

UNIVERSITY OF KWAZULU-NATAL

**FACTORS AFFECTING CONTRACEPTIVE USE  
AMONG YOUNG PEOPLE IN KWAZULU-NATAL**

HYACINTHIA NAIDOO

*"Youth are a valued possession of the nation. Without them there can be no future. Their needs are immense and urgent....."* Nelson Mandela, May 1994. National Youth Policy 2000, National Youth Commission.

## **DECLARATION**

This Master's dissertation represents original work by the authoress and has not been submitted in any form either wholly or in part to satisfy any other degree requirement either at this or any other university. Where specific use has been made of the work of others it has been duly acknowledged and referenced in the text.

The research for this dissertation was undertaken in the School of Development Studies at the University of KwaZulu-Natal, Durban under the supervision of Dr Pranitha Maharaj.

Opinions expressed and conclusions attained are those of the dissertator and not necessarily attributable to the School of Development Studies.

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**HYACINTHIA NAIDOO**

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## ABSTRACT

Although sexual and reproductive health practices among young people are well documented, little is known about the factors that affect their decisions to use contraception. This is of paramount importance particularly in KwaZulu-Natal for two reasons: 1) the increasing number of teenage unplanned pregnancies in KwaZulu-Natal and 2) the inherent implication that unprotected sex can result in the transmission of diseases like sexually transmitted infections, including HIV and AIDS. Additionally, the sexual risk-taking and reproductive health behaviour of young people in KwaZulu-Natal is of extreme interest to researchers and program implementers, particularly since KwaZulu-Natal is the worst HIV affected region in South Africa (World Aids Conference XIII, 1999).

The aim of this study is to investigate sexual and reproductive health practices and dynamics among males and females between the ages 14 and 22 years in two areas in KwaZulu-Natal, South Africa: Metropolitan Durban and the magisterial district of Mtuzini. It explores a selection of the factors that affect contraceptive use among young people. These include age, race, sex, geographic location, relationship status and perceived risk. The study includes a rural-urban comparison, using focus group discussions and structured interviews from a pre-existing data set. Results were analysed using the Statistical Package for the Social Sciences (SPSS). The method of triangulation was adopted as this offered a more holistic approach to the analysis of both the qualitative and quantitative components of this study. The quantitative analysis was conducted using univariate frequencies, bivariate cross tabulations and multivariate logistic regression.

The major findings of this study were that there is a strong correlation between contraceptive use and relationship status, age and sex of respondent and geographic location: (i) Both men and women in a steady relationship were more likely to use contraception, with a greater prevalence among those young adults who had previously given birth or fathered a child. (ii) respondents in the 20-22 year old age category exhibited the highest occurrence of safe sex practices, (iii) young women viewed contraception more positively than young men; particularly as a means to avoid or delay pregnancy, (iv) knowledge about contraception, its use and source of supply among both men and women between the ages 14 and 22 years is universal, with almost all having heard of at least one modern method of contraception. However, young people living in urban areas displayed a greater knowledge of the different contraceptive methods, than their rural counterparts.

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## LIST OF ACRONYMS USED

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AIDS	-	Acquired Immune Deficiency syndrome
ANC	-	Ante Natal Clinic
CASE	-	Community agency for social enquiry
DHS	-	Demographic and Health Survey
DOH	-	South African Department of Health
FHI	-	Family Health International
HBM	-	Health Belief Model
HDR	-	Human Development Report
HEARD	-	Health Economics and HIV/AIDS Research Division
HIV	-	Human Immune Deficiency Virus
HSRC	-	Human Sciences Research Council
HST	-	Health Systems Trust
IEC	-	Information, Education and Communication
IFR	-	Institute for Futures Research
IUD	-	Intra Uterine Device
KFF	-	Kaiser Family Foundation
KZN	-	KwaZulu-Natal
NGO	-	Non-governmental organisation
NPPHCN	-	The National Progressive Primary Health Care Network
RHRU	-	Reproductive Health Research Unit
SA	-	South Africa
SADHS	-	South African Demographic and Health Survey
SAHR	-	South African Health Review
SAIRR	-	South African Institute of Race Relations
SPSS	-	Statistical Package for the Social Sciences
STATSSA	-	Statistics South Africa
STD	-	Sexually Transmitted Disease
STI	-	Sexually Transmitted Infection
TFR	-	Total Fertility Rate
TRA	-	Theory of Reasoned Action
UN	-	United Nations
UNAIDS	-	Joint United Nations Program on HIV/AIDS
UNDP	-	United Nations Development Programme
WFS	-	World Fertility Surveys
WHO	-	World Health Organisation

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## CHAPTER ONE : INTRODUCTION

### 1.1. Background

During the 1960's the practice of contraceptive use was minimal in most countries. This may have been a consequence of the limited knowledge about various methods of contraception (Bongaarts and Johansson, 2002). Recently however, this trend has been reversed: more than half the number of married women in the developing world has acknowledged that they have used some form of contraceptive method (Mahy and Gupta, 2002). Currently, modern methods have been established as the most widely used methods of contraception. These modern methods include sterilisation, the intra - uterine device (IUD), the pill and the male condom. This change in contraceptive behaviour can be attributed to the influence of a number of factors, the most over-riding of which was the desire to have fewer children (SADHS, 1998). Other key considerations that have contributed to the increase in contraceptive use are the diffusion of information regarding contraception and the increased availability and accessibility of the different contraceptive methods (Biddlecom et al., 1998).

In 1993, contraceptive prevalence stood at approximately 55% in the developing world. By the year 2000, this figure was estimated to have increased to 60% (UNDP, 2004). However, the level of contraceptive practice in many African countries still remains relatively low (Bongaarts and Johansson, 2002). According to the UNDP (2004), only 10% of the sexually active population in sub-Saharan Africa use a contraceptive method. In contrast, the level of contraceptive use in South Africa is relatively high. For example, in 1994 62% of South Africa's population were using contraceptives, compared with 53% in 1985. A distribution of these contraceptors by race showed that 55% of the African population group, 73% of Coloured people, 76% of the Indian component and 85% of all Whites utilised some form of family planning method. Almost all sexually active South African women who were using a method at the time were using a modern method. It was also found that Indian

women were more likely to be practising family planning, followed by White, Coloured and Africans (SAHR, 2000).

The South African Demographic and Health Survey (SADHS) - the first survey of its kind in South Africa was conducted in 1998 (Dorrington et al., 2002). This survey collected data from almost 12 000 women aged between 15 to 49 years. The sample comprised three quarters African, ten percent Coloured, eight percent White and four percent Indian (SADHS, 1998). The SADHS demonstrated that South Africa was one of the first countries in sub-Saharan Africa to experience a national fertility decline. Conclusions from this study suggested that the total fertility rate in South Africa had been declining from 6.00 in the mid-1950's to about 4.30 in the 1980's. In addition, it was reported that the total fertility rate was 2.90 children per woman for the period 1995 to 1998 (SADHS, 1998). According to the UNDP's Human Development Report (UNDP, 2004), the total fertility rate for South African females aged 15-49 years stood at 2.60 births per woman during the period 2000-2004. The SADHS study also revealed differentials in the total fertility rate in relation to a woman's place of residence, race and age. For example, the total fertility rate among rural woman (3.90) was nearly double that of urban women and fertility was highest among African woman (SADHS, 1998). In contrast, the rate for urban Whites was 1.90, which was below their replacement level. Adolescent fertility was also found to be high especially among Coloured and rural African young women. According to this survey, one in three South African girls had been pregnant or had given birth to a child by the age of 19 years.

Hence, although fertility levels in Africa are among the highest in the world, South Africa can be singled out as displaying well-established, declining fertility rates (Statistics South Africa, 2002; Rutenberg et al., 2001, SADHS, 1998). This overall fertility decline may be attributed in part to the relatively high level of use of modern contraceptive methods. Despite this decreasing rate of fertility, the prevalence of unplanned teenage pregnancies in South Africa, particularly KwaZulu-Natal is at a high level (Jeffery et al., 2001; Rutenberg et al., 2001; Preston-Whyte, 1994). In their study, Wood et al. (1997:1) found that teenage pregnancy was largely socially

sanctioned and regarded as "infinitely preferable to the threat of condom-induced infertility". The same study emphasised that prevention of early pregnancy through effective contraceptive use was a national health priority. Garenne et al. (2000) in their study of rural South Africa found that there were two very distinct child bearing peaks in their analysis of age at first birth. The highest peak occurred during adolescence and the second corresponded to older married woman. Additionally, this latter study revealed that there were very low levels of contraceptive use before the first birth. National figures for South Africa indicated that 35% of females had either been pregnant or had given birth to a child before the age of 20 (SADHS, 1998). At a provincial level, KwaZulu - Natal had a fertility rate of 4.3 in 1991 and 15.3% of all live births were to mothers who were less than 20 years old.

## **1.2. Why focus on young people?**

According to the South African Health Review (SAHR, 2000), one in every five persons in the world is a young person and in South Africa alone there are currently about 18 million people under the age of 20 years (StatsSA, 2004b). These young people account for approximately 44% of the total population of South Africa. Of this group, 49.5% were male and 50.5% female (StatsSA, 2004b). Of the total national population of youngsters, more than three quarters were African, just over one tenth were White, exactly one tenth were Coloured, and the minority were Indian. The province of KwaZulu - Natal comprises the highest number of young people.

According to the World Health Organisation (WHO), the period of adolescence (defined by them as all people between the ages 10-19 years) is seen as the 'gateway to health' because behavioural patterns acquired during this period tend to last throughout their adult life. In light of the major impact that HIV/AIDS has had on young people, it is important to acknowledge that young people are critical in any endeavour to reduce the spread of HIV/AIDS. In support of this, recent research has noted that the greatest reduction in HIV/AIDS is evident when interventions targeted those in the 14-24 year old age category (KFF, 2004).

Biddlecom and Bakilana (2003:3) cite Rindfuss's concept of the young adult's life as being "demographically dense" since so many life-changing decisions take place during the period between the teens and the twenties. For instance, leaving school, seeking employment, sexual debut, migrating, marrying and child bearing. Hence this is the period during which a number of vital transitions take place. In addition, Mfono (1998) declares that this period is particularly confusing for young adults as they often receive contradictory messages about their sexuality. Based on the evidence above, it has become imperative to understand the factors affecting contraceptive use among young people in KwaZulu-Natal.

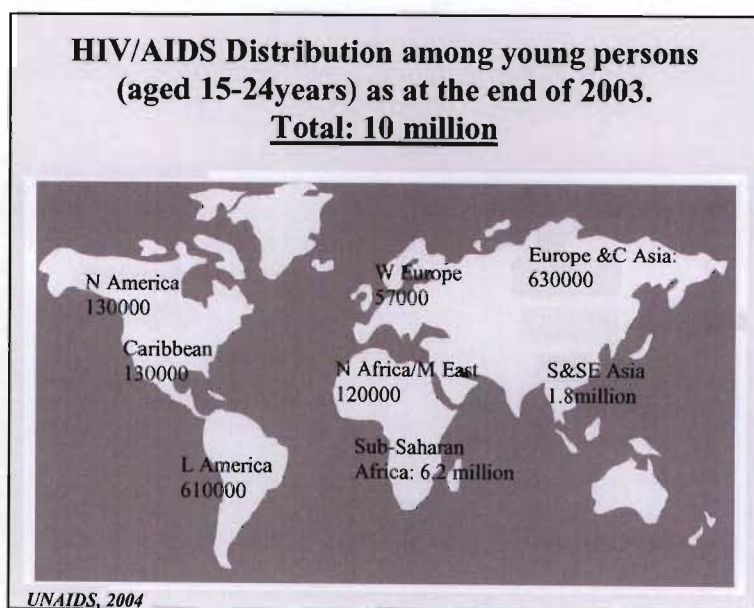
There is a substantial degree of variance in the interpretation of the term "youth" at the national and international levels. For example, the WHO defines young people as any human being between the ages 15 to 24 years, whereas the South African Department of Health defines young people as being between the ages of 10 to 24 years (SAHR, 2000). The research instrument used in this study was based on secondary data from Wave 1 of the Population Council's 'Transition to Adulthood Survey'. This survey collected detailed information from young people aged 14 to 22 years. Researchers have used the concepts of 'youth', 'adolescents', 'youngsters' and 'teenagers' as substitute terminology to refer to young people. For the purposes of this dissertation, these terms will also be used interchangeably.

### **1.3. The impact of HIV/AIDS**

The impact and prevalence of the human immuno-deficiency virus and the acquired immuno-deficiency syndrome (HIV/AIDS) is a major contributing factor to contraceptive use among young people. According to UNAIDS (2004), there were approximately 37.80 million people living with HIV/AIDS in the world by the end of 2003; approximately one third of who were under 25 years old. In addition, this group of young people represented more than half of the 4.8 million people estimated to have been infected with HIV in 2003 (UNAIDS, 2004; KFF, 2004).

Figure 1, displays the global distribution of young people aged 15-24 years, living with HIV/AIDS as at the end of the year 2003 (UNAIDS, 2004). Young people constitute a significant proportion (ten million) of the global population living with HIV/AIDS. They represent 28% of all adults (aged between 15-49 years old) living with HIV/AIDS in the world. As is evident from the map below, the prevalence of HIV/AIDS among young people varies widely among regions and countries. Sub-Saharan Africa faces the worst prospects. Although only ten percent of the world's population live in sub-Saharan Africa, this region contained 62% of all youth living with HIV/AIDS in 2003 – a total of 6.2 million (UNAIDS, 2004). Across the region, HIV disproportionately affected women. This trend also presented itself in the South African context, where for every 13 adult females (aged between 15-49 years) living with HIV/AIDS; there were 10 men. This phenomenon was more pronounced among young people aged 15-24, where on average there were 36 young females living with HIV/AIDS for every 10 young men (UNAIDS, 2005).

**Figure 1.1 Global distribution of HIV/AIDS among young people in 2003**



In South Africa, the HIV/AIDS prevalence rate among young people (aged 15-24 years old) was found to be 10% with a higher rate for young females (16%) than young men (five percent) (Dorrington et al., 2004). According to the United Nations, of the 5.30 million people (aged between 15-49 years) living with HIV/AIDS at the end of 2003 in South Africa, approximately 2.90 million were females aged between 15-49 years (UNDP, 2004; UNAIDS, 2005). Overall, the estimated prevalence rate in adults was 22%. Among pregnant women it was 28% in 2003 compared with 27% in 2002 and 25% in the year before that. This is a dramatic increase from less than one percent in 1990 (UNDP, 2004). The prevalence levels among pregnant women aged between 15-24 years have continued to rise: from 23% in 2001 to 24% in 2003 (RHRU, 2004). The most striking impact has been recorded in KwaZulu-Natal with an overall prevalence of 38% as is evident in the ANC surveillance study (UNAIDS, 2004).

Nowhere has the impact of HIV/AIDS been more severe than in Sub-Saharan Africa (UNAIDS, 2004). Table 1.1 summarises the trend in HIV/AIDS prevalence in sub-Saharan Africa over the recent past.

**Table 1.1 : HIV/AIDS prevalence in sub-Saharan Africa**

Year	People living with HIV/AIDS	Number of females	New Infections	Adult Prevalence (%)
2004	25.4 million	13.3 million	3.1 million	7.40
2002	24.4 million	12.8 million	2.9 million	7.50

*Source: Aids Epidemic Update, UNAIDS (2004).*

Although the controversy over the effectiveness of HIV tests, and the accuracy of HIV/AIDS prevalence rates has not been resolved, there is no doubt that AIDS is

spreading rapidly throughout Sub-Saharan Africa. This is based on the finding that 60% of the total number of people living with HIV/AIDS in the world is housed in this area. This, together with the fact that an estimated 3.10 million new infections were recorded in this region for 2004 alone has earned Sub-Saharan Africa the reputation of being the global epicentre of the HIV/AIDS pandemic (UNAIDS, 2005).

The bulk of HIV infections, that is 11.40 million are concentrated in the southern parts of Sub-Saharan Africa (UNAIDS, 2004). This includes Botswana, Lesotho, South Africa, Swaziland and Zimbabwe that together constitute about 30% of the global number of people living with HIV/AIDS in an area where only two percent of the world's total population resides. According to the UNDP (2004), South Africa has the highest level of HIV infections. Since no simple and reliable method to assess HIV incidence in sub-Saharan Africa exists, the closest proxy would be the HIV prevalence rate in the 15-24 year old pregnant women, which shows that in South Africa infection levels continue to rise. These HIV prevalence figures have been based on the results of annual, anonymous, antenatal clinic attendee surveys. This surveillance has measured HIV infections since 1990 and represents the most reliable available statistics for the country. According to this survey, South Africa had an infection rate of less than one percent in 1990 but by the year 2002, the average infection rate rose to over 27% (SAHR, 2004). However, the predominant (90.2%) attendees in these state clinics were African, female and pregnant at the time. Hence this study provided adequate coverage for that particular sector only and is not representative of the South African population as a whole since only pregnant African females of low socio-economic status who attended municipal and state clinics were tested. Many other infected groups have not been sampled or tested. These include males, non-pregnant women, pregnant women who use private health service providers and the more economically advantaged African women are under represented.

