

“ZAZI-Know Your Strength”- A reception Analysis of contraceptive utilisation in correlation to unplanned and unwanted pregnancies among young female learners’ in Umnini, KwaZulu-Natal

By

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Declaration

I Yonela Vukapi, declare that the work presented in this dissertation is my own, and that any work done by other persons has been duly acknowledged.

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Abstract

Approximately 30% of teenage pregnancies are reported as unplanned in South Africa and KwaZulu-Natal, in particular, has one of the highest concentrations of teenage pregnancy. While there are advances made in addressing this issue, teenage pregnancy remains a social problem. Most teenage mothers report limited contraceptive use before falling pregnant. Health communication campaigns have been implemented as a response to this social problem, including ZAZI-Know Your Strength (ZAZI) campaign. The study is a reception analysis of perceptions and experiences of young female learners towards contraceptive use in correlation to unplanned pregnancy after being exposed to the ZAZI campaign. This study is framed by the culture-centered approach which says that health communication programmes should be planned, implemented and evaluated within the context of the relevant socio-cultural beliefs and value systems prevalent in a particular community. Focus group discussions and semi-structured interviews were administered to determine the reception of the ZAZI campaign. Findings indicated that there is knowledge of the different contraceptive methods; however this knowledge often did not translate to contraceptive use. Key findings highlighted the need for more access points that provide contraceptives, including healthcare workers' attitudes towards young women at the health care facilities. The circumstances of young women in this study speak to the larger social and economic issues of the country and reflect the need to prioritise young women's health in rural areas for health interventions like ZAZI to have a greater impact.

Keywords: Contraceptives, ZAZI, Reception Analysis, Teenage pregnancy

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
CCA	Culture-Centered Approach
CCMS	Centre for Communication, Media and Society
CADRE	Centre for AIDS Development, Research and Evaluation
CARMMA	Campaign for the Accelerated Reduction of Maternal, Neonatal and Child Mortality in Africa
DEO	Department of Education
DramAide	Drama in Aids Education
FGD	Focus Group Discussions
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HSRC	Human Social Research Council
JHHESA	John Hopkins Health Education South Africa
KZN	KwaZulu-Natal
NGO	Non-Governmental Organisations
RHS	Reproductive Healthcare Services
SEMCHB	Social Ecology Model of Communication and Health Behaviour
STI	Sexual Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organisation

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Chapter 1: Introduction

This study seeks to uncover the link between unplanned pregnancy and contraceptive use among young women who have been part of the ZAZI: Know Your Strength campaign. The primary focus of this study is the reception and the manner in which young women¹ who have been exposed to ZAZI make sense of health issues, particularly on contraceptives as a preventative method against unplanned pregnancy. It is also the objective of this study to understand how the lack of contraceptive use has contributed to the increasing percentage of the Human Immunodeficiency Virus (HIV) infection among young women in KwaZulu-Natal (KZN), South Africa.

South Africa has a reported teenage pregnancy rate of 30% and that nearly all of these pregnancies were unplanned (Pettifor et al., 2005; Jewkes et al., 2009; Willam, 2013). Although the overall national teenage pregnancy rate is falling, the Department of Education (DoE) numbered school learners who became pregnant in 2007 to 49 636, the highest proportion of these learners were in KwaZulu-Natal (Morrell et al., 2012). Monica Grant and Kelly Hallman, (2008:371) revealed that “the majority teenage girls who get pregnant during school, only a few return to school after childbirth. Although the number of childbirths are fewer; unplanned pregnancies among teenage girls remains “unacceptably high” (Willam, 2013:4). There are multiple factors that drive teenage pregnancy rates in South Africa; this study will present a few possible factors relevant to the context of young women. Willam (2013:4) postulates that there is a basic amount of knowledge that teenagers have about contraceptives and how to “protect themselves from unplanned pregnancies and STIs including HIV”. Teenagers are often reported as having insufficient knowledge of the multiple contraceptive methods, and how to use them correctly and consistently (Willam, 2013).

Closely linked to the issue of unplanned pregnancy among teenagers, is the risk of HIV infection. The HIV pandemic remains a significant health problem globally, taking almost 1.2 million lives in the year 2014 globally (WHO, 2015).² Roughly 36.9 million persons were living with HIV at the end of 2014, with 2.0 million becoming newly infected globally (WHO, 2015). Reports show that the Sub-Saharan African region is most affected, with 25.8

¹ Young women in this study refer to females between ages 18-20 years old.

² WHO 2015: <http://www.who.int/mediacentre/factsheets/fs364/en/>

million persons living with HIV in 2014 (WHO, 2015). These statistics indicate the need for strategies that will focus on individuals at different levels, suitable for their setting.

The Sub-Saharan Africa region accounts for “almost 70% of the global total of new HIV infections” (UNAIDS, 2014). In 2012, it was estimated that 12.2% of the South African population was HIV positive, which means “1.2 million more PLHIV than in 2008” (Simbayi et al., 2014). In comparison to previous findings, these results show that the overall HIV prevalence differs substantially by province, sex and age in South Africa (Simbayi et al., 2014). In 2014, it was estimated that the number of people living with HIV is 6, 800, 000 (UNAIDS, 2014).³ Simbayi et al. (2014) conducted a survey which produced data at sub-provincial levels. Amidst the nine provinces, KwaZulu-Natal had the highest percentage of HIV prevalence, with eThekweni being the leading local community (Simbayi et al., 2014). KwaZulu-Natal had the highest (16.9%) HIV prevalence in contrast to other provinces in South Africa, with women showing the highest prevalence rate (Simbayi et al., 2014). Furthermore, looking into the HIV incidence rate in South Africa, 469,000 new HIV infections occurred in 2012. “Among adults aged 15-49 years, the number of new infections was 1.7 times higher in females than in males” (Simbayi et al., 2014: 32). Furthermore “The HIV-incidence rate among female youth aged 15–24 was over four times higher than the incidence rate found in males in this age group (2.5% vs.0.6%)” (Simbayi et al., 2014).

The staggering evidence of HIV infection has placed young women at greater risks due to factors such as intergenerational relationships, recently referred to as the ‘sugar daddy syndrome’ and the power dynamics within those relationships. “Throughout sub-Saharan Africa studies have revealed that young women’s power to negotiate condom use is often compromised by age disparities and economic dependence” (Leclerc-Madlala, 2008:18)

This has created a gap for sexual negotiation to increase, making women less in-control of their sexualities. For this reason women are specifically chosen to be empowered, to know their worth; to have knowledge about all available preventative methods against pregnancy and HIV and AIDS. South Africa has had health campaigns in the past, such as the loveLife⁴ campaign was launched late in 1999, with the overall aim to reduce the increased rate of HIV infections, particularly among the South African youth (loveLife, 2015). Additionally, the

³ (UNAIDS, 2014) : <http://www.unaids.org/en/regionscountries/countries/southafrica>

⁴loveLife campaign: <http://www.lovelife.org.za/>

Scrutinize⁵ campaign was launched, with an aim to encourage the youth to ‘scrutinize’; be aware of the high risk of HIV associated with having multiple sexual partners. (SCRUTINIZE, 2015). Within the field of health communication and other HIV prevention strategies, the focus on women and their empowerment have become crucial in the fight against HIV and AIDS. Behavioural change campaigns have been one of the primary strategies used in creating awareness and thereby reducing the spread of HIV and AIDS.

In the past, behavior change campaigns often investigated HIV and AIDS and its contributing factors theoretically, which meant that the individual was the agent of their own change. Whereas Collin Chasi (2011: 139) states that “without the meaningful understanding of the needs of real individuals in real situations, there is little chance that subjectivities or experiences of the people are accounted for”. This observation confirms that in trying to understand individual behaviour, the individual cannot be separated from the environment from which they come (Chasi, 2011). HIV and AIDS studies and interventions that often negate the community interaction are at risk of also ignoring the ‘context’ of the individuals researched (Govender, 2011). Context includes the socio-economic factors, culture and social norms of the individual. This study explores the ZAZI campaign and young women learners’ perceptions and views on how they have received the campaign with a particular focus on contraceptive use in correlation to unplanned pregnancy.

Relevance of the study

Mpolokeng Mpele (2005), conducted a reception analysis of *Soul City* with a focus on the audience’s decoded message of the Choose Life booklet. The aim was to uncover how the booklet influenced participants who watched the *Soul City* television programme. More relevant to this study is the analysis which highlighted the lack of contraceptive use among adolescents in Lesotho (Mpele, 2005). A study among rural and urban women exploring the HIV incidence rate in KwaZulu-Natal showed 35.7% HIV prevalence among rural women and 59.3% amongst urban women. The incidence rate was 6.5% amongst rural women and 6.4% of urban women (Karim and Karim, 2010). Despite the attempts that have been made to stabilise HIV prevalence in the past, this study indicates that there remain high HIV incidence rates amongst young women in rural and urban areas in KwaZulu-Natal. Hence, campaigns such as ZAZI were developed to address women from different cultures about issues such as the escalating HIV prevalence.

⁵ SCRUTINIZE campaign: <http://www.scrutinize.org.za/about-scrutinize.html>

Tesfagabir Tesfu (2003) also conducted a study which evaluated the communication strategies used in voluntary counseling and testing (VCT). The primary concern in this study was that if young people were sensitised about the benefits of VCT, many lives would be saved. The study explored literature around communication for behaviour change, specifically looking at how most health campaigns deliver messages that attempt to increase awareness, informing individuals what to do, specifying who should do it, and cueing them regarding when and where to do it. This relates to the idea that health campaigns involve detailed formative research, effective participation of target groups, and establishing strong partnerships among stakeholders (Tesfu, 2003).

ZAZI-Know Your Strength

In light of the above statistics, the objective of this study is to explore young female learners' perceptions of the ZAZI campaign. ZAZI is a health communication campaign that was launched and implemented with the objective of prosocial behavioral change among women and girls. ZAZI was launched on 25th May 2013 under the leadership of the South African National AIDS Council (SANAC) Women's Sector, with support from the USAID/JHU HIV Communication programme and PEPFAR in partnership with the Department of Women, Children and People with Disabilities, the Department of Health and the Department of Social Development (ZAZI, 2015). It is a campaign aimed to lessen the increasing spread of HIV and AIDS among South African women. It advocates for women and girls to know their self-worth and draw on their inner strength. It seeks to equip women and girls to become confident and independent, owning their power and self-confidence to know what they stand for, and guide their decisions about the future (ZAZI, 2015). It also advocates for women and girls to have better access to vital health care services and facilities to help stop new HIV infections; minimise unplanned pregnancies and prevent mother to child transmission of HIV (ZAZI, 2015). The main objective of the ZAZI campaign is to reduce the number of new HIV infections by at least 50% amongst women by the year 2016. This study is interested in the reception of the campaign, specifically among young female learners between the ages of 18-20 in the community of Umnini, and how they received and made sense of the message contained in the ZAZI campaign.

Rationale and objective of study

This study seeks to explore young female learners' perspectives on the ZAZI campaign. The primary aim of the study was to examine young female learners' reception of the ZAZI campaign, seeking to understand their perceptions, attitudes and experiences towards contraception use and unplanned pregnancy. Although the study is interested in the perceptions of contraceptive use in correlation to unplanned pregnancy; the high risk of HIV infection forms a part in gaining understanding about contraceptive use. Therefore, the high risks of HIV infection will be mentioned throughout the study. Singh (2005) states that in order to protect young women and the society from the consequences of unplanned pregnancy; the issue of sexuality need to be tackled immediately. We cannot deny that social-sexual stimuli, peer pressure and mass media tend to make sexual activity attractive and exciting to young people (Singh, 2005). Hence, there is a need to equip young people with accurate information so as to enhance their understanding and responsibility towards their sexual behaviour. The researcher is interested in the way young women learners' cultural beliefs, social norms and perspectives of contraceptive use and unplanned pregnancy influence their reception of ZAZI. Based on the findings of the study, the researcher will then be able to make relevant conclusions as to whether or not the ZAZI campaign has influenced behaviors of contraceptive use among the young women. By establishing the young women's perceptions of contraceptive use and unplanned pregnancies, the researcher wishes to discover their level of knowledge broadly around HIV and AIDS, the risk of infection and their perceptions around issues of prevention.

Questions asked

1. What are women's perceptions of the ZAZI campaign?

The understanding of how young women learners perceive the ZAZI campaign will reveal how much they know about all the key issues that ZAZI aims to address. Issues such as pregnancy (planned or unplanned), contraceptive knowledge and use and HIV and AIDS. Their perceptions of the campaign will also be an indicator of whether such strategies are effective or not when it comes to behavioural change. This study will present the findings through focus group discussions and interviews.

2. What are the women's perceptions about contraceptive use as a preventative method against HIV and AIDS?

This objective seeks to understand the views and opinions of young women about contraceptive use. The researcher is anticipating that general knowledge of different contraceptive methods will be revealed. The participants' general knowledge will offer an understanding of some of the barriers that hinder contraceptive use.

3. How has reception of the ZAZI campaign contributed to their contraceptive knowledge and utilisation in correlation to unplanned pregnancy?

Reception of the campaign will not only reveal an understanding of contraceptive knowledge and usage in line with an unplanned pregnancy. It will also give an understanding of what young women know about the campaign and its objectives. The reception of the ZAZI campaign will also reveal the level of influence it has had toward behavior change, what the participants have learnt from the campaign and whether it had behavioural change implications towards contraceptive utilisation. Focus group discussions will give a broad overview of what the young women understood about the campaign, and then it will narrow down that understanding to what they have applied directly to their lives from the campaign.

Theoretical framework

The Social Ecology Model of Communication and Health Behaviour (SEMCHB) describes the complexity, interrelatedness, and wholeness of the components of a complex adaptive system, rather than just particular parts in isolation from the system (Kincaid et al., 2007). This SEMCHB meta-theory informed the strategy and formation of the ZAZI campaign in its developmental stages. The campaign employed SEMCHB because it regards health behaviour as an outcome of the interaction between people and the environment they live. It is what the developers of the campaign used so that the campaign can cater for different individuals. Therefore, this study proposes to use this model to review the aspects of communication and health visible in the ZAZI campaign according to the various levels discussed in the SEMCHB, specifically at the individual and community levels. The SEMCHB is a meta-theory in the sense that each level shown in the model encompasses theories of change for that particular level (Kincaid et al., 2007). For example, the Health Belief Model which assumed that behaviour is a result of an individual's expectations is directly linked to the individual level.

By using the SEMCHB this study seeks to present the connection between the different levels of influence on individual behaviour. It takes into consideration the mutual influences of a person's family, peers, community and their society on behaviour (Sallis et al., 2008). This interconnectedness reiterates the importance of understanding context, a strategy that uses systematic processes to understand people's situations and influences (Govender, 2011). Individual behavioural change, without the company of social change, is not sufficient (Govender, 2011). It is the inclusion of understanding society, people and the environment that any permanent behaviour change can occur in individual lives. Therefore, this study will also use the culture-centered approach to understand the structures that inform systems of culture at the community level of the SEMCHB meta-theory. It also introduces the notion of the agency; which is the capacity of cultural members to enact their choices and to participate actively in negotiating the structures within which they find themselves (Dutta, 2008).

The culture-centered approach identifies key characteristics that can be applied at the community level. Some of these include voice and dialogue, structure, context and space, values and lastly criticism (Dutta, 2008). The voice and dialogue seek to introduce the voices of local communities in ways that health issues can be interpreted and communicated. Meaning that there is a dialogical engagement between the researcher and the community (Dutta, 2008). Structural processes also need to be understood for dialogical engagement to be successful. Structures create conditions of stigmatisation that continue to construct those at the margins as inferior, primitive and passive recipients to interventions targeted at them (Dutta, 2008). It is important to understand the context and space in which individuals live their day-to-day lives. It enables us to understand how context connects individuals to the culture within which they live (Dutta, 2008). The criticism offered by the culture-centered approach of previous approaches, that focused on the individual as being responsible for their own behaviour change, is an effort to return the gaze that is typically cast in the subject position of the participant to the producer of knowledge in order to uncover the dominant interests active in constructing certain truths used in health communication (Dutta, 2008). The culture-centered approach is relevant to this study because it assists the researcher to understand what influences young women learners perceptions and decision-making around the issues of contraceptive use. The characteristics will enable the researcher to have an in-depth

understanding of the context of the research participant, avoiding any previous assumptions about the participants.

Encoding/Decoding

To make sense of the findings, Stuart Hall's encoding/decoding model will be applied (Fiske, 1989). Stuart Hall's encoding/decoding model (1980) should reveal the ways in which audiences read the ZAZI message; whether they hold an (i) dominant, (ii) negotiated or (iii) oppositional position in decoding the message. This model highlights the importance of active interpretation. Encoding means the making of messages and decoding is the interpretation of these messages by the reader (Hall, 1996). Hall's model explains that the audience's decoding may not follow inevitably from what the producer had encoded. Therefore, there is no necessary link between the encoded message and the decoded message, the former can only attempt to 'prefer' but cannot directly guarantee the latter. The making of meaning is an interactive process where the receiver of the message is an active part of its encoding (Tomaselli, 1988). The different interpretations of meaning are attributed to the structural differences in which different individuals live. Therefore, this study makes use of the culture-centered approach as a tool to understand the cultural aspect of the person's life. Hall argues that for one to decode a message meaningfully, it has to be within the confines of understanding his/her culture (Hall, 1996). The encoding/decoding model should reveal the ways in which young women learners read and received the ZAZI campaign. Therefore, there is a direct link to the structures of the culture in which individuals live and how they understand encoded messages.

Organisation of the dissertation:

Chapter One provides the reader background information on contraceptive knowledge and unplanned pregnancies. It also presents the rationale and objectives of the study and highlights the central research questions that are in the study. Lastly, it gives a framework into which the study fits.

Chapter Two reviews the literature, documenting some of the arguments and findings around contraception and unplanned pregnancy amongst young women. It will discuss some of the contributing factors of the inconsistencies in contraceptive use.

Chapter Three is the theoretical framework that assists in making sense of the data collected, and theories employed to analyse the data. Theories include Stuart Hall's (1980) encoding/decoding model and reception analysis (Fiske, 1989), the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid et al., 2007), the Health Belief Model (HBM) at the individual level of the SEMCHB meta-theory and lastly the culture-centered approach at the community level of the SEMCHB meta-theory (Dutta, 2008).

Chapter Four is the methodology; this chapter delineates the methodological approach of this study. It outlines a qualitative research approach, how data collection was conducted, what kind of data was collected, and the sample size. It also explains how the data was analysed using both inductive and theoretical thematic analysis, along with encoding and decoding.

Chapter Five presents the research findings and analysis. The chapter begins with a background outlining the context of the study. A presentation of the findings follows, grouped into themes that emerged from the community dialogues, focus groups and the semi-structured interviews.

Chapter Six presents the conclusions and recommendations based on the findings of the study.

Chapter 2: Literature Review

Introduction

This chapter will briefly discuss the nature of HIV and AIDS in South Africa. It will also discuss some of the key factors that influence teenage pregnancy in relation to the low rates of contraceptive use among adolescent girls in South Africa. It provides a brief history of contraception and its present function as a preventative means of unplanned and unwanted pregnancy. The chapter concludes by highlighting what has been done to address teenage pregnancy and the lack of contraceptive use.

Overview of HIV and AIDS in South Africa

Rachel Jewkes *et al.* (2009) noted that the first decade of the HIV pandemic in South Africa, rates of HIV prevalence were not as increasingly high as they are currently, with 29% in 2007. Shisana (2005) drew from these rates that HIV was not spreading equally among different groups; there were marked racial differences, with estimates showing men and women that come from white and Indian ethnic groups having a prevalence of 0.6% and 1.9% respectively. The African ethnic group reported having the highest prevalence rate of 13.3%. Pettifor *et al.* (2005) also reported that within the age group 15-24, young women have a 15.5% chance of being infected with HIV whereas young men have a 4.8% chance. Gray *et al.* (2001:1152) stated that “higher infectivity could possibly be due to biological factors such as cervical ectopy in young women which may facilitate HIV-1 transmission” (Simbayi *et al.*, 2014).

In the year 2012 it was estimated that 12.2% of the South African population was HIV positive, determining that 1.2 million more people were living with HIV than in the year 2008 (Simbayi *et al.*, 2014). In comparison to previous findings, these results showed that the overall HIV prevalence differs substantially by province, sex and age in South Africa (Simbayi *et al.*, 2014). In 2012 the World Health Organisation (WHO) also showed high HIV prevalence rates of 17.9% among the general population between the ages of 15-49 in South Africa. This is despite the already existing knowledge of preventative methods. The sub-provincial survey conducted by (Simbayi *et al.*, 2014) showed KZN (16.9%) having the

highest percentage of HIV prevalence in comparison to the other nine provinces. Mpumalanga had the second highest (14.1%) with free state having (14.0%) (Simbayi et al., 2014). The Western Cape (5.0%) was reported having the lowest rates. Apart from the overall statistics, HIV prevalence amongst young women was eight times that of young men, suggesting that females are less likely to engage in sexual relationships with partners their own age. This has been identified as one of the factors that have contributed to the high levels of teenage pregnancy in South Africa. Unplanned pregnancy among teenagers remains an accepted “social and public health concern globally, affecting nearly every society” (Panday et al., 2009:9). Therefore, teenage pregnancy requires all the relevant stakeholders to recognise it as one of the key reproductive health problems. Panday et al.,(2009:9), continue to say that:

Despite public health literature and family planning services treating HIV and pregnancy as distinct, they share many common qualities chief amongst which is unprotected sex. Furthermore, there is evidence that pregnancy and lactation increase the susceptibility to HIV infection through immunological changes induced during pregnancy.

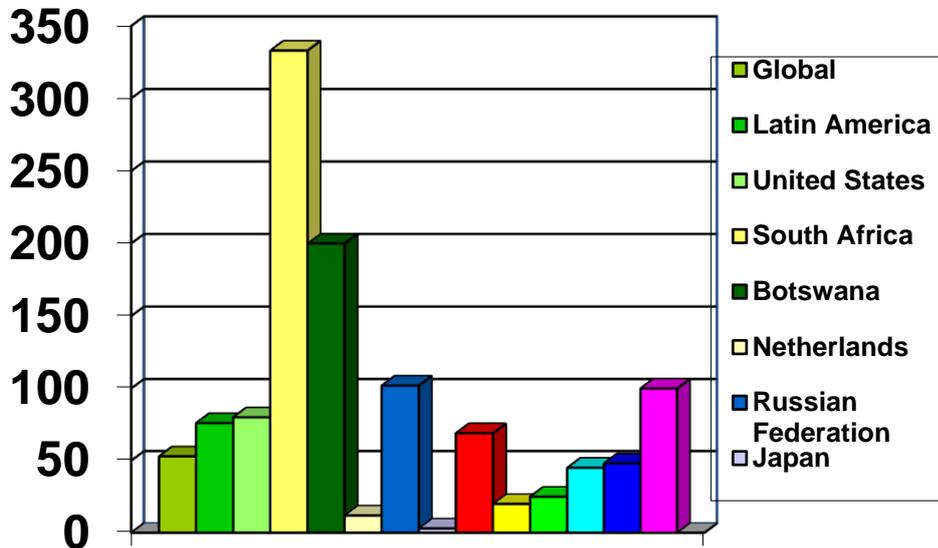
Teenage Pregnancy

Mothiba and Maputle (2012) define teenage⁶ pregnancy as a pregnancy of a woman who is less than 19 years of age. For some teenagers pregnancy and childbirth are planned and wanted, but research shows that for other teenagers, pregnancy is unplanned (WHO, 2015). “Despite high levels of knowledge about modern contraceptives, a large cohort of young people do not use contraception, and many use them inconsistently and incorrectly” (Panday et al., 2009: 15). Studies show that some teenage girls often do not know how to avoid getting pregnant; this is mostly attributed to the lack of sex education in many countries (Panday et al., 2009: 15). Perhaps, teenagers may feel too reserved or humiliated to seek contraception services or contraceptives may be too expensive and not widely or legally available (WHO, 2015). However, WHO postulates that sexually active adolescent girls are less likely to use contraception even if it is widely available. The reason could be that girls are sometimes subjected to unwanted sex or coerced sex, which tends to be unprotected because they are

⁶ In this Chapter the term ‘teenager’ and ‘adolescent’ will be used interchangeably

unable to refuse it (WHO, 2015). It is these factors that have exacerbated the high rates of teenage pregnancy in South Africa (See Fig. 2.1).

Figure 2.1: Teenage pregnancy globally



Source: (Gibson, 2007)

Mothiba and Maputle (2012) established in their study, that teenage pregnancy is found commonly amongst young women who have been disadvantaged and have poor expectations regarding their education or the job market. Nevertheless, research indicates that multiple factors have contributed to the high rates of teenage pregnancy. Chohan and Langa (2011) conducted a qualitative study with adolescent mothers aged 15 to 19 years who attended a public school in Johannesburg, South Africa. The authors were looking to explore their experience and possible reasons for early motherhood. This study presented the dominant discourses that construct teenage motherhood, as being ‘deviant’ and ‘immoral’. Many-a-time these discourses associate teenage mothers with poverty, social grants, high drop-out rates at school, and poor academic performance (Eaton et al., 2003; Macleod, 2010; Rolfe, 2008; Schultz, 2001). The main argument in this study was directed at revealing the many social ills in society around the issue of teenage pregnancy and contraceptives that are shifted onto teenage mothers rather than onto the social structures of poverty, unemployment, inequality and culture (Chohan and Langa, 2011).

