk of HIV infection is based on perceptions of whether the benefits outweigh the costs and also, whether they are capable of changing behaviour. The final stage occurs when the individual takes action to achieve this reduced risk.

### **3.6 Critique**

These theories are not without limitations. Wright (1998: 272) argues that “volitional behaviour” which forms part of the reasoned action theory as one of the limitations of this theory. According to Wright (1998), the fact that volitional behaviour does not require any great skill or social cooperation delimits the theory of reasoned action. Furthermore the specification of effort linking intentions and behaviour greatly enhances the limitation associated with reasoned action theory (Wright, 1998). In addition, since the social phenomena is complex in nature “attitudes may produce behavioural intentions, but these intentions are difficult to enact as successful behaviour” (Wright, 1998: 272). Another limitation associated with the reasoned action theory is that intentions which form part of the theory may change subject to different circumstances at a particular point in time (Wright, 1998). The concept of behaviour is complex, difficult to achieve, often requiring substantial skills, abilities and social cooperation (ibid). This research will draw heavily on the health belief and the theory of reasoned action and will propose a more in-depth conceptual framework.

### 3.7 Proposed Conceptual framework

The conceptual framework for the study incorporates ideas extracted from the health belief model (HBM), the reasoned action theory (RAT) and the social learning theory (SLT). According to these theories, knowledge is an important, if not sufficient condition for behaviour change. According to the theory of reasoned action, individuals are rational beings and as a result, they weigh the costs and benefits before taking action. Behaviour is influenced by a person's attitudes towards performing a particular behaviour. It is proposed that attitudes will influence decision-making and as a result the sexual behaviour choices of young men. Therefore, positive attitudes may impact favourably on their choices and consequent behaviours. However, certain negative attitudes may impact unfavourably on their choices and consequent behaviours. For example, negative attitudes to condoms may serve as a barrier to use. According to the SLT, exposure enables one to observe matters in his environment which leads to one gaining experience. Thus, knowing someone with HIV/AIDS may affect one's attitudes and subsequent behaviours. In addition, an individual's socio-demographic factors such as age, gender, marital status and education also influence knowledge, attitudes and behaviour.



## **Chapter Four**

### **Methodology**

#### **4.1. Introduction**

This chapter provides an explanation of the methods that were employed in the study. This chapter begins by providing a brief description of the context of the study. The study relies on secondary data collected in KwaZulu Natal, South Africa. Finally, the methods used for data analysis and some of the main limitations of the study are discussed.

#### **4.2. The Context**

##### **4.2.1. South Africa**

The country of South Africa lies on the southern tip of the African continent. In total, South Africa constitutes 1.2 million square kilometres and it has a population of approximately 45 million inhabitants (Statistics South Africa, 2005). There are four main racial groups in the country, *viz.*: Africans, Coloureds, Indians and Whites (SADHS, 1999). South Africa is a country of great cultural diversity. There are 11 official languages used in the country. English is one of the most popularly used languages particularly for business and public affairs. Most of the South African population subscribe to the Christian religion.

The population of South Africa is typical of many developing countries. According to the 2001 population census, a fairly large proportion of the population is concentrated in the younger age categories (less than 20 years of age), and a relatively small proportion of people are concentrated in the older



age categories (65 years of age or more) (Statistics South Africa, 2005). Over the past few years there has been a slight improvement in the standards of living in South Africa according to the 2001 population census. For example, in spite of the number of informal dwellers which are recorded to be the same in 2001 as they were in 1996; the overall proportion of households living in formal dwellings (houses, flats and townhouses) rose sharply between 1996 and 2001, with a corresponding decline in the proportion of households living in traditional dwellings. There was also a decline in the number of households living in backyard accommodation (Statistics South Africa, 2005).

The population of South Africa is also faced with the challenge of the HIV/ AIDS epidemic. South Africa is one of the countries with the fastest growing HIV/ AIDS epidemic in the world (Kim et al., 2003). In 2000, about 40% of the deaths among the 15 to 49 year age group were attributed to HIV/ AIDS (ibid: 61). Doherty and Colvin (2004), note that out of the 40% of deaths that occurred in South Africa in 2002, 52% of them were in the KwaZulu Natal province. By mid 2002 there were 688 000 cumulative AIDS deaths in South Africa (Doherty and Colvin, 2004). In the same year there were approximately six million people living with HIV in the country (Doherty and Colvin, 2004). The national prevalence of HIV amongst pregnant women in South Africa was estimated to be 26.5% (Department of Health, 2000). The impact of the HIV epidemic is projected to increase in the next 10-15 years (Manning, 2002). Thus HIV/ AIDS is a prevalent issue that needs to be addressed.

#### **4.2.2. KwaZulu Natal**

KwaZulu Natal is the largest province in South Africa. The province lies on the east coast of the country along the Indian Ocean (Magnani et al., 2005). The 2001 census shows that the province of KwaZulu Natal has 9.4 million inhabitants

(Statistics South Africa, 2005). Africans constitute 84.9% of this population, Coloureds 1.5%, Indians 8.5% and Whites 5.1% (ibid).

Along with high population rates, the KwaZulu Natal population also faces high rates of poverty (Magnani et al., 2001). The South Africa Demographic and Health Survey (1999) reveals that 93% of the 15-19 year old respondents were unemployed, while 81% of the 20-24 year olds were also not employed. Accordingly, there were 65% of respondents who did not have any jobs during the year preceding the survey and all of them originated from KwaZulu Natal (SADHS, 1999). Many areas in rural KwaZulu Natal lack such facilities as: access to public transport, electricity and piped water (Maharaj, 2001). There is a general imbalance in the provision of health services between rural and urban areas in KwaZulu Natal (Cullinan, 2004).

The province of KwaZulu Natal also has one of the highest rates of HIV prevalence. The national antenatal surveillance report stated that HIV among pregnant women in KwaZulu Natal grew from two percent in 1990 to as high as 36% in 2000 before falling slightly to 34% in 2001 (Magnani et al., 2005). Some factors that may contribute to this high HIV/AIDS prevalence in KwaZulu Natal are related to its large ports, which are the busiest in the African continent (Manning, 2002). To facilitate transport back and forth from these ports are truck-routes that head to various business centres throughout the country. Associated with these ports and truck-routes is the high prevalence of sex workers which may potentially be contributing to the continual and rapid spread of HIV/AIDS in KwaZulu Natal.

#### **4.2.3. The Study Sites**

This study relies on data from the Transitions to Adulthood survey conducted at two sites in KwaZulu Natal, i.e. the Durban metro and Mtunzini magisterial districts. These districts were purposively selected to include urban, transitional, and rural areas within the province (Macintyre et al., 2004). Durban Metropolitan is mainly an urban area and has a population of approximately three million inhabitants (Durban Metro Council, 1998). The Mtunzini district which is located on the north of Durban, has a population of approximately 640 000 (Statistics South Africa, 2005).

#### **4.3. Research Methodology**

The study relies on quantitative methodology. Babbie and Mouton (2001) describes the quantitative methodology as the medium for describing data in a manageable form. The quantitative methodology thus entails “drawing conclusions about a population from the study of a sample drawn from it” (Babbie and Mouton, 2001: 458). Through the use of quantitative methodology, single variables can be described while the association between different variables can also be explored (ibid).

Quantitative research methodology saves time. As opposed to qualitative research methodology that can be impossible to be repeated if an error has occurred since the event under study might no longer exist; quantitative research methodology may be repeated should a mistake arise (Babbie and Mouton, 2001: 393). The quantitative methodology is regarded as less intrusive than the qualitative methodology. According to Babbie and Mouton (2001), this means that the researcher seldom has any effect on the subject being studied. The statistical expressions featuring in quantitative analysis provide the analysis with

an aura of scientific respectability; and “the analyses appear to be based on objective laws rather than the values of the researcher” (Denscombe, 1998: 204). Because the findings of the quantitative study are based on measured quantities rather than impressions, the study is able to provide a sound description and analysis of results. Quantitative studies are about tables and charts which can succinctly and effectively organise data and provide an easy presentation of findings (Denscombe, 1998).