A comparison of the nine provinces demonstrated that KwaZulu-Natal had the highest HIV/AIDS prevalence rate in South Africa (Dorrington et al., 2002). The level of HIV prevalence among young people here had dropped slightly from 17% in 1999 to 16%

in the year 2000. While this was much lower than the prevalence rates for all South African women in their twenties (29% for women aged 20-24 and 31% for women aged 25-29 years), it was likely that many of the HIV positive women might have been infected during their teenage years (Dorrington et al., 2002). According to Desmond et al. (2002), 43% of females aged 15-19 years old were HIV positive in KwaZulu-Natal as opposed to 17% young males. The high level of HIV amongst this age group underscores the importance of exploring the factors that influence youth's sexual decision-making.

#### **1.4. Justification**

A literature review of studies concerning contraceptive use among young people has revealed that further investigation is required. Kaufman et al. (2001) claimed that very little research on adolescent reproductive behaviour exists in South Africa. Despite increasing documentation concerning contraceptive prevalence among sexually active people, very little seems to exist regarding the pathways that lead young people into making the choice to use a contraceptive method. A growing number of studies have addressed various aspects of sexual and reproductive health among adolescents, yet little attention has been devoted to the factors that affect contraceptive usage among young people in KwaZulu-Natal. Since this province has been regarded as the epicentre of the AIDS pandemic, focusing on issues concerning contraceptive use among young people in KwaZulu-Natal is particularly relevant to policy researchers, strategic decision-makers and sexual and reproductive health program implementers. It is also assumed that since the prevalence of HIV and AIDS and teenage pregnancy is very high in KwaZulu-Natal, *any* information that may assist in minimizing this situation will be forthcoming.

Furthermore, sexual and reproductive health behaviour is a major source of information for both pregnancy and HIV/AIDS transmission. Hence an investigation into the factors that affect contraceptive use among young people in KwaZulu-Natal

will contribute to the identification of appropriate and relevant sexual and reproductive health programs for specific sectors of the population.

Most studies have been narrow in their focus, either concentrating solely on one sex for example men only (Fapohunda and Rutenberg, 1999; Maharaj, 2001; Nzioka, 2001 and Varga, 2001). Yet others have examined sexual and reproductive health issues by specific types of residential areas. For instance, some samples were restricted to rural youth only (Harrison et al., 2001 and Jackson and Harrison, 1999) while others focused only on urban young people (Mfono, 1998 and Richter, 1996).

Previous research on sexual and reproductive health behaviour and practices among young people has been based on a single approach: either the qualitative or quantitative method. This could be a possible explanation for their apparent contradictory results. For this reason, it was found more appropriate to adopt the method of triangulation, whereby both focus group discussions and a structured questionnaire were used.

### **1.5. Aims and objectives**

The aim of this research is to develop an in-depth understanding of the factors affecting contraceptive use among young people. The focus is on knowledge of contraceptive methods, source of supply, attitudes to contraception and teenage pregnancy and contraceptive use.

The specific objectives of this research are twofold:

- to measure the extent of contraceptive use among young people in KwaZulu-Natal,
- to establish the factors influencing contraceptive use among young people in KwaZulu-Natal.

## **1.6. Organisation of dissertation**

This dissertation is divided into six chapters. This first chapter provides a brief introduction and cites contraceptive prevalence rates, total fertility rates, teenage pregnancy statistics and the impact of HIV/AIDS on sexual and reproductive decision-making. It is followed by chapter two, which outlines the theoretical framework of the study. Chapter three reviews the literature on factors affecting contraceptive use among young people. Chapter four focuses on the methodology and data used in this study. The results are presented in chapter five. Chapter six analyses the salient features from the focus group discussions. Chapter seven discusses the main findings of this research. Finally, this dissertation ends with a conclusion and recommendations for future research and action.

## **1.7. Summary**

This chapter provides the contextual background to the study. The researcher then highlighted the problem that motivated the investigation and understanding of the factors affecting contraceptive use among young people. Brief discussions of the presenting problems were documented after which the impact of HIV/AIDS was discussed. The method of analysis and the justification for the study was then described. The last aspect of this chapter outlined the aims, objectives and organisation of this dissertation. In chapter two that follows the theoretical framework is presented.

## CHAPTER TWO : THEORETICAL FRAMEWORK

### 2.1. Introduction

This chapter presents and explains four of the most commonly cited models of human behavioural change and how an individual's behaviour change is likely to occur. These are the health belief model, the stages of change theory, the theory of reasoned action and the social cognitive theory. These theories do not capture the elements necessary for behaviour change in every culture and population, but they do provide four examples of how the behaviour change process is believed to occur.

### 2.2. Health Belief Model

The Health Belief Model was originally developed in the 1950's by a group of social psychologists to explain the reasons why people fail to participate in public health programs which were aimed to prevent or detect disease (Janz & Becker, 1984). In 1974, Becker and Rosenstock improved on this model by focusing on the attitudes and beliefs of individuals in order to predict and explain their health-related behaviours (Baume, 2000; Family Health International (FHI), 1996; Health Knowledge, 2002).

According to Rosenstock, et al. (cited in FHI, 1996), the Health Belief Model proposes that preventive health behaviour is influenced by the following factors:

Perceived barriers to performing the recommended response. This is the individual's perception of the potential negative consequence that may result after following a particular health action. Witte (1999) points out that these barriers to health behaviour could be physical, psychological or in the form of financial demands.

Perceived benefits of performing the recommended action are the belief in the effectiveness of specific strategies that are designed to reduce the threat of illness.

Perceived threats may be either in the form of one's perceived susceptibility or one's perceived severity towards a particular health condition.

Perceived susceptibility: is the individual's subjective interpretation of the risk of contracting a specific health condition, while

Perceived severity refers to one's feelings regarding the seriousness of actually contracting an illness or of leaving it untreated.

In addition, the Health Belief Model assumes that the likelihood of an individual engaging in a given health behaviour will be dependant on the magnitude of the perceived threat as posed by the disease (Stroebe, 2000).

Cues to action: These could be internal for example the effects that a health condition has on a person's body (as is evident in physical symptoms); or external such as a mass media campaign, medical advice or death of a friend of similar age and lifestyle (Stroebe, 2000). These then become motivating factors for the individual to take corrective action. This is supported further by Rosenstock (1974), (as cited in Stroebe, 2000), who found that 'a cue to action' may be necessary to trigger appropriate health behaviour.

Other variables: These include demographic, psychosocial and structural factors that influence an individual's perceptions and hence his/her health-related behaviour.

Self-efficacy: This is the belief that one is able to successfully carry out the recommended action or behaviour in order to produce the desired outcomes (FHI, 1996; Janz & Becker, 1984).

Hence, according to the Health Belief Model, people weigh the benefits against the costs of engaging in particular health promoting behaviours and if the perceived benefits outweighs the perceived costs; then they will engage in that specific behaviour (Stroebe, 2000). For example, in contemplating to use condoms one will have to weigh the benefits of preventing pregnancy and the transmission of sexually transmitted infections (including HIV and AIDS) against the cost of decreased sexual pleasure. In applying this approach to the chances or risks of contracting HIV for example, the individual must perceive him/herself as being vulnerable to infection and also realize that the consequences may be fatal.

The Health Belief Model has been applied to a multitude of health behaviours and to many diverse populations. For example, it has been used to promote a better understanding of risky sexual behaviours (FHI, 1996). By far the most influential variable in the Health Belief Model for predicting and explaining health-related behaviours is 'perceived barriers'. Bandura explained that an individual's perceived ability to carry out a health strategy successfully influences his/her decision and the ability of him/her to sustain a changed behaviour (FHI, 1996; Janz & Becker, 1984). For instance using contraception to prevent or delay pregnancy.

### **2.3. Stages of Change Theory**

The Stages of Change Theory originated in 1992 and postulates a cycle of change. It was delineated by psychologists: James O. Prochaska at the University of Rhode Island, Carlo C. DiClemente at the University of Houston, and John C. Norcross at the University of Scranton. This theory identifies the psychological processes people undergo and the stages they reach as they adopt new behaviours. There are four

original components of the Stages of Change Theory: pre-contemplation, contemplation, action and maintenance.

Pre-contemplation: refers to the stage where the individual has a problem (whether he/she recognises it or not) but has no intention of resolving it. It includes the following processes: consciousness raising (information and knowledge); dramatic relief (role-playing); and environmental re-evaluation (i.e. how the problem affects physical environment).

Contemplation: refers to the stage where the individual seriously considers modifying one's behaviour once he/she has identified the problem. This process of assessing one's feelings with the intention of changing one's behaviour is called self-evaluation.

Preparation for action: refers to the stage where the individual decides to change his/her behaviour within the next month following the recognition there is a problem. At this stage, concerted efforts to bring about a change in behaviour may be identified and reported. This process of believing in one's ability to alter one's behaviour to making a definite commitment to ensure that this change does take place includes self-liberation.

Action: refers to the stage where the individual has been able to maintain consistent behaviour change for less than six months. This process includes reinforcement management (overt and covert rewards); helping relationships (social support, self-help groups); counter-conditioning (alternatives for behaviour); and stimulus control (avoid high-risk cues).

Maintenance: refers to the stage where the individual maintains the new behaviour for six months or more (FHI, 1996). Originally these stages were presented as a linear process of change. However the model was later modified to show that these

components were part of a cyclical process and that the pathway through these stages was specific for each individual. In addition, a fifth stage called 'preparation for action' was incorporated into this theory. Ten processes that helped to predict and motivate individual movement across these stages were also added.

This theory will be useful in this present study because it has been successfully applied to research on sexual behaviours (FHI, 1996). Furthermore, it offers a method for evaluating and measuring individual behaviour change, which in this case is contraceptive use.

#### **2.4. Theory of Reasoned Action**

Martin Fishbein of the University of Illinois and Icek Azjen of the University of Massachusetts proposed the theory of reasoned action in 1975 (Azjen and Fishbein 1980). It specifies that the adoption of a specific behaviour is a function of intent. This is determined by a person's attitude (that is their beliefs and expected values) toward performing a particular behaviour and of their perceived social norms (for example, the importance and expectations that others expect one to perform that behaviour).

The Theory of Reasoned Action has been used to explain and predict a variety of human behaviours. This theory assumes that humans are rational and that they make systematic use of the information available to them before they decide to take a particular course of action. The theory therefore posits that people consider the implications of their actions before they decide to engage in a given behaviour (Azjen and Fishbein 1980). The theory provides a construct that links individual beliefs to their behaviour, intentions and attitudes (FHI, 1996). The variables in this theory are behaviour, intention, attitude and norms.

Behaviour: Behavioural beliefs are a combination of a person's beliefs regarding the outcomes of a defined behaviour and the person's evaluation of potential outcomes and is defined by a combination of four components: action, target, context, and time. For example, implementing a sexual HIV risk reduction strategy (action) by using condoms with commercial sex workers (targets) in brothels (context) every time (time).

Intention: is the best predictor of whether a desired behaviour will actually occur and is influenced by one's attitudes and norms.

Attitude: According to this theory, the major factors determining a person's intention to perform a particular behaviour are the person's positive or negative feelings toward performing the defined behaviour. These attitudes are determined by the individual's beliefs about the likelihood and evaluation of the consequences of performing a particular behaviour (Ajzen and Fishbein 1980).

Norms: refer to a person's perception of other people's opinions regarding the defined behaviour (FHI, 1996). Normative beliefs are a combination of a person's beliefs regarding other people's views of a particular behaviour and the person's willingness to conform to those views. Hence, this theory also highlights the significance of social influences on whether to engage in a particular action or not. In this dissertation, the role of peer influences will be examined as a social factor that influences the choice to use contraception.

The theory of reasoned action provides a framework by which each of the above variables is linked. The behavioural and normative beliefs (also referred to as cognitive structures) influence individual attitudes and subjective norms respectively. Thereafter, a person's attitudes and norms shape his/her intention to perform a specific behaviour. Finally, a person's intention remains the best indicator that the desired behaviour will occur. In summary, the theory of reasoned action proposes a linear

process where changes in an individual's behavioural and normative beliefs will ultimately affect the individual's actual behaviour (FHI, 1996).

## **2.5. Social Cognitive Learning Theory**

Albert Bandura formulated the social cognitive learning theory at Stanford University in 1977. This theory is the most comprehensive model of community interventions and changing behaviour. In social cognitive learning theory it is believed that behaviour is determined by the expected consequences of that behaviour. Hence the expected outcome serves as an incentive or motivation. Where reward is expected that specific behaviour increases and vice versa.

Outcome expectation refers to the individual's belief that a certain behaviour will lead to a particular outcome (Witte, 1999). For example, young people may believe that the use of contraception will lead to pregnancy prevention and condom use will result in the protection against the transmission of sexually transmitted infections (including HIV/AIDS).

Perceived self-efficacy: This theory also assumes that a person's perceived self-efficacy is central to people's decisions to engage in specific health promoting behaviours (Witte, 1999).

Self-efficacy is the belief in the ability to implement the necessary behaviour (UNAIDS, 2000). Perceived self-efficacy is what the individual believes about his/her own capability to perform a certain action (Witte, 1999). If he feels incapable to achieve his goals then he is more reluctant to initiate change.

In order to change health behaviour programmes based on this theory, the following four components are essential. Firstly, there will be a need to have an information component that highlights the risks and benefits. Secondly, there must be provision of a means to change in (for example, by teaching self-regulating skills). Thirdly, the individual must be taught how to persevere in using skills in difficult situations and finally, support to address factors in the environment must be provided.

## **2.6. Critique of the models**

The limitations of the health belief model are as follows. Most research based on the health belief model has only incorporated a selection of its components. As a result, the usefulness of the model as a whole was not tested. The health belief model, in addition, does not take into consideration such factors as the environment or economic influences that may impact on health behaviours. Thirdly, this model does not take into consideration the influence of social norms and peer pressures on people's decisions regarding their health behaviours. This is extremely pertinent to this present study as the impact of peer relations plays a vital role in influencing the contraceptive behaviour of young people.

One of the limitations of the stages of change theory is that it focuses on the individual without assessing the role that environmental issues may have on a person's ability to enact behaviour change. Secondly, each of the steps in the stages of change theory may not be appropriate to the characteristics of all population groups.

The theory of reasoned action have the following limitations: It does not take into account the role of the environment and because of its linear nature, it does not allow for the fact that individuals may change their behaviour first and then only their beliefs or attitudes toward it.

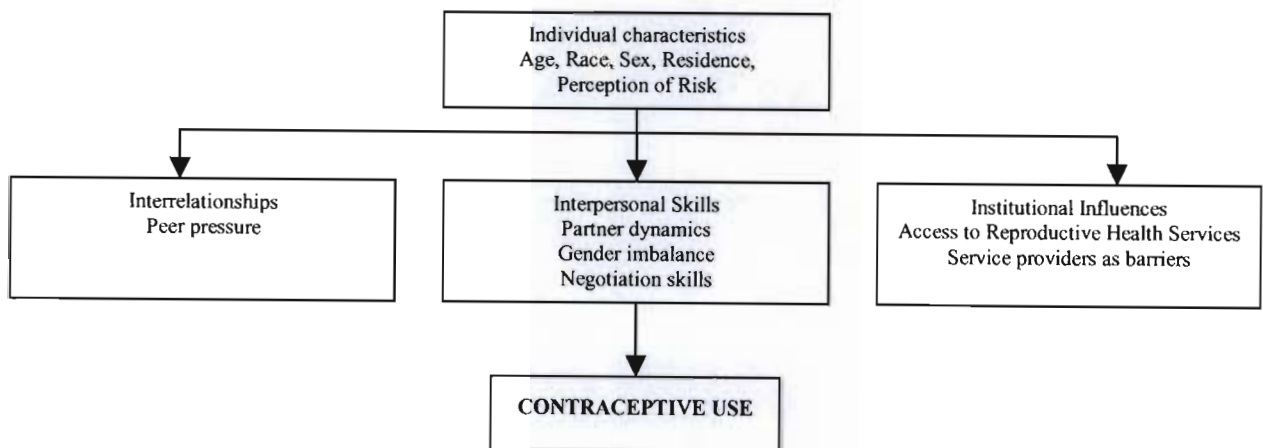
## 2.7. Proposed conceptual framework

The similarities inherent in the four theories above will be used to structure the arguments for this dissertation. In summary, the higher the perceived risk, the more likely it will be for people to carry out protective behaviour, which in this case will be 'using contraception'. Furthermore, the more positive attitudes people have regarding contraception, the higher their chances will be of practising safe sex. This implies that people's behaviours will be shaped by their rational decisions. It is also proposed that the choice to use contraception will be dependant on the following factors: respondent's age, race, sex, residential area, knowledge of contraceptive methods and their advantages; knowledge of a source of supply of contraceptives; attitudes to contraceptive use; knowledge of how to use the different methods of contraception; self-perception of risk of infection and/or falling pregnant and peer pressure.