There is a pool of studies that have been conducted, in an attempt to understand the sexual behaviours of youth in South Africa (Kau, 1988; Mwaba, 2000; Van Eijk, 2007; Morake,

2011), many of which, were shaped by the continuous structure and development of the country since apartheid. It is these developments that have been evolving the way in which sexuality is perceived and accepted in many communities and cultures. Alongside structural, political, social and economic developments in South Africa; the culture and the shared beliefs of a larger society were also developing and changing over time.

Evidence of this can be found in a study conducted by Nolwazi Mkhwanazi (2010), this study shows that in previous studies about early childbearing, cultural and societal dynamics were different. There was cultural value placed on childbearing, for a young woman it was a marker of femininity. “It provided a way for a teenage girl to show that she was fertile and to demonstrate ‘successful womanhood’” (Mkhwanazi, 2010:348). This was during the apartheid rule, a time in South Africa, where the spread of HIV was not as rapid as it is today. “In recent years with the capitulation of the apartheid regime and the advent of a new democracy, South Africa has undergone significant changes affecting every sphere and level of society” (Mkhwanazi, 2010:348).

The findings of the study highlight that “despite the negative perception of teenage pregnancy within the township, certain social and cultural circumstances provided fertile ground for its occurrence” (Mkhwanazi, 2010:356). Therefore, contraceptive use, unplanned pregnancy, and decision making among young women about sexuality cannot solemnly be attributed to ‘behaviour change’. Multiple contributing factors must be taken into account; however, these factors are also dispersed selectively depending on the nature of each community. For example; in rural areas the lack of education is one of the key influences ascribed to young women giving birth during their adolescent years.

The dynamics of behaviour change are complex; they cannot be generalised but are tailored to each context. In line with this study, the focus will be on the possible factors that influence or inhibit contraceptive use amongst young women.

Contributing factors to teenage pregnancy

Teenage pregnancy has proven to be a global crisis driven by multiple factors worldwide. For over a decade in South Africa scholars have been researching some of the driving influences that have caused teenage pregnancies to rise. Research has been conducted in relation to teenage pregnancy and contraceptive use globally, what stands out about each study is that they are all conducted within different cultural, structural and environmental contexts. Each study respectively represents a particular culture, with norms and values that the people in that community practice and believe. The development of each community also has an influence on how women construct their understanding of sexuality. Generally, “all cultures have their own set of rules, values and morals by which those who are part of that culture are expected to live’ (Selikow et al., 2002:23).

A study was conducted by Davies et al, (2006) that focused on the possible reasons for inconsistent contraceptive use among African-American adolescents. This study discovered that adolescents in had an innate desire to conceive. They had subjective beliefs that their partners shared the same desire due to evidence of their ‘monogamous’ behaviour towards them (Davies et al., 2006). In the context of the study the findings suggest that multiple factors anticipate future inconsistent contraceptive use because the adolescent participants were knowledgeable about the different methods of contraception.

In the Sub-Saharan African context, teenage pregnancy continues to be on the rise, with different contributing factors that influence adolescents engaging in sexual relationships that lead to unplanned and unwanted pregnancies. Bankole et al. (2007) conducted a comprehensive analysis of the knowledge of correct condom use and consistency of it, among adolescents in four African countries. One of the main findings of this study showed that age difference between partners is a major determinant of consistent use of contraception (Bankole et al., 2007:1).

This study seeks to give an overview of how to understand the factors that influence teenage pregnancy. Specifically, this study highlights that teenage pregnancy is both a developmental and a health problem. This is similar to Govender's (2011) assertion that HIV and AIDS was a developmental and health issue, this study seeks to demonstrate that teenage pregnancy can also be seen as a developmental and a health problem. Seeing teenage pregnancy as a

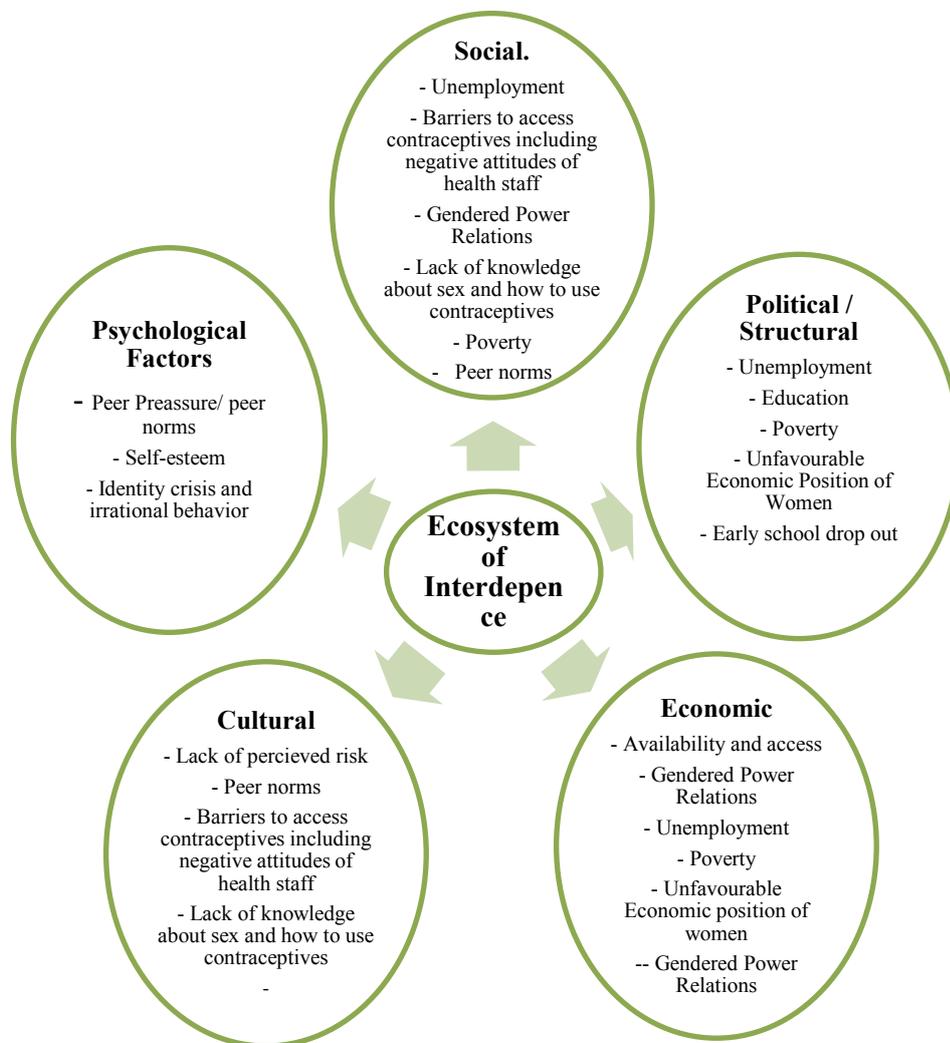
developmental problem would also result in communities, civil society and government addressing it as a larger problem of poverty, inequality and gender relations. On the other hand, teenage pregnancy as a health issue focuses on the sexual decisions of individuals as an approach to address behaviour change (Govender, 2011). Acknowledging this creates a place for a clearer understanding that factors are linked and interdependent.

We also recognize that sexual behaviour is ‘widely’ diverse and deeply embedded in individual desires, social and cultural relationships and environmental and economic processes hence making the process of evaluation enormously complex (Odotolu, 2005: 240).

Within the South African context, researchers have often categorised factors that contribute to unplanned and unwanted pregnancies within four categories: social, economic, cultural and political. Although they are disconnected in custom, these factors are interdependent. For example; when attempting to negotiate socio-economic issue of unemployment in South Africa and how it affects young people; there firstly needs to be a move among the political and structural level. With a probability of new policies and systems that support more employment opportunities for young people. This interdependence can be described as an *ecosystem*; showing the complex set of structures, policies, cultures and relationships that form our understanding of teenage pregnancy and contraceptive use.

Figure 2.2: Contributing factors to teenage pregnancy

Source: Vukapi, (2015)

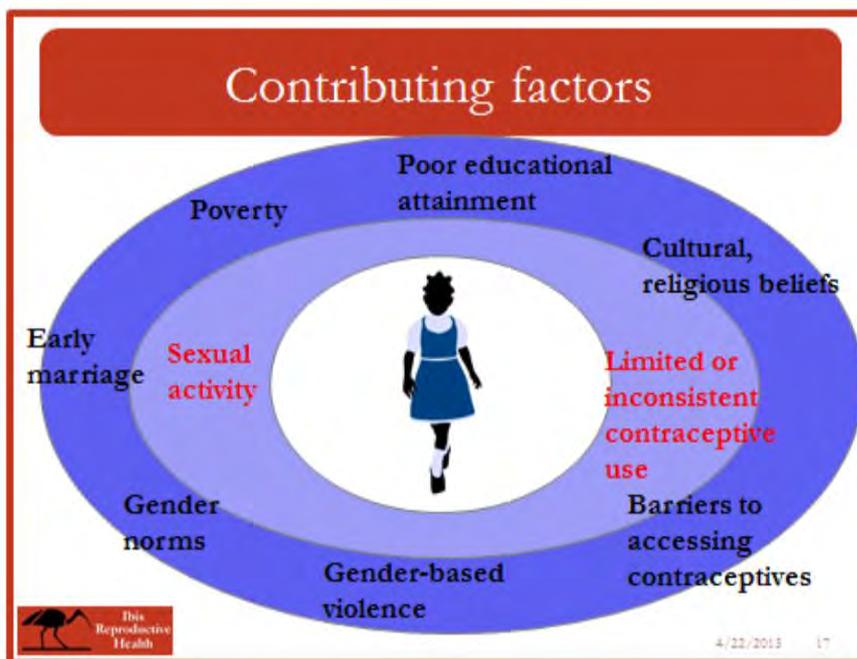


This figure above depicts the interaction between the multiple factors that influence teenage pregnancy, showing the connectedness among all of these categories of factors. For example, looking at this diagram, it is evident that what others perceive as a cultural issue, in a society could be both cultural and social. Therefore, this interdependency makes it challenging for this study to explore some of these factors without stepping into the terrain of the others. Eaton et al. (2003: 150) shared a similar understanding and said that:

If we wish to understand sexual risk behaviour in Southern Africa, we need to consider the interactive effects of factors at three levels: within the person, within his or her immediate context, and within the distal context.

To further illustrate this, Flanagan *et al.* (2013) provided a comprehensive diagram that incorporates the interdependency of factors. It also highlights how sexual activity and lack of contraceptive use place teenagers at immediate risk of unplanned pregnancy.

Figure 2.3: Interdependency of factors contributing to teenage pregnancy



Source: Flanagan *et al.* (2013)

While influencing factors to teenage pregnancy are interconnected, this study also directs its focus towards psychological factors such as the development of adolescent identity and the psycho-cognitive transition from childhood to adulthood. Furthermore, it will present some of the cultural perspectives and contexts of teenage sexual relationships. This is because “culture comprises of aspects such as tradition, the norms of the larger society, the social discourse within society, shared beliefs and values” (Eaton *et al.*, 2003:150). Another important influencing factor is that of the existing power differentials of intergenerational relationships between males and females and the socio-economic and political challenges that

they face. Studies show power differentials is most common in relationships younger women have with older men (Luke, 2005; Meekers and Calvès, 1997; Kuate-Defo, 2004; Wyrod et al., 2011; Leclerc-Madlala, 2008). Petersen (2009:100) postulates that what is missing from interventions and preventative programs is the understanding of how gender roles are negotiated in immediate contexts and how much negotiation influences sexual risk. Hence, briefly exploring intergenerational relationships in this study will enhance the understanding of gender roles and sexual negotiation.

Psychological factors

In order to understand the influences that contribute to the high rates of teenage pregnancy, it is important to firstly explore the manner in which teenagers perceive relationships and the environment in which they take place. Cvetkovich *et al.* (1975) highlighted that contraceptive use amongst adolescents can be described as being irrational. This view is reinforced by the seeming prevalent non-use of contraception among sexually active teenagers who have been educated about the different contraceptive methods available to them, this paradox can be understood as the behavior of irrationality (Cvetkovich *et al.*, 1975). To account for the irrationality it is important to discuss the psychological, cognitive-emotional development typical of the adolescent years. It is the purpose of this study to highlight the psychological perspectives that can influence the behavior of teenage girls in light of unplanned and unwanted pregnancy and HIV and AIDS. Psychosocial theories and perspectives will be discussed as contributing psychological factors in line with understanding behaviour change communication.

The levels of knowledge about sexual health risks in South Africa have not changed the increased level of HIV infection amongst young people, (Campbell and MacPhail, 2002). Both male and female sexual experiences are understood within a context where leading social norms of masculinity portray young men as “conquering heroes and macho risk-takers in the sexual arena” (Campbell and MacPhail, 2002:332). Whereas femininity is portrayed in a manner that places women in positions to respond to “passivity or fruitless resistance in the face of male advances” (Campbell and MacPhail, 2002:332). In this context, sexual intercourse is “limited and restricted by conditions of emotional pressure, and physical

coercion of young women” (Campbell and MacPhail, 2002:332). These findings are consistent with an extensive body of literature which advocates that the empowerment of young women is an essential requirement for safer sex practices amongst young people (Campbell and MacPhail, 2002). Therefore, it is crucial to understand some of the psychological factors that influence adolescent behaviours, which will be discussed in the following sections.

Identity crisis - The transition from childhood to adolescents

Growing up from childhood to adolescence involves a process of “identity formation” (Panday et al., 2009:66). This is the period of their lives where children move away from depending on parents and siblings who have been the sole source of influence and start making decisions on their own (Panday et al., 2009). It is said that at this stage children “start interacting with other role models - best friends, peers, teachers and community members, begin to expand their sphere of influence” (Panday et al., 2009: 66). The attitudes of peers, norms and behavior, as well as perceptions of norms and behavior among peers, have a significant and consistent impact on adolescent sexual behavior. Studies have shown that “when teenagers believe that their friends are engaging in sexual intercourse, they are more likely to also engage in it and when a positive perception about condom use is perceived by peers, adolescents are more likely to use condoms and contraceptives” (Berk, 2003; Bearinger *et al.*, 2007; Clark and Clark, 2007; Panday et al., 2009).

The term “identity” as it relates to adolescents gives reference to Erikson’s (1959) adolescent stages of development when adolescents are dealing with the challenge of achieving ego identity and avoiding role confusion. It is a time when adolescents ask difficult questions about themselves in an effort to make sense of issues of character, social identity and their own values and ideals (Louw & Louw, 2007; Meyer, Moore & Viljoen, 2003). “Identity refers to a sense of who one is as a person and as a contributor to society” and is what makes one “move with direction; it is what gives one reason to be” (Sokol, 2009:5). In line with this study, it is important to understand the state of mind and the heightened emotions caused by the sudden growth and development that adolescents go through. Therefore understanding the context in which teenagers make decisions regarding their sexuality and behavior is essential in this study. In order to understand some of the socio-economic and cultural factors that

influence high rates of teenage pregnancies that are commonly unplanned, this study highlights some of the psychological and cognitive factors that could affect low contraceptive use among adolescent girls.

For an adolescent girl “with adulthood on the horizon”, identity formation questions emerge: “Who am I? and What is my place in this world? When an individual is able to access their personal attributes and match these with outlets for expression available in the environment, it is safe to say identity has been formed” (Sokol, 2009:5). The formation of identity would mean that a teenage girl develops within a society and within an environment in which she finds herself with an already existing knowledge of whom she is and where she fits in. She would not be subject to influences from her surroundings, but rather, would be better equipped to be the catalyst of her own future. This appears to be the perfected image of a teenage girl; however, James Marcia (1980) states that identity formation does not happen neatly. This is a time when adolescents must relinquish their parents, relinquish childhood ideology and most importantly abandon the fantasised possibilities of multiple, glamorous lifestyles. In the ongoing construction of an identity, that which one negates is known; what one affirms and chooses contains an element of the unknown.

In keeping with this study, the researcher is exploring the phase of identity crisis among teenage girls as a possible contributing factor to the low rates of contraceptive use among adolescent girls. When attempting to understand issues of behaviour change, knowledge of the risk of HIV infection and teenage pregnancy among adolescent girls; it is critical that one comprehends how an identity that is not well-formed at this junction can influence the decisions adolescents make about their sexuality.

Cliques and crowds – Peer pressure

“The social influence to fit in with friends is seen as a big reason why many young people are sexually active” (Myers, 2014:34). In a study conducted by Vundule *et al.* (2001) adolescents reported that sex often happened because they saw other people who were their age engaging in sexual intercourse. “Although peers encourage sexuality among friends; pregnancy is highly denounced as it is regarded as a poor showing of female decorum” (Kaufman *et al.*, 2001). The study also reported that the understanding of femininity require women to be faithful and agree to sexual fidelity. Furthermore, young women allow the pressure from friends to maintain multiple sexual partnerships as a means to gain peer group respect (Kaufman *et al.*, 2001). Furthermore, Wood *et al.* (1997) found that young women

who excluded themselves from peers and decided not be sexually active were isolated by their friends and regarded as children. Although friends (40%) and peer circles are not a reputable source of information about HIV, in comparison to teachers and parents (Foundation, 2007), 72% of them have spoken to their friends about HIV (Pettifor et al., 2005).

Self-esteem

It is postulated that generally, “a person with a poor sexual self-concept may rely on others for self-confidence”; this is often done through having multiple sexual encounters (Eaton *et al.*, 2003:159). Research has found that “low self-esteem is associated with earlier onset sexual activity and having more sexual partners” (Eaton *et al.*, 2003; Perkel *et al.*, 1991; DiClemente, 1990; Myers, 2014).

“A more generic driver of teenage pregnancy is thought to be a lack of self-esteem, self-efficacy and vision for the future (Myers, 2014). It is generalised that young women who are most likely to successfully use contraception are those who had well-defined plans for themselves, ‘who know what they want’ in life and who have clear educational goals” (Myers, 2014:34). It is the young women who are assertive and confident who are said to be less influenced by peer pressure (Myers, 2014).

There is also an indication that “young people with a low self-esteem may be more concerned about what their partners think of them, with avoiding displeasure or rejection from partners than are people with more positive, self-affirming self-concepts” (Eaton *et al.*, 2003:159). Therefore, an individual with a low self-esteem is more likely to consider condoms and any other methods of contraception as offensive to their partner (Eaton *et al.*, 2003). They believe that a condom will give off the impression to their partner that they go around sleeping with other women. The use of a condom is viewed as dishonoring their sexual partners (Eaton *et al.*, 2003).

Hoosen and Collins (2004) introduced an important aspect of understanding the issue of self-esteem. In the ‘Discourses of love’, they postulate that the idea of love makes it hard for women to enquire about fidelity that might threaten the basis of their relationships (Hoosen and Collins, 2004). Sexual practices are constructed as an expression of devotion where

paradoxically both protected sexual practices and unprotected sexual practices could be feelings of romantic love (Hoosen and Collins, 2004). On one hand, love is expressed through unsafe sexual practices as a form of intimacy, whilst on the contrary; love could be expressed through sexual practices with a condom. In the past the expression of love and devotion among young women to male partners was also encouraged by mothers and grandmothers. Teenagers were abetted to become pregnant by their partners to prove their love, maturity and fertility (Preston-Whyte et al., 1990; Varga and Makubalo, 1996; Wood *et al.*, 1997). Furthermore, trust is an important aspect of romantic love which makes it difficult to broach the subject of risk, as this would entail breaching the implicit expression of faith in the fidelity of the other partner's mind (Hoosen and Collins, 2004). Trust and love are explanations that are used for "not engaging in safe sexual practices, even though some women are aware that their partners are unfaithful to them" (Hoosen and Collins, 2004:497). The discourse of love entrenches the subordination of women by supporting women's silence around talking about sex. This is one the factors that have exacerbated teenage pregnancy in South Africa.

Poor school performance vs. socio-economic status

Research interventions and prevention programs have mostly focused on sexual risk factors as the main contributors to teenage pregnancy. This is because sexual risk factors are more directly related to pregnancy and HIV and are more amenable to change (Panday *et al.*, 2009). Kirby *et al.*, (2001), for example, asserts that sexual risk-taking has many nonsexual antecedents, including poor school performance and delayed completion. Many scholars debate the issue of teenage pregnancy being the consequence of school leaving. Bhana *et al.* (2012) highlighted that in South Africa it is the early pregnancy that causes a delay in completing school. The delay, however is caused by "girls with poor school performance" who are "significantly more likely than the best students to become pregnant" Grant and Hallman, 2008:370). The Division of Family Health / GTZ Support Unit (1988) also highlighted that grade repetition in schools among low achievers may be partially responsible, lengthening the period in which girls remain in school and are at risk of becoming pregnant. "A perceived lack of returns to continue schooling, fueled by low expectations of advancing, may influence girls' simultaneous decision to begin childbearing and drop out" (Grant and Hallman, 2008: 7).

Incomplete schooling is a significant factor for teenage pregnancy in South Africa (Panday *et al.*, 2009; Chigona and Chetty, 2007). A study among adolescent girls reported that “the overwhelming majority of girls did not want to have a child until they had completed school and obtained the financial means to care for a child” (Panday *et al.*, 2009:58). Fuller and Liang (1999:182) found a “relationship between a family’s financial strength, measured by the level of household expenditure and access to credit, and the likelihood that a daughter will remain in school”. They found that “household asset ownership and housing quality were also consistently related to girls’ educational attainment” (Fuller and Liang, 1999:182). Therefore, dropping out of school, which can become a driving factor in teenage pregnancy is motivated not only by sexual risk factors but by a larger spectrum of socio-economic and political factors.

Morrell *et al.* (2012) explore the rise in teenage pregnancy, specifically in KwaZulu-Natal from a policy perspective, explaining that the policy that allowed pregnant learners to continue attending school was also held responsible for the rise of teenage pregnancies. Because of the policy, girls were not to be expelled because of pregnancy and they did not have to face the threat of an end to their school days. In the past, however, being pregnant was often grounds for expulsion from school in South Africa (Mungai, 2002). Furthermore, Kelly Hallman and Monica Grant (2003) show that both early schools leaving and adolescent pregnancy are strongly associated with low economic status. This is summarised by Lloyd and Mensch (1999: 85) as follows:

Rather than pregnancy causing girls to drop out, the lack of social and economic opportunities for girls and women and the domestic demands placed on them, coupled with the gender inequities of the education system, may result in unsatisfactory school experiences, poor academic performance, and acquiescence in or endorsement of early motherhood.

Another study conducted among 548 teenagers, of which 88 were girls from the Cape Flats, Western Cape, found three reasons why teenage girls leave school. In order of importance, these were: “not liking school, poor academic progress, and economic constraints” (Morrell *et al.*, 2012: 11). The dominant concerns of financial issues and lack of interest in school serve as an acknowledged catalyst serving unplanned and unwanted pregnancies among teenagers.

The cultural perspective

The aspect of culture in understanding the factors that influence teenage pregnancy has previously been overlooked. Interventions and behavioural change strategies have already substituted the cultural context of people and replaced it with cultures and traditions alien to their own communities and societies. There has been a movement towards more context-specific strategies, with researchers highlighting the importance of participation (Airhihenbuwa, 1995; Cardey, 2006). To understand the cultural context in which people live can sometimes go beyond knowing their cultures in an abstract manner, and cause researchers to first observe the lifestyle within a community when trying to understand behaviour change.

Cultural and contextual conditions should be appreciated far more because they play an important and often decisive role in how people make meaning of their lives in general, and in particular, how negotiations and decisions relating to sex (uality) are made (Petersen, 2009: 100).

Recent research shows that the constraints of culture and traditional constructions are part of the factors that are perceived to have influenced teenage pregnancy. Ouzgane and Morrell (2005) associate these traditional constructs to the historical background of South Africa, where male virility was measured by how many sexual partners one has within polygamous marriages. The patriarchal divide, which is the power that being a man gave them the right to choose to exercise power over women, is still evident even in contemporary sexual relationships (Ouzgane and Morrell, 2005). Baxen and Breidlid discuss how women have been socialised from an early age to be subordinate and submissive to men, due to how relationships were shaped historically (2009). “In many societies, women lack control over their bodies and, for the most part, over decisions about their lives” (Petersen, 2009: 101). The sex act itself has become the site of multiple power differentials (Holland et al., 1990).

Eaton *et al.* (2003:161) discuss “discourses that surround the subordination of women and reveal two main themes relating to male sexuality: biologically determined need, and sexual rights”. The claim of male sexuality is that “it is in man’s nature to want many partners and that staying with one woman goes against the essence of being a man” (Eaton *et al.*, 2003:161). Some women come to believe this too. Due to the patriarchal nature of African cultures, most decisions affecting females and their reproductive health are in the hands of

males, leading to some women covertly using contraception without the knowledge of their spouses (Ncube, 2012). The notion that masculinity implies having unprotected sex with numerous partners is “particularly well-developed in South Africa” (Eaton *et al.*, 2003:161). Similarly, youth defends their habitual, unprotected sex using the approach of biology (Eaton *et al.*, 2003). The discourse of ‘rights’ is evident in the way young men interact and claim ownership over their sexual partners (Eaton *et al.*, 2003). This behaviour of ownership is permitted by the social norm that a masculinity earns men the right to sexual intercourse within a romantic relationship (Eaton *et al.*, 2003).