Nevertheless, quantitative studies are not without disadvantages. The secondary data that is used through quantitative methodology is often subject to biases. These biases can sometimes be rectified by means of cleaning the data; but there can still be unrecognised biases that can complicate the interpretations and the ultimate findings of the research process (Alreck and Settle, 1985). This is supported by Babbie and Mouton (2001) who observe that irrespective of how carefully the data may have been collected, errors are inevitable. During the secondary data processing, “these errors may result from incorrect coding, incorrect reading of written codes, incorrect sensing of blackened marks and so forth” (Babbie and Mouton, 2001: 417). Alreck and Settle, (1985) note that interpreting the statistical tables and graphical expressions can be difficult if the categories are too many. The quantitative researcher can sometimes recode the data to suit his/her objectives, but some information can be lost during the process. This is particularly the case when “there are a very large number of scale points or values for the variable” (Alreck and Settle, 1985).

#### **4.4. Research Strategy**

This study relies on the secondary data (quantitative data) from the 2001 Transitions to Adulthood survey conducted in KwaZulu Natal among 14 to 24 year olds. The transition to adulthood survey was undertaken in two rounds,

one in 1999 and the other one in 2001. This research project was conducted jointly by the School of Development Studies at the University of Natal in Durban, the Horizons Project, Policy Research Division of the Population Council and Focus on Young Adults and MEASURE / Evaluation Project of Tulane University in New Orleans. In 1999, interviews were completed from 1 974 households in 117 of the selected segments; in most cases, the head of the household responded to the household questionnaire (Magnani et al., 2004). Prior to the survey, 118 enumeration areas were selected from a sampling frame consisting of all census enumeration areas (CEAs) in the two districts using a systematic-random sampling procedure with probability proportion-to-size (Magnani et al., 2004). Within the delineated areas, sample households were selected using a modified stratified multistage cluster sampling approach (ibid). The field supervisors were responsible for this exercise and they performed it based upon counting "households undertaken as a preliminary field operation" (Macintyre et al., 2004: 241). In 2001, the second wave of the survey was conducted which comprised of individual interviews with all young people (aged 14-24 years old) in these households (Magnani et al., 2004: 13). The objective of the 2001 survey was to interview the same individuals who were interviewed in 1999 in order to capture possible changes in their lives over time. Thus, this involved multiple call-backs, identifying youth who had moved but still remained within Durban Metro or Mtunzini districts. This process entailed even sending interviewers out of the study area in order to try and contact youth who had migrated (ibid: 14). In 2001, there were 2 349 households and 4 185 individual interviews conducted.

The survey collected information on a broad range of topics including: socio-demographic characteristics, education and work history, knowledge of and attitudes towards condoms, as well as pregnancy history and sexual and contraceptive behaviour (Magnani et al., 2005). Interviews were conducted by a field worker of the same race and sex as the respondents (Macintyre et al., 2004:



241). The research team made every effort to ensure confidentiality during the collection of all notes and completed questionnaires. Only identification numbers (and no names) were recorded on the questionnaires and data files. During the survey, interviewers obtained informed consent for both household and youth interviews. For those who were under 16 years of age, parental consent was elicited. Attempts were made to ensure privacy by conducting the interviews in a private room when possible or even going outside. The data collection for this survey was conducted between September and December of the 2001.

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

During the initial stages of the data analysis, descriptive analysis was conducted in order to identify particular variables of interest. In order to determine the association between the dependent variable and the major explanatory variables, a bivariate analysis was used. The bivariate analysis was undertaken through the use of chi-square tests in order to establish the relationships between the chosen variables. A number of socio-economic and demographic characteristics were found to influence the likelihood of contraceptive and condom use including age at last birthday, race, relationship status and years of schooling. The chi-square test was used to test the statistical association between variables. In addition, the study relied heavily on the multivariate technique of logistic regression. The multivariate logistic regressions were used to explore factors associated with contraceptive use among sexually experienced young men.

On the one hand, one of the outcome variables was the use of a method of contraception. Respondents were asked if they or their partner had used a method to prevent pregnancy the last time they had sex. Respondents who reported that either they or their partner were using any method for preventing pregnancy were regarded as using a method to prevent pregnancy and all other

respondents were regarded as non-users. On the other hand, one of the outcome variables was consistent condom use with most recent sexual partner. Respondents were asked how often they used a condom with their most recent sexual partner. They were also asked the main reason for condom use. Respondents who reported using condoms always were regarded as consistent condom users and all other respondents were regarded as inconsistent users.

The SPSS package (Statistical Programme for Social Scientists) was used for analysing the quantitative data. For the purposes of this paper, the analysis was limited to boys and young men aged 14 to 24 years. Thus the primary data set was filtered to cater for the latter.

#### **4.6. Limitations of the Study**

Many people regard sexual matters as highly sensitive and private. Therefore, some respondents may feel "intensely embarrassed or threatened when asked to reveal what they do, think, and feel during their sexual encounters" (Catania et al., 1990: 340). Also, there may be a possibility of respondents giving socially desirable responses. According to Catania et al. (1990), gathering information on sexual matters is subject to measurement error. Catania et al. (1990) argue that "measurement error is of critical concern to AIDS research" (ibid: 340). High levels of measurement error may distort estimates of high-risk sexual practices and, consequently, weaken behavioural epidemiological work. If, for example, large percentages of heterosexuals over-report condom use, the predictions of the spread of HIV in the heterosexual population will be underestimated. Gathering information on sexual matters is also subject to participation bias. Numerous factors may serve as barriers to participating in the study. Catania et al. (1990) point out that: privacy, embarrassment and fear of reprisals are some of the reasons that may motivate people to conceal their true sexual behaviour.



Moreover, it is possible that some respondents have trouble recalling how often and with how many people they have had sexual relationships (Catania et al., 1990).

## **Chapter Five**

### **Data Analysis**

#### **5.1 Introduction**

In this chapter, quantitative data is presented and analyzed. The basic socio-demographic characteristics of the sample are described in order to provide the basic background information. The chapter further explores the knowledge, attitudes and behaviours of boys and young men in the sample. The factors which influence the protective behaviours of these young men are also explored.

#### **5.2. Socio-Demographic Characteristics**

The sample was restricted to 1985 boys and young men aged 14 to 24 years. The sample reflected the demographic profile of the population of the province of KwaZulu-Natal. Of the sample, 75.3% were African, 18.3% Indian, 2.2% Coloured and 4.2% White. The sample was relatively young with almost 68% under the age of 20 years. The level of education of the sample was relatively high with the vast majority of respondents having attained at least a secondary school education. Few respondents had no schooling. Less than one percent of respondents had never been to school.

The majority of respondents (66.1%) subscribed to the Christian religion. Other religions were not well-represented in the sample. More than 10% subscribed to the Hindu religion while 1.6% respondents subscribed to the Muslim religion. Almost 20% of respondents reported belonging to other religious groups. Interestingly, the highest proportion of the sample was single. Only 47.8% reported that they were in a steady relationship.

**Table 5.1: Socio-demographic characteristics of the sample**

Characteristic	%
Age	
14-16	27.9
17-19	40.1
20-24	31.9
Race	
African	75.3
Coloureds	2.2
Indians	18.3
Whites	4.2
Years of Schooling	
None	0.3
<8	21.2
8+	78.5
Religion	
Christian	66.1
Muslim	1.6
Hindu	11.8
Other	20.6
Sexual Relationship Status	
Single	52.3
Steady	47.8
Sexually Active	
Yes	60.9
No	39.1
Number of Sexual Partners	
0	11.9
1	53.1
2+	34.9
Don't Know	0.2
N	1985

NB: Totals may not tally because of rounding off

The respondents were asked if they ever had sexual intercourse in the last twelve months preceding the survey; and those respondents who responded *yes* to that question were regarded as sexually active. Almost 61% of respondents were sexually active with the median age of first sexual intercourse of 15 years. The majority of youth reported that they had only one sexual partner. Interestingly, it was discovered that more than one third of respondents had more than one sexual partner. There were two respondents who reported that they did not know the number of sexual partners they had ever had. This response may be construed to mean that those respondents had many and/or frequently changed sexual partners, as they could not even remember the number of sexual partners they ever had.

### **5.3. Awareness of HIV/AIDS**

Awareness of HIV/AIDS was high, with the majority having heard of it. When respondents were asked whether they had heard of HIV/AIDS almost all of them (99.7%) responded that they had heard of it. There were various responses from these respondents that showed that they were fairly well informed about HIV/AIDS. In general, respondents had a fairly good knowledge of the routes of HIV/AIDS transmission and precautionary measures.