Figure 2.1 below summarises the proposed conceptual framework that will be investigated in this study:

**Figure 2.1**

### **Proposed conceptual framework: Factors affecting contraceptive use**



## 2.8. **Summary**

This chapter presented four models of human behaviour and how change is likely to occur. After a critique of these models, a conceptual framework for this dissertation was proposed.

## CHAPTER THREE : LITERATURE REVIEW

### 3.1. Introduction

The complexity of studying the factors affecting sexual and reproductive health behaviour and practices among young people is encapsulated in the following quotation : "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" (Magnani et al., 2002:82). This provides a possible explanation as to why Preston-Whyte (1999:139) declared that reported protective behaviour appears "contradictory", "inconsistent", and "conflicting". Hence it is almost impossible to provide a "coherent picture of trends in risk avoidance" with respect to contraceptive use among young people

This chapter will review existing literature on the factors influencing contraceptive use with particular focus on young people, bearing in mind that these decisions are made in a complexity and multiplicity of social situations. It is also important to recognise that the parameters and constraints on decision making change as people move through life.

#### 3.1.1. Teenage unplanned pregnancy

Despite the fact that "lifetime fertility levels have fallen close to replacement" (Kaufman et al., 2001:148), fertility rates among young people have remained high in sub-Saharan Africa. This has caused a great deal of concern about premarital fertility especially in sub-Saharan Africa in recent years. For example, data from World Fertility Surveys (WFS) indicated that more than 30% of first births are conceived premaritally in some African countries (WFS, 2000). It was also found that in many cases, these pregnancies were unwanted and unplanned. Gage-Brandon and Meekers

(1993), using DHS data concluded that more than two fifths of teenage births were unwanted or mistimed in Botswana, Ghana, Kenya, Liberia and Togo. The DHS also showed that the teenage birth rate for South Africa was 77 births per 1000 women. This was much higher than the teenage birth rate of 54.4 births per 1000 females that was experienced in the USA (SADHS, 1998).

A study in South Africa on sexual debut also shows that young people are becoming sexually active at much earlier ages (Manzini, 2001). Of a sample of 796 young women, Manzini (2001) calculated that almost half had already had their first sexual experience by the age of 16 years. In addition, it was found that approximately 50% of the respondents had ever been pregnant. In most cases, these pregnancies were recorded as being unplanned and unwanted. Blanc and Way (1998) also observed that in sub-Saharan Africa, the period between first intercourse and first marriage was increasing. In addition, they found that the increase in age at marriage was larger. Hence, as young people postpone marriage to later ages the risk of premarital sexual activity increases and ultimately the likelihood of an unplanned pregnancy.

There are a number of factors that may contribute to early childbearing. These include: inadequate knowledge of human reproduction, low levels of contraceptive use, limited access to family planning facilities, violence and coercion and relationships with older, wealthy men who offer young women financial benefits in exchange for sexual favours.

Similarly, a multitude of factors influences one's choice to use contraception. Below is a summary of previous research pertaining specifically to young people and their reproductive health behaviour.

### **3.2. Education as a determinant in contraceptive use**

The role of education as a factor that influences sexual and reproductive behaviour has been well documented (Singh and Samara, 1996). For example, with an increase in the number of years of schooling, the period between menarche and marriage is lengthened. This in turn results in the extension of the period of premarital exposure to the risk of conception (Gage-Brandon and Meekers, 1993).

Mahy and Gupta (2002) also found that a person's educational level had a particularly strong influence on early reproductive outcomes. They found evidence of correlations between education and reduced fertility, increased contraceptive use and delayed union formation. For example, they asserted that in many sub-Saharan countries women with no formal schooling had two or three children more than women with secondary or higher education. In addition, the SADHS (1998) showed that in South Africa the fertility rates were consistently lower for women with higher levels of education. This ranged from 4.5 for women with no education down to 1.9 for women with higher education.

A growing amount of literature on teenage pregnancy suggests that early childbearing led to high school dropout rates. According to Gage and Meekers (1993), 10% of Kenyan female students drop out of secondary school each year as a result of pregnancy. These girls were permitted to resume their schooling after the birth of their child, but their additional responsibilities, make it difficult for them to complete their education. This is evident in a study conducted by Gorgon et al., (1993), where students were not forced to leave school while they were pregnant and were allowed to return directly after the baby was born, yet the school dropout rate was still high. After about two years most students dropped out of school because of the difficulties they experienced trying to juggle the responsibilities of motherhood with the demands of schooling. A similar trend exists in South Africa, despite the South African School Act of 1996 that ruled against the expulsion of pregnant schoolgirls (Everatt and Jennings, 1996).

An earlier study by Preston-Whyte et al. (1988) revealed that most adolescent mothers were allowed to return to school after the birth of their child and in some cases even to the same school. Kaufman et al. (2001) who also agreed that pregnant South African girls were not expelled confirmed this, but allowed to return to school once the child was born. Furthermore, they found that educated girls tend to fetch a higher bride price and this encouraged parents to support their daughter's schooling (Kaufman et al., 2001). This group of researchers maintain that even though the system of bride-wealth continued to operate; a causal link between education and delayed second birth seemed to exist, suggesting the value that is now placed on education. Kaufman et al. (2001) cites a study conducted by Richter (1996) in support of this trend whereby only 12% of young (aged 16-19 years) African girls in three South African metropolitan areas indicated that they wished to have a child in the next year or two. The majority stated that they wanted to do so to prove their fertility. Most girls indicated that they did not want to have a child until they had finished school and had the means to provide for their child. Thus, "shifting opportunities" in the form of educational advancement provides a direct incentive for young mothers with one child to delay the second birth. Kaufman goes on to quote work done by Varga and Makubalo (1996) and Wood and Jewkes (1997), which found that girls rarely wish to become pregnant at an early stage and if they did, the support they received from the family members was uneven. Hence, this recent evidence presents a slightly different scenario to the findings of Preston-Whyte (1988).

### **3.3. Knowledge, source and use of family planning methods / contraception**

An abundance of literature reveals that knowledge of at least one contraceptive method (traditional or modern) is universal (UNDP, 2004). In their study, Gage-Brandon and Meekers (1993) found that on the whole this information was widespread amongst most sexually experienced never-married women. More than 90% of unmarried sexually active women in Botswana, Kenya and Zimbabwe and more than 70% of females in the remaining countries knew of at least one modern contraceptive method (Gage-Brandon and Meekers, 1993).

The SADHS (1998) found that three quarters of the South African women that were interviewed replied that they had used a contraceptive at some time in their lives. Sixty one percent of these sexually active women reported that they were currently using a contraceptive. Just under a third used injectables, three percent took the pill, twelve percent made use of the sterilisation method, only two percent used the male condom and one percent opted for the more traditional methods of periodic abstinence, withdrawal or herbs. Young women, those that live in urban areas and those with higher levels of education were found to be more likely to use contraceptives (SADHS, 1998).

Knowledge of family planning methods on its own does not automatically translate into action or practice (Gage, 1998; Magnani et al., 2002). In contrast, Maharaj (2001:252) stated that the knowledge that contraception can prevent or delay pregnancy "is an essential first step for their acceptance and subsequent use". However, knowledge of the different types of contraceptive methods by itself is insufficient to bring about a significant change in behaviour that reflects correct usage (Gage-Brandon and Meekers, 1993). Maharaj (2001), in her study of male attitudes to family planning cites the example of Uganda, where almost every respondent had heard of condoms, but only 10% knew how to use one correctly.

Zheng et al. (2001) found in their exploratory research of Chinese women aged 16-25 that the majority lacked basic information about reproduction and contraception. Neither did they know where and how to obtain contraception. In addition to this, most young women were very eager to please their male partners and hence refrained from using any form of protection that would appear obtrusive to their sexual experience. Consequently, very few unmarried adolescents used any protection during premarital sex. Resultant pregnancies usually led to one of two outcomes: induced abortions or a hasty marriage.

This same group of researchers discovered that most young females in their study only became aware of contraception after an unwanted pregnancy had occurred. They

only began using a contraceptive method after they gave birth or had had an abortion. In South Africa, Preston-Whyte (1999) confirmed that contraceptive use had increased after the birth of the first child. Varga (1999) argued that one possible explanation for this trend is that young women need to prove their fertility in order to increase their value as marriageable.

On the other hand, a number of researchers have discovered that economic and social barriers and not knowledge impede safe sexual behaviour (Hulton et al., 2000; Magnani et al., 2002; Wood and Jewkes, 1997). The underlying premise to these studies was that the *primary* reason why women engage in risky sexual behaviour is because of their perceived threat to their socio-economic survival and their lack of power in sexual decision-making.

#### **3.4. Attitudes to family planning and contraceptive use**

Young people use contraception for a number of reasons including the desire to prevent or delay pregnancy, protection from sexually transmitted infections, fear of the monetary and social costs of pregnancy and among both adolescent mothers and fathers the fear of being dismissed from school (Gage, 1998). Possible reasons why adolescents do not use contraception may be due to gender imbalances, social pressures and economic constraints. Young people are susceptible to poor decision making because of identity and autonomy issues. They are particularly vulnerable to peer-pressure especially during adolescence. In addition, young girls in low-income communities may be susceptible to the coercive powers of men with power and money (Gage, 1998). This is referred to as the "sugar-daddy" syndrome.

Contraceptive use is for the most part, quite high amongst South Africa's young people, with almost two thirds of sexually active young people currently using a modern method of contraception (SADHS, 1998). However, in some areas of South Africa, contraceptive use has been estimated to be as low as 25% amongst sexually

active young people, with the injectable being the most popular method. Just over half the number of females aged 15-19 years old were currently using a method. The SAHR (2000) reported that most young people did not use a condom during sexual intercourse or if they did, they were used inconsistently. This is confirmed by the results from the SADHS (1998) which found that only four percent of teenage women who were interviewed reported that they were using a condom as their current method of contraception. However, one in five young females reported using a condom during their last sexual encounter. The apparent discrepancy in these results may be explained by the finding that some people do not regard condoms as a form of contraception but rather as a method of prevention against sexually transmitted infections including HIV/AIDS. Preston-Whyte (1999: 139) also observed: "actual use (of condoms) tends to be inconsistent and decreases with time." Varga (1999) discovered that young Black South Africans accepted the idea of using condoms, but she could not ascertain the extent to which this change was translated into action. In fact, she found that just the act of carrying a condom was not only interpreted as evidence of having multiple partners, but also of being HIV positive.

It has been found that women's knowledge of contraceptive methods (especially female-controlled methods) is higher than that of men (Maharaj, 2000). However actual use of condoms in South Africa shows that twice as many men as women ever used condoms (Maharaj, 2000). A possible explanation for this is that generally, young men viewed it more important to use a condom with a casual partner (in order to avoid infection), whom he did not trust, rather than with his more permanent, 'real' girlfriend, whom he regarded as 'clean' (Preston-Whyte, 1999). Harrison et al. (2001:63) claims that condom use is highest among young people with "almost 20% of sexually active teenage women reporting use at their last intercourse". However, only four percent of these women were using the condom for contraceptive purposes.

### 3.4.1. Contraception is a woman's responsibility

Recent research has confirmed that generally young men regard the acquisition of contraceptive supplies and the use of a contraceptive method to prevent unplanned pregnancies as the responsibility of women (Mfono, 1998; Hulton et al., 2000; Maharaj, 2001 and Nsioka, 2001). With specific reference to the actual practice of family planning, Maharaj (2001) found that although the majority of men in her focus group discussions expressed favourable attitudes towards family planning, they continued to regard it as the responsibility of the women. Additionally, a study of adolescents in Uganda by Hulton et al. (2000) showed that males rarely consider a partner falling pregnant an immediate concern for them. As a result it was not something they were going to take active steps to avoid. In contrast, girls professed to be more wary about an early or mistimed pregnancy. For many boys, having a baby was seen as a means of improving their status and the male's desire to have a child seemed to be more of an influential factor than the desire to prevent a pregnancy (Hulton et al., 2000).

In Nsioka's (2001) study, 12% of Kenyan rural males aged 15-19 years old reported that they had caused a pregnancy. He found that boys were ambivalent about making girl's pregnant (Nsioka, 2001). On the one hand, fathering a child was seen as a sign of pride and "sexual prowess" as making girls pregnant was a sign of their virility (Ibid:112). On the other hand, most young men in this study appeared to blame the girl (and her parents for not teaching her the 'safe period' method), if an unwanted pregnancy occurred. Furthermore, the same study concluded that young males tended to boast about their sexual conquests to peers, yet they were unwilling to obtain condoms from places where anonymity was not ensured. In contrast, some boys expressed concern about the negative impact that a mistimed pregnancy had on the girl's educational and economic prospects.

### 3.5. Barriers to contraceptive use

Kaufman et al. (2001) has categorized barriers to contraceptive use into socio-economic, institutional and cultural groupings. Institutional barriers have been governed by the implications of the apartheid policy in South Africa. However, no longitudinal data exists concerning sexual and reproductive health behaviour and practices of young South Africans, hence the actual degree of impact that transformation has had cannot be measured (Kaufman et al., 2001).

With specific reference to condoms as a form of contraception Varga (1999) found that there was considerable resistance to the use of condoms by both males and females as it was linked to promiscuity, lack of trust and was regarded as physically uncomfortable. These findings are further supported by a study conducted by MacPhail and Campbell (2001) who found that the youngsters in their sample were of the opinion that condoms were not a preference in steady relationships as they reduce sexual pleasure which they regarded as integral to their sexual interactions. In addition, the use of a condom with a permanent regular partner may be interpreted as a sign of infidelity and untrustworthiness. For example, if a partner initiates a discussion on condom use it might suggest that he/she suspects his/her partner of being infected or even worse that the partner is hiding his/her own infected status (Varga, 1997). This link between condom use and lack of trust has been confirmed by a Durban study by Tillotson and Maharaj (2001) who discovered that young males used condoms when they did not trust their partners either because they did not know them well or suspected her of having multiple partners.

Another barrier to condom use is the reliability of the condom itself: In the study conducted by Tillotson and Maharaj (2001), there was the concern that condoms may have holes in them and hence respondents were reluctant to utilise them. A further misconception that prevented some young males from using condoms was that they thought that the condom itself might carry the HIV virus (Maharaj, 2001).

Mfono (1998) states that girls were reluctant to use contraception (for eg the pill) because of the importance they placed on physical appearance and self-image, as they believed that some methods resulted in weight gain. Another factor that affected contraceptive use was its supply and availability. According to Mfono (1998: 180), "adolescent's access to contraception in South Africa has traditionally been restricted by legislation requiring parental consent."

### 3.5.1. Partner dynamics and communication

*especially during adolescence. Not adolescence.*  
Power imbalance that exists between intimate couples poses another barrier to contraceptive use. Hence, negotiation skills and decision-making practices are important variables in the choice to use contraception or not. Varga (1999: 29) found that "the sexual dynamics of young people were characterised by poor communication". In many cases, sexual activity was spontaneous and as a result they were unprepared for the event. This trend is consistent with work done in other parts of sub Saharan Africa (Gage, 1998). According to Varga (1999:20), couples who did talk about such matters usually communicated through "oblique references." As a result, there was a lack of clarity concerning partners' expectations of each other. This has forced some women to adopt covert methods of family planning (Maharaj, 2001). Most of these are female-controlled methods that prevent unwanted pregnancy but provide no protection against sexually transmitted infections (including HIV/AIDS).

#### 3.5.1.1. Violence and coercion

Violence against women and the imbalance of power within sexual relations serve as a major barrier to safe sexual behaviour. Usually men have more power in sexual relationships than women. Patriarchal attitudes, structures and procedures often undermine young women making them particularly vulnerable to the risk of unwanted pregnancy and sexually transmitted infections including HIV/AIDS. On many occasions young women have less power over their own bodies than men, and are

often required to be more accountable for their actions than young men (for e.g. teenage pregnancies).

The role of violence and coercion in sexual and reproductive health behaviour and practices has been interpreted differently by men and women. For example, some females accept their male partners using force to initiate sex (Gage, 1998). Jewkes et al. (2001) reported that one third of young girls in South Africa experience sexual initiation by force. In the year 2000, 13% of South African women reported being beaten by their intimate partners (SAHR, 2002). Varga (1999) found that many young women described physical coercion in a sexual relationship as being normal and a sign of love from their partners. Furthermore, she discovered that 71% of females in her pilot study stated that refusing sexual advances was met with physical coercion (Varga, 1999:18). In this study coercive sex was viewed as acceptable by both men and women and generally seen as a "male mandate" (Varga, 1999:28). Wood et al. (1998) also found that violence is so common place in sexual relationships, that South African adolescents have come to accept violence as inevitable.

Gender-based violence is a significant reason why some young people do not practice contraceptive use. Young women in particular are at a disadvantage to negotiate safe sexual practices if they are faced with physical and verbal abuse. There also appears to be a link between gender-based violence and early childbearing. Research in the western Cape revealed that one third of pregnant teenagers had encountered forced sexual encounters (Wood and Jewkes, 1997).