Progression of youth culture

Selikow *et al.* (2002) argues that to understand gender relationships between youth it is important to understand the youth culture that informs these relationships. Selikow *et al.* (2002) postulate that understanding the dynamics and nuances of any sub-culture require an in-depth historical analysis. They introduce the notion of a ‘paradigm shift’, which is a shift that occurred in South Africa within the youth sub-culture.

Selikow *et al.* (2002) suggest that while the 1970s and 1980s offered youth activities through political involvement much of the youth in South Africa have lost interest in politics and are mainly apolitical, they refer to this as the depoliticisation of youth. The current apolitical stance among young people led to the introduction of a culture of consumerism, where there is an increased emphasis placed on material belongings, dress code and a spuriously glamorised lifestyle (Selikow *et al.*, 2002). Accompanied by the culture of consumerism was the gendered socio-economic marginalisation, where most youth still live in poverty and do not have access to education or employment. Therefore, it is this context that has made sex an important commodity for women who often lack marketable skills that can empower them to seek employment (Caldwell *et al.*, 1989; Strebel, 1996). Although many young men also lack marketable skills, the introduction of this youth culture has caused young men to have access to money through their involvement in the crime. “As it is less likely that women will be involved in crime, they often become dependent on men for money and stability” (Selikow *et al.*, 2002:24). Numerous researchers describe the importance of understanding gender dynamics as being the underlying factor to HIV infection risk which is linked with unplanned pregnancies (O'Sullivan *et al.*, 2006; Wood and Jewkes, 1998; Kelly and Ntlabati, 2002).

Selikow *et al.* (2002) offer an illustration of what the youth culture entails by defining the audience through three characters, *Ingagara*, *Regtes* and *Cherry*; and what influence these characters conveyed to the youth in the late 90's. The imperative of an *Ingagara* is to have many girlfriends, which is the way in which a man can achieve status among his peers and the community as a whole. "This is exacerbated by the erosion of traditional values in urban townships and the declining importance of traditional ways of achieving manhood" (Selikow *et al.*, 2002:24). "Within the *Ingagara's* multiple relationships, there is a distinction between *Regtes* and *Cherries* and associated sexual behaviour and relationship norms" (Selikow *et al.*, 2002:25). A *Regte* is referred to as "the 'right one' or a steady girlfriend, also known as 'mosad' in Sesotho and 'umfazi' in isiZulu, or 'mother' or 'wife to be' in English. The *cherry* is also known as the '*makhwaphen*' (this is a Nguni word meaning 'roll-on', as in deodorant)" (Selikow *et al.*, 2002:25). One of the female participants in this study, as cited said:

Maybe you are the second girl; the *regte* must not know about you. You must keep your relationship a secret. When he talks to his friend, he is going to say, 'that one is just a roll-on'. Roll-on is something that you put under your arm, it is hidden; no one can see it. Other people won't even know about you. He will only come when he wants to have sex with you, he just comes and picks you up and have fun and have sex with you and then brings you back. You won't be seen with him, so it means you are a roll-on (Selikow *et al.*, 2002: 25).

While the term *makhwapheni* refers to the idea that the *cherry* is hidden, it does not always happen that way. Often some *regtes* know about *cherries* but are powerless to insist on monogamous relationships (Selikow *et al.*, 2002). Although this study was conducted in the late 90's, within the context of young people in townships, it is still relevant. The conception of *Ingagara* is still maintained, where male partners within sexual relationships are reported having multiple sexual partners. It is, however, important to note that not all young people follow these norms. This study seeks to exemplify where the current sexual behaviours stem from in order to understand some of the circumstances that young women are confronted with in sexual relationships. It is to encapsulate a frame within which young women fall prey to teenage pregnancy and high risks of HIV and AIDS.

Power differentials – Intergenerational relationships

“I do love him but at the same time, food has to be on the table.” (Selikow and Mbulaheni, 2013: 86). This is a statement that reflects the sentiments of South African students who are involved in sugar daddy relationships for conspicuous consumption. Studies have shown that power differentials are as a result of the age gap between the young women and the sugar daddy. The age gap has positioned teenage girls to sometimes submit to conditions and timing of sexual intercourse defined by these older male partners (Wood and Jewkes, 1998). The legitimacy of this experience was reinforced by female peers in a study who indicated that silence and submission were the appropriate response (Wood and Jewkes, 1998). The experience of male dominance is said to have become common among teenage girls, leading them to perceive it as an act of love from their partners. “Teenagers said that they perceived their partners loved them because they gave them gifts of clothing and money” (Wood and Jewkes, 1998: 233). In keeping with this study, evidence of this male dominance shows that teenage girls are at a high risk of unplanned pregnancy and HIV infection due to the lack of power to negotiate safer sex practices within these relationships.

Contrary to the belief that male dominance is an act of love, Zygmunt Bauman (2013) describes relationships under modernity as being contingent and temporary. He discusses that in a liquid modernity characterised by consumerism and technology, relationships become objects of consumption and love becomes liquid and disposable (Bauman, 2013). This is similar to the culture of consumerism highlighted by Selikow *et al.* (2002) that has forced teenagers into the confinement of a glamourised expensive lifestyle that is unaffordable to them. Bauman (2013) argues that not only has the concept of *sex* become a commodity for material possessions among young women but that the notion of *love* has also been diluted. Findings from Bankole *et al.* (2007) showed that age difference between partners was the major determinant of consistent use of contraception. Power differentials among relationships between older men and younger women have led teenage girls to become passive partakers who do not have the “capacity to protect themselves against sexually transmitted diseases and pregnancy” (Wood and Jewkes, 1998:6).

Transactional sex

Women enter transactional sex relationships for survival (needs) or for conspicuous consumption (wants) or for elements of both (Masvawure, 2010; Selikow and Gibbon, 2010).

According to Barthelemy Kuate-Defo (2004) intergenerational relationships often involve an ‘exchange’, an element in social and or sexual relationships that is frequent in all cultures. This confirms the findings in (Bankole et al., 2007) that showed that age differences between partners are a major determinant of consistent use of contraception. It can lead to power dynamics that forces micro-level sexual decision making into the agenda. How, why, and when are decisions made by individuals to have sex, and how are inequalities played out and resisted within intergenerational sexual relationships? Wood and Jewkes, (1998) raise the question of who is allowed to negotiate condom use and who isn’t in relationships with a significant age gap? Interestingly, Selikow and Mbulaheni (2013) highlight that researchers are increasingly challenging simplistic ideas that the provider of resources is imbued with absolute power while female recipients lack agency. Stoebenau et al. (2011) assert that most transactional sex-based relationships, conventionally are often within the context of highly unequal gendered power and position, indigent women portrayed as victims, resort to ‘survival sex’ to acquire basic needs. Vicci Tallis (2012: 40) confirms this assertion by saying:

The context of some sex work in Africa is survival sex, where sex work is a means to make money in order for women and their families to remain alive. In this way, survival sex is a form of small-scale informal money making.

There are several ways in which women can exercise agency, for example, they could exploit sexuality for material gain and avoid or delay sex after receiving resources (Masvawure, 2010; Stoebenau *et al.*, 2011; Wamoyi *et al.*, 2011). Further, it has been argued that agency fluctuates within various phases of transactional sex relationships with agency being particularly evident in relationship initiation, diminishing in maintenance and resurfacing in termination (Luke, 2005; Masvawure, 2010; Poulin, 2007).

Unplanned pregnancy and HIV

Though the available meanings of teenage pregnancy have left a considerable scope for debate about its problematic nature, the escalating HIV epidemic among young women in South Africa provides an additional dimension to bio-medical concerns (Rohleder *et al.*, 2009). It creates a new approach to understanding teenage pregnancy and the high risk of sexual activity. In South Africa, sex in the context of inadequate and inconsistent male

condom usage has been identified as the key behavioural driver of HIV (Rohleder *et al.*, 2009). The inconsistent condom use has also led to many unplanned pregnancies, specifically among teenage women. The second national youth risk behaviour survey in 2008 by the South African Medical Research Council, was of learners in Grades 8 to 11 in public sector schools across the nine provinces in South Africa. The survey found that “37.5% of learners had already had sex, of which 17.9% indicated that they used no contraception. Overall, 45.1% of learners who had already had sex indicated that the method of contraception that they most commonly used was a condom. Only 7% used injectable contraceptives and 4.2% used oral contraceptives” (DOH, 2012:18).

This shows that teenagers are not only prone to early pregnancy but are also at a high risk of contracting sexually transmitted infections (STIs) including the HIV. Condom use appears to be the most common prevention method used by many teenagers who are in sexual relationships, indicating the connection between unplanned pregnancy and HIV. However, in the South African context, the link between HIV and unplanned pregnancy is very complex. Contraception and the different types of contraceptive methods available, sit at the core of understanding this relationship. Hence why health communication campaigns such as ZAZI, are strategies implemented to bridge the gap between the HIV and pregnancy. ZAZI does not educate about contraceptive use, but also about the risk factors associated with HIV infection when young women engage in unsafe sexual practices. MacPhail and Campbell (2001) conducted a study on condom use among adolescents and young people. The study indicated that there is little perception of risk to HIV, despite the high levels of infection. Almost 70% of young men did not know whether or not they were personally vulnerable. Their response indicated that they did not connect their own behaviour with HIV risk. The results also indicated that the rates for young females were similar (MacPhail and Campbell, 2001). There is a high level of knowledge about HIV and pregnancy; however the participants in this study mention that condoms are unnecessary in steady relationships, one specifically noting that they would use a condom when there is a risk of pregnancy (MacPhail and Campbell, 2001). This study showed that young people often do not relate condom use to the risk of HIV infection in comparison to teenage pregnancy.

HIV and AIDS, young women and risk

“HIV prevalence in South Africa is estimated to be 17.9%, with an estimated 5.575 million persons living with HIV” (DOH, 2012:19). The National Antenatal Sentinel HIV and Syphilis Survey (2010) indicate that the overall HIV prevalence among pregnant women is 30.2% (Health, 2012). Although there has been a slight change in prevalence in the past three years, the persistently high HIV prevalence among young women remains a major concern, with 15–25-year-old women being the highest incidence group in the general population (DOH, 2012).

Statistics in the antenatal survey showed HIV prevalence in girls aged 10-14 was 9.1%. This value raises significant concern as it characterises young teenagers at a high risk and a vulnerable age group that warrants special attention (DOH, 2012). In the National Contraception and Fertility Planning and Service Delivery Guidelines, the Department of Health recorded that “many women are ‘simultaneously’ at risk for both unintended pregnancy and HIV infection” (DOH, 2012:19). Preferably, women are encouraged to use condoms as both a method of contraception against unplanned pregnancy and for protection against HIV transmission or use condoms combined with another contraceptive method. Nevertheless, studies show that women are not always able to negotiate condom use. Therefore, it is important to recommend contraceptive methods that do not increase a woman’s vulnerability to HIV infection (DOH, 2012).

In light of the high increase of unplanned and unwanted pregnancies and the risk of HIV, there is an emerging need for teenagers to understand the different contraceptive methods, apart from condoms, that can prevent unplanned pregnancy. “Despite public health literature and family planning services treating HIV and pregnancy as distinct, they share many common antecedents chief amongst which is unprotected sex” (Panday *et al.*, 2009:9). What is more, there is evidence that pregnancy and lactation increase the susceptibility to HIV infection through immunological changes induced during pregnancy (Panday *et al.*, 2009). Therefore, there is a growing need for teenagers to be introduced to multiple contraceptive methods that can prevent unplanned pregnancy, which ultimately will significantly reduce the HIV infections.

The history of contraception in South Africa

Women in South Africa have not always had the access to reproductive systems because of policy guidelines that were implemented by the government. Reproductive control and family planning in South Africa during the apartheid Government was “tightly bound up with the policies and laws which entrenched social and economic inequality by race” (Kaufman, 2000:106). These policies spilt over and affected every system in South Africa. There were massive shortfalls in the social, economic and political systems, but especially in the social. Basic health services were rendered according to the association to one of these groups (Kaufman, 2000). “Under the ideology of ‘separate development’ the apartheid government, assuming power in 1948, expanded existing policy to ensure separateness of race and the appropriate distribution of black labour to serve white needs” (Kaufman, 2000:106).

During the apartheid government human rights and privileges were apportioned on the basis of skin color, and the family-planning program predictably became a focal point of racial and political contestation (Kaufman, 1998). The National Family Planning Programme (FPP), formally established in 1974, was meant to restrict and regulate the population growth. Family planning services that were affordable were made accessible to all racial groups but separately. In municipal areas family planning was offered as an integral part of their overall services, but elsewhere national and provincial health departments developed strong vertical family planning services. Nonetheless, in the 1980s and early 1990s the family planning services were integrated into primary health care service. Kaufman (1998) argues that the effects of conflicting policies and programs instituted under apartheid were, by no means, felt evenly across the African segment of the population. Reproductive patterns varied widely across ethnic divides and former homeland boundaries.

The National Contraception Guidelines, from the Department of Health, listed legislation that impacted on family planning services such as (i) Abortion and sterilisation: it operated under strict criteria that made termination of pregnancy illegal and inaccessible for most women. (ii) Apartheid legislation: during this period race had major role in determining a person’s legal state. There were land laws, separate development laws, which affected all aspects of the lives of people of different races, including access to health services. (iii) Women’s legal capacity: the laws subjected a woman to her husband’s marital power (Panday et al., 2009). These legislations translated into women requiring their husband’s consent in order to be

sterilised and in some places, even to receive any family planning method. During this time of policy making and legislation by the government, there was a growing need amongst South African women for contraception (Panday et al., 2009). However, there were major influencing factors that determined contraceptive use, apart from racial segregation. Contraceptive use was influenced by factors including socio-economic development; urbanization; women's education and status in society; cultural norms and beliefs; and the knowledge and attitudes of individuals.

This is evident with the Depo-Provera (DEPO), a long-lasting injectable received with enthusiasm in the 1960's (Tyler, 1968; Karstadt, 1970; Ferguson, 1974), and its suitability as a contraceptive method lasting for up to three months was directly acknowledged by The National Family Planning Programme. Differences in contraceptive use patterns by race emerged. In the past the injection was the method given to over 50% of all Black users and 40% of Coloureds, while the pill and sterilisation predominated among Indian and White users (Kaufman, 2000). Abuses of contraception related to employment were also a source of controversy. Employment opportunities were limited for black South African women and most positions were not suited to the 'inconveniences' of child-bearing or child care. Women who became pregnant often lost their jobs (Kaufman, 2000). Contraceptive provision continued to have racial undertones, where the long lasting injectable contraception was promoted amongst the non-White people. The pill, on the other hand, a less severe form of contraception, was encouraged amongst White people.

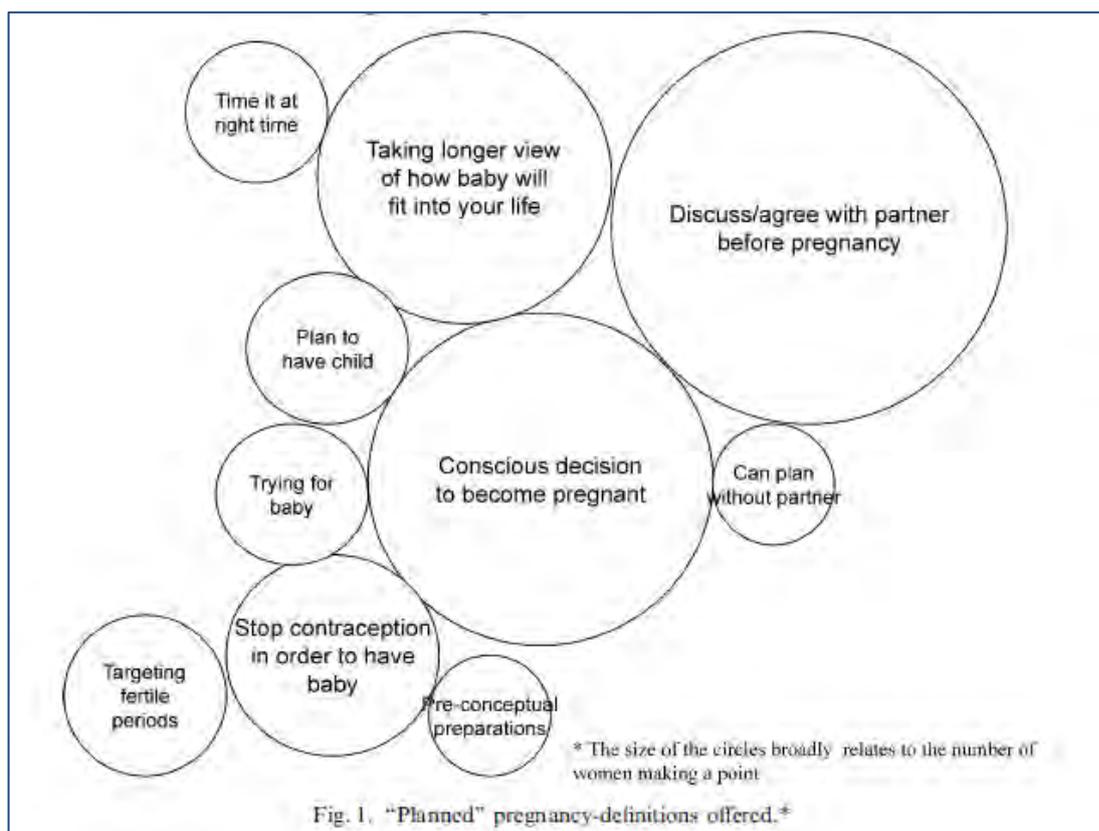
As a result the skewed distribution of resources along racial lines that was synonymous with the apartheid government and the hampered successes of family planning programs have been perpetuated into the post-Apartheid era (Kaufman, 2000). The link between social structures and reproductive health issues cannot be separated and thus, the successes of the current family planning programme remain relative.

Defining contraception use

Contraception according to the South African Department of Health National Contraception Policy Guidelines can be defined as a method of preventing unintended pregnancies (DOH,

2012). An alternative term closely associated with contraception is family planning and the two are commonly used synonymously and most service users do not differentiate between the two (Bafana, 2011). In understanding these terms Hagenfeldt (1991) defines family planning as not only including contraception but also access to other reproductive health options such as safe legal abortions, antenatal care, infertility investigation and treatment, however all of these stem from planning. “Planning” can include setting an individual intention, taking action to conceive or avoid conception, and/or making broader life preparations to have or expand a family (Stevens, 2015). Family Planning offers an agreement with the partners; it offers young women conscious decision making and a longer view of how a baby will fit into their lives, Fig. 2.4 offers more definitions of the concept of family planning (Barrett & Wellings, 2002)

Figure 2.4: Understanding the concept of family planning



Source: Barrett & Wellings (2002)

Classification of contraceptive methods

Traditional methods and modern methods are the two main classification categories of contraceptives. Traditional methods include “periodic abstinence, withdrawal, and folk methods” (Robey *et al.*, 1992:11). Modern contraception includes the female condom, the male condom, injectable/injection, implants and the oral contraceptive pill (See Table 2.1). “Modern contraceptive methods are generally more effective in preventing pregnancy than are traditional methods, although effectiveness varies with the quality of practice” (Trussell and Kost, 1987).

Hormonal contraceptives are made from artificial estrogen and progestin hormones which work to inhibit the body’s natural hormones and prevent pregnancy. Hormonal contraceptives usually stop the body from ovulating, they also change the lining of the cervix, making it difficult for the sperm to enter the uterus and fertilise an egg (Pleaner, 2013:57).

There are three categorisations of contraceptive methods:

Barrier methods: are methods that block the male’s sperm from entering the female’s uterus to fertilise the egg. Barrier methods include the male condom, spermicidal foam, sponges, diaphragm and cervical cap (Pleaner, 2013)

Hormonal methods: are methods that usually prevent the body from ovulating, they also change the lining of the cervix, making it difficult for the sperm to enter. Hormonal contraceptives can also prevent pregnancy by making the lining of the womb inhospitable for the implantation of the fertilised egg. They include injectable, the pill and the implants (Pleaner, 2013)

Natural methods: are referred to as those methods that do not require any medicines, operations or modern contraception, for example, abstinence (Pleaner, 2013)

Table 2.1

Modern contraceptive methods			
Method	Description	Advantages	Disadvantages
Male Condom	Made of latex rubber, some are coated with a dry lubricant or with spermicide	The male condom can protect women from getting pregnant and both partners from HIV and STI's	Some people have an allergic reaction which causes itching, burning and swelling
Female Condom	The female condom is a soft polyurethane tube with one closed end, and one open end. Both ends have a flexible ring or rim. The ring at the closed end is inserted into the vagina over the cervix to hold the tube in place, the ring at the open end remains outside the opening of the vagina	A female condom can be put in just before sex, or up to eight hours before sex. It also protects women from pregnancy and both partners from HIV and STI's	There are no recorded disadvantages
Injectables	The injectable contains hormones given to you at regular intervals by a healthcare provider.	It is a highly effective method. Only needs to be repeated every 2-3 months depending on the type of injection. Can be used by breast feeding mothers. It does not affect the enjoyment of sex.	If you are late for an appointment or miss an appointment you will not be protected against pregnancy. Side effects may include changes to the menstrual period, headaches, spotting, mood changes, dizziness, weight gain or breast tenderness.

Implant	Hormonal implants are small, thin; flexible plastic rods, about the size of a matchstick inserted under the skin by a health care provider, and can be removed at a later stage.	This highly effective long-lasting method works for up to three to five years, depending on the type of implant.	Side effects may include weight gain, redness, headaches, dizziness, mood changes, nausea, and changes to menstrual periods.
Oral Contraceptive Pill	The pill comes in a 28 or 21-day pack. The pills contain hormones that regulate your system to prevent pregnancy.	This effective method can help to make your menstrual period more regular.	It is less effective if you forget to take a pill, are taking some other medicine, or are vomiting or have diarrhoea. Side effects can include irregular menstrual periods
Post-Exposure Prophylaxis (PEP)	PEP is a 28-day course of antiretroviral drugs which helps prevent HIV from developing in the body	In an emergency situation, if a person has been raped or exposed to HIV in another way, PEP can prevent HIV from developing.	
Emergency Contraceptive Pill	The emergency contraception pill (morning after pill) is used to prevent an unplanned pregnancy after unprotected sex	The ECP should be used if a condom breaks during sex. It can also be used if you are raped or forced to have sex.	Side effects include nausea, vomiting, breast tenderness or vaginal bleeding
Emergency Cu IUD	Cu IUD can be inserted into the womb up to five days after having unprotected sex to prevent pregnancy	It is a long-lasting method that can be left in as a regular contraceptive	Side effect is the same as the Cu IUD, and can include cramping, pain during and after insertion.

Source: (Pleaner, 2013)

Most commonly used form of contraceptive

With regards to contraceptive use, statistics show that contraceptive use is comparatively high, with an estimated 65% of sexually active women between the ages of 15-49 using a modern contraceptive method (DOH, 2012). Within the context of this study, it is important to also highlight the patterns of contraceptive use among adolescents. Overall, 45.1% of learners who had already had sex indicated that the method of contraception that they mostly used was a condom. Only 7% used injectable contraceptives and 4.2% used oral contraceptives (DOH, 2012). In a high prevalence country such as South Africa, the male condom is presented to be the most effective ways to prevent HIV infection and pregnancy. There was a sharp increase in condom use from 2002 (27.3%) to 2008 (62.4%) followed by a slight decline in 2012 (59.9%).

Government involvement in the era of HIV and AIDS

Dating back to the late 1990s, the South African government has had a significant role in the management of HIV. Prior the election of the second democratic president in 1999 there was very little focus given to HIV and AIDS as a pandemic. The primary focus of government at the time was placed on reconciliation and reforming the old apartheid system of governance (Rohleder et al., 2009). It was later on in 1999 and early 2000 that the government began to recognise HIV as a pandemic that required control and needed treatment and possible preventative methods. However, this was the period when HIV was viewed as “a ‘syndrome’ rather than a disease, emphasising the viewpoint that people die of ‘consequent’ opportunistic infections rather than of the disease itself” (Tomaselli, 2011:31). The government were not helpful in shaping peoples’ responses to the pandemic as they offered not only controversial but also unconventional and questionable scientific alternatives (Baxen and Breidlid, 2009). The result of this is a population ravaged by the pandemic and still confused. Many traditional and cultural beliefs remained as options for healing HIV in the minds of people in South Africa, even after the introduction of treatment. It is particularly relevant to note how this discourse still has implications for the role of treatment for HIV and AIDS.

The effect of HIV and AIDS and further health challenges such as Tuberculosis (TB) have affected the ability for South Africa to accomplish some of its development goals (DOH, 2012). In response to this, the government introduced a host of health programmes and strategies such as HIV and AIDS voluntary testing and counseling (VTC); prevention of mother to child transmission; HIV treatment and care; medical male circumcision (MMC); TB control programmes; and National Strategic Plan on HIV, STI, and TB (DOH, 2012).