A large number of respondents were aware that HIV/AIDS is largely transmitted through sexual intercourse. Out of 1938 respondents, 73.6% of them reported that HIV/AIDS is transmitted through sexual intercourse. Almost 18.2% of respondents also reported that HIV/AIDS could be transmitted or contracted through blood or blood products such as, blood transfusion, accident etc. Only 5.3% of respondents reported drug use to be one of the main routes of HIV/AIDS transmission. A few respondents also mentioned mother-to-child transmission during pregnancy, birth and breastfeeding. The rest of respondents

reported other means through which HIV/AIDS may be transmitted such as insect bites, sharing shaving material and using an infected person's toothbrush. There are some common myths about routes of transmission of HIV/AIDS that are held by young men. These may serve as a barrier to protection.

Some commentators argue that the behaviours of young men are regarded as playing a pivotal role in the course of the HIV/AIDS pandemic (Karim et al., 2003). It is therefore important to determine whether or not young men are aware of any precautionary measures to prevent HIV/AIDS. Awareness of precautionary measures to protect against HIV/AIDS is also high. Almost 98% of respondents knew that people could protect themselves against HIV infection. Of those who knew that people could protect themselves, almost 71% of young men identified condoms as the method of protection against HIV infection. Some respondents (26.4%) mentioned abstinence as one of the methods for preventing HIV/AIDS. A few respondents (2.3%) also mentioned avoiding contact with infected blood. These respondents stressed the need to use sterilized needles.

Many young men deny the fact that they are at high risk of contracting HIV. An overwhelming majority of young men (92.3%) perceived little or no risk of HIV infection. Only 3.4% and 4.3% respondents perceived themselves to be at medium and high risk of HIV infection respectively. There were only three respondents who did not know whether they were at risk of contracting HIV or not and were therefore categorized as *other*. The low perception of risk of HIV infection is probably because the vast majority of young men had not been tested for HIV/AIDS. When respondents were also asked if they had ever been tested for HIV, only few (10.1%) responded that they tested for HIV.

**Table 5.2: Awareness of HIV/AIDS**

	%
Heard of HIV/ AIDS	
Yes	99.7
No	0.3
Routes of HIV Transmission	
Sexual intercourse	73.6
Drug use	5.3
Blood and blood products	18.2
Mother to child transmission (MTCT)	0.5
Other	2.1
Methods of HIV/ AIDS Prevention	
Condom use	71.0
Abstinence	26.4
Blood and blood products	2.3
Other	0.3
Perceived Risk of Contracting HIV	
No risk	65.7
Small risk	26.6
Moderate risk	3.4
High risk	4.3
Other	0.2
Ever had HIV/ AIDS Test	
Yes	10.1
No	89.9
N	1985

#### **5.4. Attitudes towards People Living with HIV/AIDS**

Respondents were asked if they knew anyone with HIV/ AIDS. The vast majority of them did not know anyone with HIV/ AIDS. Only 11.1% reported that they knew someone with HIV/ AIDS. In most cases, this was an acquaintance, friend or distant relative. Few respondents reported that they knew a close family

member who was living with HIV/ AIDS. Respondents were also asked if they personally knew anyone who died of AIDS. Almost one third of respondents stated that they personally knew someone who died of AIDS. However, only seven percent reported the person who died of AIDS was a close family member. This is not surprising since the stigma associated with HIV/ AIDS may also affect the families of people living with HIV/ AIDS.

**Table 5.3: Experiences with HIV/AIDS**

	%
Know someone with HIV/ AIDS	
Yes	11.1
No	88.9
Know someone died of HIV/ AIDS	
Yes	33.6
No	66.4
Perceived Community Treatment to HIV/ AIDS Sufferers	
Worse	28.9
Same	41.7
Better	4.9
Other	24.5
N	1985

In order to determine the community’s reactions to people with family members who had died of AIDS, respondents were once again asked to express their perceptions regarding how they felt the community treated families who lost members due to AIDS. More than 40% of respondents (41.7%) felt that they were treated the same by the community while 28.9% felt that they were treated worse by the community. Only a minority of about 5% felt that families were treated better in their community. The remaining 24.5% respondents stated that they were not aware of any families who had lost someone to AIDS; as a result they were not able to comment on how those AIDS victims were treated by the community.



## 5.5 Stigma Associated with HIV/AIDS

In general, stigma involves a spoiled identity or social category that is often sustained by certain individuals particularly those suffering from certain illnesses (Fife and Wright, 2000). Often the severity of the illness determines the results of stigmatization. This frequently stems from the fact that people with illnesses are less able to partake in normal social life, resulting in them becoming isolated and rejected; and, "the more severe the illness the greater the difficulty in concealing the illness and the more obvious the individual's differences become to others" (ibid: 63). There are dimensions which are often associated with stigma including social rejection, internalized shame, social isolation and financial insecurity (Fife and Wright, 2000).

The stigma attached to HIV/AIDS involves among other things people avoiding contact with the people living with HIV/AIDS. This often involves reluctance in sharing amenities, foodstuffs etc. with HIV/AIDS sufferers, including isolating them from social groups and even from homesteads. Recently, there has been a widespread belief that HIV infection could be transmitted through sneezing or coughing (Lane, 2002). This perception may further perpetuate the exclusion and hence the stigmatization of people living with HIV/AIDS.

Respondents were asked about their perceptions of somebody who is infected or who they suspected is infected with HIV. Overall, respondents demonstrated highly favourable attitudes towards people living with HIV/AIDS. It would seem from the responses in Table 5.4 that respondents do not discriminate against people living or suspected of living with HIV/AIDS. For example, more than 80% of boys and young men stated that they would not mind sharing amenities like toilets, rooms, utensils etc. with HIV positive people. It is

interesting that very few respondents held negative perceptions of people living or suspected of living with HIV/ AIDS. Less than five percent of respondents felt that HIV/ AIDS sufferers should be chased away from home or excluded from social groups. Interestingly, more than 90% also felt that they will sustain their friendship with a person living with HIV/ AIDS.

**Table 5.4: Stigma related matters**

Reaction towards people living HIV/ AIDS	%
Sit next to a person with HIV/ AIDS	96.2
Touch or hug a person with HIV/ AIDS	93.4
Share a bed with (no sex) with HIV+ person	76.5
Share kitchen utensils with HIV+ person	76.2
Share food with an HIV+ person	74.8
Believes that HIV+ person should be allowed to go to school	76.1
Help someone with HIV/ AIDS to toilet	92.4
Bathe someone with HIV/ AIDS	88.9
Ask HIV+ relative to leave house	2.8
Use same toilet as HIV+ person	88.9
Feed someone with HIV/ AIDS	95.9
Sustain friendship with HIV+ person	95.5
Work together with HIV+ person	95.7
Exclude HIV+ person from group	4.7
N	1985

## 5.6 Sexually Transmitted Infections (STIs)

STIs are closely linked to the incidence of HIV/ AIDS. Therefore, it is important that young people are aware of STIs and the possible means to avoid them. Many studies have shown that STIs may lead to infertility and even HIV/ AIDS if left untreated (Sangani et al., 2004; Moore et al., 2004). In the current study, respondents were asked if they had ever heard of STIs other than HIV/ AIDS. Knowledge of STIs was relatively high, with almost 53% of respondents reporting that they had heard of it. When asked about whether they had ever

had STIs, the majority of respondents reported that they had never had an STI. Only 12.7% of sexually active respondents reported having ever had an STI.

Those respondents who ever had STIs were asked whether they had received any treatment for it. Respondents mentioned various sources in this regard. The majority of respondents (80.7%) mentioned that they obtained treatment from the clinic, hospital or private doctor. A large proportion (12.4%) responded that they obtained treatment from the traditional healer. Few respondents (3.9%) reported to have received treatment from the pharmacy.

**Table 5.5: Awareness of STIs**

	%
Heard about STIs (besides HIV/ AIDS)	
Yes	52.3
No	47.7
Ever had an STI	
Yes	12.7
No	87.2
Source of Treatment for STI	
None	3.1
Pharmacy	3.9
Health Facility	80.7
Traditional healer	12.4
N	1985

## 5.7 Knowledge of Family Planning

Knowledge of methods of family planning is “an essential first step for their acceptance and subsequent use” (Maharaj, 2001: 252). In order to determine their knowledge of methods of family planning, respondents were asked the following question: “Which family planning methods do you know to avoid getting pregnant?” The majority of respondents were able to identify at least one method

of family planning. Only two percent of respondents had not heard of a method of family planning. The majority of respondents were more likely to report knowledge of modern than traditional methods of contraception (see Table 5.6). The most popular method of family planning was the condom, followed by the pill and injectables. Noteworthy also is that almost eight percent of respondents identified the female condom as a method of family planning. Only few respondents identified traditional methods of family planning. Another traditional method of family planning which a substantial number of respondents mentioned was abstinence.