The threat of violence constitutes a major obstacle to sexual negotiation especially for women, but more so for young women in particular. To this end, Jewkes et al. (2001) reported that a third of young South African girls experienced sexual initiation by force. Wood and Jewkes (1997) found that among Xhosa young people in South Africa it was common for male partners to enforce the conditions under which sexual relations occur often by violent means. Violence was accepted as an inevitable part of the relationship and "reinforced by female peers who indicated that "... submission

was the appropriate response" (Wood and Jewkes, 1997:23). In some instances, male violence was interpreted as indicative of affection or commitment.

The seriousness of this practice is manifested in research conducted by Harrison et al., (2001: 68), where young women's description of the 'ideal' partner was "one who will not beat me". In this same study, young males were interviewed separately yet were uncomfortable discussing the issue of sexual violence, as if they experienced it and were ashamed.

#### 3.5.1.2. Sexual decision - making and negotiation

One of the most significant findings in a study conducted by Varga (1999:14) was that both sexes faced "similar constraints" when attempting to negotiate the terms and conditions of sexual relations. Even though the male played the dominant role in sexual decision-making, both viewed unprotected sex as an 'integral part' of a serious love relationship (Varga, 1999: 18). However, gender imbalances also inhibit negotiation among partners to the extent that partner dynamics are characterized by: avoidance of direct communication, unspoken assumptions about appropriate sexual conduct and male dominance in most aspects of sexual decision-making. An earlier study by this same researcher revealed that most women admitted that their refusal to engage in unprotected sex nearly always resulted in physical coercion, abuse, abandonment or threats of rejection (Varga, 1997). As a result, the majority of women opted to remain silent and passive in the sexual decision making context. Blanc and Way (1998) also found that sexual negotiation might be limited because in many cultures girls are not supposed to be knowledgeable about sex and are expected to be passive in sexual matters. Furthermore, refusal to submit to her partner's sexual demands implied that she had other sexual partners (from the man's perspective). This, in turn led to increased violence and abuse.

Harrison et al. (2001:69) discovered that most young women in her peer group discussions viewed a "desirable relationship" as one in which the male partner made the decisions, introduced condoms and controlled the timing of sex. Such beliefs represent the acceptance of subtle forms of control. This is confirmed in a study conducted by Preston-Whyte (1999) which found that women were subjected to abuse from their partners if they insisted on condom use. Furthermore, these women tolerated this treatment because of the fear of financial abandonment. According to Kaufman et al. (2001:148) "women who are to achieve financial independence may be better positioned to negotiate the terms of their relationship" (for example whether to use contraception and which methods to employ).

Manzini (2001) found sexual decision making and negotiation to be almost absent in many instances of sexual debut. Almost a third of all young females interviewed stated that they were 'persuaded', 'tricked', 'forced' or 'raped' the first time they had sexual intercourse. Similarly, Rutenberg et al. (2001) found that 29% of girls in her study reported non-consensual sex and 12% had been physically forced hurt/threatened during sexual debut.

### **3.5.2. Peer pressure**

According to Buga (1996) and the NPPHCN (1996), both young men and women experience considerable same-sex pressure to be sexually active. Men are pressurised to prove their manliness by having many sexual partners. For young women, pressure comes from sexually experienced peers who exclude inexperienced girls from their group discussions referring to them as "children" (Wood et al., 1997). The following is an example of the pressure that young people, especially males find themselves exposed to. Preston-Whyte quotes the following words of a 14-year old pregnant girl from one of her focus group discussions: "He said he wanted to have sex with me because the other boys were saying he was like a child. If I didn't agree, then he said he would go to another girl" (Preston-Whyte et al., 1988:18).

In addition, peers have a negative attitude towards condom use, increasing the likelihood of unprotected sexual practices (MacPhail and Campbell, 2001). Some adolescents have branded their peers as being 'stupid' for using condoms, while females who carry condoms face the risk of being labelled: 'promiscuous', 'bitch' or sexually available, as young men regarded these condom-carrying females as having 'many lovers' (MacPhail and Campbell, 2001).

### 3.5.3. Emphasis on fertility

Recent research suggests that proving a young woman's fertility in the African culture is not as important as previously indicated. This section provides both views. The high levels of teenage pregnancies are an indication of the increasing numbers of young people that are engaging in unprotected sex. A recurring theme in the literature on the sexual behaviour of young people is the difficulty in understanding the persistence of this situation despite the increasing awareness, availability and accessibility of contraceptives. Preston-Whyte (1999:143) referred to this phenomenon as the "fertility conundrum". In an attempt to fathom this trend, Preston-Whyte et al. (1988) provided a perspective from the stance of adolescent mothers themselves. They found that despite initial parental disapproval of unplanned pregnancy, this did not necessarily translate into alienation or ostracisation of the teenage mother or her baby. Ultimately, they received support from either their own families or the family of the child's father. Another factor that did not make premarital pregnancy unattractive was the fact that both mother and child could remain in her family's home thus securing financial and physical assistance with the maintenance and upkeep of her child. Hence, for many young women early childbearing was not always a complete disaster.

In addition to the idea that premarital pregnancy was not something that needed to be consciously avoided, are the numerous examples of single parenthood role models that young African people were exposed to. As Preston-Whyte et al. (1988:14)

declared “some of the most successful and respected women in the urban black community have not married, but have children.” Moreover, the value placed upon children was so high in the black community that marriage was, in some contexts, quite irrelevant to bearing a child.” The idea therefore of a ‘shot-gun’ wedding was not a preferred option and seldom if ever took place, as the bride’s family also stood to forgo the much-valued bride wealth or ‘*illobolo*’. Kaufman et al. (2001) cited Singh and Samara (1996) in support of this trend. They found that premarital birth (especially in Southern Africa) did not necessarily result in marriage.

In their study of teenage pregnancy amongst African females, Preston-Whyte et al. (1988:13) offered a possible explanation for the positive dimensions to early pregnancies that caused young people to be inclined in this direction. Adolescent mothers did not have to find separate accommodation for herself and her child nor was she forced into an immediate marriage. Hence young girls grew up in an environment in which premarital pregnancy did not lead to ostracism from the family home and neither did it threaten the support they could expect from it. In addition, in South Africa it is customary for girls to return to finish her schooling after the birth of a child. Consequently, they did not feel at risk of ending their educational and professional aspirations as a result of premarital pregnancy. This is supported by the findings of a study of adolescent mothers by Kalil (2000) where respondents did not view childbirth as an impediment to their aspirations. In fact, early childbirth appeared to have motivated 80% of young mothers who believed that having a child increased the importance of securing a good job which translates into economic independence and hence the ability to better provide for their children. However, it is important to note that at least a quarter of adolescent mothers felt that giving birth to a child did in fact hinder their future prospects.

In African society, high emphasis is placed on fertility. It is common for unmarried females to prove their fertility in order to ‘market’ themselves as being more marriageable (Gage-Brandon and Meekers, 1993:15). The importance of this custom cannot be underestimated as it has been put forward as the main reason why most young African women only commence contraception after having proved their ability

to give birth to a live child. This practice is compounded by the belief that contraceptive use will ultimately lead to infertility.

However, some studies provide evidence to the contrary (Rutenberg et al., 2003, Kaufman et al., 2001). A recent report by Rutenberg et al. (2003:122) echoes this changing perspective on adolescent childbearing. They found that young people have "ambivalent" attitudes towards pregnancy as a result of their perception of the risk of HIV infection. This study also found that early childbearing was perceived as a major problem among African girls. Early childbearing is likely to interrupt their education hence stifling better employment opportunities. These young women use contraception because they are motivated by the desire to delay childbearing.

#### **3.5.4. Access to health services and service providers as barriers**

The issue of access to health services is a major one for young people in South Africa because of past imbalances. By the year 2000, it was found that almost all young White (95%) and Indian (93%) women and men were able to access health facilities within thirty minutes of their place of residence. On the other hand, only 61% of young Black men and women and 84% of young Coloured people could do so (SAHR, 2000). However, service providers have been "notoriously unsupportive" towards young people seeking reproductive health services, making them feel unwelcome by scolding them for being sexually active at such a young age and refusing to provide them with contraception without their parents' consent (Kaufman et al., 2001, Klugman, 1992 and Mfono, 1998). Abdool Karim et al. (1992b) in their study of teenagers seeking condoms at family planning clinics also found that some clinic staff simply refused to provide young girls with this form of protection. Some reproductive health providers regarded the use of condoms as being an unreliable method of contraception and hence discouraged their use. In cases where condoms were supplied, no guidance was provided as to how to use a condom; yet others felt too embarrassed to dispense condoms to young men. In one Durban clinic, nurses resorted to obtaining the services of their security guard (since he was the only male

available) to distribute condoms to young men (Abdool Karim et al., 1992c). Other important findings were that at times the clinics ran out of stock and that contraception was dispensed in a setting that lacked privacy.

### **3.6. Perceived risk**

Young people need to make important choices with respect to their sexual activity. These include: whether or not to have sex at all; whether to remain sexually active after the first experience; whether to use contraception at every sexual encounter and whether or not to engage in premarital sex (Gage, 1998). This choice will be dependent largely on the young person's level of self-perceived risk.

Young peoples' perception of risk is likely to affect their protective behaviour. However, Nsioka (2001) argued that despite a high knowledge of sexual risks, fear of HIV/AIDS and the awareness of the protective value of condoms; the young men in his focus groups still exhibited high risk behaviour in order to conform to the social mores of male prowess, early sexual experience and having sex with more than one partner.

Harrison et al. (2001) argues that there is a gap between awareness and practice. They argue that in spite of years of public campaigns, a pronounced gap is evident between high awareness of sexual risk and the practice of safe sex behaviour.

The impact of AIDS should also increase awareness of risky sexual practices. In her study of South African youth, Varga (1999) found 'acute' awareness of the presence of HIV in their communities and it is a frequent topic for discussion. Despite the acknowledgement that AIDS is a significant social health problem, young people do not appear to feel *personally* at risk of HIV infection.

Kalunde (1997) drew similar conclusions in her study of the sexual behaviour of Zambian youth. She found that regardless of the race, sex or educational backgrounds of the respondents, they did not believe that HIV/AIDS would be a threat to their own lives.

Richter's (1996) survey among Black youth in South Africa confirmed that although some teenagers have adequate knowledge they displayed a low perception of risk. On the other hand research conducted in two former Black townships in Durban revealed a combination of high knowledge levels and high self-perceived risk of HIV infection (Varga, 1999). According to this study, two thirds of the respondents expressed the desire to change their behaviour to reduce the risk of HIV infection.

Recent research has shown that in addition to the effects of education and employment opportunities, the danger of HIV infection is "becoming part of the calculus of the desirability of a pregnancy" (Rutenberg et al., 2003:122). The increase in the awareness of the prevalence of HIV infection is now becoming a major factor when considering whether or not to fall pregnant.

### **3.7. Culture as a factor in contraceptive use**

Closely linked to gender-specific sexual behaviour is the influence of culture. Numerous studies have reported culturally defined gender roles. These stereotypes of male dominance and female submissiveness have a significant impact on sexual and reproductive decision making. For example communication on sexual matters between partners becomes restricted (Varga, 1999). This form of gender bias limits women's power to prioritise their own needs like protecting themselves against sexually transmitted infections including HIV. For many women, initiating the subject of 'sex' is taboo while attempting to negotiate the use of a condom with their partners is almost impossible. This attitude is encapsulated in the following excerpt from a study conducted by Harrison et al. (2001: 69): "Perhaps the most powerful finding is

that girls said it would be easier to try to refuse sex than negotiate condom use." This signifies what little importance women have placed over their own prevention needs as ultimately condoms are male-controlled. In addition, women were found to be apprehensive about asking their partners to use condoms as this was viewed as a sign of mistrust or promiscuity (Harrison et. al., 2001). Hughe and McCauley (1998) confirmed these findings when they discovered that in some parts of Brazil it was considered unmanly to wear a condom yet if a woman carried condoms, she was considered promiscuous.

Wood and Jewkes (1997:23) stated that in the Xhosa culture a woman was expected to play a submissive role in sexual matters and was regarded as a 'whore' if she had many partners. For men however, a demonstration of multiple sexual conquests or "isoka" was socially expected and accepted (Varga, 1999: 18). This reinforces the belief that it is acceptable for men to engage in high-risk sexual practices. Maharaj (2001) also found that culturally prescribed gender roles were often used to perpetuate male control over women. In addition, Gage (1998) asserted that some Sub-Saharan countries reward males for 'polygamous' behaviour before marriage. In these situations, women strive for the affection of a man, trying to be his "main" partner, since the male may threaten abandonment if sex is not part of the relationship. This results in women having little control in sexual relationships, which are generally risky as a result of inconsistent condom use (Gage, 1998).

Another instance where the role of culture has had an important impact on contraceptive use was highlighted by Zheng et al. (2001). They stated that in the rural villages of China, premarital pregnancy caused the couple and their parents to lose face if others found out. The study found that contraceptive use was low among adolescents and as a result, abortion was rife. In this society, the belief that premarital pregnancy brings disgrace has had the opposite effect on contraceptive use – they have actually resorted to abortions as a form of 'family planning'. Alternatively, premarital fertility was found to precipitate premature marriages or consensual unions that eventually contributed to family instability. In some cultures, therefore childbearing before marriage may produce an increase in female-headed households

and resultant poverty (Gage-Brandon and Meekers, 1993). It is therefore important that future intervention programs take cognisance of this by ensuring that they are "culturally sensitive" (Preston-Whyte, 1999: 42).

### **3.8. Type of residential area**

Research on residential area by typology has revealed differences in terminology: some refer to rural-urban categories, some to urban, non-urban and yet others to formal versus informal residential areas. Rural-urban differentials as a socio-demographic variable in the sexual and reproductive health behaviour and practices of young people has been the focus of a number of studies: For example, Mahy and Gupta (2002) found that an increase in urbanisation resulted in a decline in fertility levels by about one third. In the 1960's, there was an average of six lifetime children per woman - this has been reduced to about four today. Forgey et al. (2001:55) also noted that there were 'sizeable' differences in fertility levels between urban and non-urban South African women. The total fertility rates for non-urban were almost double that for those females residing in urban areas. Among African women living in non-urban areas, the total fertility rate was four children per woman, while the total fertility rate among urban African women was 2.4 (Forgey et al., 2001). In contrast, the total fertility rate for White urban females was 1.9.

Variance in the levels of unwanted or premarital pregnancies were also evident depending on the type of residential area in which the mothers lived. For instance, Kaufman et al. (2001) cited Bledshoe and Cohen (1993), who found that specifically in urban areas the number of premarital pregnancies was increasing as the age at marriage was rising. In contrast Maharaj (2000 & 2001) found in two totally independent sexual and reproductive health studies that urban-rural differentials were non-existent: Firstly, in her study on male involvement in reproductive health, Maharaj (2001) discovered that both urban and rural men strongly supported the practice fertility regulation. Secondly, her research on the prevalence of unwanted pregnancy in KwaZulu-Natal revealed that levels were reported to be high in both urban and rural areas (Maharaj, 2000).

Place of residence may also impact on contraceptive choice. In a study in Kenya, Nsioka (2001) found that rural men were less likely to use modern contraception compared with those residing in urban areas. Nsioka (2001) argues that information, education and communication (IEC) programs were not reaching rural areas. Another reason why people in rural areas could be less likely to use contraception could be their lack of knowledge about the different types of contraceptive methods, their uses and effects. Problems pertaining to the lack of easy access to contraception have also contributed to a lower prevalence of contraceptive users in non-urban areas. According to Akwara et al. (2003), people in remote areas might not be aware of the risk of unprotected sex because public awareness campaigns are not reaching them.

### **3.9. Conclusion**

This literature review has identified a number of factors that promote or inhibit contraceptive use. The higher the number of years of schooling, the greater the likelihood of using a family planning method and the lower the fertility level. Knowledge of contraception was almost universal, although knowledge of its use and source of supply varied. Generally, females' knowledge of family planning methods was higher than their male counterparts. Older youth were more likely to practice safe sex. Young men tended to regard contraception as the responsibility of the women. One of the most common barriers to condom use was found to be its association to promiscuity, lack of trust and physical discomfort. Negotiation and decision-making skills were important variables in the choice to use contraception. Physical violence in sexual behaviour was viewed differently by males and females. Both sexes were influenced by peer pressure when making reproductive choices. Certain cultures required proof of fertility as a criterion for marriage; this encouraged premarital fertility. Some health care providers displayed a negative attitude towards young people seeking contraceptive support. Perceived risk was not necessarily linked to knowledge levels. Rural residents were less likely to engage in modern contraceptive methods, and their pregnancy levels were higher than in urban areas.