South Africa's first contraception policy was written within this context; the *Contraception Policy within a reproductive health framework* and the *Contraception Service Delivery Guidelines* were launched in 2001 and 2003 respectively (DOH, 2012). The policy has been developed against the background of the HIV epidemic in South Africa, where approximately one third of young women are HIV positive. The policies and strategies are tools that will aid in responding to the unacceptably high rates of HIV, teenage pregnancy, unplanned and unwanted pregnancies, infant and maternal mortality (DOH, 2012). Contraception and planning for conception contributes to the reduction of HIV transmission, thereby supporting the National Strategic Plan on HIV, STIs and TB. Contraception and planning has the potential to contribute to South Africa achieving the Millennium Development Goals (MDG), particularly MDGs 4 and 5 (DOH, 2012). MDG 5 includes the reduction of maternal deaths, and includes universal access to reproductive health. MGD 4 aims to reduce child mortality and MDG 5 indicates that complications related to pregnancy and childbirth are among the leading causes of mortality among women of reproductive age in South Africa (UN, 2014). The improvement of maternal and child health forms a key role in this study, as teenage pregnancies contribute largely to the mortality rates in South Africa. Promoting women's reproductive rights and improving access to voluntary contraception contribute to progress towards achieving all eight MGDs.

To respond to this condition, the governments together with Non-Governmental Organisations (NGO's) are working to ensure the successful implementation of the African Union's Campaign for the Accelerated Reduction of Maternal, Neonatal and Child Mortality in Africa (CARMMA) to which South Africa is a signatory.

Government's response to contextualising action on HIV and AIDS

The impact of the denialist position and its influences has been recorded by many scholars (Tomaselli, 2011; Kalichman, 2009; Baxen and Breidlid, 2009). There remains an enigma almost three decades into HIV and AIDS research, asking why the government chose this path. Kalichman (2009) documented that many analysts tried to find possible explanations to why the denialist notion was introduced in South Africa. Some argue that it was a rational strategy from the 'elite' employed not to pay extra taxes in support for antiretroviral (ARV) treatment for those who were unemployed. Some analysts say that the country lacked the economic and institutional capacity to deal with AIDS (Kalichman, 2009). Nonetheless, this study does not discuss in detail the dynamics of the denialist notion, but merely uses it as a contextual tool, to bring in-depth understanding of the current status of government involvement of HIV and AIDS programmes.

The denialist position created a lasting impact on how people view HIV. It exacerbated misconceptions mostly around African cultures and traditions, creating myths and superstitions that HIV was a form of witchcraft based on the rivalry between families (Tomaselli, 2011). Some traditional beliefs furthermore believed HIV treatment to being a 'White people' ingredient to control people (Tomaselli, 2011). These beliefs and misconceptions stem from the denialist position. 'All kinds of mystical explanations are sometimes given to explain the occurrences of diseases such as HIV and AIDS' (Baxen and Breidlid, 2009:119). Some in South Africa believe that HIV is contracted through unprotected sex; people who hate you and witchcraft, for example 'while you are sleeping, their demons come holding a syringe, and they inject you' (Steinberg, 2008:189-190). "It is traditional beliefs such as this that underpin the belief that sexual behaviour is not a factor in the spread of HIV" (Tomaselli, 2011: 30). Jonny Steinberg, (2008) writes about a young man who refused to get tested for HIV because of fear that if he were positive he would face rejection by his society; risking the chance that he might never have a family of his own. This went beyond the traditional beliefs of witchcraft but exposed the limitations of an existing disconnect between modern medicine and culture.

The Denialist position has negatively affected everyday conceptions of the HIV pandemic, fueling responses that have made behaviour change slow, even in the face of adequate knowledge (Baxen and Breidlid, 2009: 118).

Government's response to remedy this position, which targeted education as a key strategy in responding to the pandemic, has for the most part used a medical discourse that 'assumes' (a) linearity and positive correlation between knowledge and behaviour; and (b) a decontextualised system that operates outside a context marked by a complex array of intersecting discourses (Baxen and Breidlid, 2009). These assumptions have led to the development and implementation of a host of interventions and campaigns. Many of which offered more knowledge about protection, treatment and care, but have not gone far enough in asking questions about where, discursively, this knowledge is mediated (Baxen and Breidlid, 2009). The outcome of this has been 'one-size-fits-all' modernist interventions that provide more knowledge to people. These interventions have overlooked the deeper epistemological concerns about the frames of references used to interpret and mediate this knowledge, and deeply politicised, raced and gendered social spaces within which the individual and collectives make meaning of their lives (Baxen and Breidlid, 2009).

What has been done in addressing contraception?

South Africa has been a signatory of a variety of policy changes, development programs and health interventions directed at improving women and girls' sexual and reproductive health and rights (Willam, 2013). However, research indicates that the knowledge and the exposure that individuals have of these changes and developments does not always translate to the behavioural change. Although behavioural change is not commonly distinguished; such developments create awareness and provide citizens with clear commitments and targets to aspire towards (Willam, 2013). The Millennium Development Goals (MDG's) are an example of such commitments, with the aim of promoting women's reproductive rights and improving access to voluntary contraception. In line with this study, MDG's 4 and 5 are relevant, as they seek to work towards preventing unintended pregnancies.

MacPhail and Campbell (2001) state that health promotion programs are to provide the setting of the renegotiation of leading high-risk behavioral norms by young people, and for the shared formation of new norms of behaviour. Hence why the ZAZI campaign adopted a

participatory communication approach, so that the voices of individuals from marginalised communities could be heard. This approach recognises that development is an on-going dialogue with and between audiences and continues over time through a process of mutual adjustment and convergence. The ZAZI campaign allowed for greater insight to be obtained through drawing upon the audiences knowledge of their peer networks, family relationships, partner relationships, community relationships, and societal norms. It is, therefore, important for research to focus on the way in which dominant norms place young people's sexual health at risk. But it is also important to focus on the way particular young people resist these norms, sometimes leading to alternative and less risky sexual behaviours and practices (MacPhail and Campbell, 2001).

The South African youth have mostly received the majority of their knowledge of sexual health promotion from government mass media campaigns (MacPhail and Campbell, 2001). These approaches have been mostly participatory, involving peer education. The understanding of the influences on sexual behaviour and the mechanics of sexual behaviour change are still limited, particularly in the Southern African context (MacPhail and Campbell, 2001). This study is grounded on the idea that it is the inadequacies in our knowledge and the limited tools for understanding that is driving the epidemic amongst young people. A better understanding of the influences that drive the epidemic will allow for an improved understanding of the factors that aid or hinder existing programmes and could potentially assist with improving future interventions.

The understanding of sexuality when attempting to understand behavioural change among young people appears to be an important factor, Kippax and Crawford (1993) criticise the concept of 'sexual behaviour' used in most studies. They argue that sexuality is too complex a phenomenon to be conceptualised in terms of decontextualised and quantifiable individual behaviours such as condom use. Holland et al. (1990) argue for a more complex and contextualised definition of sexuality and state that:

By sexuality we mean not only sexual practices but also what people know and believe about sex, particularly what they think is natural, proper and desirable. Sexuality also includes people's sexual identities in all their cultural and historical variety. This assumes that while sexuality cannot be discovered from the body, it is also socially constructed (Holland *et al.*, 1990:339).

While understanding the cultural, social and normative contexts in which individual-level phenomena such as knowledge, attitudes and behaviour are negotiated or constructed is where this study is located. Literature around young women and unplanned pregnancy predominantly in developing countries has focused on issues of sexuality at the level of the individual while neglecting their culture and society at large. (MacPhail and Campbell, 2001). Concentrating on the individual-level presumes that sexual behaviour is based on the ability of an individual to make rational decisions based on knowledge they have attained (MacPhail and Campbell, 2001). However, these are strategies take little account of the hindrances which young women face in attempting to put this knowledge into practice in their sexual encounters (Holland *et al.*, 1990).

But the future has never been as precarious for young people. While the quantity of education is expanding, its quality is contracting; when more young people can access education for longer, fewer are able to find work; when healthcare has advanced exponentially in the last century, new communicable diseases are hobbling the opportunities of young people; when rights to participate in decision-making is entrenched in law, too many are withdrawing their participation; and in the age of an information, communication and technology (ICT) explosion, behaviour change has never been as difficult to bring about. In such a context, where the linearity of transitions has been fractured, early childbearing and its consequences for individuals and for institutions take on new levels of significance and meaning (Panday *et al.*, 2009:20).

In reality the complex nature of sexuality means that adolescents conduct their sexual lives through experiences and beliefs that have been generated through their membership of particular societies and communities (MacPhail and Campbell, 2001). Much emphasis in public health campaigns around HIV and AIDS has been placed on the acquisition of knowledge in order to dispel ignorance and secondly on condom use as protection against infection (Holland *et al.*, 1990). As a result, health campaigns in South Africa have focused on issues relating to unplanned pregnancy and uptake of contraception use.

Conclusion

This chapter discussed the nature of HIV and AIDS in South African context, using the relevant literature. It also discussed some of the key factors that influence teenage pregnancy in relation, specifically looking at some of the psychological, cultural and social contributing factors. Relevant literature illustrated that multiple factors influence unplanned pregnancy, and that each factor therefore, needs to be considered when exploring behaviour change communication. Lastly, it provided a brief history of contraception in order to understand some of the some of the work that has been done previously with HIV preventative methods. The chapter highlighted what has been done to address teenage pregnancy and the lack of contraceptive use in the past, giving contrast to the work that still can be done.

Chapter Three: Theoretical Framework

Introduction

This chapter explores a theoretical framework which will make it possible to analyse the reception of the ZAZI – “Know Your Strength” campaign among young women in Mnini, in the rural KwaZulu-Natal, to determine how relevant it was within their context. The principal theories and model that inform the research are Stuart Hall's (1996) encoding/decoding model, the Social Ecology Model of Communication and Health Behaviour (SEMCHB) (Kincaid et al., 2007; Sallis et al., 2008), and the Culture-Centered Approach (CCA) (Dutta, 2008). In keeping with this study, the SEMCHB model seeks to present the different levels at which individual behaviour change occurs. The reception of the ZAZI – “Know Your Strength” campaign is influenced by both the community, society and the context in which people live. Hence, the use of the CCA will focus on the role that culture plays within these contexts. Stuart Hall's (1996) encoding/decoding model in the context of this study accounts for the different interpretations that each participant will have about the ZAZI campaign. It creates the understanding that a message can be interpreted and understood in various ways, apart from what the sender had intended. This will also account for the different themes that will emerge in the analysis of data.

Encoding and Decoding

Stuart Hall's (1996) Encoding/Decoding Model is borrowed to understand individual's perceptions and experiences about health issues and how they draw meaning from it. This model accounts for how the sender formulates and transmits the intended message which is then communicated to the receiver (Procter, 2004). The process of transmission from sender to the receiver of the message is called encoding. “Encoding means the making of messages and the interpretation of these messages by the reader is decoding ” (Mpeli, 2005: 34) This model is rooted within the ‘transmission model’ of communication, where the transmitter transfers a message to a receiver who is seen as interpreting the message largely as envisioned by its creator (Hall, 1996). Stuart Hall's mediation was to assert that the active construction, rather than passive reception, of meaning is a socially arranged procedure, and that in order to completely understand the complexities imbedded in a text, the communication process overall needed to be well-thought-out (Hall, 1996). Hall (1996) argues that media texts are ‘polysemic’- signifying that various meanings can be generated out a single text in diverse social and

cultural frameworks and that there is no binding link between the encoded meaning projected by the producer and the decoded meaning that arrives to the receiver (Hall, 1996).

The four-stage theory of communication within this model is: productions, circulation, consumption and reproduction, represent the process in which a message can be interpreted by the receiver (Hall, 1996). This reiterates the analysis that the encoding of the text does not control its reception by individuals; this is because texts have a complex structure (Hall, 1996). For example, whether a text is written or spoken, whether it is a video, or a song, one cannot assume that the individual receiving it will read and interpret it the way the sender had intended for it to be received, “the former can attempt to 'prefer' but cannot prescribe or guarantee the latter (Wren-Lewis, 1983). In keeping with this study, this model should aid in revealing all the pre-ferred interpretations of the ZAZI campaign without the influence of what the message had intended to do. It will give opportunity to the analysis of the study to take into account the different ways in which the campaign ministered to each individual.

Although this model has been criticised for its linearity, (sender, message and receiver) method (Hall, 1996); linearity usually occurs when there is a vertical relation between two or more factors, where information is given and not shared. This model should reveal the ways in which audiences read the ZAZI message; whether they hold a (i) dominant, (ii) negotiated or (iii) oppositional position in decoding the message. Hall (1996) refers to these levels as the ‘three hypothetical positions from which decoding of a message might be made (Procter, 2004):

(i). The dominant-hegemonic position: In this position, the audience decodes the message in terms of the codes legitimated by the encoding procedure and the overriding cultural order (Procter, 2004). In line with this study, the dominant position will highlight the preferred meaning of the ZAZI campaign. One of the main objectives of the ZAZI campaign is to strengthen women, encouraging them to look within themselves, to know their worth when it comes to their sexual relations with male partners. This position of interpretation will reveal whether there are participants whom were directly affected and responsive to the preferred meaning of ‘*Know Your Strength*’ sent by ZAZI campaign. This is an example of ‘perfectly transparent’ communication (Procter, 2004: 69).

(ii). The negotiated position: This is a contradictory position, where the receiver has the potential to determine that this campaign is nothing more than an attempt to actively involve people about the issues that young people face from health practitioners, opposing the dominant (obvious) codes. It accords the privileged position to the dominant definitions of events while reserving a right to make a more negotiated application to “local conditions” (Procter, 2004: 69). In line with this study, the

negotiated position of interpretation will enrich the data of this study by raising a silent assessment of the preferred message. This position will bring to the surface other possible meanings from the message 'Know Your Strength' directed at women. Procter (2004) provides an analogy of a worker's response to reports of a pay freeze. The worker may agree such a freeze is in the national interest and, therefore, adopt the dominant-hegemonic position. However, this may have little bearing on her decision to strike at shop-floor or union level (Procter, 2004). In the context of this study, women can have a 'common sense' interpretation of the ZAZI campaign, but it does not guarantee that they will yield to it in their own personal lives. The obvious meaning of the campaign does not secure that women will embrace it, they negotiate, come up with different perspectives before they accept the message as it is. Hall (1996) confirms that the method in which the recipient decode texts rest on not only, or even largely, on the content of the message itself. It is also formed by the social setting of the receiver and the various codes, abilities and experiences they have entrance to and draw from as a result (Hall, 1996).

(iii) The oppositional position: Within this position the "viewer recognises the dominant codes and opposes them" (Procter, 2004:69). In relation to this study, the oppositional position will reveal the young women who do not agree with the message that encourages women to 'know their strength'. This position should bring an analysis to whether the self-esteem and knowledge of inner strength among young women plays a role in behaviour change. Within the study there could be women who come from societies and communities that do not embrace women as people who have a voice when it comes to relationships with male partners. Therefore, their interpretation would be oppositional to that of the ZAZI message.

The message within the ZAZI campaign is encoded using a mass media strategy. This consists of four types of 'texts', a television advert, a radio advert, a music video and the written print and online messages. They all encompass one message, which is to inspire young ladies to resist peer pressure and express their own values so that they can avoid unwanted pregnancies with the use of contraceptives; prevent HIV; have a safe pregnancy and healthy baby when they decide to fall pregnant. All of these texts and the encoded messages are interrelated because the television advert addresses the issue of 'sugar daddies' in intergenerational relationships, and the music video shows a series of issues including Gender Based Violence (GBV). These are issues that are often associated with why young women do not use contraception as preventative methods against HIV and AIDS and pregnancy, even amongst those who know about the different available methods. Therefore the encoding and decoding model will allow the audience to decode from the various perspectives of the

campaign. Nonetheless it is important to note that this research will focus on contraceptive knowledge and use among young female learners, in relation to the high pregnancy rate.

Audience reception cannot be understood in simple behavioural terms (Wren-Lewis, 1983). This means that it is not sufficient to assume an individual on behaviour patterns; their reception is also largely influenced by the environment in which they live. It is framed by structures of understanding and produced by social and economic relations, which determine how the audience realise a message as meaningful, permitting such meanings to be changed into practice or consciousness (Wren-Lewis, 1983). David Morley (1980) elaborated with the study about class; he confirmed that class does not in any way directly correlate with decoding frameworks. This was due to the overemphasised role of class in the production of different readings which underestimated the variety of other factors that determined different meanings. In practice there are very few perfectly dominant or purely oppositional readings and as a result in reading a text, audiences enter in a process of negotiation with the text (Fiske, 1989). The making of meaning is seen as an interactive, dialogic process of translation, where the receiver of the message is an active participant in its decoding (Hall, 1997; Tomaselli, 1988). In keeping with this study, the environment in which participants live will be accounted for, in order to understand their reception of the ZAZI campaign. To show how the varied ways in which encoded and decoded texts can produce meanings, Hall (1993) draws from the lineage of semiotics and meaning-making. The process of meaning-making has been understood by different researchers who either added or critiqued this model (Fiske, 1989; Morley, 1980).

The Social Ecology Model of Communication and Health Behaviour (SEMCHB):

There is an ongoing evolution of thinking and a progression toward a complex fusion of constructs combining aspects of active audiences processing, societal/political/institutional context, and interpretation of meaning (Storey and Figueroa, 2012). The result of this progression has led health communication practitioners to account for all levels of social engagement from individual action to structural change and for interactions among them, meaning that they can no longer attempt to understand the behaviour of individuals without accounting for the context of the individuals (Storey and Figueroa, 2012). The early applications of theory within health communication emphasised the individual level theories of learning, persuasion, and decision making as they related to health behaviour and, especially, behaviour change (Storey and Figueroa, 2012).

Psychosocial theories such as Albert Bandura's (1977) Social Cognitive Theory were used in interventions and behaviour change programmes; however they overemphasised that the individual

was responsible for their own behaviour. Although research confirmed the prognostic values of these theories, it became clear that there were omitted theoretical elements, notably community-level processes and how they contribute to health outcomes (Storey and Figueroa, 2012). It is this clarity that led to the introduction or rather the integration of ecological models into behaviour change programmes. The SEMCHB is a model that recognises the relevance of dialogue and context when one wants to understand the behaviour of individuals.

The SEMCHB was developed in the 1960's and 1970's, it was applied in campaigns with regards to the harmful effects of tobacco (Sallis et al., 2008; Stokols, 1996). In order to understand the model, it is significant to firstly understand the terms that describe it. The term ecology is commonly used in the natural sciences to refer to the interactions among plants and animals and the environment in which they are (Stokols, 1996). In turn, when studying how individuals live and interrelate within the environment they find themselves, the term ecology is applied. The relationships and interactions of individuals vary from one environment to another, and this is what makes the SEMCHB a multi-disciplinary meta-theory. The term social ecology is used to concentrate its attention on the social and physical settings contextualising behaviour as well as the interplay between human actors and exterior factors modelling their agency (Panter-Brick et al., 2006). The Purpose of social ecology viewpoints is to observe relations among people within their social and physical settings, over time and across several levels of analysis: personal, familial, cultural and institutional (Panter-Brick et al., 2006).

The SEMCHB being a multi-disciplinary meta-theory creates room for practitioners to establish which methods of communication may function within a particular group of people and the culture from which they come. Quarry and Ramirez (2009) conclude that certainly, context drives functions. They make a reflection in their text, expressing the difficulties of what it was like working within Arabic community implementing participatory communication. The difficulty was caused by the lack of recognizing context. "You don't force communication approaches in a context that does not invite it" (Quarry and Ramirez, 2009: 112). This approach is relevant in understanding the culture and context of the young woman learners within the Umnini community. Through this approach the researcher will be able to perceive early what forms of communication will function within their culture, and whether or not it will bring about dialogue, and ultimately behaviour change.

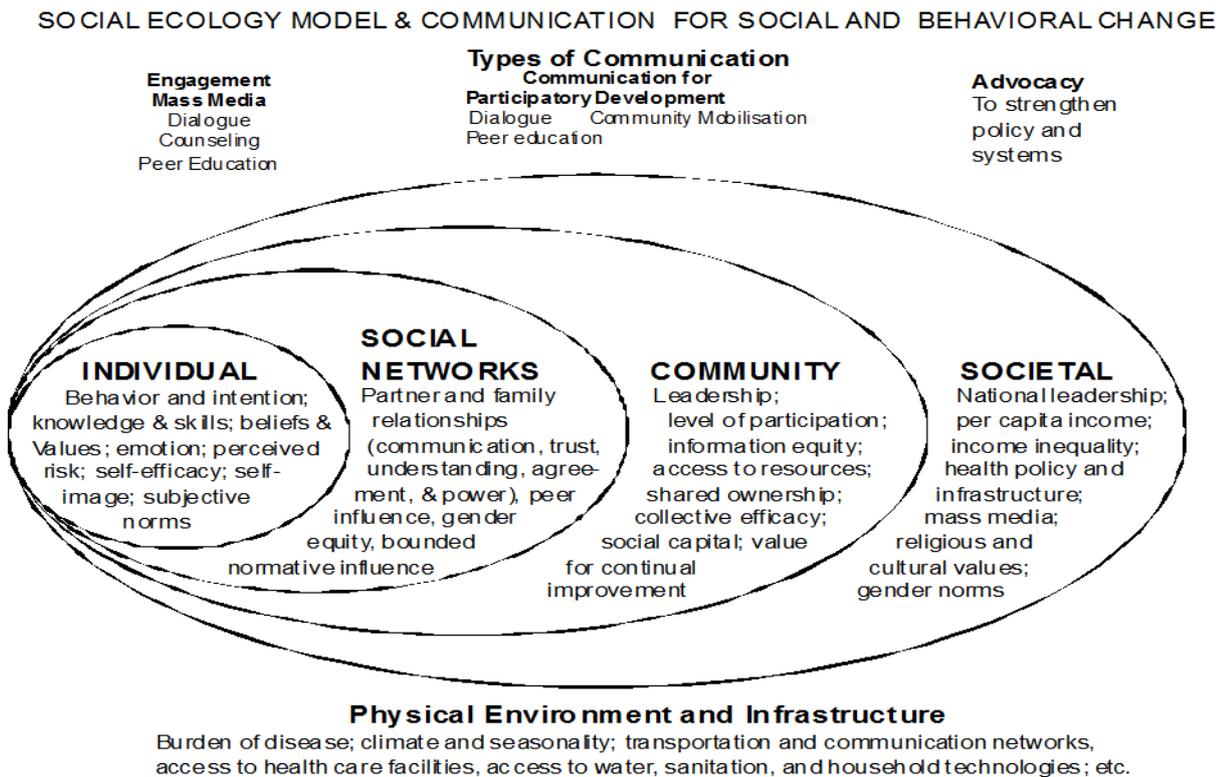
The reception of a message by an audience, according to Hall (1996), cannot be understood in simple behavioural terms, it is framed by structures of understanding and produced by social and economic relations, which determine how the audience realise a message as meaningful, permitting such meanings to be changed into practice or consciousness (Hall, 1996). This understanding is supported

by Fiske (1989) who postulates that to understand both the production of programmes and the production of meanings from the audience, it is important to understand the workings of this discourse. That is why this research employs SEMCHB as a tool to understanding these structures according to the different Meta levels that can explain the social and economic determinants of making meaning. “Ecological models of health behaviour emphasise the environment and they lead to the explicit consideration of multiple levels of influence, thereby guiding the development of more comprehensive intervention” (Sallis et al., 2008: 460).

Behaviour change has proven over the decades to be a complex phenomenon which has caused great reservations in the field of health communication as to how to approach it. To be successful, interventions and health programmes that aim at specific behaviour change should look at past interventions and where those interventions have lacked. This should reveal what it is that lead them to unsustainable behaviour change. Looking closely at past interventions, it is evident that they aimed at addressing health issues at the individual-level, without carefully studying the environment and the context in which people come from. These interventions did not consider factors that influenced an individual, but rather the focus was retained on bringing change in behaviour through educating people; this is substantiated by Fourie (2011), stating that information alone does not guarantee development.

The issue of context has been a determining factor that leads past interventions and health campaigns that were aimed at behaviour change, to be ineffective. This is why this study focuses on a framework that takes into consideration multiple factors that have a direct effect on an individual. Nevertheless, it is important to note that the SEMCHB as a framework was also adopted by the *ZAZI* campaign as part of their strategy to understand the context of the individual. The SEMCHB labels the density, interrelatedness, and totality of the components of a complex adaptive system, rather than just particular components in seclusion from the system (Kincaid et al., 2007). It assists in understanding that people are part of a larger complex social ecology (Sallis et al., 2008). In addition, it separates the environment into four spheres that influence and in turn are influenced by health behaviour (McLeroy et al., 1988). The four spheres are (1) Individual; (2) Social Networks; (3) Community; (4) and Societal. This model carries the assumption that alterations at the appropriate stages will result in changes in the singular level, similarly as the individual changes, the level features also change.

Figure 3.1: The Social Ecology Model & Communication for Social and Behavioural Change



Source: Kincaid et al. (2007).