**Table 5.6: Awareness of family planning**

	%
Heard about Family Planning	
Yes	98.0
No	2.0
Heard of Particular Family Planning Methods	
Pill	51.1
Injection	34.5
Male Condom	81.7
Female Condom	7.6
Traditional Medicine	0.3
Non-penetrative Sex	0.9
Abstinence	3.4
Withdrawal	0.6
Other	0.8
Source of Information on Family Planning	
Radio	45.4
Television	47.9
Newspaper/Magazine	37.6
N	1985

Respondents were asked about the source of information on family planning. They all mentioned that they obtained information from multiple sources.

However, the main source of information on family planning was the mass media. Almost half of youth reported that they had heard of family planning on the radio and television. The most important source of information on the television was a programme called 'Soul City'. In addition, 37.6% of young men reported that they had obtained information on family planning from the newspaper and 43% reported that they had obtained information from posters and billboards.

### 5.8 Knowledge of Pregnancy Risks

Young people, particularly males, are often subject to the lack of experience about pregnancy related matters such as the menstrual cycle and the period of greatest risk of pregnancy. Some young people subscribe to the myth that a girl cannot fall pregnant after one sexual encounter. During the primary data collection for this study, respondents were asked the following questions: *what time of the month do women have the greatest chance of falling pregnant? And, do you think that girls may fall pregnant after having sex only once?*

Most respondents had limited knowledge about the risk of pregnancy. More than one third of respondents did not know which part of the monthly cycle a woman has the greatest chance of becoming pregnant. In addition, almost 15.2% reported that women have the same chance of falling pregnant all the time. The large majority of respondents (19%) responded that a woman has a higher chance of falling pregnant in the middle of her menstrual cycle. Other respondents (13.2%) suggested that a woman has higher chances of falling pregnant immediately after her menstrual cycle begins. Only few (13.9%) respondents suggested that a woman has higher chances of falling pregnant during her menstrual cycle.

**Table 5.7: Knowledge of pregnancy risks**

Statement	%
Time of the month a woman has greatest chances of falling pregnant	
In the middle of her cycle	4.3
During her period	13.9
Immediately after her period	13.2
Just before her period begins	19.0
Same chance	15.2
Don't Know	34.8
A girl can fall pregnant after having one sexual encounter	
Yes	83.3
No	12.9
Don't Know	3.7
N	1985

Young people were asked: "if you discovered your partner was pregnant, would that be a big problem, a small problem or no problem for you?" A large majority (70.5%) of respondents responded that the pregnancy would pose a big problem for them. Only 13.7% of the respondents reported that pregnancy of their partners would not be a problem for them. In addition, 14.5% of respondents stated that pregnancy would pose a small problem for them. Less than one percent of respondents stated that they did not know if the pregnancy would pose a problem for them. In addition, some youth reported that they could not have any children.



**Table 5.8: Perceptions of pregnancy, ideal number of children and age at first birth**

	%
Perception of pregnancy as problematic	
Big problem	70.5
Small problem	14.5
No problem	13.7
Other	
1.3	
Ideal number of children	
1	8.0
2	49.2
3	23.3
4	13.1
5+	5.1
Age of first birth	
16-19	1.4
20-30	80.4
31 +	5.2
Other	13.0
N	1985

Respondents were asked about the ideal number of children they would prefer. The majority of respondents (49.2%) reported that they would like to have two children. In addition, almost 19% of respondents reported that they would like to have more than two children. Few respondents (8%) reported wanting only one child. The age of first birth is important as it has long-term socio-economic consequences. Respondents were asked about the ages at which they would prefer to have their children. Less than two percent (1.4%) of respondents reported wanting to have their first child before age 20. The majority of respondents (80.4%) wanted to have children between the ages of 20 and 30. At least 5.2% of respondents wanted to have children at ages 31 and above. About



12.5% stated that they would like to delay childbearing until they were financially secure.

**5.9 Partner Communication**

Partner communication is regarded as important for positive reproductive health outcomes. Respondents were asked if they had talked to their partners about specific reproductive health issues. Overall, partner communication was high. The majority of young men reported discussing a range of sexual and reproductive health issues with their partners. More than 70% reported discussing avoiding pregnancy, HIV/AIDS and STIs with their partners. In addition, more than 70% reported having discussed condom use with the partner. However, the proportion of young men who reported discussing delaying sex with their partners was substantially lower. Only 43.2% of young men reported that they had ever talked about delaying sexual intercourse with their partners.

**Table 5.9: Partner communication about a range of topics**

Topic	%
Delaying sex	43.2
Avoiding pregnancy	75.3
Condom Use	79.7
Avoiding HIV/ AIDS	79.1
Avoiding STIs	72.4
N	1985

## 5.10 Ever and Current Use of Family Planning

Knowledge of family planning methods by itself does not automatically translate into use (Gage, 1998; Magnani, et. al., 2001). The majority of respondents did not use any contraceptive method to prevent pregnancy during the first time they had sex. Only 30.3% of the respondents reported that they used contraception to prevent pregnancy the first time they had sexual intercourse. Respondents were more likely to report male methods of contraception.

**Table 5.10: Contraceptive use by sexually active respondents**

	%
Used a Method at First Sexual Intercourse	
Yes	30.3
No	69.7
Method Used at First Sexual Intercourse	
Pill	5.5
IUD	0.3
Injection	1.6
Male Condom	91.2
Non-penetrative Sex	0.3
Abstinence	0.3
Used a Method at Last Sexual Intercourse	
Yes	68.2
No	31.2
Don't Know	0.6
Method Used at Last Sexual Intercourse	
Pill	7.3
IUD	0.6
Injection	4.3
Male Condom	88.4
Female Condom	0.4
Withdrawal	0.3
Don't Know	0.8
N	1985

The method which the respondents reported to commonly use was the condom. Respondents who had sexual intercourse in the past 12 months were asked if: “the last time you had sex with him/her, did you or your partner use or do something to prevent pregnancy?” Almost 68% of youth reported that they used a method to avoid pregnancy. The main method used was the condom with about 88.4% reporting having used it in their most recent sexual encounter. Some respondents (7.3%) mentioned using the pill as their contraceptive method to prevent pregnancy. A minority of respondents reported using other methods including the withdrawal method. Few respondents answered ‘don’t know’ to the question. This was probably because their partner was using the method and they (as partners) were not communicating about it.

Table 5.11 explores contraceptive use at last sexual intercourse by selected background characteristics. The results of the bivariate analysis show that contraceptive use increases with age. However, this relationship was not significant. In addition, rural men were significantly more likely than urban men to report using a method of contraception. In addition, non-African respondents were significantly more likely to be currently using contraception as opposed to the African reference group. The level of education was strongly associated with the level of contraceptive use. Men with higher levels of education were more likely to report using a method of preventing pregnancy. Also, men who were not in steady relationships were more likely to use a method to prevent pregnancy than men in steady relationships. There is a significant decline of contraceptive use with the increase in number of sexual partners. Men with one partner were significantly more likely than men with more than one partner to use a method of contraception. No association was found between contraceptive use and perception of risk of pregnancy.

**Table 5.11: Contraceptive use at last sexual intercourse by selected characteristics**

Characteristic	%
Age	
14-16	66.7
17-19	68.7
20+	69.9
Place of Residence	
Rural	70.3*
Urban	63.2
Race	
African	65.9*
Other	81.8
Years of Schooling	
<8	43.0
8+	72.2*
Sexual Relationship Status	
Single	76.3
Steady	66.2*
Number of Sexual Partners	
1	71.3
2+	64.4*
Perceived Risk of Pregnancy	
No	65.7
Low	69.5
High	69.4
N	1985

\*Significant at  $p < 0.05$

Table 5.12 shows the adjusted and unadjusted results of the logistic regression for contraceptive use. According to the bivariate logistic regression, years of schooling emerge as the dominant predictor of contraceptive use. Men with higher levels of schooling have higher odds of using a method of preventing

pregnancy than men with lower levels of schooling. In addition, single men are 1.65 times more likely than men in steady relationships to use a method of contraception. However, men with two or more sexual partners have significantly decreased odds of using contraceptives.