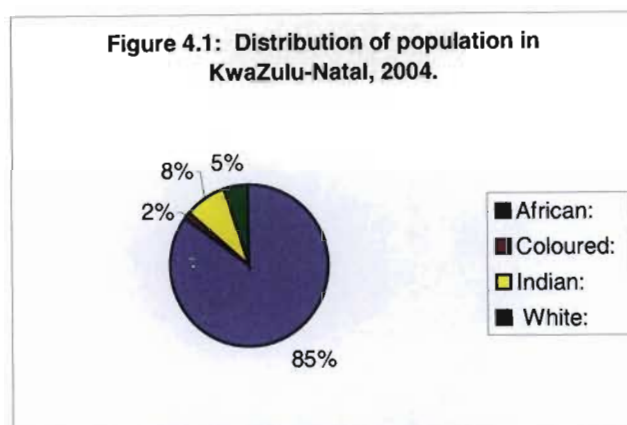
## **CHAPTER FOUR : DATA AND METHODOLOGY**

### **4.1. Introduction**

This chapter begins by examining the context of this study. It provides a brief description of the two study sites. This research draws on both qualitative and quantitative data. Quantitative methods describe and summarise data into frequencies and cross tabulations examine casual relationships. The main analytical tool used in this study was the multivariate logistic regression model. The qualitative contribution of the focus group discussions provides insights into the personal and private experiences of young people. Use of this method of triangulation enhances the validity and reliability of the findings in a study as Babbie and Mouton (2001:277) claim that triangulation is "the best way to elicit the various and divergent constructions of reality."

### **4.2. Contextual Background**

KwaZulu-Natal is situated on the eastern coast of South Africa and covers an area of approximately 92100 square kilometres which constitutes eight percent of the country (STATSSA, 2004a). With a population of over 9.4 million (STATSSA, 2004b), KwaZulu-Natal is South Africa's most populous province, containing one-fifth of the country's population. According to the 2001 national population census, there was a greater proportion of females (53%) than males (47%) in KwaZulu-Natal (STATSSA, 2004a). Most people that live in this province are rural and African. The distribution of the population in KwaZulu-Natal by race is presented graphically, below.



*Source: Statistics South Africa, 2004*

The province of KwaZulu-Natal comprises the highest number of young people with over 1.9 million in the 14-22 year old age group in 2004 (STATSSA, 2004b). Total fertility rates are also high in KwaZulu-Natal. It had a fertility rate of 4,3 in 1991 when 15,3% of all live births were to mothers who were less than 20 years old (SAHR, 2004). By 1996, the total fertility rate dropped to 3.1 and then to 3.3 in 1998 (SADHS, 1998).

A comparison of the nine provinces in South Africa demonstrates that KwaZulu-Natal has the highest HIV prevalence rate (SAHR, 2004). Since 1990, KwaZulu-Natal's antenatal clinic results have exceeded the national average. HIV prevalence increased from 1,6 in 1990 (that is double the national average of 0.8) to 14.4 in 1994 and to 36.2 in 2000, which is the worst recorded in Africa (SAHR, 2004). It is extremely alarming that the HIV infection level had risen in 2000, after stabilising between 1998 and 1999. However, the SAHR (2000) reported that it declined to 33 in the year 2001. (These statistics should be viewed in accordance with the cautionary note with regard to the methodology of the ANC surveillance results as mentioned in the introduction).

### **4.3. Study Area**

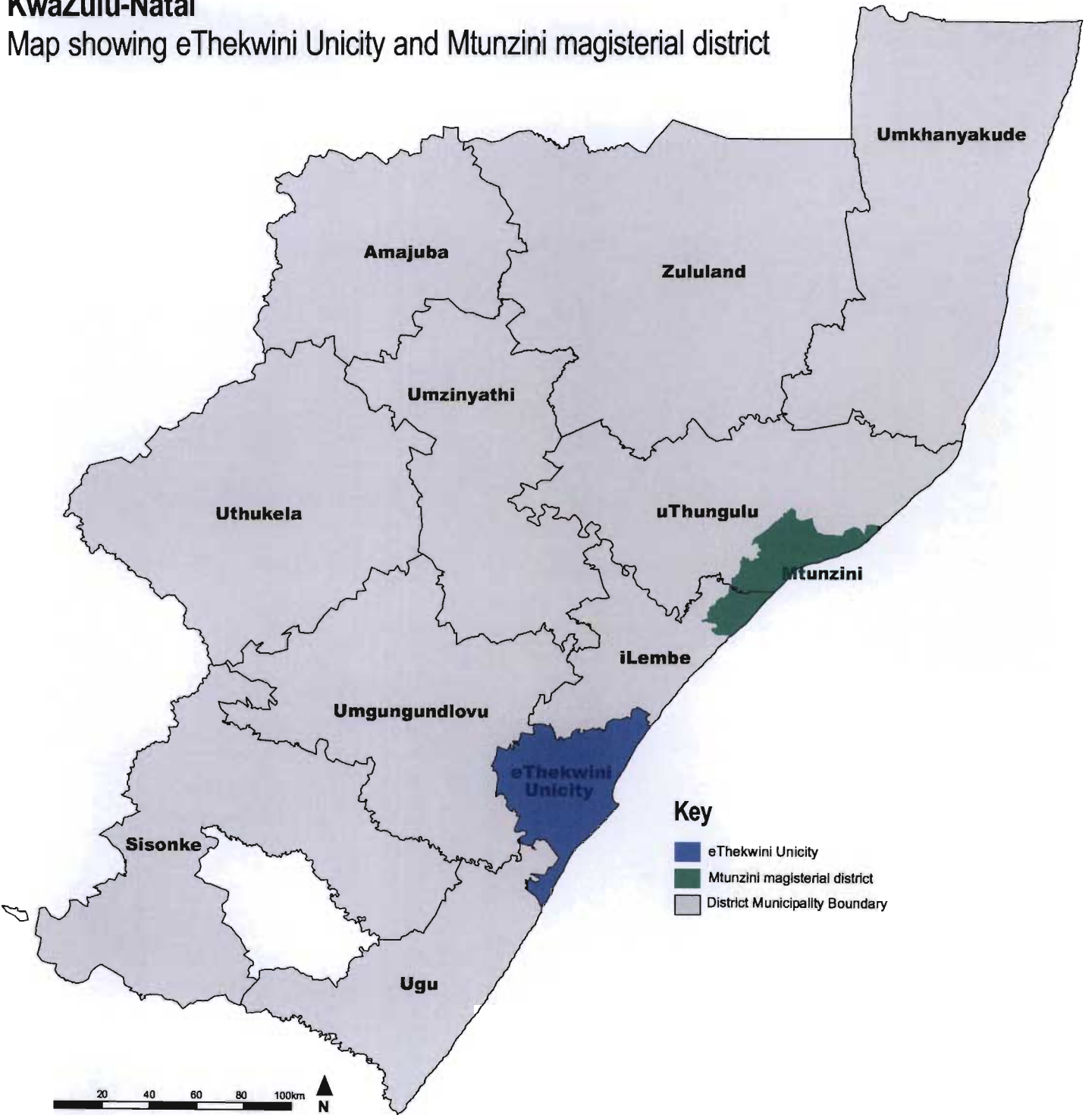
The attached map shows the province of KwaZulu-Natal and highlights the two areas (viz. eThekweni and Mtunzini) from which the sample for this study was selected. The names eThekweni and Durban are used interchangeably, in both official and unofficial sources, to refer to the recently amalgamated municipality that includes the Durban central area and a number of surrounding communities. The terminology “municipality” and “Unicity” are also used interchangeably, and all four terms will be used in this dissertation. Metropolitan Durban is predominantly urban in character and has a population of 3.15 million (eThekweni Municipality, 2004). Mtunzini which is located to the north of Durban has a population of approximately 640 000 (STATSSA, 2004b).

### **4.4. Data and Variables**

The findings in this research are based on the first round of the 'Transitions to Adulthood in the Context of Aids in South Africa' study, which was conducted in KwaZulu-Natal in 1999. This is a research project conducted by the School of Development Studies at the University of Natal, Durban; the Horizons Project; the Policy Research Division of the Population Council; Focus on Young Adults and MEASURE / Evaluation Project of Tulane University in New Orleans. The Transitions to Adulthood Survey data was used for the quantitative part of this study. The study obtained a representative sample of young people from KwaZulu-Natal. It was designed to provide information on various socio-demographic variables as well as educational and employment experiences. A section of the survey also contained information on sexual and reproductive health indicators, which make it a good source of data for this kind of study.

# KwaZulu-Natal

Map showing eThekweni Unicity and Mtunzini magisterial district



#### 4.5. Selection of Sample

Two administrative areas in the province of KwaZulu-Natal – Metropolitan Durban and the Mtunzini Magisterial District – were selected to ensure uniform representation of urban and rural regions. All respondents from Durban and the urban section of Mtunzini made up the urban sample (77%). The rural group (23%) was selected from the rural areas of Mtunzini. The study used a “modified multistage cluster sample approach” (Rutenberg et al., 2001:6) where 120 enumerator areas (as demarcated by Statistics South Africa in the 1996 Population Census) were randomly selected within the two districts. These occurred in 113 communities or suburbs and was distributed as follows:

**Table 4.1 : Distribution of sample by community**

<b>Race and Residence</b>	<b>Number of Communities visited (N=113)</b>
Rural African	16
Urban African	61
Urban Indian	14
Urban Coloured	2
Urban White	7
Urban Mixed Residential	13

##### 4.5.1. Sexually Active Sub-sample

Table 4.2 shows the proportion of respondents that had engaged in sexual intercourse (by which is meant full penetration). Of the 3096 respondents that answered this question, only 48% (or 1472) had ever engaged in sexual intercourse. Females

comprised at least 51% of this sub-sample. It was only in the Coloured and White population groups that males exceeded their female counterparts. Only those who responded affirmatively to this question were asked additional questions about their sexual experiences.

**Table 4.2 : Respondents who said they were sexually active by gender (N = 3096)**

Response	Males (N=1403)		Females (N=1693)	
	N	%	N	%
Yes	715	48.57	757	51.43
No	678	42.43	920	57.57
Did not respond	10	38.46	16	61.54

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

Caution should be exercised when using the findings from this research, as they should not be generalized to the whole of South Africa. When compared to other provinces, KwaZulu-Natal has the highest prevalence of HIV/AIDS. KwaZulu-Natal is also unique in that it has the highest number of Indians in the country. Finally, there is the issue of 'courtesy bias', whereby the respondent may have provided answers that they thought the interviewer would have liked to hear in order to please the interviewer. As a result, the reliability of young people's responses to questions pertaining to the sexual and reproductive practices is questionable (May and Gupta, 2002).

Certain questions in this study was dependant on information pertaining to the timing of events (for example, age at first sex, contraceptive use at sexual debut,

communication about protection against pregnancy before sexual encounters, etc), therefore an assessment of the quality of these age-related responses is important. Discretion should also be utilised with regard to recall errors due to memory lapses, duration heaping and event omissions. Crosschecks for age were built into the questionnaire by asking for 'age at last birthday' as well as 'date of birth' as separate items.

#### **4.7. Research Strategy**

Research on contraceptive use has been conducted using a variety of approaches, including survey and case study methodologies. The case study is used to conduct in depth, holistic investigations of a small number of cases (less than 50) into the processes and relationships of social phenomena, for example in ethnographic research. According to Babbie and Mouton (2001), this strategy deals with subtleties and intricacies of unique cases, has high construct validity and enables the establishment of rapport with the research subjects. Given the heterogeneous nature and complexity of sexual and reproductive health behaviour and practices, the case study method would have been well suited to a project of this nature. However, although case studies provide rich detail, they are restricted by their small sample sizes, and as a result generalisations of findings is often not possible. Furthermore, data collection and analysis can be very time consuming when using the case study method. An alternative methodology that counters the limitations of the case study approach is the survey approach. In this study, the survey approach together with focus group discussions is used.

As a research strategy, the survey has advantages and disadvantages. Surveys produce valuable empirical data (Descombe, 2003). Other advantages of surveys are the broad coverage achieved and the savings in cost and time (for the amount of information generated), relative to some other strategies. On the negative side, Descombe (2003) points out that the broader significance of the data collected through the survey can be neglected when a large volume of information has to be processed. Also, while

achieving broad coverage, surveys often produce superficial information. Validity and reliability of survey responses can be compromised. For example, accuracy and honesty of responses can be questioned (Descombe, 2003) and the applicability of survey instruments in different contexts is contentious, for example language does not always translate into the same meaning (Babbie and Mouton, 2001). This study therefore is concerned with secondary analysis of statistical information collected using questionnaires and qualitative data from focus group discussions. The bulk of the information used in this study was collected from face to face interviews with a representative sample of young people in KwaZulu-Natal. Data Research Africa conducted the fieldwork for this survey.

Structured questionnaires were administered to 2007 households and 3096 young people completed individual interviews. The goal of the survey was to establish a comprehensive profile of adolescent life. Information on social, economic and demographic characteristics, as well as in-depth data on sexual relationships, knowledge, attitudes and use of contraception, connectedness to school, family and community, alcohol and drug abuse and reproductive history was recorded. This data formed the basis of analysis in this research.

Table 4.3 below shows that the response rate varied by population group: the highest being among rural Africans, followed by the urban African group. The remainder of the urban sample resulted in about a 70% response rate. The overall response rate of the survey was 82% and could be said to be satisfactory (Rutenberg et. al., 2001).

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**Table 4.3 : Survey Response Rate by Residence and Race (N=3096)**

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<b>Residence and Race</b>	<b>Response Rate in Percentage</b>
Rural African	90,90
Urban African	83,60
Urban Indian	69,60
Urban White	67,50

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#### **4.8. Method of Data Analysis : Quantitative Results**

In order to examine the link between factors affecting contraceptive use and actual contraceptive practice as revealed by the respondents this research focused mainly on sexually active young people or those who reported having had sexual intercourse (defined as 'full penetration'). A variable was created with the coding, '1' for those who reported ever engaging in sexual intercourse and '0', for those who did not report it. A sub-sample of those who reported sexual activity was selected. Only 1476 young people reported that they had ever experienced a sexual encounter. This sub-sample of 1476 sexually active young people was used for the quantitative analysis.

In the survey, respondents were asked if they had used a method of contraception over the past twelve months. This variable, 'current use of contraception', was the dependent variable. The main reason why all forms of contraception was considered in this study is because most other studies have concentrated on condom use only especially as a method of dual protection against pregnancy and disease. The focus of this study is restricted to factors affecting contraceptive use with respect to family planning practices of young people in KwaZulu-Natal. The independent variables were age, gender, race, number of living children, type of residential area, and perception of pregnancy risk.

The quantitative data from the 'transitions' survey was analysed using SPSS, a software package used for quantitative data analysis. Frequencies were used to describe and summarize the data while cross tabulations were used to show the relationship between the independent and dependent variables. The main analytical tool used to carry out this study was multivariate logistic regression. This method of analysis was used to determine how each independent variable affects the dependant variable, while controlling for all other independent variable in the model. Because the dependent variable was neither normally distributed nor continuous, binary and multivariate logistic regression was used in place of linear regression. Hence, the multivariate logistic regression model was used to consider the probability of young people using contraception for the purposes of delaying pregnancy. Logistic regression was used to examine the effect of certain factors on contraceptive use. Logistic regression was chosen because it is a special form of multiple regression whereby the dependent variable is a dichotomous variable ('contraceptive use' in this instance). A dichotomous variable is the term given to a non-metric variable that is transformed into a metric variable by assigning a '1' or a '0' to a subject (Hair et al., 1998). In this case, '1' represents contraceptive use and '0', non-use of contraception. Another reason why logistic regression was chosen is because of the ease with which odds ratios can be interpreted. Odds ratios refer to the likelihood of an event occurring, which is defined as the ratio of the probability that the event will occur to the probability that it will not. The main purpose of logistic regression analysis is the prediction of changes in the dependent variable, which is in response to changes in the independent variables (Hair et al, 1998). In order to analyse the relationship between the dependent (contraceptive use) and the independent variables, some models were used in this study.

#### **4.9. Focus Group Discussions**

In order to conform to urban - rural differentials and personal experiences of young people in different population groups, a qualitative analysis was included in this

study. The qualitative approach in social research "takes as its departure point the insider perspective on social action" (Babbie and Mouton, 2001). Referred to as the "emic" perspective by anthropologists, qualitative researchers attempt to study human action from the perspective of the social actors themselves. The primary aim of the qualitative approach is to describe and understand rather than explain human behaviour. Qualitative research focuses on process rather than outcome with the intention to understand human actions. One rationale behind using focus group discussions is that it saves time and money; however much valuable data can be lost at the individual level. Morgan (1997) states that the advantage of focus groups is that it presents the "opportunity to observe a large amount of interaction on a topic in a limited period of time" (Babbie and Mouton, 2001). Qualitative studies reveal insights that could not be captured by survey data.

Hence, focus group discussions were selected for this study because they reveal the opinions of a reasonably homogeneous group (in this case, age, race, gender and area of residence were qualifying characteristics) of representatives. In many ways, the focus groups that were selected for this study served as a microcosm of the processes underlying sexual and reproductive health choices of young people. These peer groups are particularly appropriate for facilitating discussions of taboo topics because the "less inhibited members of the group often break the ice for the shyer participants" (MacPhail and Campbell, 2001:1618).

Qualitative data was derived from a total of seven focus group discussions. These were conducted with 77 young people who lived in a variety of residential area types and who belonged to different population groups. Males and females were almost equal in proportion. The mean age of the focus group participants was 19 with an overall average educational level of grade 10 or Standard 8. Sensitive questions regarding sexual and contraceptive practices were administered separately to males and females. It was also explained that respondents could refrain or refuse to answer any question or withdraw at any point in the discussion, though none did.