The individual level encompasses subjective emotions and perceptions of individuals which in turn motivate the norms they adhere to in their day to day activities; their knowledge of the health issue; their attitudes and beliefs regarding the issue and their perceived self-efficacy (Mckee *et al.*, 2014). At the individual level, Albert Bandura, (1977) defines self-efficacy as an individual’s confidence in the possibility of successfully carrying out certain behaviours or actions. Similarly at the community level, Mohan Dutta (2008) refers to self-efficacy as the confidence one has in their ability to successfully change their behaviour or follow directions of the health campaign (Dutta, 2008). The issue of self-efficacy at both levels is significant to this study, as the researcher seeks to understand the extent to which perceived benefits and perceived barriers affect the adoption of behaviour change strategies such as ZAZI. Stokols (1996) refers to these as psychological influences on personal behaviour. The social network level is concerned with the ways in which people interact with those around them such as family members, peer groups and their partners (Mckee *et al.*, 2014).

Most Behaviour Change Communication (BCC) approaches were previously based on cognitive models of action, for example, the Theory of Reasoned Action (TRA) (Ajzen and Fishbein, 1980). The Theory of Reasoned Action suggests that the individual’s intention to perform or not perform a

behaviour is a result of that person's attitude toward a specific behaviour and the evaluation of the behaviour by important others. Behaviour change models for HIV and AIDS communication began with ascertaining the knowledge, attitudes, and behaviours among a target audience, and then communication interventions are targeted to address these deficiencies at the individual level. One of the main assumptions of the BCC approach at this particular level is that all individuals are capable of monitoring their context (Singhal, 2003). Nevertheless, whether or not an individual can get an HIV test, use condoms and be monogamous, all are affected by cultural, economic, social and political factors over which the individual may exercise little control (Singhal, 2003).

Applying the SEMCHB to the study

The *ZAZI* campaign employed SEMCHB because it regards health behaviour as an outcome of the interaction between people and the environment they are exposed to. This is what the developers of the campaign were interested in, in order for the campaign to cater for different individuals who come from different contexts. This is recorded in community dialogues that were conducted within communities in KwaZulu-Natal, prior the development strategies of the campaign. The dialogues created a more personal understanding of the issues that young women are faced with. The aim was to allow the campaign to be in some ways relevant to the context of the people. Therefore, this study proposes to use this model to review the aspects of communication and health visible in the *ZAZI* campaign according to the different levels discussed in the model, specifically the individual and community level.

By using the SEMCHB model this study seeks to enquire whether the existing relationship between the four different levels of influence affects the way individuals respond to health issues raised within the *ZAZI* campaign. This could reveal that this interconnectedness of the levels of influence has an impact in the way individuals behave and make decisions, again reinforcing the importance of understanding context. Individual behaviour change, without the company of social change, is not sufficient (Govender, 2011). It is the inclusion of understanding society, people and the environment that any permanent behaviour change can occur in individual lives.

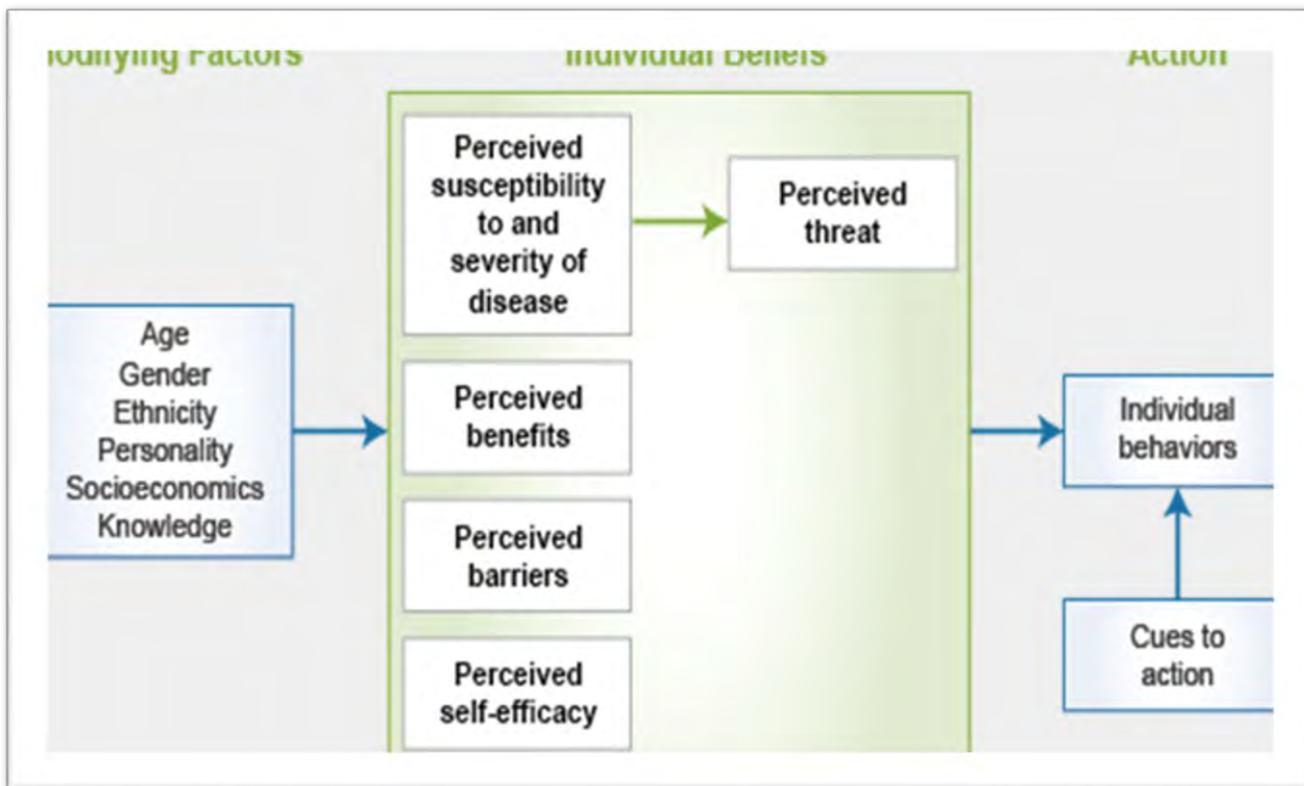
The main two features of this model are: the assumptions of embeddedness, which is a state in which one system is nested in a ladder of other systems at different levels of analysis, and emergence, which is the system at each level, is greater than the sum of its parts (Storey and Figueroa, 2012). The

feature of embeddedness is accurate in the sense that, the systems at the individual level are all nested in the hierarchy of the other systems in place at the other three levels of analysis. If individual change is enabled and maintained by the social change at greater levels it is more likely to be self-sustaining (Kincaid et al., 2007). Every level presented in the model encompasses theories of transformation for that specific level (Kincaid et al., 2007). For example, the Health Belief Model (HBM) which assumes that behaviour is a consequence of an individual's expectations which is directly linked to the individual level of the SEMCHB. The model positions the individual's probability of being involved in the health behaviour within the realm of perception, meaning that perceptual procedures filter the manner in which an individual evaluates the proposed preventative behaviour and the outcomes linked with it (Dutta, 2008). The CCA understands the structures that inform systems of culture at the community level. It also introduces the notion of the agency; which is the ability of cultural members to enact their choices and to participate profoundly in negotiating the structures within which they find themselves (Dutta, 2008). Therefore, the study will use the CCA to understand the structures that inform systems of culture at the community level. Although there are four levels of influence, this research will mainly focus on the Individual and community level.

Health Belief Model: Individual Level

Health Belief Model (HBM) was established in the 1950s to clarify the prevalent failure of tuberculosis screening (Glanz et al., 2002). This model assumes that behaviour is a consequence of individual's expectations. Hence behaviour is performed in answer to beliefs and principles held (Armitage and Conner, 2000; Champion and Skinner, 2008). The underlying concept of HBM is that health behaviour is determined by personal perceptions about a disease and the tactics open to decrease its occurrence (Hochbaum, 1958). The HBM comprises of several prime concepts that foretell the reason people will take action to prevent, to screen for, or to control illness conditions; these include susceptibility, seriousness, benefits and barriers to behaviour, cues to action and most recently, self-efficacy (Glanz et al., 2008).

Figure 3.2: Health Belief Model Components and Linkages.



Source: (Glanz et al., 2008)

Constructs

Perceived Susceptibility

Perceived susceptibility denotes the belief about the possibility of contracting a disease or ailment. For example, a woman must accept as true that “there is a possibility of getting breast cancer before she will be concerned in obtaining a mammogram” (Glanz et al., 2008:18).

Perceived Severity

The second element is the perceived severity. This element asserts that feelings about the likelihood of contracting an illness or of leaving it untreated involve “evaluations of both medical and clinical consequences (for example, death, disability, and pain) and possible social consequences (such as effects of the conditions on work, family life, and social relations)” (Glanz et al., 2008:19). The grouping of susceptibility and severity has been labelled as perceived threat (Glanz et al., 2008). This is the individual’s valuation of the outcome associated with preventative behaviour (Dutta, 2008).

Perceived Benefits

The perceived benefits element asserts that even if a person recognizes personal susceptibility to a severe health disorder (perceived threat), whether this awareness results in behaviour change will be influenced by the person’s beliefs concerning perceived benefits of the various available actions for reducing the disease risk. “Other non-health-related perceptions, such as the financial savings linked to quitting smoking or pleasing a family member by having a mammogram, may also impact behavioural decisions” (Glanz et al., 2008:19). Thus, individuals showing optimal beliefs in susceptibility and severity are not obligated to accept any recommended health action unless they also perceive the action as potentially beneficial by reducing the threat (Glanz et al., 2008).

Perceived Barriers

“The potentially negative aspects of a particular health action—perceived barriers:—may act as obstacles to undertaking suggested behaviours (Glanz et al., 2008). A kind of no conscious, cost-benefit analysis occurs wherein individuals weigh the action’s expected benefits with perceived barriers — “It could help me, but it may be expensive, have negative side effects, be unpleasant, inconvenient, or time-consuming” (Glanz et al., 2008).

Cues to Action

In addition to the four beliefs or insights and modifying variables, the HBM asserts that certain individual behaviour is also influenced by cues to action. Cues to action include events, people, or things that influence people to change their behaviour. Examples include illness of a family member; media reports and mass media campaigns (Graham, 2002). They are specific stimuli that are needed to trigger the appropriate health behaviour (Dutta, 2008).

Self-Efficacy

Bandura (1997) defines self-efficacy as “the conviction that one can successfully execute the behaviour required to produce the outcomes”. For behaviour change to thrive, people must (as the

original HBM theorizes) feel susceptible by their present behavioural forms (perceived susceptibility and severity) and have confidence in that change of a specific kind will result in a valued outcome at an acceptable cost (perceived benefit). They also must feel capable (self-efficacious) to overcome apparent barriers to taking action (Glanz et al., 2008).

Applying the Health Belief Model to this study

The HBM has been used comprehensively to determine relationships between health beliefs and health behaviours, as well as to notify interventions (Glanz et al., 2008). It was established in order to understand the reason individuals did or did not use preventive services offered by public health departments in the 1950's, and has evolved to address newer concerns in prevention and detection. The HBM theorises that people's philosophies about whether or not they are at risk for a disease or health problem, and their perceptions of the benefits of taking action to avoid it, effect their eagerness to take action (Glanz et al., 2008).

The values of an individual towards health campaigns such as the ZAZI influence their behaviour and decision-making processes. The individual will take action towards a risky health condition, only if they personally esteem themselves as vulnerable to that condition; if they believe it to have possibly serious penalties; if they consider that a course of action accessible to them would be beneficial in reducing either their susceptibility to, or the severity of, the condition; and if they believe that the anticipated barriers to (or costs of) taking the action are compensated by its benefits. However the HBM's tries to predict individual's health-related behaviours by accounting for individual differences in beliefs and attitudes goes beyond the scope of this component, it is also influenced by many other factors, especially socio-demographic factors that need the careful understanding of the individuals community. This model is criticised because of its individualistic approach, separating the individual from their environment.

The Culture-Centered Approach

Culture plays a dynamic role in shaping the level of health of the individual, the family and the community. This is precisely applicable in the context of Africa where the standards of extended family and community considerably influence the behaviour of the individual (Airhihenbuwa and Webster, 2004). The CCA is an emerging approach to health communication that queries the compositions of culture in traditional health communication theories and applications; it examines

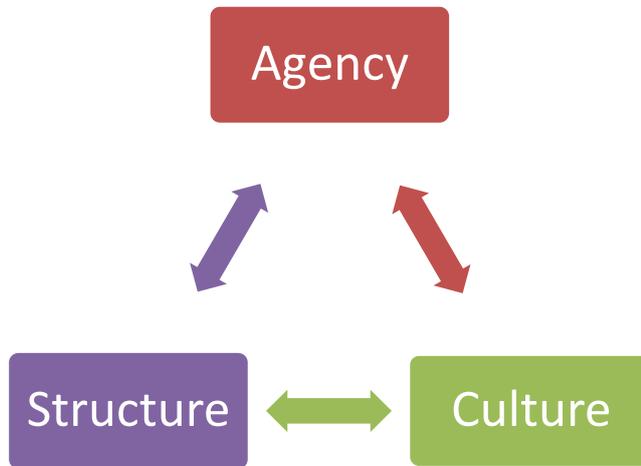
how these applications have thoroughly removed the cultural voices of marginalised communities in their constructions of health and forms spaces for engaging with these opinions (Dutta, 2008).

Quarry and Ramirez (2009) state that much of their early work focused on individual and behaviour change. Nevertheless, these efforts failed because they were based on a series of mistaken assumptions (Quarry and Ramirez, 2009). The early approaches assumed that information alone would lead to behaviour change. They assumed that individuals are able to control their context when in fact the most vulnerable cannot (Quarry and Ramirez, 2009). The individuals at the lower socio-economic segments are seen as most vulnerable. These past approaches expected that individual women can make decisions of their own free will about condom use when in fact it is largely men who determine what protection is used. Lastly, they assumed that individuals make decisions in a rational manner when in fact sexual behaviour is more complex (Quarry and Ramirez, 2009).

CCA builds on the criticism of the models of health communication which were very individualistic. They were individualistic in the sense that they viewed culture as a fixed set of beliefs and practices, yet every human being is born into a particular culture and every culture provides a context for individual progress and expansion. Therefore, each culture functions to provide a sense of self, identity, and belonging to its members through common values, principles, customs and perceptions (Basso and Selby, 1976). Airhihenbuwa and Webster (2004) argue that the actions of an individual in relation to family and community is a key cultural factor that has implications for sexual behaviour and HIV and AIDS prevention and control efforts.

The CCA predominantly centres on understanding health meanings and experiences in marginalised settings. Marginalised settings are those communities that have limited access to healthcare resources and to the various communication platforms which discuss healthcare policies and disseminate information on health (Dutta, 2008). The culture centred approach is rooted in the understanding of the interconnectedness of culture, structure and agency (Dutta, 2008)

Figure 3.1: The Culture-Centered Approach to health communication



Source: Dutta (2008)

The interaction of culture, structure and agency, illustrated in Fig 3.1, contribute to the co-construction of meanings by cultural members of a community, thus advocating that the connection of people’s culture and structures can either limit or enhance the agency to negotiate these existing structures.

Structure

In the context of the CCA, the structure “looks at aspects of social organisation that constrain and enable the capacity of cultural participants to seek out health choices and engage in health-related behaviours” (Dutta, 2008). Structure entails services that are important to the health care of cultural members, such as medical services, transportation and the provision of food (Dutta, 2008). It is deeply connected with the material resources and their availability to individuals and to the communities within which they live (Dutta, 2008).

Moreover, structure limits the resources and opportunities for participation in particular marginalised communities. Marginalised communities do not hold dominant social possessions; therefore access to power is determined by economic access. Due to this, individuals from marginalised communities have no control over the social system (Dutta, 2008)

Individuals from such communities are left without a voice when confronted by dominant health communication structures. It is from this perspective that the CCA is concerned about listening to the voices, and encouraging voice and dialogue of the marginalised as an approach to increasing agency.

Culture

Culture provides the context of life that forms knowledge making, observations, sharing of meanings and performance changes (Dutta, 2011). Obregon and Airhihenbuwa (2000), postulate that culture is people's ability to control/dominate their environment. The CCA recognises culture as the strongest framework for providing the context of life that shapes knowledge creation, perceptions, sharing of meanings and behaviour change (Dutta, 2011). Within the CCA, culture is framed with reference to the context in which individuals come, the emphasis is on the importance of the day-to-day practices of individuals and how they interpret health. CCA acknowledges the importance of designing culture-specific health programs, compatible to the culture and lifestyles of individuals it is designed for.

Agency

Agency refers to the ability of human beings to relate with structures in order to produce meanings (Dutta, 2008). Such meanings provide scripts for marginalised individuals interacting with the structures to sustain and transform them. Agency is an active procedure through which individuals, groups, and communities participate in actions that trial the structures that contain their lives (Dutta, 2008). It is through agency that cultural members have the ability to participate in influencing health communication strategies, providing health care that caters for everyone. Participation requires active voice and dialogue, which is fundamental to CCA.

Empowerment is also a critical factor that can either limit or enhance agency. In line with this study, the ZAZI campaign advocates for young women to know their strength, to exercise agency in negotiating safer sex practices. However, if young women are not empowered to exercise agency, they will remain vulnerable to HIV infection and unplanned pregnancy. Vicci Tallis, (2012:52) states that "an empowered person is able to make free and informed decisions, and act according to these decisions". Therefore, empowering young women to exercise agency and negotiate safer sexual practices will inform their decisions within sexual relationships, contextual and cultural factors that hinder participation in communication strategies. It will also encourage young women to negotiate structural factors that are a barrier to exercising agency.

Applying the CCA to the study

The three characteristics of CCA uncover the bankruptcy of behaviour change models; the lack of understanding that preventing HIV and AIDS is based on cultural norms, that often reconcile individual decisions in ways the individuals may not continuously comprehend (Obregon and Airhihenbuwa, 2000). Therefore why culture-centered approaches' to prevention, care and support is increasingly recognised as an important strategy (Airhihenbuwa and Webster, 2004). This is the premise from which this study finds the CCA relevant, as it involves the active participation of those who wish to bring about change within the different communities. This study explores the reception of the ZAZI campaign around issues of contraceptive use linked to the high rates of teenage pregnancy among young women. The CCA thus becomes relevant for its cultural perspective as it can enhance the young women's capacity to engage, from their own experiences and opinions about teenage pregnancy, contraceptive use and high rates of HIV infection.

In the context of this study, structure refers to health care facilities that are available to young women learners for access to contraceptives. Structures also refer to the communities in which young women live and the infrastructure in the schools that they attend. From the CCA point of view, the structure has the ability to promote or impede the health choices of young women. Agency is outlined as the ability of young women to engage about their experiences with regards to contraceptive use and teenage pregnancy. Participation of young women in this studies enquiry about contraceptive use is viewed by the CCA as an act of agency.

The underlying objective is to use the CCA as an entry point to gain a deeper insight into the perceptions and perspectives of young woman learners, in the community of Umnini, KwaZulu-Natal.

Conclusion

The various theories and models reviewed in this chapter enable the researcher to identify the different ways health campaigns are received and given meaning by the audience. The use of the decoding/encoding model also explores how message decoding inspires or results in behaviour change. The CCA allows the understanding that an individual's behaviour is influenced by the environment in which they live and therefore should be studied in context of their culture, beliefs and norms. This chapter also discussed the SEMCHB in conjunction with the Health Belief Model and the Social Cognitive Theory, which enabled an exploration of how perceived benefits and barriers can influence behaviour, perceptions, attitudes and beliefs.

Chapter Four: Research Methodology

Introduction

This chapter describes the research methodology and methods that will be used in this research. It begins with the research methodological map that gives the study structure, continues to explain the theoretical approach and the reception analysis. A clear outline of the study's data collection is provided and the method of analysing the data. Relevant data collection techniques that together bring reliability and validity to this research will also be discussed.

Table 4.1 Methodology of the study

Methodological Map	
Theoretical Perspective & Approach	<p>Qualitative research approach</p> <p>In qualitative research, the interpretive approach aims to offer insights into how young women in rural schools perceive contraceptive use.</p>
Research Design	<p>Reception analysis of qualitative data</p> <p>What is important in a reception analysis, within a qualitative study, is how individuals make sense of the text in comparison to their everyday lives. It also highlights the importance of understanding that these texts were reaffirming the audiences positions in society, and what extent these texts are being used to challenge these positions.</p>
Methods	<p>This study will administer four focus group discussions with the ZAZI peer groups; review community dialogues that were conducted in the communities around KZN prior the launch of the campaign; and semi-structured interviews with the educators who coordinate the peer groups in the schools for the ZAZI campaign.</p>
Selection of Participants	<p>Participants will be selected using purposive sampling. In purposive sampling, the researcher selects participants who manifest certain characteristics that the researcher is interested in (Struwig & Stead, 2013). This study has identified the gender, age and area of residence of the participants, which is an important characteristic in purposive sampling.</p>
Qualitative Data Analysis Package	<p>Thematic Analysis, “is a method for identifying, analysing and reporting patterns (Themes) within data”. Braun & Clarke (2006:79).</p>

Qualitative approach

Due to the complexity of contraception as an area to study, it is the aim of this study to explore the detailed perceptions and perspectives of the participants and their personal experience of the ZAZI campaign. This study discovered interpretations and meanings that participants have derived from the ZAZI message. Mary Rodwell (1998) emphasises the importance of understanding the “context bounded nature of reality” as being crucial in the research process and how assessment and investigation cannot be fully carried out except through field-based methods, taking into perspective the local context. Qualitative methodology attempts to increase understanding of why things remain the way they are in the social world and why people act out their daily lives the way they do. Qualitative studies within the interpretive paradigm see the world as constructed, interpreted, and experienced by people in their interactions with each other and with wider social systems. Therefore, when applying this approach, researchers want to learn what is meaningful or relevant to the people they are studying and how they experience everyday life within their context.

Sotirious Cardey (2006) identifies the Interpretive Paradigm as the framework within which qualitative research is conducted. The ontological perspective in this paradigm is that reality is limited to context, space, time and individuals or groups in a given situation and cannot be generalized into one common reality (Chilisa, 2011). This research falls within the interpretive paradigm, which views participants as interactive beings, who have the ability to create and interpret meaning. “For interpretive researchers, the goal of social research is to develop an understanding of social life and discover how people construct meaning in a natural setting” (Neuman, 2011:26). The interpretive paradigm is most commonly used by researchers in qualitative studies because it allows for collaboration between the researchers and participants. This study uses this paradigm as a platform to explore the knowledge of contraception as a preventative method against unplanned and unwanted pregnancies.

Qualitative research is well-suited in this paradigm because it does not come with a predetermined discussion which excludes the voices of the target audience; it will house the participants in this study in a process of ‘participatory inquiry’ where both the researcher and participants actively participate in creating knowledge (Neuman, 2011). There are four main characteristics that explain the fundamental purpose for applying the qualitative approach in research: (1) The participants’ and researchers’ perspectives; this is when “researchers are interested in understanding the issues being researched from the perspective of the research

participant, meaning that you are trying to see through the eyes of the participants” (Struwig and Stead, 2013:11). (2) Contextualism; in qualitative research, the way people behave “does not occur in a vacuum. It is necessary to provide a comprehensive description and analysis of the environment or social context of the research participants” (Struwig and Stead, 2013:11). In this study, the researcher seeks to understand the perceptions young women have on issues of contraceptive knowledge and its use, in correlation to unplanned and unwanted pregnancy. Therefore, it is crucial that the researcher explores the community in which the participants live and the factors that influence their lives.

The nature of qualitative research reinforces that the researcher cannot divorce the need to explore their environment and social settings because often the behavior of individuals is inextricably linked to their experiences and the world around them (Struwig and Stead, 2013). (3) Process; individual behaviors are not static; it is constantly changing and therefore, understanding this change is a process (Struwig and Stead, 2013). (4) Flexibility and the use of theories; in qualitative research, researchers tend to mistrust theories prior to research because of the understanding that the context of participants could be different to those discussed in the theories. Researchers have to be flexible in their approach, sensitive to the unexpected events during research (Struwig and Stead, 2013).

In applying this approach, the researcher is inter-subjective, engaging in conversation with the participants, to understand their ideas of everyday life, meaning that the researcher is trying to see through the eyes of the participant (Struwig and Stead, 2013). The purpose of interpretive research is to understand people’s experiences of the different and complex happenings around their environments and within their own individual lives, and for this study, it is to understand the perceptions of contraceptive use among young female learners using the ZAZI campaign as the case study.