**Table 5.12: Odds ratios of contraceptive use at last sexual intercourse by selected characteristics**

Characteristics	Unadjusted	Adjusted
Age		
14-17	1.00	1.00
17-20	1.10	0.90
20+	1.16	0.95
Place of Residence		
Rural	1.00	1.00
Urban	0.73*	0.82
Race		
African	0.43*	0.61*
Other	1.00	1.00
Years of Schooling		
<8	1.00	1.00
8+	3.45*	3.37*
Sexual Relationship Status		
Single	1.65*	1.68*
Steady	1.00	1.00
Number of Sexual Partners		
1	1.00	1.00
2+	0.73*	0.77
Perceived Risk of Pregnancy		
No	1.00	1.00
Low	1.19	1.11
High	1.19	1.19

\*Significant at  $p < 0.05$

Somewhat surprising, men living in rural areas had greater odds of using a method of contraception than their urban counterparts. Table 5.12 also shows that perception of risk of pregnancy is not significantly related to contraceptive use. After controlling for the other variables, this relationship remains unchanged. However, place of residence and number of partners was no longer a significant predictor of contraceptive use.

### **5.11 Awareness of Condoms**

According to Hock-Long et al. (2003), increased use of condoms has contributed to a decline in adolescent pregnancy rates in many western countries. Access to condoms may influence their use. Respondents were asked if they knew of a place where one could get condoms. Awareness of a source of supply of condoms was almost universal. Almost 98% of respondents reported that they knew of a place where one could get condoms. The most commonly cited source of supply of condoms was the health facility. Respondents stated that they obtained condoms from hospitals, clinics, pharmacies and doctors. A substantial proportion of respondents also identified shops as an important source of supply of condoms. Few respondents mentioned other condom supplying sources.

The majority of respondents were very confident about accessing condoms. Almost 79% of respondents felt very confident about getting a condom if they needed one. Almost 10% were somewhat confident with regard to accessing condoms, while 11.6% of them were not confident about accessing condoms at all. In addition, the majority of respondents (65.7%) were very confident about their ability to use condoms. However, 14.9% were somewhat confident about their ability to use condoms and 19.4% were not confident about their ability to use condoms. Despite the easy access to condoms, a large proportion of respondents were not sure about their ability to use condoms correctly.

5.12 Attitude to Condoms

In general, attitudes to condoms were relatively positive. Respondents seem to be divided about whether or not carrying a condom makes sex look as if it is planned. The majority (58%) disagreed that carrying condoms makes it look as if sex is planned. However, almost 41% agreed that carrying condoms makes it look as if sex is planned. Few respondents felt that it is embarrassing to buy or ask for a condom. The majority of respondents (83%) disagreed with the statement that “it is embarrassing to buy or ask for a condom.” Only 34.5% respondents agreed that condoms reduce sexual pleasure. However, it is worth noting that almost 52% respondents disagreed with the statement that condoms reduce sexual pleasure.

**Table 5.13: Percentage of respondents who agree with specific statements about condoms**

Statement	%
Carrying condoms is difficult because it makes it look as if one has planned to have sex.	40.9
It is embarrassing to buy or ask for condoms	17.2
Using condoms reduces sexual pleasure.	34.5
When a relationship moves from casual to serious, it is no longer necessary to use a condom.	28.0
A woman loses a man’s respect if she asks him to use a condom	12.1
Using a condom is a sign of not trusting your partner.	23.5
N	1985

Almost 28% agreed that condoms are not necessary in a serious relationship. However, the vast majority of respondents (71%) disagreed with the statement that “when a relationship moves from casual to serious, it is no longer necessary to



use a condom". In addition, only 23.5% agreed that using a condom is a sign of not trusting a partner while 76% disagreed with the statement that using a condom is a sign of not trusting a partner. Some young men held negative perceptions about women who suggest condom use. Almost 12.1% of young men stated that a woman loses a man's respect if she asks him to use a condom.

### **5.13 Condom Use**

Respondents who had sexual intercourse in the past 12 months were asked if they had used the condom at their last sexual encounter. Condom use was relatively high as almost 67% reported used it the last time they had sexual intercourse. The main reason for using condoms was prevention of pregnancy and STIs/HIV. Almost 63% of young men reported using condoms for dual protection against the risk of pregnancy and STIs/HIV. Interestingly, condom use seemed to be influenced more by the desire to prevent pregnancy than preventing diseases. Almost one quarter of respondents reported using condoms for preventing pregnancy, compared with only 8.9% of those who reported using condoms for preventing STIs/HIV. Those respondents who had used condoms were asked: "the last time you had sex, who made the decision to use a condom?" A slight majority (47.6%) stated that they made the decision to use a condom. However, 46.3% stated that they made the decision to use a condom jointly with their partner. Only few respondents (6.1%) reported that their partner made the decision to use a condom. The overwhelming majority of respondents stated that they felt very confident that they could convince their partner to use a condom if they wanted to use one. Only 8% of young men did not feel confident about convincing their partner to use a condom. However, condom use is not consistent (as shown in Table 5.14) although over half of the respondents stated that they used the condom always. It is worth pointing out

that 10.5% reported that they usually use the condom and 10.6% reported using the condom sometimes or rarely.

**Table 5.14: Condom use with most recent sexual partner**

	%
Condom Used at Last Sexual Intercourse	
Yes	66.7
No	33.3
Main Reason for Condom Use	
Prevention of Pregnancy	23.9
Prevention of STIs/HIV	8.9
Prevention of Pregnancy and STIs/HIV	62.9
Other	4.3
Decision to Use Condoms	
Self	47.6
Partner	6.1
Both	46.3
Consistency of Condom Use	
Always	55.7
Usually	10.5
Sometimes	9.8
Rarely	6.2
Never	17.7
N	1985

### 5.14 Determinants of consistent condom use

Table 5.15 shows the percentages of sexually active respondents who consistently used condoms by selected socio-demographic characteristics. Consistent condom use does not vary drastically by age group. The African men were significantly less likely than men from other race groups to report consistent condom use. Rural men were significantly more likely than urban men to use condoms

consistently. The number of years of schooling is positively associated with consistent condom use.

**Table 5.15: Consistent condom use by selected characteristics**

Characteristic	%
Age	
14-18	50.9
17-21	58.5
20+	54.3
Place of Residence	
Rural	57.7*
Urban	49.4
Race	
African	53.7*
Other	65.2
Years of Schooling	
<8	32.3
8+	58.9*
Sexual Relationship Status	
Single	64.2
Steady	56.7*
Number of Sexual Partners	
1	58.1
2+	52.0*
Perceived Risk of Pregnancy	
No	48.5
Low	55.7
High	58.1*
Perceived Risk of HIV Infection	
No	62.6
Low	52.2
High	29.5*

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\*Significant at  $p < 0.05$

Consistent condom use increased with the number of years of schooling. Men with eight or more years of schooling were more likely than men with less than eight years of schooling to report consistent condom use. In addition, single men were significantly more likely than men in steady relationships to report consistent condom use. However, men with two or more partners were significantly less likely to report consistent condom use than men with only one sexual partner. Interestingly, as the perception of pregnancy as a problem increases, the level of consistent condom use also increases. However, the opposite is also observed, that: as the perception of risk of HIV infection increases consistent condom use declines.

Table 5.16 shows the odds ratios of consistent condom use with most recent sexual partner by selected characteristics. According to the bivariate logistic regression, years of schooling emerge as the dominant predictor of consistent condom use. Men with higher levels of schooling have higher odds of consistent condom use than men with lower levels of schooling. In addition, single men are 1.59 times more likely than men in steady relationships to use condoms consistently. However, men with two or more sexual partners have decreased odds of consistent condom use. The perception of the risk of pregnancy significantly influences consistent condom use. The odds of consistent condom use are 1.48 times higher among men who perceived pregnancy as a problem than men who did not. The odds of consistent condom use decrease as the perception of the risk of HIV infection increases. After controlling for the other variables, this relationship remains unchanged. However, the number of sexual partners was no longer a significant predictor of consistent condom use.