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**Table 4.4 : Background characteristics of participants in focus groups (N=77)**

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<b>Race and Residence</b>	<b>Gender</b>		<b>Mean Age in years</b>	
	<b>Male (N=38)</b>	<b>Female (N=39)</b>	<b>Male (N=38)</b>	<b>Female (N=39)</b>
African Rural	10	10	18	20
African Urban	18	15	19	19
Indian Urban	5	7	18	18
White Urban	5	7	22	21

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The rural African group consisted of two groups of five males and five females in each group. Females were generally older in this category, and most participants were rural Africans and the majority were in grade nine.

The focus group discussions were facilitated by university graduates in order to avoid great age differences with participants, and lasted two hours on average. One of the key strategies in qualitative research is the importance of gaining trust and establishing rapport with the focus groups. This enabled the facilitator to get as close as possible to the respondents and simultaneously win their confidence. Participants could respond in English (or any other language they preferred).

Three separate sub groups made up the urban category. The average grade passed in the urban African group was grade ten or standard eight, which is the same as for the Indian urban group. Both the urban White and Indian groups comprised 12 participants each. The White group was much older than the other groups, with an average age of 21.50 years. They were also the most highly educated. Most were currently engaged in post matriculation activities at the time of the focus group discussions.

#### **4.10. Method of Data Analysis: Qualitative Findings**

Conversations were tape-recorded, transcribed and analysed using the QSR NVIVO software program. All discussions were transcribed from the recordings as Microsoft Word files. These were then converted into text files and imported into NVIVO as a new project. Each focus group discussion was attributed a different text colour in order to facilitate the identification of the original source. This was necessary for reference purposes when use was made of direct quotations. Transcripts were read and re-read to obtain a 'feel' for the responses. An initial list of 'free nodes' was constructed and the semi-structured questionnaire that was used as a guideline by the facilitators during the focus group discussions formed the basis for creating new 'tree nodes'. However, as more sub-categories became evident, further coding had to occur. It was decided that the qualitative analysis would have to be based on gender, race, and place of residence at the 'free node' level.

The initial intention was to code the major factors affecting contraceptive use (namely: peer pressure, gender differentials, attitudes to contraceptive use, source and supply of contraceptives, and communication between partners about who initiates contraception). However, the theme of 'teenage pregnancy' continued to recur as a major issue, although it was not an intentional topic for discussion. It was therefore decided to create another tree node and code it 'teenage pregnancy'. This was achieved by using the node browser to explore all data that cited 'teenage pregnancy, unplanned or unwanted birth.

As the nodes were created, memos about trends, reactions, differences of opinion and unusual occurrences were created. For example, the deliberate intention of some Indian young people to fall pregnant in order to force their parents to accept their children's marriage partners (discussed in greater detail later). The major themes and responses were analysed and are presented in the results.

The questions that were selected for analysis in this research report were aimed at understanding young people's sexual and reproductive health choices. This involved clarifying the concepts and terminology they used, their knowledge, attitudes and perception of sexual and reproductive health risks, timing and motivation of their first and subsequent sexual encounters and strategies for dealing with sexually transmitted infections and teenage (sometimes unwanted) pregnancies.

#### **4.11. Triangulation**

Triangulation is defined as: "the use of multiple [research] methods, or a plan of action that will raise [the researcher] above the personal biases that stem from single methodologies" (Denzin, 1989 as cited by Babbie and Mouton, 2001:275). Hence, the triangulation method was used in this study to examine how certain factors affect contraceptive use among young people in KwaZulu-Natal. Triangulation is a research technique that is used to examine the same phenomenon from multiple perspectives. It also enriches one's understanding as it allows new or deeper dimensions to emerge (Jick, 1983:138). Triangulation is considered effective since the weaknesses of a single method would be compensated by the counter-balancing strengths of another (Jick, 1983). Triangulation is generally considered to be one of the best ways to enhance reliability and validity in qualitative research (Babbie and Mouton, 2001:275).

#### **4.12. Summary**

This chapter examined the research method used in this study. As part of the research methodology, the design of the study was described as being exploratory and the reasons for choosing it have been explained. The instruments used used to gather data from individual members were also explained.

## CHAPTER FIVE : RESULTS

### 5.1. Introduction

This chapter incorporates the results of the analyses that were conducted in the quantitative component of this study. It begins by examining the socio-demographic characteristics of the respondents in the sample. This is followed by an analysis of their fertility preferences, age at first sex, sexual behaviour patterns, knowledge of, and attitudes to family planning. Finally, the multivariate logistic regression results of contraceptive use and explanatory variables are presented. The multivariate technique of logistic regression is used to identify the factors influencing contraceptive use. Given the important differences in the underlying social and biological processes shaping reproductive behaviours among men and women, each sex is treated distinctly in the analysis that follows.

### 5.2 Socio-demographic characteristics of respondents

Females comprised approximately fifty-five percent of the sample. Males were slightly under represented because of the difficulty interviewers had in finding eligible young male adults at home during the time that the fieldwork was conducted (Rutenberg et al., 2001). Almost a quarter of the respondents were between 14-15 years old; half fell into the 16-19 year age category and the remaining quarter were between 20-22 years old. The mean age for the entire sample was 17 years.

The sample reflects the race distribution in the study area, where the majority are African (75%). Metropolitan Durban has the highest Indian population compared to other South African cities (STATSSA, 2004a); hence, they represent a little over 16% of the sample. Whites and Coloureds constitute a small proportion of the

**Table 5.1 : Background Characteristics of all Respondents ( N = 3096)**

<b>Background Characteristics</b>	<b>Males (N=1403)</b>		<b>Females (N=1693)</b>	
	<b>N</b>	<b>%</b>	<b>N</b>	<b>%</b>
<b>Age</b>				
14-15	343	24.45	420	24.81
16-19	754	53.74	862	50.92
20-22	306	21.81	411	24.28
<b>Race</b>				
African	1038	73.98	1311	77.44
Coloured	31	2.21	28	1.65
Indian	236	16.82	262	15.48
White	98	6.99	92	5.43
<b>Place of Residence</b>				
Urban	1113	79.33	1319	77.91
Rural	290	20.67	374	22.09
<b>Current relationships</b>				
No relationship	1012	72.23	1212	71.80
In a relationship	389	27.77	476	28.20
<b>Currently working</b>				
No	1237	88.23	1545	91.26
Yes	165	11.77	148	8.74
<b>Education Level</b>				
Primary	164	15.21	123	10.68
Secondary	830	76.99	931	80.82
Post Secondary	84	7.79	98	8.51

*N.B. Totals may not tally because of missing data.*

population, six percent and two percent respectively. All the respondents from the Coloured, Indian and White sample live in urban areas. Together with the urban African group they comprised almost 79% of the sample. The remaining 21% came from the rural district in Mtuzini and were African.

Over a quarter of all 3096 respondents said they were in a relationship. Females were more likely to report that they were in a relationship (55%). Only 10% were employed, the majority being men (53%). Table 6 reveals that 72% (or 2230) were still at school at the time of the fieldwork. Of this, almost 79% were in secondary school and eight percent were engaged in post secondary education.. The remaining 13% were currently attending primary school; the majority of whom were from the African population group. Females made up the greater portion in both the secondary and post secondary categories (53% in each).

### **5. 3. Age at first birth**

Because of the strong links between fertility and sexual activity, this analysis also focuses on the fertility preferences of the respondents. Male reproductive behaviour is also explored.

Almost a third (30%) of the respondents who said that they had had sex had either given birth or fathered a child. More females than males reported that they were already parents, although some of them (about 11%) could not remember the age at which they had had their first child. Just under two thirds of these adolescents who responded to this question said that they had had their first child between the ages of 15 and 19 years. Approximately a third of those who had given birth did so between 20 and 22 years old. The remaining six percent had their first child when they were younger than 15 years old.

When asked what would be the preferred age to have their first child, half responded when they would be financially stable, and definitely over 25 years old. Just under a half (48%) said the ideal age to start having children would be between 20 and 25 years old. Most females indicated that they preferred this stage of their lives to start a family (20-25 years). The majority of men preferred to delay child bearing for when they were older and economically independent.

#### **5.4. Age at first sex**

According to Mahy and Gupta (2002), much of the high fertility levels in sub-Saharan Africa can be attributed to young age at first sex, young age at first union and young age at first birth. This present study does not investigate age at first union, but does analyse age at first birth.

Using retrospective data compiled from young men and women in this study, age at first sex was established. Males initiated sex at a much younger age than females. African males displayed the lowest age (7 years) at sexual debut. Coloured males also began sexual activity before their female counterparts (at age 12 as opposed to 16 years). The youngest age for females was 10 years. This was characteristic of both the African and Indian groups. The mean and median age at which sexual activity began was 16 years for all groups, except for White males, which was 18 years.

With regard to partner's age at sexual debut, it was found that women were more likely to have older partners, while men tended to choose younger mates than themselves (data not shown).

## 5.5. Knowledge of Family Planning

This section deals with respondents' knowledge of family planning and is measured by an analysis of their knowledge of the different methods of contraception, its source of supply and young people's knowledge of how to prevent pregnancy. In the survey, respondents were first asked: "Which family planning methods do you know of to avoid getting pregnant?"

Table 5.2 reveals that knowledge of at least one modern method of contraception was universal and almost all sexually active respondents in this study knew of at least one source of supply of contraceptives (especially condoms). Over 93% of both males and females obtained their contraceptive supplies from government hospitals or family planning clinics (data not shown), while approximately 20 % of the sexually active sub-sample utilised the facilities provided by mobile clinics. Males were more likely than females to rely on mobile clinics. The third most popular source of contraceptive supplies was private health services. This was used by about 17 % of all contraceptors, with females being in the majority.

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**Table 5.2 : Percentage of respondents who knew a source and method of contraception (N=3096).**

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Statement	Males (N=1403)	Females (N=1693)
	%	%
Knowledge of at least one modern method of contraception	94.87	91.26
Knowledge of at least one source of family planning	64.9	59.89
Knowledge of source of supply of contraception	96.56	95.65

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## **5.6. Attitudes toward family planning**

### **5.6.1. Perceived risk of pregnancy**

Table 5.3 presents a selection of young people's knowledge about the circumstances under which a female can fall pregnant. Approximately 80% answered positively to the statement "A girl can fall pregnant from having sex once". Girls were more likely than were boys to know this. A more detailed analysis (data not shown) revealed that older White and Coloured respondents were more likely to be aware of this risk than the other groups of young people.

Only 16% of young people answered that a girl can still fall pregnant even if a boy withdraws almost two thirds (60%) of whom were females. The remaining 84% said either that withdrawal can prevent pregnancy or that they had no idea.

Knowledge of that part of the monthly menstrual cycle when a woman has the greatest chance of pregnancy is one measure of pregnancy risk. The results in Table 5.3 show that only 7% of all respondents knew the correct time in the menstrual cycle that a woman has the highest chance of pregnancy. Urban Whites (27%) exhibited the highest levels of knowledge about a woman's fertile period. This was followed by urban Coloureds (10%), urban Indians (8%) and then urban Africans (6%). The lowest level of knowledge was found amongst rural Africans (4%).

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**Table 5.3 : Percentage respondents who agreed with specific statements about family planning (N=3096).**

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Statement	Males (N=1403)	Females (N=1693)
	%	%
A girl can fall pregnant after having sex once	75.50	83.69
Withdrawal can still lead to pregnancy	13.85	17.22
Highest chance of pregnancy is the middle of a girl's cycle	19.90	9.80

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### 5.6.2. Partner communication

Table 5.4 below presents the distribution by gender of young people who spoke about their sexual and reproductive practices on any sexual encounter. Communication between partners is a crucial factor when examining contraceptive use for the purposes of preventing pregnancy. This will reduce the occurrence of unwanted and unplanned births. Over two thirds of this study participants responded that they discussed contraceptive use to avoid both pregnancy and infection including STDs and HIV/AIDS. Women were more likely to report communication about contraception than men were. Table 5.4 also shows that avoidance of pregnancy was uppermost in the minds of females, with 77% initiating the topic. Slightly more men than women broached the subject of contraceptive use, while almost twice as many females as males discussed avoiding sex altogether. In fact, from the five topics analyzed "avoiding sex" was of lowest priority for males. Overall, men were more concerned about avoiding HIV/AIDS than pregnancy, but the opposite was observed for females. Approximately 61% (data not shown) of those young people with two partners reported having discussed pregnancy avoidance, however in this instance more men (77%) took the initiative.

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**Table 5.4 : Percentage of respondents who discussed selected topics by gender (N=3096)**

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Topic	Males (N=1403)		Females (N=1693)	
	N	%	N	%
Avoid sex	277	43.97	464	64.71
Avoid pregnancy	415	65.87	554	77.27
Contraceptive use	442	70.16	500	69.73
Avoid HIV/AIDS	431	68.41	530	73.92
Avoid STDs	376	59.68	454	63.32

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### **5.7. Contraceptive behaviour**

Only those sexually active young people who were currently using contraception have been analysed in this section. Respondents were asked who made the decision to use contraception. Women were more likely to report that the choice to use contraception was as a result of their own decision. Table 5.5 shows the distribution of those young people who made the choice to use contraception in a relationship. In 44% of the cases the decision was taken jointly. The respondent decided 42% of the time and on 13% occasions, partners were left to make the decision themselves. It is worth noting however, that women were more likely than men to report that they themselves made the decision to use contraception.

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**Table 5.5 : Percentage of respondents by who made the decision to use contraception at last sex. (N = 817)**

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	Males (N=392)		Females (N=425)	
	N	%	N	%
Self	144	37.11	195	46.10
Partner	66	17.01	36	8.51
Both	177	45.62	183	43.26
Don't know	1	0.26	9	2.13

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### 5.7.1. Contraceptive use at first sexual encounter

In this analysis, 'contraceptive use' includes all forms of protection that young people use to prevent pregnancy. 'Ever use' refers to any occasion in the youngster's lifetime that contraception was used and is measured by a range of questions on 'first' and 'last' sexual encounters. It should be noted that 'ever use' of contraceptive methods did not necessarily imply *continual* use since sexual debut. Neither did it mean that there was *consistent* use with each and/or every partner. 'Current use' is defined as a young person's use of contraception at the time when the survey was being conducted. It is measured by analyzing all questions relating to the respondent's sexual experiences in the twelve months preceding the fieldwork for the 'transitions' survey.

Table 5.6 shows contraceptive prevalence by type of method used during first sexual encounter. Just under a third (29%) of all sexually active respondents said that they used some form of family planning method at sexual debut. Women were more likely than men to report using a method. Tables 11 and 12 may be compared to show the change in contraceptive behaviour from first to last sexual encounter. Overall, contraceptive used doubled over time, but by last sexual encounter more men than

women responded that they were using a method. The use of the male condom proved to be the most popular method chosen by both sexes during first and last sexual encounters. However, for males condom usage more than doubled, while for females it increased by over seven percent. The injection rated second highest for both first and last sex and its usage more than doubled from their first to their last sexual encounter. Female's choice of the injection as a family planning method increased by three and a half times between first and last sexual experiences. The contraceptive pill was the third most popular method chosen by the sexually active young people in this study and its usage more than tripled over time. Preference for traditional methods of contraception was very limited and very few respondents said that they used more than one method (data not shown).

**Table 5.6 : Method of contraception used at first sex (N=1472)**

Method	Male (N=715)	Females (N=757)
	%	%
No Method	76.10	66.20
Condom	20.60	21.80
Injections	1.80	6.00
Pill	1.30	3.80
IUD	0.10	0.40
Other	0.10	1.90

### 5.7.2. Contraceptive use at last sexual encounter

In this section, questions concerning current contraceptive use are analysed. Overall, 60% (see Table 5.7) of sexually active youth reported using a contraceptive method to prevent pregnancy the last time they had sex. Males were more likely than females to report using a method. The most popular method used by both sexes was the male condom. This may be due to the advantage it offers for dual protection against both pregnancy and disease transmission. Injectables proved to be the second most common choice among girls. An analysis of contraceptive use by background socio-demographic characteristics revealed that urban young people were more likely to use contraception than rural adolescents and use appears to increase with age (see Table 5.8). Older youth however preferred the more long-term methods like the injection and the pill (data not shown). The younger groups, on the other hand, made more frequent use of the male condom – this could be due possibly to the vigorous condom campaigns that have been promoted in KwaZulu-Natal (Love Life, 2000).

**Table 5.7 : Contraceptive method used at last sex**

Method	Male (N=715)	Females (N=757)
	%	%
No Method	38.00	40.80
Condom	44.80	29.30
Injections	5.10	21.00
Pill	10.80	6.20
IUD	0.60	2.00
Other	0.60	0.80

### **5.7.3. Contraceptive use at last sexual encounter by background characteristics**

Table 5.8 below, displays the socio-demographic characteristics of those respondents that used contraception during their last sexual encounter. Young people in the 20-22 year old age group were more likely to report using some form of contraception, indicating that use increased with age. When assessing contraceptive use by race and gender, the most striking differences existed between Indian males and females (data not shown). About twice as many Indian males as their Indian female counterparts reported contraceptive use at last sexual interaction. It is possible that Indian females under-reported their use of family planning methods as premarital sex is generally discouraged among traditional Indian families. Overall, both sexes in the African group displayed lower contraceptive use than the other race groups.