The Meaning-Making Process: Interpretative Phenomenological Approach

The Interpretive Phenomenological Analysis (IPA) has two components. It is Phenomenological, attempting to understand how participants make sense of their experiences. It does not assume that participants’ accounts refer to some verifiable reality, but it recognizes that this involves a process of interpretation by the researcher (Hancock, et al., 2009). Phenomenology is a philosophical perspective which believes that truth lies within the human experience. “For phenomenology the ultimate source of all meaning and value is the lived experience of human beings” (Armstrong, 2005). Phenomenology rejects the concept of

objective research, which belongs to the positivist paradigm and advocates that truth lies within human experience and is therefore multiple and bound by time, space and context (Chilisa, 2012). It is interpretive, recognising negotiation between researcher and researched to produce the account of the insider's perspective, so both researcher and researched are "present" (Hancock, et al., 2009). This can be linked with Stuart Hall's (1980) encoding/decoding model that speaks of the 'active audience. The concept of the active audience is based on the notion that, when the audience receive a message, they have the liberty to interpret the message according to their context, creating multiple meaning to a single message. An important element of the active audience is that the audience does not receive the message passively; some may hold a negotiated position in decoding the message. When there was a more passive conception of audience, there was no need to focus on interpretation as it was assumed that everyone received and perceived the content the same way. The reception of a message is rooted on how the audience interprets the message and on how they come about the meaning that they attach to the received message. Both Phenomenology and the encoding and decoding model emphasise 'interpretation'. Tomaselli (1998) reiterates by saying the making of meaning is seen as an interactive process where the receiver of the message is an active part in its encoding. These different interpretations of meaning are attributed to the structural differences that different individuals live in; this is related to the interpretive approach phenomenology. Phenomenologists believe that people should be explored because they can only be understood through the unique ways they reflect the society they live in. That is why this research will use methods that are less restricting, in order to allow participants to share their perceptions on any given subject.

Reception analysis

This study offers a reception analysis also known as an audience reception, of the ZAZI – 'Know Your Strength' campaign among young woman learners in Umnini, KwaZulu-Natal. Specifically, this study is looking at the campaigns awareness towards the use of contraceptive methods as preventative measures against HIV and AIDS; unplanned and unwanted pregnancies. It will examine the perceptions of the learners as the active audience. Qualitative methods which aid the interpretation and understanding of people's perceptions will be administered. One of these methods includes focus group discussions and semi-structured interviews, which provide the basis for interpretive and critical analysis of the study.

The conception of the 'active audience' was developed from Stuart Hall's (1996) Encoding/Decoding model of the relationship between text and audience. The development of this notion increased in the 1980's and the 1990's with David Morley (1980) 'Nationwide Audience'; Dorothy Hobson's (1982) and John Fiske's (1989) 'popular culture'. Hall's theory of encoding/decoding as an example of reception analysis understands the message and the included meaning as encoded by a sender and meaningfully decoded by the audiences with influencing, persuading, emotional, ideological and behavioral effects.

This study seeks to discuss issues of HIV and AIDS and the use of contraception as a preventative method for unplanned and unwanted pregnancies among adolescents. The study offers a reception analysis of the ZAZI-Know Your Strength campaign, using qualitative methods which aid the interpretation and understanding of perceptions held by young women learners who have received the message of contraceptive use and unplanned pregnancy. It examines the perception of the readers as receivers of the encoded message. The Interpretive approach has allowed this study to select qualitative methods that start from the position that our knowledge of reality, including the domain of human action, is a social construction by human actors (Walsham, 2006). Therefore, each human action can be interpreted actively and according to the context and environment in which people are. Meaning can be derived from any event or message in more than one way; a message can contain more than one possible reading, Hall (1996) refers to this as active interpretation. This was when the concept of 'active audience' was conceived (Fiske, 1989; Morley, 1980).

Hall (1996) is one of the main proponents in this school of thought; this approach, the Encoding/Decoding Model of Communication reveals the relationship between studying people's behaviours and how meaning is deduced thereof. This reiterates the analysis made by Hall (1996), that the encoding of the text does not control its reception by people; because texts have a complex structure. This Cultural Studies framework has shaped the data collection methods used in this study. It allows and supports the flexibility of qualitative research stated by (Marshall and Rossman, 2014), when he explained that qualitative research design is essential in studies that seek to understand a phenomenon as experienced by a specific group of people as it goes beyond simply understanding the surface meanings attached to particular actions but further exposes the researcher to an understanding of the meanings that everyday activities hold for people, thereby gaining a richer detailed understanding of the subject.

There are other approaches that have been applied to reception analysis; Sonia Livingstone (1998) identified six trajectories towards reception studies that converged during the late 1970s; apart from the paired concepts of encoding and decoding. Researchers in a domain traditionally opposed to cultural studies that of uses and gratifications, saw the new focus on audience interpretation between gratifications studies and cultural studies, exploring the selective responses of audiences with the key concept of active audience. The intension was opening up a broader conception of what audiences might do with texts (Dayan and Katz, 1992). The third direction to reception studies drew upon moves within critical mass communications research to shift attention away from an exclusive focus on the ideological and institutional determinants of media texts towards including a role for a possibly active audience, which ultimately resulted in the focus of the ‘resistant audience’ (Fejes, 1984). A fourth approach was towards textual analysis (Seiter et al., 2013; Livingstone, 2013). Fifthly, it is the feminist approaches that resulted “in a consideration of the mapping of good and bad, ‘masculine’ and ‘feminine’ genres,[...], cognitive and emotional responses onto high and low culture, and offers instead an alternative set of valuations which mapped primarily onto active and passive audiences, critical and normative readings and open and closed texts” (Livingstone, 1998: 4). Lastly, the sixth approach shifts the focus away from the moment of textual interpretation and towards the contextualisation of that moment; this involves the detailed analysis of the culture of the every day, stressing the importance of ‘thick description’ as providing grounding for theory (Livingstone, 1998).

Qualitative Data Collection

Qualitative data is extremely varied in nature. It includes virtually any information that can be captured that is not numerical in nature. A report on thirteen community dialogues was analysed, these were conducted prior the formulation and launch of the ZAZI – “Know Your Strength Campaign”, as a tool of understanding some of the notions that women have towards contraceptive use and their level of risk to HIV and AIDS that affect women in KwaZulu-Natal. The analysis of these dialogues forms the foundation of data in this study; they contain the main findings that led to the development of the ZAZI campaign. The thirteen community dialogues were facilitated by DramAidE⁷ comprising of one community dialogue in each of the districts in KwaZulu-Natal with two dialogues taking place in the EThekweni District. In addition to the analysis of the community dialogues, the researcher

⁷ A public health communication organisation that uses arts and participatory methodologies to: <http://www.unizulu.ac.za/outreach-centres/dramaide/>

will conduct four focus group discussions among young female learners in the three schools in Umnini. There is one school that has a large group of ZAZI peer educators, therefore focus group discussions were separated into two groups. Five semi-structured interviews were also conducted among the educators who are following up the peer groups in their respective schools. There are two educators allocated in two of the school, and one educator in the third school.

Community Dialogues

The Provincial Government of KwaZulu-Natal (PG-KZN) launched Operation Sukuma Sakhe (Let us stand and build), which promotes a partnership between the KZN Provincial Government and communities to rebuild the fabric of society and the nation, with a particular emphasis on women and girls. Thirteen community dialogues were conducted throughout KwaZulu-Natal (KZN) during the month of November 2011. The thirteen dialogues were facilitated by DramAidE from 15-25 November 2011. This comprised one community dialogue in each of the districts of the province of KwaZulu-Natal with two dialogues taking place in the EThekweni District (Delate et al., 2011). The purpose of these dialogues was to listen to the voices of communities, women, men, young people, traditional and faith-based leaders, on what actions can be undertaken to improve the health and well-being of all women and girls in KwaZulu-Natal. The findings from these community dialogues assisted with the development of a provincial advocacy, communication and social mobilization strategy that responds to the key issues identified by communities; the ZAZI – “Know Your Strength” Campaign. Low rates of contraceptive use amongst women and girls linked to high rates of unplanned pregnancies were one of the key findings. This is one of the main issues that the ZAZI campaign targeted to address in their objectives. Within this study, the analysis of these dialogues and findings form the bulk of the qualitative data that will be analysed. This is data that was generated prior to the formulation of the campaign, highlighting not only the current state of the thirteen communities but the state of the KwaZulu-Natal province as a whole.

Semi-structured interviews

Semi-structured interviews, a qualitative data collection method, was chosen as it provides more detailed information on the person’s thoughts and perceptions around a subject, therefore giving detailed contextual information (Boyce and Neale, 2006). Qualitative

researchers usually employ semi-structured interviews which involve a number of open-ended questions based on the topic areas that the researcher wants to cover. The open-ended nature of the questions posed defines the topic under investigation but also provides opportunities for both the interviewer and the interviewee to discuss some topics in more detail (Hancock, 2007). In preparation for the interviews, an interview guide with a set of questions was developed at the beginning of the study (SEE appendix C).

The questions are drawn from the objectives of the study and designed in line to answer the research questions. These questions guide and do not need to be strictly adhered to; the guide should not restrict the interview, but should rather allow follow up of points of interest to either interviewer or interviewee. The interviews took on a conversational and discursive style allowing the interviewee to speak freely. According to Struwig and Stead (2013) Semi-structured interviews give the opportunity to discuss issues beyond the questions' confines; Ranjit Kumar (2011) refers to this method as being flexible, free and spontaneous. The interviewing process began by inviting each of the five educators for a briefing session. The sessions were held in each school in Umnini. The participants were then requested to sign a consent form (SEE appendix A); giving an indication that they understand what the interview is all about.

This study is a reception analysis of how young women have received a campaign; whether the objectives of the campaign are being met was determined by the young women's perception and overall reception of the campaign. The educators provide deeper insight on what changes in behavior are noticeable in the school and community at large, assuming that there are any changes that there any changes.

Focus Group Discussion

Four focus group discussions (FGD) were conducted as part of the study's data collection process. All four discussions were conducted at school three schools Umnini, Umcothoyi High School, Esdelile High School and Esizibeni High School located in KwaZulu-Natal. A focus group is described by Sarantakos (2005) as a loosely constructed discussion with a group of people brought together for the purpose of the study. This method of data gathering relies on the interaction between the group members for data and is useful for ascertaining diversity within a group. Struwig and Stead (2013) view focus groups as planned discussions

that elicit perspectives on a topic in a non-judgmental way and in an accepting, safe environment. FGD's are often seen to complement the semi-structured interviews, in the sense that they both rely on the aid of topic guides to help them keep the discussion relevant to the research questions. This may also be considered useful for checking validity. In each of the FGD's, there was a free interaction as most of the young women knew each other because they are all part of the ZAZI peer group and attending the same school. In a FGD the group interaction allows more realistic perceptions of issues. Information is also checked for accuracy as members' question, complement, and corroborate what others say (Chilisa, 2011).

Data analysis: Thematic analysis

Thematic Analysis offers an accessible and theoretically flexible approach to analysing qualitative data (Braun and Clarke, 2006). This study used a thematic analysis as the method of analysing data. A thematic analysis is a method that "pays attention to describing both the implicit and explicit data, through a thorough process of identifying, analysing and reporting pattern (themes) within the data" (Braun and Clarke, 2006: 6). Thematic analysis was selected as a preferred method as it moves beyond merely describing the data but identifies both the unspoken and obvious ideas within data (Guest *et al.*, 2011). Hardy and Bryman (2004: 93) state that this method of analysing data involves two processes, "the mechanical and the interpretive component", both inextricably linked. The mechanical process refers to the physical activity of reading and rereading the data in search of key words, trends and themes that will help shape the analysis before any analysis takes place (Guest *et al.*, 2011). The interpretive process of the analysis occurs when the researcher immerses themselves in the data, looking for the unarticulated meaning to it, based on the broader picture presented by the findings (Rodwell, 1998).

Thematic analysis becomes a flexible method of analysing data when it permits an integrated analysis of data collected using different qualitative methods. To analyse the FGD's and interviews, the inductive approach was used to identify themes that were strongly linked to the data. This is because; the data was collected specifically for the research and the themes identified with the some of the questions that were asked of the participants (Braun and Clarke, 2006). The community dialogues were thematically analysed using the theoretical approach. This form of thematic analysis tends to provide less rich description of data and more a detailed analysis of some aspect of the dat (Braun and Clarke, 2006). Therefore, the

community dialogues were preliminary data that the researcher was fitting into an already existing framework.

Sampling technique

Purposive sampling “aims to identify a sample of information-rich participants; meaning that it looks for participants who show characteristics that the researcher is interested in” (Struwig and Stead, 2013:27). Purposive sampling will be applied in both the selection of participants in the semi-structured interviews and the focus group discussion. Purposive sampling is the selection elements based on the judgment of the researcher on what elements will facilitate an investigation (Adler and Clark, 2014). Rubin and Rubin (2005) indicated three strategies the researcher can apply for selecting participants using purposive sampling, “First, the participants must be knowledgeable about the cultural arena or situation or experience being studied, secondly, is the willingness to talk and lastly, participants must be representative of the range of points of view” (2005: 66).

For the focus group aspect of this study, it was crucial that the participants were schooling within the three high schools in which the ZAZI campaign was implemented. The selection was also linked to the target groups that the campaign is aiming to reach the ages 15-24, however for the purposes of this study, participants were selected between ages 18-20 years of age. One FGD was conducted in two of the three schools, the FGD’s consisted of 10 participants in each school . Participants were purposively selected according to age and being a ZAZI peer educator at school. The third school, had 30 young female learners who were part of the ZAZI peer education group. The researcher conducted two FGD’s in the third school, consisting of 10 participants each. There was a total number of four FGD’s conducted in three high schools in Umnini.

For the semi-structured interviews, educators were also purposively selected in this study, this was because the educators were already selected by ZAZI facilitators to monitor the peer education group in each of their schools, and evaluate their growth in each school. There was one educator appointed in the first two of the schools, Esizibeni High School and Umthoyi High School and two educators in the third school, Esdelile High School. This was because Esdelile, there were 30 young female learners within the ZAZI peer groups. The educators were the primary source that could offer insight on how the campaign had been affecting the learners who are part of the ZAZI peer group; indicating patterns of behavior change in comparison to the learners who are in the same school and community and were not part of

ZAZI. To capture the in-depth vocal expressions of the learners and the educators, all interviews and FGD's were recorded using note-taking and two voice recorders. This assisted in accurately transcribing and translating the responses, ensuring that the study reflects participants' true perceptions and lived experiences, providing the validity of the study

Validity and reliability

Neuman (2011), defines reliability in two words; 'dependability' or 'consistency', and validity, 'truthfulness and trustworthiness'. According to Durrheim and Wassenaar; "dependability refers to the degree to which the reader can be convinced that findings did indeed occur as the researcher says they did" (1999: 64). In this study reliability can be found in the consistency of findings from the community dialogues, focus group discussions and the semi-structured interviews. The findings will be reviewed for important themes that contribute towards answering the research questions.

Ethical considerations

At the beginning of the FGD's, informed consent forms were distributed to all the participants. This was important because participants had to understand not only what the study was about, but that participation in the study was voluntary and that they could discontinue and withdraw at any time. Participants were assured that their identity and views would remain confidential; that their responses would only be used for the purpose of this study under pseudonyms when necessary.

Limitations of the study

The language used in the focus groups was a primary limitation to the study; participants used English, which is their second language, as the language of discussion. The researcher translated some of the key questions from the focus group guide; the participants were unable to understand terminologies such as '*vulnerability*' and '*reception*'. So the researcher conducted the focus group discussions both in IsiZulu and English. There was a level of meaning that was lost in translation, during the transcribing period. Some expressions that were used by participants in IsiZulu could not be directly translated into English.

Secondly, the focus group discussions were conducted in Umnini; the researcher was not allowed to conduct focus group discussions outside the school premises and during school

hours. Therefore, time was a limitation; it did not allow the researcher to probe for deeper insights on the personal experiences of the young girls.

Conclusion

In conclusion, this chapter highlights the qualitative approach the study took and the qualitative methods used to collect data. The data collected through the FGD's and interviews was used to compare and contrast the successes and failures of the ZAZI campaign in bringing about knowledge that could lead to behaviour change communication.

Chapter five: Research Findings and Analysis

Introduction

Bogdan and Biklen (2003), describe the research findings and analysis chapter as one that includes, working with data, organising it, breaking it into adaptable components, synthesizing it, finding patterns, discovering what is important and what is to be learned, and deciding what you will tell others. The aim of this chapter is to present the findings of young women learners' perceptions and reception of the ZAZI: Know Your Strength (ZAZI) Campaign. Described in chapter four, the main focus of this study within the ZAZI campaign is contraceptive use in correlation to unplanned pregnancies. The findings are presented using a thematic analysis (TA). "TA is essentially a method for identifying and analysing and reporting patterns in qualitative data" (Clarke and Braun, 2013: 6). Furthermore it is a designed to organise and explain data in rich detail. TA also often goes further than this, and interprets various aspects of the research topic (Clarke and Braun, 2013).

This chapter presents findings from community dialogues that were conducted prior to the formulation of the ZAZI campaign. This was a means of understanding the condition and women's notions about contraceptive use; unplanned pregnancy in KwaZulu-Natal (KZN), where high rates of teenage pregnancy are mostly concentrated. The dialogues will be presented as preliminary data for this study. This will enable the researcher to realize similarities and differences of young women's voices towards contraceptive use in line with the findings from the focus group discussions conducted with young women learners who are part of the ZAZI peer groups in Umnini rural of KZN.

This chapter will further present findings from semi-structured interviews that were conducted with educators whom were coordinating the peer groups in each school. This chapter further explores the perceptions of young women learners' towards the ZAZI campaign. The researcher closely looks at the audience's' general understanding of the campaign and how effective it has been with regards to contraceptive use and unplanned pregnancy. The researcher also explores which mode of media communication was perceived to have communicated the ZAZI message well. Due to the relationship between methods that prevent HIV, STI's and pregnancy, this chapter will present briefly some of the key findings from the community dialogues and from the focus groups conducted with ZAZI peer groups. This is to show the risk perception levels that young women have toward HIV infection.

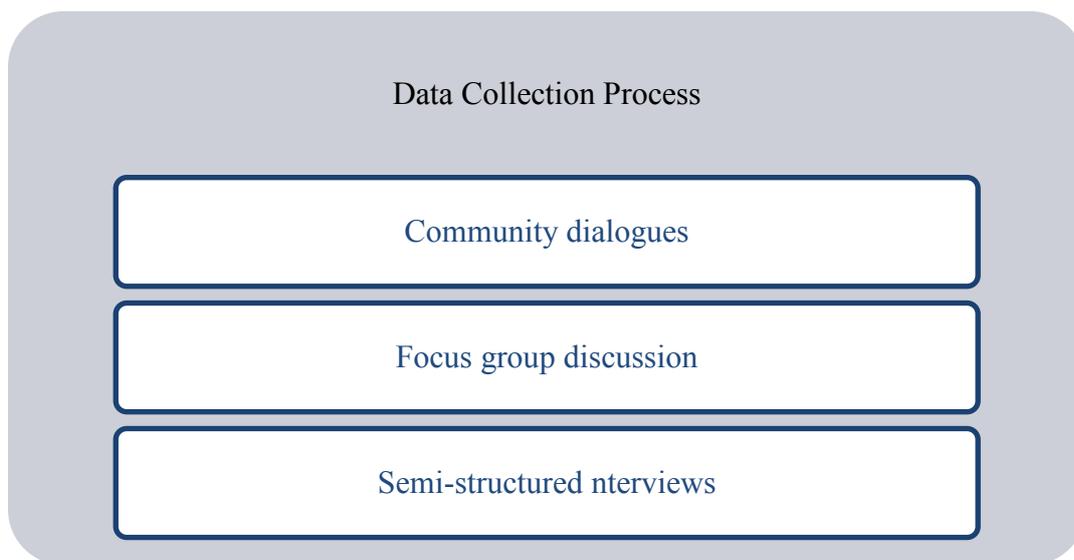


Figure 5.1 Data Collection Process of the study

This chapter aims to present findings that will address the following research questions:

1. What are young women learners' perceptions of the ZAZI campaign
 - What do they understand the campaign to be about?
2. What are the young women learners' perceptions about contraceptive use as preventative method for HIV and AIDS?
 - What are their views on contraception?
3. How has the reception of the ZAZI campaign contributed to the contraceptive knowledge and utilisation in correlation to unplanned pregnancy?
 - Has the ZAZI campaign brought about any change around the issues of contraception, unplanned pregnancy and HIV and AIDS?

Background of data collection

The community dialogues were conducted in thirteen districts around KZN with the purpose of listening to the voices of communities on what actions can be taken to improve the health and well-being of all women and girls in KwaZulu-Natal. Using a participatory communication approach the community dialogues were a tool to gain greater insight into the lives of individuals through drawing into the participant's knowledge of peer networks,

family relationships, partner relationships, community relationships and social norms (Delate et al., 2011). The findings from the community dialogues were to assist with the development of a provincial advocacy, communication and social mobilization strategy that responds to key issues identified by communities. These are the findings that led to the development of ZAZI.

The focus groups discussions were conducted at three different high schools within Umnini. Umnini was chosen because rural areas in KwaZulu-Natal are considered to have high rates of HIV infection; and unplanned pregnancies. The main purpose of the focus groups discussions was to explore how the reception of the ZAZI campaign contributed to the contraceptive knowledge and utilisation among young women. The semi-structured interviews were conducted among the educators that were coordinating the ZAZI peer group programme in each of the schools. The teachers were able to communicate to the researcher the rates of teenage pregnancy within their schools. During the interviews the educators were expressive of their concern toward young women and that when the ZAZI team approached their schools, they were more than happy to give the team permission to teach and conduct workshops with the female learners around issues of contraceptive use, pregnancy and HIV.

Listening to the voices of communities: Community dialogues

This chapter will present the main findings from the community dialogues with regards to the low rates of contraceptive use linked to high rates of unplanned pregnancy. It is significant to note that these findings were reported in relation to the priority areas identified by the stakeholders who were involved comprising of the Department of Health, the Department of Social Development and the United States Agency for International Development (USAID)/President's Emergency Plan For Aids Relief (PEPFAR). Findings include:

- Low rates of contraceptive use amongst women and girls linked to high rates of unplanned pregnancies.
- High rates of HIV infection
- Low levels of exclusive breast-feeding by pregnant women
- Sexual and Gender Based Violence
- High levels of smoking and alcohol consumption even during pregnancy,
- Late detection of breast and cervical cancer (Delate et al., 2011).

These are the key findings that encouraged the development of a national campaign focusing on women and girls, ZAZI. For the purposes of this study, as stated in previous chapters; the researcher explores the low rates of contraceptive use among young women and linked to high rates of unplanned pregnancies, also the high rates of HIV infection is a key finding that will be explored in this study. Therefore, this chapter will begin with presenting the findings from the community dialogues, showing what participants within the different communities consider to be the cause for the low rates of contraceptive use and for the high rates of HIV infection. This study presents the community dialogues as preliminary findings; the relevance of these findings is that they provide a foundational understanding of how the ZAZI campaign was developed, which in turn will aid the understanding why the campaign advocates for young women to “know their strength”.

Some of the key issues that emerged from the community dialogues were: knowledge and experiences in using contraceptives; illegal termination of pregnancy; negative attitudes of health care workers; multiple sexual partners and condom use. These themes are presented according to the key findings of what has caused the low rates of contraceptive use and the high rates of HIV infection among young women. The mentioned themes around the low rates of contraceptive use and the high rate of HIV infection were identified by the recurring responses of the participants from the different districts; participants shared similar experiences and expressed similar concerns.

The researcher highlighted that the community dialogues are preliminary data for this study. They were undertaken in order to gain the perspectives of individuals in the different communities on the issues and barriers to women’s health. These dialogues involved participants drawn from as many parts of the community as possible to exchange information, share personal stories and experiences, perspectives, clarify viewpoints, and develop solutions to community concerns about women’s health (Delate et al., 2011). The main purpose was generating deeper understanding of the nature of the HIV epidemic and high levels of teenage pregnancy among young women and communities in order to influence change.

Women’s knowledge and experiences in using Contraceptives

Studies show that “65% of sexually active women use contraception, and that women have good knowledge about condoms and the injection, but many women do not know about other

methods of preventing pregnancy” (Pleaner, 2013:45). Some women who use contraception do not do so regularly, or as instructed by the health care provider; and fall pregnant without intending to (Pleaner, 2013). Within relationships in these communities the use of contraceptives is often tied to notions of love and faithfulness that may hamper the uptake of contraceptives even where women wish to do so (Delate et al., 2011).

They see us as unfaithful if we use contraceptives, they see us having secret lovers
(Participant from, Amahlongwa: 22 November 2011)

A number of accounts were given of the potential side-effects of contraceptives that inhibit their uptake by women as these may not meet the satisfaction of their male partners. Some of the accounts were that contraceptives make women too wet during sex, make them put on weight, change their body shape or result in a loss of appetite. There is also a belief that women will not be able to fall pregnant at all or for the same period as when they were using contraceptives (Delate et al., 2011).

Although contraceptive use is said to be done by couples together, where women and men talk openly with their partners about their wish to have children or wish to delay or prevent having children, (Pleaner, 2013). However, women continue to face contraceptive use and choices alone, without the sexual partners. Ouzgane and Morrell (2005) attribute this to the existing patriarchal divide, with men having power over women. Partner communication influences contraceptive decisions (Davies et al., 2006).

Contraceptives make a body bubbly and private parts watery and our boyfriends do not like us to be like that. (Participants, Amahlongwa: 22 November 2011).

If I do use the injection I will get fat and the risk of blood pressure is higher.
(Participant from, KwaXimba: 16 November 2011)

It's very humiliating when men say we're wet and watery, that's why we don't use pills and injections.

(Participant from, KwaXimba: 16 November 2011)

In a community dialogue at KwaXimba, male participants reported that they could tell which women were using contraceptives through their “loose bodies” and “popping veins down their legs” (Delate et al., 2011). They were also of the opinion that women who use contraceptives were less attractive. In some instances the use of contraceptives by women

may result in physical violence and an ending of the relationship by their sexual partners (Delate et al., 2011).