**Table 5.16: Odds ratios of consistent condom use with most recent sexual partner by selected characteristics**

Characteristics	Unadjusted	Adjusted
Age		
14-19	1.00	1.00
17-22	1.36	0.93
20+	1.14	0.84
Place of Residence		
Rural	1.00	1.00
Urban	0.72*	0.72*
Race		
African	0.62*	0.93
Other	1.00	1.00
Years of Schooling		
<8	1.00	1.00
8+	3.00*	3.41*
Sexual Relationship Status		
Single	1.59*	1.64*
Steady	1.00	1.00
Number of Sexual Partners		
1	1.00	1.00
2+	0.78*	0.91
Perceived Risk of Pregnancy		
No	1.00	1.00
Low	1.34	1.34
High	1.48*	1.44*
Perceived Risk of HIV Infection		
No	1.00	1.00
Low	0.65	0.60
High	0.25*	0.25*

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\*Significant at  $p < 0.05$

### 5.15 Summary

Awareness of methods of preventing pregnancy and HIV infection is high among young men in the sample. The majority of them were able to identify a range of methods. Knowledge of condoms was particularly high, with the majority identifying it as a method of prevention of HIV and unwanted pregnancies. However, knowledge of pregnancy risks is still low, although a large proportion perceived a high risk of pregnancy. Overall, attitudes to condoms are high. In addition, condom use is high among young men. However, consistent condom use is still a problem. The results from the multivariate logistic regressions show that education is an important predictor of consistent condom use. In addition, men who perceived a higher risk of pregnancy were significantly more likely to report consistent condom use than other men.

## **Chapter Six**

### **Discussion**

This chapter discusses the major findings explored in the preceding chapter. In some instances these results are discussed in comparison with findings extracted from similar studies.

The focus of the study was on boys and young men aged 14 to 24 years. The majority of them were in the 17-19 year age bracket. Most of these youth were single and only a few of them were married or living with a partner. The reasons for that may include the fact that respondents were still young and that marriage is to a large extent not the norm in South Africa. The level of education for these respondents was fairly high as almost 80% of them had already completed primary school. The four South African racial groups i.e. Africans, Coloureds, Indians and Whites were represented in the sample. Most of them subscribed to the Christian religion while the minority of them subscribed to different religions such as, Muslim, Traditional and Hindu. The respondents were recruited from two magisterial districts that are typical of rural and urban areas.

The majority (61%) of respondents were sexually active in the current study. Many of the respondents had two or more sexual partners. Pettifor et al. (2005) found that although the majority of South African young men had regular sexual partners, 17.6% of them reported that they had casual sexual partners as well. Simbayi et al. (2004) reported similar finding as they noted that the majority of school age South African youth claimed to have practiced sex with one sexual partner during the year preceding the survey, whilst 10 to 25% of them reported having had more than four sexual partners per year. The major problem about multiple partners is that it is associated with increased risk of HIV infection.



The study found that awareness of HIV/AIDS is nearly universal, with the majority of young men reporting that they had heard of HIV/AIDS. The majority of boys and young men were also aware of the main routes of HIV transmission and the means of protecting against the risk of HIV infection. Almost three-quarters of the respondents identified sexual intercourse as the main route of HIV transmission. In addition, more than 70% of respondents identified condoms as an effective method of protection against HIV infection. These findings are consistent with a number of other studies in the region where heterosexual intercourse is the main route of HIV/AIDS transmission. For instance, Saha (1998) also found that youth in East Africa were aware that heterosexual intercourse is the leading cause of HIV transmission. The study found that 96% of men and 90% of women knew that HIV/AIDS is transmitted through heterosexual intercourse. In addition, this study found that respondents who had heard about HIV/AIDS knew of at least two methods of preventing HIV/AIDS. In their study, Hulton et al. (2000) also found that teenage participants had accurate knowledge about all forms of HIV transmission routes.

Perceived susceptibility to HIV infection may be an important factor in motivating behavioural change. Individuals who are aware of the risk of HIV infection and who feel that they are personally at risk may adopt appropriate action to protect themselves against the risk of HIV infection. The findings of the current study do not support this statement. Almost two thirds of boys and young men perceived no risk of HIV infection whilst 27% perceived a low risk of HIV infection. Other studies have also found low perceived risk of HIV infection. Lutalo et al. (2000) found that about 24% of men responded that they were likely to be at risk of acquiring HIV/AIDS whilst 16% of them responded that they were unlikely to acquire HIV/AIDS. There were respondents (14%) who claimed that they did not know whether they were at risk of acquiring HIV/AIDS or not

and the rest of the respondents were grouped in the *other* category (Lutalo et al. 2000).

In spite of the high prevalence of HIV/AIDS in KwaZulu Natal and/or South Africa, many respondents appear to not impose much stigma on AIDS sufferers. This is encouraging as it shows that people have an increased level of understanding about the incidence of HIV/AIDS. Lane (2002) witnesses this perception and argues that the levels of stigma associated with HIV/AIDS are decreasing in many societies as a result of individuals becoming increasingly informed about HIV/AIDS. This perception has shown to be true in United States despite many misperceptions about how HIV/AIDS is transmitted (Lane, 2002).

There were only a few respondents (11%) who knew of someone with HIV/AIDS in the current study. The majority (89%) reported that they did not know anyone with HIV/AIDS. About one third of the respondents (33.6%) responded that they knew someone who had died of HIV/AIDS. The lack of knowing someone with HIV/AIDS may stem from the fact that HIV/AIDS is not a visible disease and therefore its sufferer(s) may not be easily recognized. Those respondents who knew someone with HIV/AIDS might have only known that if the AIDS sufferers were their close friends or relatives. Knowing someone who died of AIDS might be as a result of announcements made during the funerals of the deceased regarding the cause of death. According to the South Africa Demographic and Health Survey (1999), 12.8% of the 15-19 year old respondents reported that they knew someone with HIV/AIDS. Furthermore, 18.2% of the 20-24 year old respondents claimed to know someone with HIV/AIDS (SADHS, 1999). Of those respondents who reported knowing someone with HIV/AIDS, 17.2% of them were currently in sexual relationships, 20.5% were formerly in sexual relationships, 18.5% had experienced sexual intercourse and 10.9% had

never experienced sexual intercourse (ibid). Pettifor et al. (2005) found that a substantial proportion (40%) of young people knew someone who died of AIDS.

One of the major challenges in the fight against HIV/ AIDS is the stigma attached to it. Some of the contributing factors to social stigma are that HIV/ AIDS is invisible and that often leads to the under-reporting of the disease (Garner, 2000). The social stigma associated with HIV/ AIDS also influences the decision of whether to undertake HIV testing or not. According to Maclean (2004), people who have been tested for HIV/ AIDS have lower odds of having stigmatizing attitudes towards HIV/ AIDS sufferers than those who have not been tested for HIV/ AIDS. Simbayi et al. (2004) found that 18.4% of young men tested for HIV, and 15.6% of them knew of their personal HIV status. Similarly, Pettifor et al. (2005) found that only 14.7% of the South African male youth had been tested for HIV. In the current study, there were only 10.1% respondents who reported having been tested for HIV and the rest of them responded that they never tested for HIV.

The incidence of STIs is closely associated with HIV. Surprisingly, many respondents indicated that they had not heard of STIs despite their universal awareness of HIV/ AIDS. The fact that a large proportion of respondents had not heard about STIs may not be surprising given that some respondents who took part in this survey were still young. A significant proportion of the sample was not sexually active and as a result may not have heard of STIs. In some societies, communication about sexual matters is minimal. Some of the respondents might not have been exposed to issues related to sexual matters since such debates are sometimes not entertained in some societies and are not talked about with young people. In addition, some respondents who may have experienced symptoms of an STI may not even be aware that it was an STI. Thus, few respondents (12.7%) reported having suffered from an STI. In a similar study conducted in South

Africa, Pettifor et al. (2005) found that about nine percent of young men mentioned that they had experienced an unusual genital discharge (in the year preceding the survey), while six percent reported having suffered from genital ulcers.

Age at first sexual intercourse signals the beginning of exposure to the risk of pregnancy and HIV infection (Manzini, 2001). The age at first sexual intercourse for boys and young men is relatively low. The median age at first sexual intercourse was 15 years. A review of current studies suggests that at least half of young people in South Africa are sexually active at age 16 and approximately 80% are sexually experienced by the age of 18 years. Men are more likely than women to report early sexual debut (Eaton et al., 2003).

The most important variable for this study is condom use since it is the only reliable method for protection against both the risks of HIV and unintended pregnancy. The analysis shows that condom use amongst boys and young men is high with more than half reporting having used a condom at last sexual intercourse. Condom use was lower among Africans than other groups. This finding is consistent with another study conducted by the University of Witwatersrand Reproductive Health Unit (2004), which found that the young Indian population used condoms more than the other racial groups. The study found that 52% of Indian youth used condoms, followed by 43% Whites, 33% Africans and lastly 28% of Coloureds. Thus, race was an important factor influencing condom use among young people.