Geographic location of youngsters also seems to impact on contraceptive use. Table 5.8 shows that urban dwellers were more like to make use of modern contraception than their rural counterparts. Additionally, gender and relationship status also played a role in contraceptive behaviour. Males who were in a steady relationship displayed a higher usage of contraception, while single females were more likely to opt for protected sex than those females who were in a relationship. Both males and females who were already parents tended to use some form of family planning method, although there was no significant difference between them and those teenagers that had not had any living children. Young men and women who had a higher perception of pregnancy risk were more likely to use contraception but this was also not significant.

**Table 5.8 : Percentage using contraception at last sex by selected background characteristics and gender**

Background Characteristics	Males (N=717)		Females (N=757)	
	N	%	N	%
Age				
14-15	36.00	36.10*	30.00	53.30
16-19	367.00	61.60	377.00	57.00
20-22	226.00	66.80	307.00	62.20
Race				
African	527.00	59.80	641.00	57.60
Other	101.00	73.30*	69.00	72.50*
Place of Residence				
Urban	498.00	66.50	568.00	62.70
Rural	131.00	45.00*	146.00	45.20*
Current relationships				
No steady relationship	318.00	55.00*	389.00	59.40
In a steady relationship	310.00	69.40	325.00	58.80
Number of living children				
0	590.00	61.90	415.00	56.60
1+	39.00	64.10	299.00	62.50
Perceived risk of pregnancy				
Low	165.00	58.80	151.00	58.90
High	455.00	62.60	538.00	59.60

*Note: \* - Significant at the 5 % level.*

*Totals may not tally because of missing data.*

## 5.8. Contraceptive use: Results of logistic regression model

In order to establish the relationship between the socio-demographic characteristics of young people and their use of contraception, a multivariate logistic regression was conducted with contraceptive use as the dependant variable. Table 5.9 below shows that there were six variables that are significant or that have an influence on contraceptive use. The following independent variables were used in the regression analysis: age, race, geographic location, relationship status, number of living children and perceived risk of parenthood as having an effect on contraceptive use. The multivariate logistic regression presents the odds ratios of current contraceptive use for each category of a co-variate, whilst controlling for all other variables.

According to Table 5.9, respondents' age was a significant variable in contraceptive use. The age interval 14-15 years was used as the reference category as it formed the basis for comparison with the other two age categories. The model shows that men aged 16-19 years are 2.94 times more likely to use contraception than those between 14-15 years old are. However, the probability of practising safer sex is greatest for those in the age group 20-22 years old for both males and females. The odds of males (20-22 years old) using contraception was 4.08 times more likely than the reference category (14-15 years), while females between the ages 20-22 years old were 1.18 times more likely than those girls in the 14-15 year old age group to use a contraceptive method.

The second significant variable was race. The model below shows that the African respondents were less likely to have been currently using contraception as opposed to the non-African reference group.

The most significant variable whilst controlling for all other factors is geographical location. Table 5.9 shows that there was a greater likelihood of urban respondents using contraception than their rural counterparts, with urban males more than twice as likely and urban females 1.95 times as likely as rural residents.

With respect to relationship status, the multivariate logistic regression showed that both males and females who were in a steady relationship were more likely to use contraception than those who were single.

Females who had living children displayed a greater likelihood of using contraception by 1.37 times more than those young women who were not mothers.

The multivariate logistic regression also showed that those young people who perceived themselves to be at a high risk of falling pregnant and/or infection were more likely to use contraception, most of whom were female. However, this was not significant.

**Table 5.9 : The odds ratios of using a method of contraception: results from logistic regression (N=1472)**

<b>Background Characteristics</b>	<b>Odds Ratios and 95% confidence levels</b>	
	<b>Males (N=717)</b>	<b>Females (N=757)</b>
<b>Age</b>		
14-15	1.00	1.00
16-19	2.94 (1.42-6.09)*	0.99 (0.46-2.13)
20-22	4.08 (1.92-8.70)*	1.18 (0.54-2.58)
<b>Race</b>		
African	0.068 (0.41-1.12)	0.57 (0.32-1.02)
Other	1.00	1.00
<b>Place of Residence</b>		
Urban	2.17 (1.43-3.29)*	1.95 (1.32-2.87)*
Rural	1.00	1.00
<b>Current relationships</b>		
No relationship	1.00	1.00
In a relationship	1.63 (1.16-2.30)*	1.03 (0.75-1.43)
<b>Number of living children</b>		
0	1.00	1.00
1+	1.07 (0.52-2.19)	1.37 (0.99-1.90)
<b>Perceived risk of pregnancy</b>		
Low	1.00	1.00
High	0.025 (0.90-1.94)	1.08 (0.74-1.59)

*N.B. \* - Significant at the 5% level*

*Totals may not tally because of missing data.*

## 5.9. Summary

Females were more likely to report that they were in a relationship. Just under two thirds of the sexually active respondents reported that they had had their first child when they were in the age category 15-19 years old. Just over half of all participants said that they were sexually active. The median age at sexual debut was 16 years old. Both males and females that were in a steady relationship were found to be more likely to use contraception than their single counterparts. Knowledge of at least one form of modern contraceptive method and knowledge of a source of supply was almost universal, with 93% using government clinics to obtain their supplies. Knowledge about the circumstances under which a girl can fall pregnant was found to be inadequate. Few respondents knew that the likelihood of a girl falling pregnant was during her ovulation or that withdrawal during sexual intercourse can still lead to pregnancy. A bit of a surprise was the discovery that rural young women were more likely to broach the subject of contraceptive use than males, suggesting their desire to limit or delay child birth. Older females were most likely to report ever using a contraceptive method. More than half the sexually active sample reported using contraception the last time that they had full intercourse; more females than males. The condom was the most popular method, especially among the younger teenagers, while the older youth preferred the pill or the injection. The probability of practising safe sex was greatest for the older, urban, non-African youth who were in a steady relationship.

## CHAPTER SIX : FOCUS GROUP DISCUSSIONS

### 6.1. Introduction

Attempts to study the sexual behaviour of young people have concentrated on individual-level indicators that have been easily measured through the use of quantitative methods. It is the intention of this dissertation to understand as well as measure the factors affecting contraceptive use among young people. Quantitative methods do not allow researchers to consider the processes at work, but rather limit them to the final outcome (MacPhail and Campbell, 2001). Hence, focus group discussions have been included in this study to provide a qualitative analysis of this complex phenomenon of contraceptive use and choice.

This section of the analysis deals with findings from seven focus group discussions. Selected background characteristics of the 77 participants (38 male and 39 female) have been outlined in Chapter 4. Broad themes/nodes were identified for analysis. Using QSR NVIVO, the following nodes were identified: teenage pregnancies, the role of peer pressure, attitudes to condom use, source and supply of contraception and partner communication and negotiation over contraceptive use. The analysis of the results from the focus group discussions has been substantiated with direct quotations from the transcriptions.

### 6.2. Teenage unplanned pregnancy

When asked the question: “What is the biggest problem facing adolescents today?” all groups except for the urban Whites immediately mentioned ‘teenage pregnancy’ as a major problem. It was also evident that in every incident it was a female that had voiced this opinion implying that adolescent pregnancy seemed to be a very pertinent and pressing problem to them and that it did not affect males to the same extent. From

all 77 participants, only one male (from the rural African group) alluded to teenage pregnancy as being a problem. Even when groups were questioned as to whether boys and girls experienced different problems, most agreed that their problems were similar *except* for teenage pregnancies (once again highlighted by a female in the urban Indian group).

This phenomenon was re-echoed when participants were asked to suggest possible reasons why children leave school before completing matric. Again, it was emphasised that this was the main reason why girls dropped out of school early. As one female reported: “ With females especially, it is due to teenage pregnancy”.

Twice during the focus group discussions with the Indian group the issue of making a girl pregnant before marriage as a pre-determined, deliberate action was voiced. It became apparent in the focus group discussions that some parents (particularly those of Indian descent), did not approve of their offspring's choice of marriage partners. As a result, young couples resorted to such desperate measures as 'falling pregnant' in order to force their parents into accepting their choice of life partner. This was the sentiment of one of the males in the urban Indian group:

*Participant*            *“Basically to get the girls pregnant so they can spend the rest of their life with the girl, so the parents cannot object” (male)*

*Facilitator:*            *You keep talking about girls falling pregnant does that happen a lot?*

*Participant:*            *“Yeah, all the time” (male)*  
*“ In order for the parents to accept the guy. It's the only way if they get involved” (male)*

*Facilitator:*            *It's a big problem?*

*Participant:*            *“Yeah a very big problem”*  
*“It happens all the time”*  
*“If the girls get pregnant then they have to accept it” (male)*

*Participant: “And another thing is that girls also commit suicide because they cannot be with the one that they want to be with” (male)*

### **6.3. Peer Pressure**

From the focus group discussions (except for the urban White group), it appeared that peer pressure played a major role in the lives of teenagers in almost all aspects of their social lives. Some turned to their friends for sexual advice. This advice may be ill informed and hence increase the young person's risk of pregnancy and infection. Some young people encouraged their friends to engage in unprotected sex in order to be accepted as 'part of the groove'. Both males and females suggested that they were equally exposed to the norms laid down by their contemporaries. However, there was a general indication that rural residents felt more pressure than their urban counterparts. In all the African groups, particular mention was made of the fear of being called 'haughty' if they did not conform to their friends' standards. The extract below alludes to the 'name-calling' that most young people would prefer to avoid.

*Facilitator: Do you feel at pressure to act like your friends at school or in your community? If so, what do you think is the cause?*

*Participant: “I don't know, it just happens”. (female)*

*Participant: “But for females it does not seem to have that much of an influence when decisions about fashion, groove and boyfriends need to be made”. (female)*

*Participant: “As for males the influence of peer pressure is strong” (male)*

*Facilitator: Why do you allow yourselves to be that much influenced by it?*

*Participant: “We allow it in order to be seen to be fashionable and being part of the groove” (male)*

*Participant: “It’s all about ukuphatha isitayela” – (the urge to be seen to be at the pulse of everything) (female)*

*Facilitator: What if you are not the type to follow trends or friends?*

*Participant: “The impression is that of an impimpi. (sell-out)” (female)*

*Participant: “You get laughed at” (male)*

*Participant: “You are called names, to insult you. Like being called a birdie” – (meaning a stupid or fool) (male)*

From the above, it was clear that males felt that peer pressure was greater for them than for females. Gage (1998) contends that youth who were less susceptible to peer pressure or who managed to resist it were more likely to practice safe sex.

#### **6.4. Attitude to condom use**

Focus group discussions revealed distinct gender differentials in response to the question ‘What type of persons use condoms?’ Most males associated condoms with multiple partners, promiscuous behaviour, high risk and casual relationships, as is illustrated in the following comment:

*Participant: “Someone who does not behave well, sexually” (male)*

*Participant “The one who sleeps around” (male)*

Hence, although young men appeared knowledgeable about the benefits of condom usage, they did not perceive personal vulnerability. Instead they opted to blame others for their own infection. Further probing in the group revealed that young males were

less likely to use condoms in regular relationships, as this would suggest lack of trust between partners. Condoms were more likely to be used in casual relationships or with partners that were perceived to be "sleep[ing] around". Females on the other hand viewed condom use as sensible behaviour as it prevented the transmission of diseases.

*Participant*    *"Those who are afraid of diseases like HIV/AIDS" (female)*

*Participant*    *"Someone who understands the danger of contracting sexually transmitted infection" (female)*

*Participant*    *"Kids who are sensible"(female)*

*Participant*    *"The clever ones" (female)*

Hence, participants gave the impression that they were fully aware of the benefits of contraception, especially condoms. For example, the majority said that condoms provided dual protection against pregnancy and sexually transmitted infections.

## **6.5. Source and supply of contraception**

All focus groups except the urban White participants agreed that condoms were freely available at local public health clinics, schools, libraries, from health field workers or they could be bought from pharmacies. (For example, one urban African female said they could also be purchased from their local 'tuck' shops, which is usually a small scale, informal structure from which a limited supply of goods or daily necessities is sold. Sometimes, these operate directly from a person's place of residence.)

Even though they were interviewed separately, both White males and females were adamant that the only source of good quality condoms was obtainable from chemists, as is evident in the following extract. The general feeling was that clinic-provided condoms were not reliable, hence those who could afford to, preferred to purchase their supplies from the chemist. These sentiments are captured in the following comments:

*Facilitator: Where do you get your condoms?*

*Participant "You don't get them you buy them "(male)*

*Facilitator: Does anybody go to the clinic?*

*Participant "I reckon if you believe in condoms and stuff like that you got to buy them" (female)*

*Facilitator: Do you reckon the quality varies?*

*Participant "Ja- I reckon the clinic ones aren't so good" (male)*

*Participant "We are not talking about a car here we are talking about your life" (male)*

*Participant "Clinic ones are gross"(female)*

*Facilitator: How do you get your condoms? Do you get them for free or do you buy them?*

*Participant "Mostly we get them for free at the clinic for family planning. But sometimes it is better to buy them as the ones that get distributed for free tear or have holes in them" (female)*

In general, participants preferred the purchased to the free condoms. Purchased condoms were perceived to be of a better quality while participants voiced concern over the possibility that the 'free' condoms may burst during sexual intercourse.

Another reason that young people preferred not using 'free' clinic facilities was the perceived negative attitudes of the service providers. Some female participants complained that reproductive health nurses chided them for being sexually active at such a young age and threatened to tell their parents. Hence they did not return to the clinic but opted to go to a chemist instead or chose to ignore family planning altogether.

#### **6.6. Partner communication and negotiation**

Only two of the 'males only' groups suggested that both partners would make the decision to use condoms. All other groups were unanimous that it would be the female who usually suggests condom use. This is evident in the following excerpt from the urban Indian female group

*Facilitator: Who suggests condom use - girls or boys?*

*Participant: "The girls suggest it because they don't want to fall pregnant" (female)*

*Participant: "The boys try to convince the girls not to use condoms" (female)*

This also emphasises the trend that most males were under the impression that pregnancy prevention is the woman's responsibility. One female participant explained that it was difficult to broach the subject of condom use "in the heat of the moment". Some female participants explained that if they were persistent about the use of condoms, they were at risk of provoking suspicion in their partners that they were

being unfaithful by having multiple sexual partners. Some female participants who were economically dependant on their partners feared that their partners would desert them if they insisted on their wearing condoms

The main reason put forward for avoiding condom use was that generally males preferred "flesh-to-flesh" sex, as they found this to be more satisfying. Condoms on the other hand, reduced sexual pleasure, interrupted sexual activities and did not allow for spontaneity.

## **6.7. Summary**

This chapter analysed the findings from the focus group discussions. Generally, young women felt that teenage pregnancy was their biggest problem, especially since it impacted on their number of years of schooling and ultimately their economic status later in life. Although all adolescents agreed that the influences of peer pressure were great, the males felt that they were under more pressure than their female counterparts because they had to compete with their friends particularly with regard to the number of women with whom they had sexual encounters.

Attitudes towards condom use were different for males and females. There were two main reasons why men adopted a negative attitude to condom use: Firstly, they tended to regard condom usage as a sign of promiscuity on the part of the female, and secondly, they gave the impression that condoms reduced sexual pleasure. Females, on the other hand, viewed condoms as sensible. All participants appeared to be knowledgeable about a source of supply of condoms. However, the trend tended to be in favour of purchasing condoms. Overall, the groups felt that it was usually the woman's duty to suggest contraceptive use.

## CHAPTER SEVEN : DISCUSSION OF RESULTS

### 7.1. Introduction

This chapter discusses the results that were found in both the qualitative and quantitative components of this study. These findings have been aggregated into five major categories, viz.: socio-demographic characteristics, fertility preferences, sexual behaviour patterns, knowledge and attitude towards family planning and contraceptive behaviour.

### 7.2. Socio-demographic characteristics of respondents

As expected most adolescents who were interviewed were attending secondary school. Females were more likely than males to be currently enrolled at school. Most participants were in secondary school. An interesting observation was that among the rural African group, females were generally older than their male counterparts in the same grade. A possible reason for this could be that girls might have started school later due to family responsibilities. A further explanation for the interruption in their school careers may be due to teenage pregnancies. The 'Transitions' study confirms these findings: pregnancy was the most frequently cited reason as to why girls dropped out of school (Rutenberg et al., 2001). Furthermore, three quarters of those girls who became pregnant while still in school dropped out as a result and the majority did not resume their schooling following the birth of their children (Rutenberg et al., 2001).

Geographic location was highlighted as an important variable that influenced contraceptive use. The distinction between urban and rural residence is important because of differences in access to reproductive health facilities, cultural beliefs and living situations. According to transition theory, modern urban commercial life

produces special motivational constraints on child bearing (Caldwell et al., 1992). Costs of children are highest in urban areas, where nearly everything must be bought. Access to modern goods and ideas can also affect an individual's reproductive decisions.