If they see their girlfriends visiting family planning clinic, they beat them up and dump them and then call them names.

(Participant from, Umbumbulu: 15 November 2011)

Within these communities, it was evident that some of the community members were still unaware of the different contraceptive methods available to them. They did not know what certain tools were and what they were for.

There is little awareness about emergency contraceptives within the participating communities. In the dialogues where issues relating to emergency contraceptives were discussed, the issue was raised by the facilitators, and participants asked "What is that for? Where you get it? Because it's the first time I hear about it.

(Participant from, Mandeni: 25 November 2011)

The above statement reveals that there are still many communities that are not exposed to the many available contraceptive methods, where women are unaware of the different contraceptive methods available to them. Similarly a study conducted by Naidoo et al. (2013), looking at the emergency contraception as preventative method found that in rural areas, the level of awareness was low. Only 17% of women were aware of the method, compared to the 35% in urban areas (Naidoo et al., 2013). Therefore, although progress has been made over the years, there remains a need for health interventions and researchers need to bridge the gap of contraceptive knowledge and use among women in rural areas.

These comments also suggest that perceptions about side-effects of contraceptives are responsible for most of the negative beliefs with regards to contraception. Similarly, a study conducted by Ndwamato and Ogunbanjo (2009) indicated that women complained of multiple side-effects such as the enlargement of the vagina, itchy watery vaginal discharge and weight gain. Therefore, although contraceptive knowledge is low, the percentage of women who have contraceptive knowledge have suspended its use due to the side effects.

Health care workers: The cause for illegal termination of pregnancy

Despite the termination of pregnancy being legal in South Africa, many young women continue to resort to backstreet or self-induced termination of pregnancies owing to the lack of support from male partners, fear of reactions from parents (including being kicked out of the house) and the community at large (Delate et al., 2011).

Young women revert to backstreet or self-induced abortions as they fear the attitudes of health care workers or those health care workers will reveal their pregnancy and decision to their parents as many health care workers are from their local communities. Using backstreet abortions ensures confidentiality as the person performing the procedure or providing assistance is committing a criminal act and will therefore not reveal the pregnancy status to any other person (Delate et al., 2011).

There is a high rate of backstreet abortion here. Our boyfriends do not want us to use contraceptives, if we do they beat us up, what's disturbing is that they even refuse to use condoms and when we get pregnant we go for backstreet abortion because we cannot afford to be seen by the nurses.

(Participant from, Umbumbulu: 15 November 2011)

Findings show that across the districts, the same cocktails being used by young women for self-induced termination of pregnancies were mentioned. These are self-made concoctions that are not medically proved for both the health of the females and that of the unborn baby. These were:

"You need bleach, manganese, staminate, and coke to facilitate backstreet abortion."

(Participant from, Amahlongwa: 22 November 2011)

Disinfectants, gobho (traditional muti), stameta (some muti sold in traditional pharmacies); chrystal potassium, permanganate, aspirin added to coca-cola which is boiled.

(Participant from, Mandeni: 25 November 2011)

Abortion in this area is done through coke, bleach, stameta and manyazini.

(Participant from, Bulwer: 17 November 2011)

Another girl aged 16 year of age, she drank mentholated spirits when she found that she is pregnant and positive. The child did not die but the girl died.

(Participant from, Umbumbulu: 15 November 2011)

The Human Sciences Research Council (HSRC) summary of teenage pregnancy in South Africa with specific focus on school-going learners identified that despite the legalisation of abortion in South Africa, few teenagers report using legal services for termination of pregnancy in both qualitative and quantitative (3%) data (Shisana et al., 2008). The failure to use legal services is related to the stigma of pregnancy and abortion generated in the community and replicated within the health system by health care workers. The report also highlighted that there was a lack of knowledge about the cost of legal termination and the stage of gestation at which legal termination can take place.

Negative attitudes of health care workers as barriers to contraceptive use

The negative attitudes of health care workers towards clients of all ages who are seeking family planning, contributes to women and girls lacking information about the various methods of family planning. This hampers the ability of clients to make informed decisions about which family planning methods would work best for them in the context of their relationship (Delate et al., 2011).

The negative attitude of health care workers serves as a barrier for women who wish to access family planning services. This includes health care workers chasing clients away from the clinic or refusing to provide them with contraceptives this can result in unwanted pregnancies and that may lead to self-induced attempts at abortion (Delate et al., 2011). Participants from the different districts in KwaZulu-Natal expressed their experiences of the health care workers:

The health care workers treat us badly when we got to the clinics. So we don't go back. They ask us why we want to use contraception, and sometimes they refuse to give us contraceptives because we are too young and they threaten to tell ourprents

(Participant from KwaXimba: 16 November 2011)

Nurses refuse to put us on injections and stuff so that we can prevent pregnancy.
(Participant from, Mandeni: 25 November 2011)

We as a youth face challenges if we want to access health facilities. We get judged by the nurses; tell us that we are too young to be using stuff like morning after pills and stuff. You find that some nurses know our parents and they say I will tell your parents that you are starting to be naughty.

(Participant from, Umbumbulu: 15 November 2011)

The lack of confidentiality by health care workers was a major area of concern for community members. There was a fear within communities that health care workers may disclose sensitive information such as a young women's pregnancy to parents without the consideration of them as clients to the clinic. This is one of the key barriers to young women accessing family planning and antenatal clinic services timeously, meaning that women delay until late in their pregnancy or until they have an unplanned pregnancy to go for any family planning method.

"We drink and get confused": Alcohol as a driver of multiple sexual partners

Multiple sexual partnerships were identified as a key issue across all the community dialogues. Participants reported that they did not trust their partners and suspected that they have other partners at the same time. Even when women find out that their partner has other female partners they are hesitant to end the relationship.

"A friend of mine was in love and living with her boyfriend. The boyfriend had another girlfriend. Every time my friend went to work her boyfriend will bring his girlfriend to the house. This went on for some time. When she went to the clinic she found that she is HIV positive. Her boyfriend did not want to go and test he continued sleeping with my friend. My friend ended up dying and her boyfriend is purposefully spreading the virus everywhere."

(Participant from, Umbumbulu: 15 November 2011)

Multiple sexual partners were strongly linked to alcohol consumption, casual sex and inconsistent condom usage (Delate et al., 2011). Harrison et al., (2008) found that men who are in multiple relationships call the most immediate sexual partner as 'Partner One' and

second partner was referred to as 'Partner Two'. This study revealed that men were much more likely than women to report casual multiple partners, thus placing women at a higher risk of HIV infection. There was increasing alcohol and drug consumption amongst young people, due to alcohol being easily accessible to young people with many shebeens operating within close proximity of schools and being used to encourage young people to drink (Delate et al., 2011).

“We drink alcohol and get confused when drunk. We sleep with different partners. You end up with a lot of partners, and that could cause you to have HIV. (Report back, Nhlazatshe: 23 November 2011)”.

When young people drink, they often do so and get drunk and then have sex with multiple partners. It was reported that teenage girls drink with anybody at taverns as long as they buy them liquor. Apart from the alcohol being the major mechanism that leads young women towards transactional sex; the issue of stability, financial stability for females is another main factor that has led to transactional sex. Findings show that there is an increasing phenomenon of older men, also known as “Sugar Daddies” engaging in transactional sex with younger women for material goods. In this instance older men may provide material goods and money in exchange for sex.

The power dynamics between men and women in relationships with multiple partners may inhibit the right of women to insist on family planning. This is often related to the male-controlled nature of most relationships. These findings validate what Eaton et al. (2003) established in his study; where he challenged the claim that it is in a man's nature to want many partners, and that staying with one woman goes against the essence of being a man (Eaton et al., 2003). Many of the relationships that are intergenerational are often male dominated. Ncube (2012) relates this with the patriarchal nature of African cultures, where most decisions affecting females and their reproductive health are in the hands of males, leading to some women covertly using contraception without the knowledge of their spouses (Ncube, 2012).

Another report back from the Hlomendlini district, within the community of Umbumbulu in KwaZulu-Natal reported that the love of money, hence the dating of older men, leads to

teenage pregnancy in that community. One of the participants expressed her observations of the dynamic of multiple sexual partners within her community.

“Next to my house, a girl 17 years of age fell in love with an old man who was moneyed. One day he took her forcefully to his friends place and said you have been spending my money and you don’t want to sleep with me and he slept with her by force. When she went back home, her mother said she must go to the clinic to check if she is pregnant. She found that she is pregnant, when she told her boyfriend about the pregnancy he said he knows nothing about that pregnancy. This guy had promised to take this girl to school. She aborted the child because she wanted to go to school. She found out that this man is HIV positive and she is also HIV positive”
(Participant from, Umbumbulu: 15 November 2011).

This experience illustrates accurately what Wood and Jewkes (1998) connotes in their findings that, “Teenagers perceived their partners loved them because they gave them gifts of clothing and money” (Wood and Jewkes, 1998: 233). The legitimacy of this experience was reinforced by female peers in a study, who indicated that silence and submission was the appropriate response (Wood and Jewkes, 1998). Young women in particular need to understand the risks of HIV infection in relation to sex with older men in particular, given the increasing levels of HIV amongst men aged 25 and above.

“If I insist on using a condom, then I don’t love him”: Issues of negotiation

The findings revealed that the introduction of condoms into existing relationships is a difficult issue for most women to negotiate, due to the association of condom usage with casual sexual relationships and the lack of trust or love. Where female partners do want to insist on the use of condoms this is often rejected by their male partners who will accuse them of cheating or that they do not love them.

“We don’t use condoms because men refuse them”
(Participant from, Mandeni: 25 November 2011).

Condoms are a waste of time you don’t feel anything

(Participant from, Umbumbulu: 15 November 2011).

This has similar findings to the study conducted by MacPhail and Campbell (2001). The study indicated that there is a high level of knowledge around HIV and pregnancy; however the participants mentioned that condoms are unnecessary in steady relationships, one specifically noting that they would use a condom when there is a risk of pregnancy (MacPhail and Campbell, 2001). Furthermore this study also showed that there is little perception of risk to HIV, despite the high levels of infection. Almost 70% of young women didn't know whether or not they were personally vulnerable, indicating that they didn't connect their own behavior with HIV risk (MacPhail and Campbell, 2001).

The majority of the participants were aware of contraceptive methods that prevent HIV infection, such as the male condom. Nevertheless, the negotiation of condom use was a futile task, because male partners associated condom use with casual relationships that lack 'trust' and 'love'. This notion of love and trust therefore leaves women at risk for HIV infection.

The audience reception of the ZAZI campaign

Struwig and Stead (2013) view focus groups as planned discussions that elicit perspectives on a topic in a non-judgmental way and in an accepting, safe environment. Focus group discussions composed of young women learners were conducted within three high schools in Umnini rural area of KwaZulu-Natal. All of the participants who were part of the discussions have been exposed to the ZAZI-Know Your Strength (ZAZI) campaign for over a year in each school. The participants in each group were representing the population of the school they are part of in its entirety. This is because the researcher was purposively working with only the learners who were part of the ZAZI peer group. The focus groups discussions were a platform for the learners to express their reception and perceptions of ZAZI and the issues of contraceptive use and unplanned pregnancy.

Table 5.1: Location of Focus group discussions (FGD)

Name of School	Focus Group Number	Location
Umcothoyi High School	One	Umnini
Esidelile High School	Two	Umnini
Esizibeni High School	Three	Umnini
Umcothoyi High School	Four	Umnini

All four focus group discussions were conducted within Umnini, as explained in previous chapters, this is the location that the ZAZI campaign was successfully facilitated among young women learners in high schools. The focus group discussions (FGD) are labeled from one to four throughout this chapter. Since the participants requested that their identity not be publicised, they are referred to by number, e.g., Participant A: FGD 1 stands for participant A. in focus group 1.

“The TV advert takes us from the beginning”: TV advert as a Preferred Media of ZAZI

The ZAZI campaign was formulated with a mass media strategy which included television adverts, radio adverts and billboards and coupled with the community mobilization which is about reaching young women face to face or in groups. These two elements of the campaign complement each other, the audience engages the campaign at the mass media level, but then it is given more identity when people are engaging with it at the community level through their lived experiences. The ZAZI campaign engaged audiences about issues of contraception and unplanned pregnancy using many modes of media communication.

Participants were asked to indicate which mode of media communication they liked most and which one they thought communicated the ZAZI message well. Majority of the participants throughout the focus groups indicated that the television advert was the one that communicated the ZAZI message well in comparison to the other media communication. Participants shared that they liked the television advert the most, and that it communicated the ZAZI message to them.

Participant A, FGD 1: *TV advert because it shows confident young woman taking steps to protecting themselves, without fear of going to the clinic for medical help and contraception. That teaches us that we should go to the clinic and get help.*

Participant B, FGD 1: *The part where the girl comes from the doctor and bumps into that woman, the GOGO. The TV advert also shows other grown-ups not to look down on children, even when they make a mistake...that they should not look down on children, even when they make a mistake...that they should encourage young women, because they learn from their mistakes...*

Participant C: *I think the whole TV advert speaks of ZAZI like the whole campaign, it takes us from the beginning when the girl enters the clinic, you can see that she is not as confident when she enters, but when she gets spotted by the GOGO, you can see that fear like when you get caught with your hands in the cookie jar, we can all relate to it because we as young people we fear what the elders will say about our actions so there is that fear...which is clearly shown in the advert.....and then when the GOGO wraps her scarf around the girl, it shows that maybe in the near future our parents will also get to our level of understanding, the things that we go through and also understand that times have changed. So that's what I think...*

This participant was aware of the concept behind the television advert that conveys the ZAZI message. The participant highlights the different meanings of each scene within the advert. It was evident that the participant was aware of what ZAZI was about and what it aimed to do. The participant was able to interpret hidden connotations from the facial expressions of the young girl in the television advert; that when she walked into the clinic, she was not confident, and was fearful of the GOGO (Grandmother).

These were some of the issues that are addressed in the second chapter of this study, around that factors that influenced teenage pregnancy, self-esteem and the lack of confidence was one of the main contributing factors. This participant indicated that she shared the young girls fear towards the elderly woman at the clinic; due to the general fear young people have towards their elders. Participants could relate to the fear of the young woman in the TV advert, and were encouraged by the confidence she showed by having the courage to go to

the clinic and face health care workers. Participants expressed that the television advert was one which depicted the notion of knowing yourself and your worth as a young woman.

Audiences as creators of 'Meaning': interpretations of ZAZI

Throughout the focus groups, participants recognised ZAZI as a campaign that taught the importance for a young woman to know what she wants out of life, how to be responsible about the future. Some of the young women went outside what the researcher had expected, and drew from their own life stories on how the campaign impacted them. The Culture-Centered Approach advocates this notion, where platforms are created for marginalized individuals to share their stories on health related issues (Dutta, 2008). The CCA encourages the researcher to engage in dialogue they gain a sense of understanding on individuals health meanings are constructed (Dutta, 2008). In keeping with the research objectives, the researcher sought to understand participants' reception of the ZAZI campaign. When participants were asked if the campaign has brought about any possible behavior change in their individual lives, they all responded positively.

What was a common response throughout the focus group discussions was that the campaign taught participants about contraception, the various methods available, how to use it, when to use it and why. Secondly, self-esteem was highlighted also as one of the major things that the campaign had intended to do that participants indicated that they learnt through ZAZI. Participants communicated that ZAZI taught them independence, that it taught them how to take care of themselves, and to become confident. These are all the key concepts that embody a 'ZAZI-woman' who knows her strength and self-worth.

Participant A, FGD 2: Yes, the campaign taught me what contraceptives I must use and to know how I can get infected with STI'S and how to prevent pregnancy if I didn't use a condom during sex, I can take a pill.

This comment illustrates the increased awareness and knowledge the participant received from the ZAZI campaign with regards to the different contraceptive methods.

Participant B, FGD 1: It has taught me to be independent!

Participant C, FGD: 3: *I can honestly say, yes there has been change in my life because I do not succumb to peer pressure.*

Participant D, FGD 2: *It taught me that to express myself, to love myself and to encourage others not to have sex at a young age because they will get pregnant.*

Participant E, FGD 1: *For me, by the time I was exposed to the ZAZI campaign, I already had a child, due to me not using a condom. But ZAZI encouraged me to go and get tested with my partner, so we both know our status...I was happy about that. I now realise the risk of unprotected sex, and I will never do it again until I am married.*

This participant stated that she did not allow her having a child to delay her from going back to school. She continued her schooling and now is ready to go to university. These positive characteristics within discourses of teenage motherhood seem absent in existing mainstream literature (Harrison et al., 2008; Trent and Crowder, 1997). Many mainstream studies associate teenage pregnancy with high unemployment rates, poor socio-economic status and high drop-out rates at schools (Chohan and Langa, 2011). Conversely, Macleod and Durrheim (2002) and Panday et al. (2009) argue that many of these studies fail to consider how socio-political, and structural factors in the capitalist labour market contribute to poor employment rates and simply attribute all social ills to teenage pregnancy (Chohan and Langa, 2011).

The researcher became conscious that within the focus groups, there were participants who were unable to speak from their own experience because they had not had their first sexual encounters. It was interesting to observe, that although they did not have firsthand experience to sexual encounters with men or experience what it is like to negotiate contraceptive use within a relationship, they received the ZAZI campaign as a warning sign; warning them of the dangers ahead of them if they do not become 'ZAZI-women'. This suggests that the introduction of the ZAZI campaign within Senior Secondary Schools is important because it can guide young girls to make safe and informative sexual decisions.

Participant F, FGD 1: *Yes it has, I now know that when I start being involved in sex, I know how to protect myself, I know how to respond to the lies that boys tell us.*

Participant G FGD 1: *I have learnt a lot of things, things I would have never imagined I would learn when I started this campaign...because I was not interested at first, but as the programs continued I learnt a lot of things. What I love about ZAZI is that women are taught to stand up themselves. Before things are about sex, it starts at the relationship level first, when you are in a relationship with a boy, [...] know what you want from the relationship and before you begin, your partner needs to know also what you want. “I love you, you love me, we are not going to have sex unless we have dated for 5 years...If we’re going to have sex, then you must marry me...I won’t have children unless we are married. So ZAZI taught me that before entering into a relationship, there are some boundaries that I need to set...It has taught me to be independent.*

This comment gives an overall understanding of the participants experience with ZAZI. The participant raises the issue of confidence and self-esteem, and how the ZAZI campaign has taught her to enter into a relationship knowing what she wants as an individual. According to the three theoretical stances of encoding/decoding, the data reveals that the audiences held a preferred meaning of ZAZI (Hall, 1996). The encoded message of ZAZI includes teaching young women to know about the different contraceptive methods so that that they are protected from unplanned pregnancy and HIV infection.

Findings from the semi-structured interviews maintain that the ZAZI campaign has helped create awareness around their schools. They acknowledge that the ZAZI campaign has aided the decrease in teenage pregnancy within their schools.

“The ZAZI campaign has helped a lot because we used to have a high rate of pregnancy, but it is now decreasing” (Educator from Esizibeni, May 2015).

“We have achieved quite a lot, we had a high rate of teenage pregnancy and with that, and we are living in a community where poverty and HIV are very high, and so we wanted to find a solution” (Educator from Mcothoyi, July 2015).

“Those who are involved in this campaign, I can say they are conscious, they know things. Even if they may engage in ‘things’, they are aware of those consequences” (Educator from Esidelile, May 2015).

The above comments speak to the dominant-hegemonic position of the encoding/decoding model, where the audience decodes the message in terms of the codes legitimated by the encoding process and the dominant cultural order (Hall, 1996). The educator’s comments indicate that the educators decoded the ZAZI message from a dominant position. They report that the ZAZI message has made learners more aware of the kinds of behaviours they should engage in and those that they need to avoid, such as being in a sexual relationship with older men for money.

The issue of confidence and knowing who one is as women, before entering into a relationship, was one of the key aims of ZAZI. Participants throughout the focus group discussions and semi-structured interviews expressed how the ZAZI campaign brought about knowledge with regards to the many contraceptive methods available to prevent pregnancy. The researcher observed in one of the focus group discussions that the participants did not have prior knowledge of any of the contraceptive tools apart from the male and female condom.

It was the exposure to the ZAZI campaign that heightened their knowledge. In chapter one of this study, one of the main research questions was addressing whether the reception of ZAZI has had any influence on contraceptive utilisation in correlation to unplanned pregnancy. The aim of the question was to understand the contribution made by ZAZI with regards to any possible behaviour changes around contraceptive utilisation.

It was evident from the responses of the participants on how the campaign affected their behavior is the issue of awareness. The researchers observed that majority of the participants are or have been in sexual relationships and that the ZAZI campaign brought about awareness of the different contraceptive methods and their advantages and disadvantages. However, participants did not indicate that there has been any behaviour change within sexual relationships; there was no confirmation from participants of whether they were able to practice any of what they learnt from ZAZI or if it brought about change in participants’ risky behaviour towards contraceptive use.

When participants responded to women's' vulnerability to HIV infection and unplanned pregnancy, participants indicated that it was because of the fear women hold towards their male partners and how women cannot say no when negotiating safer sexual practices. Therefore, the researcher observed throughout the focus group discussions, that the reception of ZAZI message among learners reached the level of awareness and knowledge among participants that did not translate to utilisation. Participants that revealed their experience of being teenage mothers due to unsafe sexual practices; they further indicated that the campaign enhanced their level of understanding and awareness of the various contraceptive methods and that they are better equipped to say no to sexual coercion from their male partners. These findings could also be influenced by the few participants who had not yet been exposed to sexual relationships. These participants spoke of being better equipped for future experiences.

The power of participatory methodology in campaign name development

During focus group discussions, participants openly expressed their general understanding of ZAZI and what they understood about the message communicated by the campaign in their personal lives. It was interesting to note that participants from all the focus groups responded positively towards the campaign. It was evident that participants were familiar with the message that ZAZI aimed to communicate because of how participants interpreted the campaign individually.

The researcher observed during the focus group discussions that interpretations of the campaign varied. Stuart Hall refers to three theoretical stances that can be taken by the audience to read a message; the dominant/ hegemonic stance, the negotiated and the oppositional stance; this is described in the theoretical framework of this study (Hall, 1996). According to the theoretical stances proposed by Hall (1996), the participants interpreted the ZAZI campaign within the dominant stance and the negotiated. However, most participants decoded the ZAZI message with the *dominant/hegemonic* stance (Hall, 1996).

Participant A, FGD 4: *The word ZAZI gives one that knowledge of knowing who they are. The way they named it was complete! It is a small word, but it says it all because you can't make someone happy if you are not happy. You have to know*

what you want in life first. It showed us, women, that you don't have to always make a man happy when you are not happy, know yourself first and then you can be with a man

Participant B, FGD 3: It is a campaign that lets everyone know about contraceptives and how they are meant to be used and if you made a mistake what can you do?

Participant B, FGD 1: It teaches us a lot about us women and how we should understand our power and protect ourselves when we engage in sexual activities...how I need to use condoms and other contraceptives-doubling up for protection.

Participant C, FGD 1: I believe the campaign is about teaching women to know themselves, their bodies and know the things that will benefit you and those that will destroy you...

Participant D, FGD 2: I think that the name of the campaign is self-explanatory "ZAZI"! So whether you are male or female you need to know yourself and try not to do things where you end up not knowing who you are.

Overall the above statements suggest that participants interpreted the of ZAZI message exactly as intended by the ZAZI campaign developers. This resonates with the *dominant/hegemonic* stance of encoding/decoding.

Negative perceptions of ZAZI

The SEMCHB states that an individual's health choices are influenced by four interacting levels which include social networks (Kincaid et al., 2007). Social networks refer to the spheres in an individual's life where their choices about health behaviour are influenced by family friends and peers. However, after scrutinizing the data from the focus group discussions, it is evident that social networks have a limited influence of one's health choices.

During the focus groups discussions, participants highlighted some of the challenges they experienced as peer educators within the context of the schools. Participants expressed how in their schools they attempted going around classes to make other learners aware of the ZAZI message, but they failed to do this.

Participant A, FGD 1: *“Last time I had a problem, a friend of mine comes to me (She stays in Durban), she tells me her story of how she almost slept with a boy, this way that way...I then told her that she should use contraception and things like that...I was very disappointed by the way she responded...she was like “You have slept with a boy and now you don’t want me to experience...you want to enjoy things on your own? I was like yho!”*

This participant expresses her disappointment in trying to educate one her peers in using contraceptives as a preventative method to possible unplanned pregnancy and making safe sexual choices. The educator from Esidelile High School confirmed this to be true during the interview discussion, saying:

“I was listening to learners from the peer groups who came to my class to teach learners about the male and female condom, the way they reacted, talking, laughing as if they already knew what they were talking about. The peer educators end up trying to pull back because they will seem like people who ‘like things’, talking about the male and female condoms”. (20 May, 2015)

Contrary to the SEMCHB, the influence of peers on individual decision making about safer sexual choices does not always yield to behaviour change.

Teenage pregnancy and the high HIV rates among young women

It was interesting to note that when the researcher asked questions about HIV infection rates among young women, there was a shared perspective from the participants. During the focus group discussions, participants correlated the high rates of HIV infection among young women to transactional sex. Similarly, when the discussion about the high rates of unplanned pregnancy among young women was discussed, participants correlated the unplanned pregnancies with the process of exchanging sex for material possessions.