The large majority of respondents used condoms during their last sexual encounters in order to prevent both STIs/HIV and pregnancy. However, more respondents indicated that they used condoms for preventing pregnancy than infection. Earlier studies found that condom use for preventing pregnancy was

low. For example, the South Africa Demographic and Health Survey (1999), found only 20% of adolescents used condoms, and only four percent of them used condoms for preventing pregnancy. Similarly, Simbayi et al. (2004) noted that 50 to 60% of sexually active youth reported that they had never used condoms and those who used them did so inconsistently. In their review, Eaton et al. (2003) also observed that condom use among the South African youth was generally poor. However, a recent national study conducted by Pettifor et al. (2005) reveals that condom use among South African youth was high with almost 57% of young men reporting use at last sexual intercourse.

In the current study, respondents raised issues that may serve as barriers to the use of condoms. For example, almost one third of respondents mentioned that condom use reduces sexual pleasure. Some respondents associated condom use with a lack of trust in the sexual relationship. Other respondents suggested that the female partner would lose the male partner's respect if she had to ask her partner to use a condom. Some responses revealed the belief that condom use was not necessary once the relationship had developed from casual to a more serious relationship. Other respondents claimed that buying or asking for condoms is embarrassing; while others said that carrying condoms is ridiculous as it makes sexual intercourse appear planned. Meekers and Klein (2002) also point out that condom use decreases sexual pleasure and some sexual partners associate it with infidelity. These factors all serve as barriers to condom use.

In their study in KwaZulu Natal, Harrison et al (2001) found that boys reported that they would never use condoms with their steady partners because they trusted them. In their work on adolescent males, Ku et al. (1994) found that only about a third of respondents reported to always use condoms. According to Ku et al. (1994), 22% of the respondents reported that they had not used condoms in the year preceding the survey, 35% had always used a condom during sexual



intercourse and the majority (43%) reported inconsistent use of condoms in the year preceding the survey. Rosenberg (2004) argues that the attitude of an individual is the core determinant towards condom use. In this regard, there are young men who only have sex with steady partners and still use condoms regularly (Rosenberg, 2004). The social pressure to use condoms is one of the factors which influence young men to have a positive attitude towards condom use and hence encourage them to use condoms consistently (ibid).

This study shows that the large majority (71%) of respondents perceived pregnancy as highly problematic. This may be linked (amongst other things) to the fact that these respondents were not sure about the appropriate time(s) of the month that a woman may have the highest chances of falling pregnant. This finding is derived from various responses whereby respondents showed enormous doubts when asked about the appropriate *time of the month a woman has the greatest chances of falling pregnant*. Moreover, the "don't know" response that the majority of respondents gave further confirms their lack of knowledge about pregnancy in relation to time(s) of the month when a woman has the greatest chance of falling pregnant. Adolescent boys and young men are fearful of making girls pregnant despite their lack of knowledge about the riskiest times of the month that a woman may fall pregnant. These youth are aware that unprotected sex may result in pregnancy and 83.3% of them are aware that a woman could fall pregnant even after a single sexual encounter.

In a similar study, Hulton et al. (2000) state that two male groups of students and non-students equally perceived pregnancy as one of the riskiest outcomes of sexual practice. Both of the student and non-student groups mentioned the heavy penalty linked with making a girl pregnant. Furthermore, the student boys' group mentioned that the bride price attached to making a girl pregnant is often expensive (Hulton et al., 2000). Similarly, Garenne et al. (2000) argue that

premarital fertility has socio-economic consequences that are often burdensome for youth to cope with. This often leads to many young parents relying on their extended family for support with childrearing. Thus the heavy socio-economic burden attached to premarital pregnancy may consequently increase young men's odds of taking precautionary means to prevent pregnancy.

In a study conducted in KwaZulu Natal, Varga (2002) had similar findings regarding adolescents and their attitudes to pregnancy. She posits that youth view pregnancy as highly problematic because of the fear of their parents' reaction. Many youth responded that they would not like to have children at an early age as they feared the social stigma attached to being a teenage parent whilst some of them raised the concern that pregnancy disrupts one's schooling (ibid). Also revealed during the proceedings of the study were issues of poverty and unemployment which impacted further on the boys and young men's attitudes towards pregnancy. In this regard, respondents linked their concerns to the fact that the pregnant girl demands health care which requires money even before the child is born. Meanwhile, there are other large sums of money that the parents of the pregnant girl would demand for her falling pregnant i.e. the *so-called* charges for damages. In addition, the young man who made the girl pregnant would have to pay for the maintenance of the child. The young man may also have to drop out of school in order for him to seek work to cater for the child maintenance. This lack of education is likely to impact negatively on his employment opportunities. Due to his lack of education, he may find himself undertaking semi-skilled work for which he is paid a meager salary. Thus, there is the possibility that he would sink deeper into poverty. Varga (2002) acknowledges that pregnancy and the costs of raising a child demand extra financial resources and many young people are generally not financially independent. Therefore, this would place a heavy financial burden on them.



However, in another study, Varga (2003) discovered that the older youth often welcomed the pregnancy. As a result, being a father was seen as being highly prestigious. Paternity entails the social and financial commitment of a young man who has gained the status of being a father (ibid). Many African young men in KwaZulu Natal often accept paternity with gratefulness as they often regard it as a symbol of being responsible and of being a real man (Preston-Whyte and Zondi, 1992). Thus many young men often appreciate it when their partners fall pregnant especially with their first-borns.

In conclusion, evidence shows that the perception of pregnancy as highly problematic is a major motivating factor for young men to use condoms consistently. Those men who perceived pregnancy as highly problematic were significantly more likely to use condoms consistently compared to other men. The majority (71%) of respondents acknowledged the fact that they were at high risk of making girls pregnant. In addition, they were aware that condom use is effective against pregnancy prevention. The mass media was a popular source of information on methods of contraceptives. As a result respondents reported that they knew of the following contraceptive methods: condoms, pills, injectables and abstinence. Consequently, a large majority of respondents reported having used condoms at last sex; about 8% of respondents reported using the pill and the rest of them reported using injectables and abstinence. The majority of respondents also reported that they had communicated with their sexual partners about avoiding pregnancy.

In a similar study, Simbayi et al. (2004) reported that out of 510 young males 3.7% of them had abstained from sex in order to avoid pregnancy, STI and HIV. In the same study, 73% had reported to have ever used a condom and about 59% of these men reported to have used a condom at last sexual intercourse. The young males responded that they communicated with their partners about

pregnancy prevention in the year preceding the survey (Simbayi, et al. 2004). Furthermore, Lee (1999) found that only 7% of men reported the use of the withdrawal method and 2% of men reported the use of condoms as their method of preventing pregnancy. In their study on adolescent males, Marcell et al. (2003) found that the majority of young men did not find it difficult to talk to their partners about sexual issues; although there were some men who felt shy, embarrassed and scared of rejection and therefore did not talk to their partners about sexual issues. Respondents also emphasized the importance of preventing pregnancy (Marcell et al. 2003). The reasons which respondents mentioned for not wanting to make girls pregnant included that: they would have to drop out of school and be responsible for supporting the child; they would get into trouble with their parents and they felt they would lose their self-respect and that of their families' as a result of making a girl pregnant. Thus the general finding is that young men want to delay early childbearing because they are concerned about their future welfare.

## Chapter Seven

### Conclusion and Recommendations

#### 7.1 Conclusion

This paper has discussed various aspects regarding how boys and young men deal with the risks of both pregnancy and HIV/AIDS. The study revealed that there is a high level of awareness of the main routes of HIV transmission and methods of protection. However, a large majority of respondents were in denial regarding their own risk of contracting HIV. This is probably because they had never taken an HIV/AIDS test before. HIV testing among young men is not a common practice. Some of the biggest challenges include the encouragement of HIV testing and to improve the risk assessment of HIV infection among young men.

There was a high level of awareness regarding HIV/AIDS amongst most of the respondents. However, knowledge of particular factors relating to the spread and transmission of HIV/AIDS remained inadequate. The majority of the respondents were aware that sexual intercourse was the most popular route of transmitting HIV/AIDS. However, many were not aware that STIs may also increase the risk of contracting HIV/AIDS. In addition, there were some myths about how HIV/AIDS is spread and it is important that prevention programmes begin to address these false beliefs.