This study found that relationship status influences contraceptive use. Generally, men preferred to use such contraception methods as condoms with their 'occasional partners' because they did not see the necessity for any protection with a steady or permanent girlfriend. They associated condom usage with mistrust and promiscuity. This exposes both partners to the risk of infection and unwanted pregnancy, as has been confirmed in previous studies (Woods and Jewkes, 1997). The findings of this study with regard to relationship status indicate that those couples who were in a steady relationship were more likely to practice safe sex.

### **7.3. Fertility preferences and contraceptive behaviour**

#### **7.3.1. Teenage pregnancy**

During the focus group discussions, teenage pregnancy was highlighted as a major problem for young people especially for females as this generally resulted in their early drop out from school. This reduced their chances of a complete education and ultimately an improved socio-economic position. Adolescent pregnancy is perceived as the cause of considerable embarrassment and distress both for the adolescent and the prospective grandparents (Wood et al., 1997; Varga, 2002; Kaufman et al., 2001). "Parents' feelings of shame because of their daughters' condition is combined with their fear of public censure" and the need to "maintain the family's social dignity" (Varga, 2002:289-290). Hence, unwanted pregnancy is viewed as a major problem among young people. However, focus group discussions revealed that some girls fell pregnant in order to force their parents to accept their partners. The issue of making a girl pregnant before marriage as a pre-determined, deliberate action was voiced on

two occasions during the focus group discussions with the Indian sector of the population.

These findings from the focus group discussions concerning teenage pregnancy reinforce the justification for this research topic to be investigated. Since teenage pregnancies are rife and are foremost in the minds of adolescent girls; then examining the factors that affect contraceptive use to prevent pregnancy becomes imperative.

### **7.3.2. Age at first birth**

Gage-Brandon and Meekers (1993) in their analysis of a number of sub-Saharan countries found that childbearing among unmarried women was almost non-existent in Burundi (2%) and very low in Ghana (9%), yet it is fairly common in Botswana (42%) and Liberia (34%). In KwaZulu-Natal on the other hand, early childbearing occurs fairly frequently. The results of this study show that two thirds of the young mothers that were interviewed had their first child between the age 15-19 years old. In addition, approximately a third of those who had given birth did so between 20 and 22 years old. The remaining six percent had their first child when they were younger than 15 years old. In contrast, Kalil (2000) found in her study of African American teenage mothers, that most had had their first child at the age of 16 and in general the fathers of the children were approximately the same age as that of the mothers.

When asked what would be the preferred age to have their first child, half responded when they would be financially stable, and definitely over 25 years old. Just under a half (48%) said the ideal age to start having children would be between 20 and 25 years old. Most females indicated that they preferred this stage of their lives to start a family (20-25 years). The majority of men preferred to delay child bearing for when they were older and economically independent.

Approximately 61% of those young people with two partners reported having discussed pregnancy avoidance; however in this instance more men (77%) took the initiative. This suggests that young male adults with multiple partners are hesitant to father a child or be held responsible for a pregnancy.

### **7.3.3. Age at first sex**

The age of the partner is vital in sexual and reproductive behaviour. For example, Mahy and Gupta (2002) have found that the effects of the age of a couple have mixed repercussions. If they remain faithful to each other, then the risk of sexually transmitted infection is reduced for both partners. However, in the case where a woman is much younger than her more sexually experienced, older male partner, then she may have increased exposure to sexually transmitted infections (including HIV/AIDS) and pregnancy as he would have been exposed to a much longer sexual history.

This study found that by their 16<sup>th</sup> birthday, 70% Coloured, 63% African, 51% Indian and 45% White young people in this study's sample had reached sexual debut. In comparison, the Kenya Demographic Health Survey showed that 32% boys and 15% girls had reached sexual debut by the time they were 15 years old (cited by Nzioka, 2001:108). This reveals that young people in KwaZulu-Natal are initiating sexual activity at an early age.

## **7.4. Sexual Behaviour Patterns**

Less than half (47%) of the young people interviewed in this study stated that they were sexually active; the majority of whom were female and belonged to the 20-22 year old age category. This is in contrast to the findings of the DHS. For example, in

sub-Saharan Africa, sexual activity, contraceptive use and childbearing among never-married woman aged 15-24 differed significantly among countries. Analysis of Demographic and Health Surveys data reveals that in some countries such as Botswana and Liberia, more than 75% of unmarried woman have had sexual intercourse, while in Burundi only 45% have done so (Gage-Brandon and Meekers, 1993). Although this group of researchers found that sexual activity among never married adolescent women was very low in some countries, they also discovered that the likelihood of engaging in sexual intercourse “more than doubles from age 15-17 [years] to age 18-19 [years]” (Gage-Brandon and Meekers, 1993:15).

The apparent low revelation of sexual activity in this study may be explained by the findings of Mahy and Gupta (2002:8) who declared that “some researchers have voiced concern that respondents, especially teenagers, might be uncomfortable with the topic of sexual activity.” Since young people may have been embarrassed to provide feedback to this question, it is possible that this section was under reported.

#### **7.5. Knowledge of family planning**

A number of factors may influence levels of knowledge of contraception. A young person's knowledge of contraceptive methods may depend on his/her reproductive experiences (either by being pregnant, fathering a child or knowing of someone who had to drop out of school as a result of a teenage pregnancy). The existence of socio-demographic differentials in knowledge of methods is consistent with the diffusion hypothesis (Cleland and Wilson, 1987). Under this theory, educated, urban residents are the first to become aware of, and to experiment with, contraception.

The first stage of the diffusion process is to become aware of and informed about contraceptive methods. Measuring the level of awareness of contraception also provides a useful measure of the success of information, education and communication campaigns as it indicates the extent to which information on a range of contraceptive options has been disseminated (Curtis and Neitzel, 1996).

Knowledge of at least one method is an essential precondition for contraceptive use, but knowledge of more than one method is required if an informed choice is to be made (Curtis and Neitzel, 1996). The present study found that the majority of young people (93%) knew of at least one modern method of contraception. The most popular of all modern methods was the male condom. This is in contrast to other studies where it was found that the pill was more often the method of choice (Maharaj, 2000 and Curtis and Neitzel, 1996). Approximately two thirds (62%) of all respondents knew of at least one source of family planning. When young people were questioned about their knowledge of a source of supply of condoms, the response rate was much higher (96%). However, fewer respondents knew that using condoms prevented pregnancy. Regarding the source of contraceptive supplies, this study found that in both the focus group discussions and the structured interviews that the local family planning clinics or pharmacy was the main source.

## **7.6. Attitudes toward family planning**

Attitudes toward family planning may also influence contraceptive use. These attitudes are formed on the basis of an individual's perception of the risk of pregnancy, which in turn is likely to be influenced by peers and partner dynamics.

### **7.6.1. Perceived risk of pregnancy**

According to Rutenberg et al. (2001:39), “understanding what adolescents know about the risk of pregnancy and pregnancy prevention is important because this knowledge affects an individual’s behaviour and reflects the general state of education on reproductive health.”

Young men and women who perceived themselves to be at risk of pregnancy are more likely to use a method. This self-perceived risk of exposure of an individual to having a child depends on a combination of the following factors: knowledge of contraception and its supply and use, consistency of using a method to prevent pregnancy with each partner and misconceptions about pregnancy prevention. In this study, less than a fifth of the sexually active respondents knew that pregnancy could occur even if the male withdraws, almost two thirds of these were females. The remaining 84% said either that withdrawal can prevent pregnancy or that they had no idea. This is an alarmingly high figure and should inform future sex education and reproductive health programs. These results are consistent with the findings of a study conducted by Mahy and Gupta (2002) which revealed that few young women in their sample correctly identified the fertile period.

In contrast, Gage-Brandon and Meekers (1993) found that in six out of the seven countries in their study less than 30% of unmarried women who had had sexual intercourse correctly identified the fertile period of the ovulatory cycle. These writers suggest that this knowledge could possibly explain why 'periodic abstinence' as a contraceptive method seemed to be more successful in their study as compared to other countries.

### **7.6.2. Peer Pressure**

According to Varga (1999:25), peer pressure has 'multiple dimensions'. She states that there appears to be a trend for young people to incorporate sex much earlier into their social lives than in previous generations, to engage in multiple partnerships and for young men to feel pressurised in terms of their expectations of their sexual conduct.

Additionally, Nzioka (2001) has found that young people are faced with conflicting pressures: adult norms that favour sexual abstinence versus peer group norms that encourage premarital and unsafe sex.

From the focus group discussions in this study, it became clear that both males and females were exposed and influenced by the effects of peer pressure. The theory of reasoned action (discussed in chapter 2), highlights the effect of social influences on one's behaviour. This is evident in the peer pressure that is exerted on young people in their choice to use contraception (MacPhail and Campbell, 2001). An important and relevant study in this context is based on research conducted by Gage (1998) who contends that youth that were less susceptible to peer pressure or who were more successful at resisting it were more likely to practice safe sex.

### **7.6.3. Partner communication**

Partner communication is regarded as important for good reproductive health. Studies have shown that men and women who have discussed family planning are more likely to use a contraceptive method (Varga, 2001, Harrison et al., 2001). Communication between partners is a vital factor influencing contraceptive use. As Harrison et al. (2001:63) state “a lack of decision-making autonomy within relationships constrained girls’ ability to practice safer sex. This implies that more women consider that the onus is on them and that it is not their partner’s responsibility to practice family planning. The results of this study tend to concur with this trend. Over two thirds of the sexually active respondents said they discussed contraceptive use with the intention of avoiding both pregnancy and infection; the majority of whom were female. This finding that women are more likely than men to take the initiative to suggest contraceptive use in order to prevent pregnancy is supported by other studies. Varga (1999) and Nzioka (2001) found that men usually relied on their partners to be responsible for family planning. A study in Uganda by Hulton et al. (2000) also showed that males rarely consider a partner falling pregnant an immediate concern. As a result it was not something they were going to take active steps to avoid. In

contrast, girls professed to be more wary about an early or mistimed pregnancy as they feared monetary loss and the social costs of pregnancy like being ostracised from school and home (Gage, 1998). With specific reference to family planning, Maharaj (2000) found that although the majority of men in her focus group discussions expressed favourable attitudes to family planning, they continued to regard it as the responsibility of the women. Even obtaining contraceptive supplies was considered the woman's duty.

Nzioka (2001) found in his study that Kenyan youth found themselves in a predominantly patriarchal setting, where males were the key decision-makers about the timing of sexual activity and contraceptive usage. This study confirms this finding, where more males than females were found to broach the subject of contraceptive use in contrast to females who preferred to avoid sex altogether. Recently, there has been a tendency for older men to develop sexual relationships with younger females. This places the female at even greater risk of contracting infection, becoming pregnant or both because older men have longer sexual histories. Additionally, in these partnerships young women have less power to negotiate safer sexual practices, particularly since some of them have been promised financial assistance from the older men (Radhakrishna et al. as cited in Manzini, 2001:45).

Hence, an imbalance of power within relationships often results in young women not being able to initiate a discussion on contraception. Such a request may lead to a violent response as it may be viewed as a sign of unfaithfulness on the part of the female partner.

The findings of this study on partner communication may be compared to similar responses recorded at sexual debut. An analysis of partner communication specifically at first sex revealed that less than a third of all sexually active respondents discussed contraception before their first sexual encounter. The majority of whom were African, urban and female. A possible reason for this is that African males may not necessarily view the use of contraception at first sex as being imperative. In addition, African

women are becoming more proactive in preventing pregnancy and in cases where the contraceptive method used was the condom, it implies that they are also very aware of the avoidance of disease. Even in the rural areas, more females than men initiated discussion on the use of contraception. In contrast, Indian and White men took the lead with respect to contraceptive use in the urban areas. In both these societies, men would be held more accountable for child rearing than in an African society; hence Indian and White males appear to be more cautious.

#### **7.6.4. Contraceptive behaviour**

##### **7.6.4.1. Contraceptive use at first sex**

According to Varga (1999), male preferences prevail in the timing of sexual intercourse and contraception. This has been confirmed in this present study where the statistics revealed that although only 29% of the sexually active sample responded that they used contraception at first sex, males predominated particularly in the Coloured and Indian urban groups. There were twice as many females in both the African urban and rural groups as their male counterparts, while Indian females were about half the number of Indian males that responded positively to this question.

##### **7.6.4.2. Contraceptive use at last sex**

Overall, the male condom was the most popular method used during last sexual encounter. This was followed by the injectable and the pill. This is in contrast to the SADHS finding that the most widely method used was the pill. A possible explanation for this may be that only married females aged 15-49 years were questioned in their study. Maharaj (2000) also found in her study that the pill and injectables were the most widely known methods used for family planning purposes, very few of her respondents viewed condoms as a means of avoiding or delaying

pregnancy. The advantages of the injection method are that it offers a more reliable option to pregnancy prevention and is female –controlled (hence there is no pressure on females to convince men to use a method for pregnancy prevention). However, they still do expose themselves to the risk of infection of STDs, including HIV/AIDS. With increasing awareness of HIV/AIDS, condoms have proved to be the safest form of dual protection against both pregnancy and infection.

The 16-19 year old age group in all cases had the most number of contraceptors, followed by the 20-22 year old age category. This implies that the older adolescents were more likely to engage in contraception in comparison to their younger counterparts. Young people with a single partner appeared to have employed the greatest variety of contraceptive methods. Second and third partners did not make use of any traditional methods, preferring to restrict themselves to the more modern methods.

## **7.7. Conclusion**

In this study, the findings from the multivariate logistic regression model used to examine the relationship between socio-demographic differentials and contraceptive use revealed that a causal link exists between pairs of events. For example: age and contraceptive use, relationship status and contraceptive use, having a child and contraceptive use and geographic location and contraceptive use.

The above discussion contributes to furthering the understanding of how young people in KwaZulu-Natal, have responded to the current HIV/AIDS pandemic. More importantly, it has illustrated that whilst factors such as the socio-demographic and individual characteristics impact upon the sexual and reproductive health behaviour of young adults, the perception of individuals within a relationship appears to be a major determinant in the choice to use contraception or not.

## CHAPTER EIGHT : CONCLUSION AND RECOMMENDATIONS

Using data collected on young people in KwaZulu-Natal, this dissertation has identified a number of important determinants of risk-taking behaviour (in this case contraceptive use). The alarmingly high levels of unwanted teenage pregnancies and HIV prevalence within the province of KwaZulu-Natal particularly among adolescents stresses the necessity to identify such key variables in order to target intervention strategies better.

The strength of local health programs can be measured through proxy indicators of whether a large proportion of the population of a reproductive age in a community has practised family planning (Mahy and Gupta, 2002). The indicators examined in this study can influence future reproductive health programs for young people particularly in KwaZulu-Natal, South Africa.

Understanding the socio-demographic causes of changes in sexual and reproductive health behaviour will assist program planners and policymakers in creating programs aimed at improving reproductive health care for young people.

This research confirms that risky sexual behaviour still persists among young people, despite their knowledge of contraception and its use being nearly universal; safe sex is not practised. A dislike for condom use, not wanting to be seen collecting contraceptives and the negative attitude of some reproductive health service providers were among the common reasons put forward for the persistence of low contraceptive use among the young people of KwaZulu-Natal. Furthermore, patriarchy still exists as is evident in the gender imbalances and power struggles highlighted in this study. Generally, males preferred to boast about their multiple partnerships and encouraged the practice of 'flesh-to-flesh' sex as an indication of male prowess.

This research proves that certain factors do influence contraceptive use, viz. age, race, sex, relational status and place of residence. It is therefore recommended that for sex education programs to be effective, these differentials need to be taken into account. Zheng et al (2001) suggest that young people need sexual and reproductive health education in the formal school education system so that they have good information and a positive attitude towards family planning from an earlier age. Consequently, interventions should be in accordance with the following suggested groupings:

- Teenagers who have never had sex,
- Girls and boys separately,
- Adolescents that have given birth or fathered a child,
- Young people who have health problems as a result of having sexual intercourse,
- Out-of-school youth
- Unemployed teenagers
- Urban young people
- Rural adolescents

Violence against women affects all women particularly young women. Hence, youth health strategies require a special emphasis on the threats to young women.

Most importantly however, there is a need for programs to address gender inequalities and emphasise behavioural skills *before* sexual activity begins. As early as 1992, Abdool-Karrim et al. (1992a) stressed the importance of providing women with communication skills in order that they could negotiate the use of contraception (especially condoms) with their partners. This study has confirmed that this need still exists and persists.

Much remains to be done to understand the dynamics of contraceptive use among young people. In this present study, an attempt at quantifying some important socio-demographic factors through one indicator, viz. current contraceptive use is presented.

This is only one element of a more complex phenomenon in which cultural, behavioural, socio-economic and socio-sexual factors all play a role and possibly interplay. A better understanding of these complex dynamics would require more extensive and better quality data on contraceptive usage among young people. This data would then be required to be cross referenced with other cultural and behavioural factors, either at the individual level or at least for typical social groups in particular urban/rural, ethnic, socio-economic and religious groups in order to achieve a more holistic approach to this extremely challenging problem.

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