It was encouraging that knowledge of methods of family planning was high. The majority of young men knew that condoms protect pregnancy. In addition, a substantial proportion reported using condoms for pregnancy prevention. However, the study also revealed that young men lacked adequate knowledge regarding the risk of pregnancy. They were aware that unprotected sexual

intercourse resulted in pregnancy. However, they were not familiar with such matters as: the menstrual cycle, period(s) of a woman's ovulation and certain contraceptive methods which all impact on pregnancy as well.

Another encouraging finding revealed that a large number of young men claimed that they could communicate with their partners about sexual and reproductive health matters. These youth were able to communicate with their partners about avoiding pregnancy, condom use and avoiding STI/HIV/AIDS. Some were even able to communicate with their partners about delaying sex which is a difficult topic to talk about and even more difficult decision to make. These findings suggest that there are some changes in behaviours of young men which will assist in the fight against HIV/AIDS and unintended pregnancy.

The study revealed that condoms are the most commonly used method amongst young men. More than 50% of young men reported using condoms at last sexual intercourse. The study indicated that there are various factors that continue to impact on the use of condoms. These factors include: race, education, sexual relationship status, number of sexual partners, perceived risk of pregnancy and perceived risk of contracting HIV infection. The study also revealed that although condoms appear to be high a substantial number of respondents who had multiple sexual partners were not practicing safe sexual intercourse. In addition, one of the major barriers is inconsistent use. Inconsistent condom use is a major problem amongst young men. All of these factors impact on the continual spread of HIV/AIDS and unintended pregnancy.

## **7.2 Recommendations**

There is a desperate need to sensitize youth about various issues pertinent to sexual and reproductive health in South Africa. Many young people know about

HIV/AIDS, however, there is still a need to ensure that youth are also aware of the consequences of HIV/AIDS. Youth need to be aware of the risk of HIV infection and need to be made aware of the risk associated with unprotected sexual intercourse. Simbayi et al. (2004) emphasize that delaying sexual debut and practicing secondary sexual abstinence are very important strategies in the attempts to prevent HIV and unwanted pregnancies. These strategies need to be reinforced within the HIV health education initiatives in order to minimize the spread of HIV (Simbayi et al., 2004).

More facilities, skilled health care service providers, parents, the media and educational centers are needed to help equip youth with skills and provide access to facilities so that they will be able to counter the spread of HIV and unintended pregnancy. Youth also need to be properly educated and shown how to use condoms correctly. Health service providers should be skilled and friendly enough to help youth with such matters as the correct use of condoms. Open communication regarding sexual initiation or other issues related to sexual intercourse is of utmost importance. Information needs to be shared between parents, their children and health professionals. Talking about sexual issues (including issues related to HIV/AIDS) is important if such issues are to be dealt with appropriately. This open communication will create a learning environment for all those involved. Thus would yield a positive effect on the fight against HIV/AIDS and unwanted pregnancy. Such a scenario would enable youth to acquire more information and advices which they may in turn communicate to their partners.

Therefore, in order for the prevention of HIV/AIDS and unintended pregnancy there needs to be a healthy and open relationship between sexual partners. Partner communication is an integral part in helping to prevent the continual spread of HIV/AIDS and unintended pregnancy. According to Kim and Kols

(2001), men have shown to be interested in sexual and reproductive health matters and therefore are willing to discuss such issues with their partners, thus enhancing partner communication. The involvement of men in sexual and reproductive health matters may lead to behavioural changes and the support of family planning (among other things) (Kim and Kols, 2001). Men and particularly young men need to be encouraged to participate in sexual and reproductive health matters in order to develop their knowledge regarding such issues further. They would also be able to access and use the reproductive health care services more effectively and efficiently (WHO, 2004). The development and facilitation of these skills and knowledge would equip men with important information that would enable them to realize the seriousness of an STI infection and of seeking prompt medical treatment.

The key for youth to positively respond to sexual and reproductive health issues (as explored in the above paragraph) is to ensure that their self-efficacy is strengthened. This will help them build their confidence and self-esteem and as a result they will be able to make better and more informed sexual choices in the future. Meekers and Klein (2002) mention self-efficacy as the core determinant for anyone to be able to design and execute a specific behavior. In this regard condom use may depend on one's self-efficacy. Eaton et al. (2003) state that youth generally lack self-efficacy and self-esteem and this may make them more vulnerable to the risk of HIV infection as it would impact negatively on the decisions they make. Therefore, youth need to be exposed to systems which would increase their self-esteem and as a result positively influence their choices and behaviours. This need to be done in order to educate youth regarding sexual matters and therefore communication must be done in a respectful and loving way. It is evident that "intervention programmes promoting negotiation skills for use during sexual encounters need further strengthening to ensure that this



becomes a standard practice among youths to control and prevent the spread of HIV infection" (Simbayi et al., 2004: 617).

School, sports and/or community participation are activities which youth should be encouraged to become involved in as they help to equip them with the necessary skills they will need to lead a responsible life. For example, Peffifor et al. (2005) note that youth who participated in a LoveLife program (that is a community driven initiative) had lower odds of being infected with HIV/AIDS. This is further supported by a study conducted by Kaufman et al. (2004), which revealed that youth who participated in sports were more likely to engage in safer sex practices. Thus school, sports and community based programmes may help to develop particular mental and physical skills necessary to make the right choices and behave accordingly when particular situation arises such as, whether or not to use a condom.

Increased participation of young men in the sexual and reproductive health sector may increase the allocation of necessary resources to the entire population. Adequate resource facilitation would increase male participation in sexual and reproductive health matters and as a result would encourage them to get more involved in family planning matters. Elwy et al. (2002: 02) claim that increased male involvement in sexual and reproductive health issues may have psycho-social outcomes such as, "increases in knowledge of HIV, condom use skills, sexual communication skills and response efficacy for using condoms". In the current study many young men reported that they have never seen anyone infected with HIV/AIDS. This may be due to the fact that these youth had (among other things) remained distant from sexual and reproductive health matters. There is a need for male involvement (especially young males) in sexual and reproductive health matters so that they can take actions to prevent the continuous spread of HIV/AIDS and unwanted pregnancy. Young men need to



be more involved in the sexual and reproductive processes in order to understand and become more aware of issues pertaining to HIV/AIDS, STIs, unintended pregnancy and so on. This increased involvement will help men to take more responsibility for their actions. Remaining distant and uninvolved in issues relating to HIV/AIDS will not aid in understanding the pandemic and taking the necessary steps to avoid contracting or spreading it.

Adequate literature on sexual and reproductive health matters would provide more incentives for men to share the responsibilities related to family planning with their sexual partners. This would encourage both partners to help and support one another regarding family planning issues. Kim and Kols (2001) state that women would feel more encouraged using contraceptives if their male partners supported them. Some societies attach stigma to men who visit family planning centers (ibid). As a result many men would not participate in family planning activities such as visiting family planning centers. The more involved would men in sexual and reproductive health matters, the more knowledge and confidence in their participation would result. Consequently, more males in sexual and reproductive health issues would mean more confidence getting involved in family planning matters which would help to slowly eradicate the stigma attached to men involved in family planning matters. Men would be informed about the suitable methods of contraceptives and possible measures of combating STIs including HIV/AIDS. Thus, increased male participation in sexual and reproductive health matters will inevitably have a positive effect on reducing the continual spread of HIV/AIDS and unintended pregnancy.

Men's access to reproductive health care services may benefit the gynecological practice (even if indirectly) (Solo et al., 1999). For example, men who participate in reproductive health matters often accompany their partners to family planning clinics. They arrange transport facilities and other maternal related

aspects during difficult times of pregnancy to and from reproductive health care centers. These men would be available in delivery wards when their partners are giving birth(s) and would therefore acquire more information on reproductive health services such as, good postpartum care, the importance of breastfeeding, the importance of preventing STIs and HIV infection etc. (ibid). In this accord, “family planning programmes ... will have a higher probability of success if they also encourage male involvement” (Maharaj, 2000: 40-41).

Male involvement in sexual and reproductive health matters may also be instrumental in minimizing the prevalence of violence between intimate partners. Moore (1999) considers partner violence as often stemming from poor sexual relations. Therefore, men and particularly young men need to be educated (formally and/or informally) in order for them to be adequately aware about sexual and reproductive health matters. This knowledge may also help curb the gender based violence in our society.

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