Participant A, FGD 3: *I think it is because we want things we cannot afford and the families we come from are not able to provide us with all the things that we want. We resolve that the easiest way to get those things is to get into relationships with people who have money.*

Participant C FGD, 4: *Once someone does a lot for you we reward them with sex.*

Participant B FGD, 3: *It's like when you meet a random guy and they ask you out, they buy you a dress and you will repay them by having sex with them but you don't know that they have HIV.*

Participant D FGD, 4: *Another thing is that we are deeply dependent on men, so if he wants sex, you are going to say yes.*

The statements above encapsulate the reality that sex for some young women has become a transaction. Several studies also confirm this, Selikow et al., (2002) state how the youth in South Africa have adopted the consumerist culture. The culture of consumerism has led young women to enter relationships where they exchange sex for material possessions. There is pressure to meet a certain standard of dressing, a standard of having belongings in order to fit in with other individuals and be associated with a particular culture.

Participant A, FGD 1: *The environment where people live also plays a role, in some instances the people are living in poverty, hence girls end up dating older men for financial support ... the men sometimes have HIV and the girl gets infected that way.*

Previous literature confirms the above statement. The environment of an individual provides a sense of self, identity, and belonging (Basso and Selby, 1976). Airhihenbuwa and Webster (2004) also state that the behaviour of an individual in relation to family and community is one major cultural factor that has implications for sexual behaviour and HIV and AIDS prevention and control efforts.

In summary, data concerning teenage pregnancy and high HIV rates among young women frames the issues that the ZAZI campaign addresses. Fundamental to ZAZI is the advocacy of women empowerment; particularly young women. The campaign acknowledges that young women specifically are disproportionately vulnerable to HIV infection.

Young Women's' vulnerability to HIV infection

Studies have indicated that socio-economic factors have a significant impact in the high rates of HIV infection among young women. During the focus group discussions, young female learners were asked whether women are in control of protecting themselves against HIV infection, the general response from the majority of the focus group discussions was 'yes', young women do have control.

Participants indicated that women have sufficient tools to protect them against HIV infection, referring to the many available contraceptive methods. The researcher seeks to understand whether women have the ability to negotiate condom use or any other form of contraceptive with their partners and whether or not they are able to suggest possible preventative methods to their partners. During the focus group discussions there are participants who pointed out that women have control over protecting themselves against HIV infection, however, they have no ability to negotiate with male partners. What was interesting is that although all of these methods are available for women to protect themselves, much of the power to do so is in the hands of their male sexual partners.

Participant A, FGD 1: Girls fear that boys respond by saying that you don't trust him, you think he is HIV positive or maybe you suggesting that he is sleeping with other girls....he gets angry and girls don't like it when their boyfriend is angry with them....

Participant B, FGD 4: No, they don't know their rights; women need to put themselves first. We have always thought that in a relationship we need to please the guys and not take care of ourselves. So, women don't have control of protecting themselves.

The second statement was made by a participant who was conflicted by the thought of girls and young women not knowing their rights and are not able to stand up for themselves in sexual relationships. The participant was opposing the notion of women who are in sexual relationships only to please men, completely neglecting their role in the relationship. The participant expressed that women do not have control within sexual relationships due to the lack of negotiation for safer sexual practices.

The element of fear also has a crucial factor in the amount of power that women hand over to their male partners. The first statement specifies that girls are afraid that their boyfriends will think that they do not trust them if a suggestion to protect themselves by using a condom or enquire about their HIV status is made. The participants indicate that the boyfriends get angry at them and girls don't like it when their boyfriend is angry with them. This statement further indicates the power that women place on men even on matters that could directly place their health at risk, for example, contracting HIV, or other types of STI's and increasing the chance of an unplanned pregnancy.

Learners' Perceptions towards teenage pregnancy

The discussion surrounding perceptions towards teenage pregnancy was dominated by negative responses from the participants. Participants articulated teenage pregnancy as being a 'problem', 'embarrassing', 'wrong' and culturally unacceptable.

Participant B, FGD 1: It is a problem that should be dealt with; it becomes a big problem for your parents because when you have a child while you're still a child yourself, you're not working and also the person who made you pregnant is still in school, how will you take care of that child? Then the burden falls on your parents...

Participant A, FGD 1: "It is embarrassing! For instance if you're living in a community ...like for example; I live close to a school. Learners get pregnant, and all of a sudden all the girls who attend that school get labeled or it almost becomes expected that if you go to that school you will get pregnant, 'it's just a matter of time'. It is really embarrassing".

Participant A, FGD 2: *I think it is wrong because the youth are not being cautious because while you are studying you have no source of income that will help you take care of your baby. I think it is better if one waits until their older and has a job so they are able to take care of the baby rather than getting pregnant while you are still in school! Where will you get the money to feed the child?*

The explanation for the negative responses concerning teenage pregnancy is a result of the undesirable consequences of teenage pregnancy such as dropping out of school. Perhaps, education is the area in which a sense of mastery and agency are promoted among teenage girls. Morrell et al. (2012), postulate that females who have children young limit their life prospects, particularly in terms of education and employment opportunities.

“We need more clinics”: *Inaccessibility to contraceptives*

The lack of health care facilities was raised as one of the main issues that also contributed to the lack of contraceptive use among young women. Participants voiced that there were not sufficient access points for them to gain access to contraceptives. During the focus group discussions participants expressed that there were clinics that were available in other areas; however it was a distance for them to travel.

Participants expressed that there should be access points that are closer to them, for example, having one within the school where it would reach more learners. This indicated that young women felt that facilities specifically allotted to them would be advantageous as it would facilitate access to contraceptives.

Participant A, FGD 2: *“There is one clinic, when we go there it gets really full. It is overpopulated by adults and the elderly people.*

Participant B, FGD 3: *There are two clinics here, but it is not easy to go, there should be one within the school for us.*

Participant C: FGD 4 *We do have clinics, but they are apart from each other; maybe if we had clinics where it is close to the people and has friendlier people*

It is clear from the above statements that the lack of clinics in Umnini is a previewed barrier for the participants to receive contraceptives. According to Champion and Skinner (2008), perceived barriers refer to negative associations that inhibit an individual from adopting recommended health behaviour. Furthermore, in relation to the CCA clinics can be seen as structures that can encourage or limit certain health behaviours. In the focus group discussions it became evident that participants viewed clinics as structures that encourage contraceptive use; however the lack of access points was a perceived barrier.

Central to this study is the reception of the ZAZI campaign by young women learners around issues of contraceptive use in correlation to unplanned pregnancy. The findings reveal that even if there is a positive reception to the ZAZI campaign, there are structural barriers such as the lack of clinics that may inhibit young women from adopting the ZAZI message about contraceptive use.

The participants acknowledged the already existing access points for contraceptives. However there was a greater need for more. Participants indicated that the facilities were mostly not within their locality and had to travel distances. This affected their contraceptive usage and consistency for those who have been previously exposed to some method of contraception. The expressions that participants gave during the focus group discussions indicated that the thought of traveling distance for a clinic with the probability of not being helped was a major discouragement towards contraceptive use.

The bridge between contraceptive knowledge and health care workers

The attitudes of health care workers were highlighted by participants as being the major cause for the lack of contraceptive use. Participants expressed strongly that there is no lack of knowledge among them about contraceptives but rather that health care workers were a major hindrance to their contraceptive use.

The researcher observed that the issue of health care worker attitudes was a limitation for the young women to use contraceptives. The participants expressed that the negative treatment

that they received when visiting their local clinics discouraged them from going back, leaving them without access to contraceptive methods. Previous studies support this notion that health care workers sometimes deny service users access to contraception, particularly young women (Campbell et al., 2006).

Participant A, FGD3: *I don't think it is the lack of knowledge of contraceptives, I think the problem is the clinics where one gets the contraceptives from. For instance, if a pupil goes to the clinic to ask for the contraceptives, obviously the nurses will judge her. And another time, I went to the clinic, I overheard a nurse talking about a young girl who had come to get contraceptives.*

Participant B, FGD 2: *When you go to the clinic and ask for help, the nurse will ask questions and be rude and so you will tell others about her.*

Participant C, FGD 1: *The nurses judge you or shout at you as a young person seeking preventative contraception. They ask you 'why do you want to prevent while you're so young'? 'Can you not wait till you older'? Most of the nurses who work at the clinic are from our neighborhood and they know us. So when we they see you coming for contraception at the clinic, they then come and tell your mother later that their child is having sex. So In the clinic there is no confidentiality between nurses and patients.*

Participants expressed the challenging encounters they had with health care workers each time they made an effort to go the clinic for contraceptives. What the researcher drew from participants responses is that a single negative encounter and individual had with the health care workers also has the potential to discourage other young people. This was not directly spoken by the participants, but it was symptomatic of the social belief and cultures that grew among young women in the school.

Mkhwanazi (2010) reveals findings similar to the one's presented above, that teenagers were aware of contraceptives and knew that these could be used to prevent pregnancy, but complained that nurses were rude to them that they were too young to be sexually active. Overall, attitudes of health care workers towards contraceptive use among young women learners

The Male versus the Female condom: a preferred contraceptive method

Overall, participants indicated that there was a need for a more suitable, easy to access and also less complicated method that women should use to protect themselves against HIV. The participants indicated that there are not enough contraceptives that were specifically made for women for protection against HIV infection. They strongly felt that the tools that are currently available were not sufficient and that they were the cause of the still growing HIV rates.

Participants A, FGD 1: I think there aren't enough contraceptives, because if we had enough then we would have less pregnancies, so from the contraceptives that is available, women are not comfortable with them. The female condom is lot of work, so if there could be something else that would protect us from pregnancy and STI's at the same time, something that is more comfortable for women...maybe it could be better or easier for women.

This comment illustrates that there is an awareness of the different types of contraceptives available including the female condom. However the female condom is highlighted as a struggle to use and the participant suggests that there should be an easier method that could protect women from pregnancy and STI's, including HIV.

Participant B FGD, 2: No they struggle to use the current available resources such as the female condom, new ones need to be introduced because as it is, there are a lot of people being infected with HIV which is an indication that the resources that are currently available are not enough to prevent HIV, new ones are needed.

This participant highlights that the current HIV prevention methods are not sufficient. The participants concluded that new methods should be devised. Another participant expressed similar concerns.

Participant C, FGD 4: *It is not enough; there is a time frame in which you have to use the female condom after putting it on but with the male condom you can wear it now and use it now.*

Participant D, FGD 1: *Mhhhh...err...maybe the health department could provide a different type of contraception one that is more suitable for women, so that when the guy refuses to use protection then the girl knows that she is protected.*

Participant F, FGD 2: *There are not many resources available that prevent HIV; most of the ones available are to protect pregnancy*

This illustrates the importance of stakeholder involvement in finding a contraceptive that is more suitable for women. Participants emphasised the need for women to have alternative methods of protection in situations where a male partner refuses to use protection.

Participant E, FGD 4: *The female condom came at a later stage and people are afraid that it will get stuck forever etc. So that is the problem*

This comment expresses the fear the participant has towards the use of the female condom; and that the female condom was introduced at a later stage when many people were already familiar with the male condom. This comment speaks to a larger issue of adherence to new preventative methods, due to the familiarity of older methods.

Participants expressed limitations of the female condom. This influenced the preference that women show to the male condom as being the better method that is equipped to protect women from HIV infection. Jill Schwartz et al. (2008) postulate that despite the global need for preventative contraceptive methods specific to women, there has been poor sustained utilisation of current methods such as the female condom and the potential impact of it as an HIV prevention strategy. Furthermore, a constellation of problems have been with female condom use including difficulty with insertion, discomfort and suboptimal functional performance during intercourse that may contribute to poor utilisation (Schwartz et al., 2008). Participants highlighted this as a major issue, and this emphasised the point that much reliance is placed in the male condom, which negates the point of women being the ones being able to protect themselves because the male condom leads back to power differentials in sexual relationships.

The majority of participants expressed that the female condom was not a sufficient means for them to protect themselves against HIV infection. There was a clear understanding from all participants within the focus group discussions that the female condom was the only barrier methods available to women as a protection against HIV infection. However; participants expressed that the female condom was a struggle to use and that the male condom was easier to use. Contrary to this, participants felt that the male condom gave power and control in sexual relationships to the male partners.

Table 5.1: Listing of the key findings

Findings from Community dialogues
Women’s knowledge and experiences in using contraceptives
Health care workers - the cause for illegal termination of pregnancy
Negative attitudes of health care workers as barriers to contraceptive use
“We drink and get confused”: Alcohol as a driver of multiple sexual partners
“If I insist on using a condom, then I don’t love him”: Issues of negotiation
Findings from the Focus Group Discussions
ZAZI - As Preferred Media Text
Audiences as creators of meaning: Interpretations of ZAZI
The power of participatory methodology in campaign name development
Negative perceptions of ZAZI
Teenage pregnancy and the high HIV rates among women
Women’s control over HIV infection
Learners’ Perceptions towards teenage pregnancy
Inaccessibility to contraceptives
Preferred contraceptives: The Male versus Female Condom

Summary of the key findings

There are key findings from the focus group discussions that were similar to the findings in the community dialogues. The issue of contraceptive knowledge and use was a key finding in both the community dialogues and the focus group discussions. However, participants in the community dialogues reported both the issue of knowledge and contraceptive use to be problematic; participants were not knowledgeable about the different contraceptive methods available for prevention against unplanned pregnancy and HIV infection. The male condom, the oral contraceptive pill and the injectable appeared to be the only methods participants knew about but were also not using.

The participants from the focus group discussions were exposed to the ZAZI campaign, therefore, were knowledgeable about the multiple contraceptive methods available to prevent unplanned pregnancies and HIV infection. Common between the participants from the community dialogues and the focus group discussions was the issue of negotiation with male partners about using protection. The difference is that participants from the community dialogues added that contraceptives had side effects that caused them not to continue using them. In line with the first research question, the positive perceptions of the young women in the focus group discussions indicate a level of effectiveness by creating an increased awareness. Although participants did not mention any significant behaviour changes, they confirmed that ZAZI increased their level of knowledge and awareness on how to protect them self from HIV and other STI's. This level of awareness proved to lack among the young women presented in the community dialogues.

The issue of contraceptive use and knowledge also speaks to the third research question within this study. Young women from the focus group discussions indicated that there was no significant behaviour change, but that the ZAZI campaign created an increased awareness of what the different contraceptive methods were. The participants were aware of methods such as Post-Exposure Prophylaxis (PEP) and that if one of them or a close friend was raped; this was the methods that they would immediately use. The reception of the ZAZI campaign had among the young women in the focus group discussions had a significant impact in the way that young women viewed them self and the role that they play in relationships. Participants indicated that ZAZI had influenced their behaviour towards taking their education at a serious level. One of the participants in focus group one from Umcothoyi High School indicated that

she had already had a child at the age of 16 when she was exposed to the ZAZI campaign. She acknowledged that the child was a result of her not using any method of protection. But ZAZI encouraged her to go to the clinic and get tested with her partners, she was also encouraged to work hard at school and is now completing grade twelve. This participant expressed that for her own life, ZAZI has changed her mindset towards careless sexual activity and her education.

In addressing the second research question, the responses from participants in the community dialogues and those who are within the focus group discussions indicated that health care worker's attitudes aggravated the lack of contraceptive use amongst them. Participants indicated that the health care workers treat them badly when attending the clinic for access to contraceptives and that they do not go back to the clinic due to this. A participant from KwaXimba (26 November 2011) within the community dialogues indicated that at times nurses refuse to give them contraceptives because they are too young; not only that but the nurses threaten to tell their parents about going the clinic for contraceptives. This was similar among the participants from the focus group discussions. Young women throughout all the focus group discussions indicated that health care workers were difficult towards them and that because the communities in which they live are small in population, the nurses knew some of their parents personally. The negative attitudes of health care workers, was the key barrier to contraceptive use and significantly also a barrier to the contraceptive knowledge.

Conclusion

There have been multiple health campaigns that aim at educating young men and women about safe sexual practices. The ZAZI campaign is one that has focuses specifically on women and young girls, advocating for young women to know their strength, and worth, particularly when engaging in sexual relationships. The audience's responses to ZAZI revealed that they acknowledged the campaign to be a useful and positive strategic tool that teaches young women about the various contraceptive methods available to protect them against unplanned pregnancies and HIV infection. The positive response to the campaign and the message of 'knowing your strength' can be attributed to the television advert, where a young woman confidently walks into the clinic, regardless of older people and health care workers being present. The audience within the focus group discussions identified with the young woman and began to understand the message of ZAZI to mean becoming an independent young woman, who has confidence and has self-esteem.

Chapter six: Conclusions

This study explores the audience reception of the ZAZI campaign, and how it has contributed to contraceptive knowledge and utilisation in correlation to unplanned pregnancy. The main objective of the study was to explore young female learner's reception of the ZAZI campaign, seeking to understand their perceptions, attitudes and experiences towards contraception use and unplanned pregnancy. The researcher sought to understand whether or not ZAZI contributed to any behaviour change among the young female learners with regards to contraceptive use. Stuart Halls' (1996) encoding' decoding model was employed to understand participant's reception and meaning making of the ZAZI message. Contributing factors to teenage pregnancy were highlighted in the literature. This study is framed by the Social Ecology Model of Communication and Health Behaviour (SEMCHB), a meta-theory which understands behaviour change communication within four levels of influence. It acknowledges that an individual's behaviour is influenced by the environment and the surrounding social network. Therefore for an individual's behaviour to change, it also necessitates that the surrounding social network is taken into consideration (Kincaid et al., 2007). The Culture-Centered Approach (CCA) revealed the importance of understanding individuals within the context in which they live (Dutta, 2008), and the Health Belief Model (HBM) showed some the young women's personal perceptions about the contraceptive use (Glanz et al., 2002).

Summary of key findings and implications of the study objectives

This study adopted a qualitative approach to data collection and analysis. Community dialogues were analysed as preliminary data to the study; focusing on already existing issues around contraceptive use that young women face in KwaZulu-Natal. This was the data collected and utilised in formulating the ZAZI campaign. This study presented data from the community dialogues to give in-depth understanding about the challenges young women face with issues of contraceptive use and preventing the risk of HIV infection. Focus group discussions and semi-structured interviews were conducted with young women learners in three high schools, within Umnini rural KZN, exploring their reception of the ZAZI campaign. This was to reveal discursively whether the campaign was able to bring about behaviour change to some of the issues that challenge young women with regards to contraceptive use.

Firstly, from the focus group discussion, the issue of health care worker attitudes was the first key findings of this study. Young women from the focus group discussions expressed that the attitudes of health care workers were a barrier for the access to contraceptives; this is similar to findings presented from the community dialogues. They indicated that health care workers were judgmental towards them for seeking contraceptives at a young age; some of the health care workers in local clinics would threaten to inform the parents of the young women who visited the clinic. The study was able to verify some of the barriers and hindrances that inhibit contraceptive use.

Secondly, the focus group discussions and semi-structured interviews revealed that ZAZI created an increased awareness among young women about the multiple contraceptive methods available for prevention against unplanned pregnancy and HIV infection. Contrary to the community dialogues where the oral contraceptive and injectable were the most commonly known. Although findings didn't reveal any behaviour change, there was an increased level of knowledge about the available contraceptives and knowledge about HIV and AIDS and the risk of infection. The ZAZI message was able to increase awareness among young women about the variety of contraceptive methods to prevent HIV infection and unplanned pregnancy.

The concept of being a ZAZI woman, "knowing your strength" and having the courage to negotiate safe sexual practices was embraced by the young. Findings indicate that the campaign created awareness among young women about the importance of knowing who they are before entering into sexual relationships. However, the dependence for financial support and stability from male partners was a barrier. Educators from the semi-structured interviews were concerned that although the campaign has created awareness, the knowledge would not translate to behaviour change due to the dependency young women have on male partners. This was an important finding which indicates that strategies such as the ZAZI campaign are effective in creating awareness about behaviour change.

Further research

Currently, the ZAZI campaign has created an increased awareness of the various contraceptive methods available for young women to protect themselves against unplanned pregnancy and the risk of HIV infection. The recommendation that emerges from this study is concerned with the translation of knowledge into behaviour change. The majority of participants reported having an increased knowledge of contraceptive methods after being

exposed to the ZAZI campaign. However, health communication campaigns such as ZAZI should be conscious of the fact that behaviour change is a long-term, on-going process. Increased awareness is the beginning of behaviour change, but it is not a sufficient stop the process at that stage, without following up until there is evidence of change. Health campaigns such as ZAZI should invest longer periods of time within the communities they seek to encourage behaviour change. Programs that are facilitated in schools should be run for longer periods; increasing the possibility of knowledge translating to behaviour change. This would also lead to legitimate observations about the effectiveness of health campaigns towards behaviour change.

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APPENDICES

Appendix A

Informed Consent Form

Informed consent – permission to interview.

Please note that this document is produced in duplicate – one copy to be kept by the respondent, and one copy to be retained by the researcher.

Researcher	Yonela Vukapi	079 7351 834	yonelavukapi@yahoo.co.za
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Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	singshen@ukzn.ac.za
<i>Please do not hesitate to contact any of the above persons, should you want further information on this research, or should you want to discuss any aspect of the interview process.</i>			

Dear Participant

Thank you for taking part in this research study. Your input will add significant value in to the research project titled: **“ZAZI-Know Your Strength”- A Reception Analysis of contraceptive utilisation in correlation to unplanned and unwanted pregnancies among young female learners’ in Umnini, KwaZulu-Natal**

This study is interested in the reception of the campaign specifically among young women learners between the ages of 18-20 in KwaZulu -Natal, and how they make sense of and receive the message contained in the ZAZI campaign.

This research is conducted by Yonela Vukapi (Student No: 210513087) towards her Master of Social Science degree.

Please be advised that that you may choose not to participate in this research study and would you wish to withdraw at any stage, you have the full right to do so and your action will not be of any disadvantage to you in any way.

Your participation in this research will be through interviews and taking part in a focus group discussion; these will be arranged to ensure minimal disruption to your schedule. The information obtained will be treated as confidential; pseudonyms will be used in identifying respondents or participants when necessary. This will be safely stored at the University of KwaZulu-Natal, Howard College Campus.

Signed consent

- I understand that the purpose of this interview is solely for academic purpose. The findings will be published as a thesis, and may be published in academic journals.

Yes No

<ul style="list-style-type: none"> I understand I will remain anonymous. (Please choose whether or not you would like to remain anonymous.) 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand my name will be quoted. (Please choose whether or not you would prefer to have your remarks attributed to yourself in the final research documents.) 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I will not be paid for participating but a souvenir will be given. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand that I reserve the right to discontinue and withdraw my participation any time. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to be frank to give the information. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> I consent to have this interview recorded. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>* By signing this form, I consent that I have duly read and understood its content.</p>		
_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

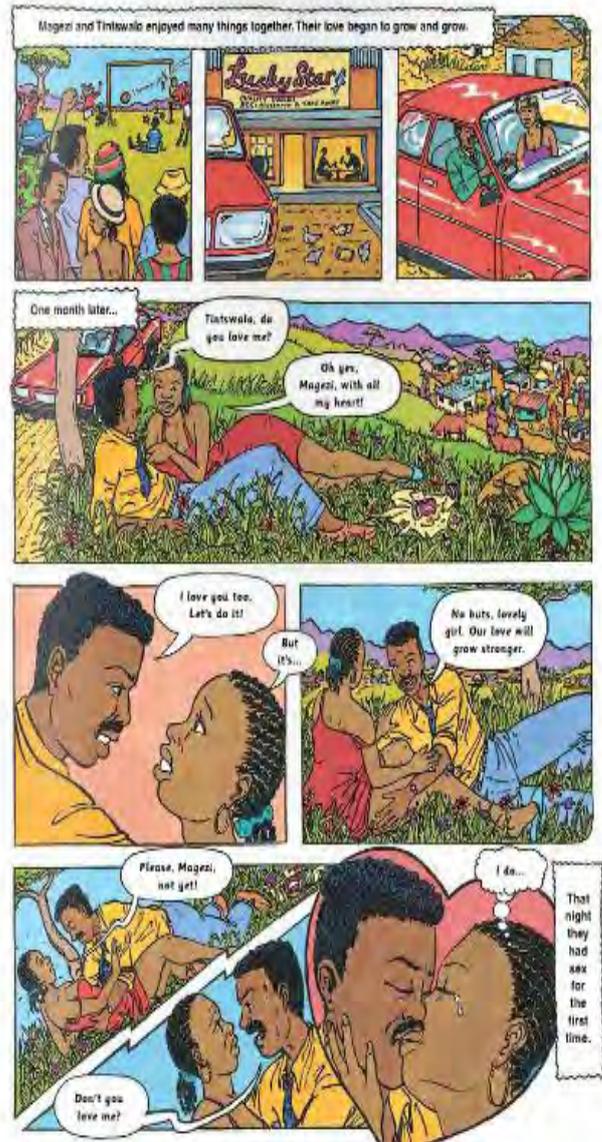
Appendix B

Thirteen communities that conducted community dialogues in KZN:

District Municipality	Local Municipality	Community	Date	Female	Male	Total
Ethekwini	Durban Metro	Umbumbulu	15-Nov-11	68	17	85
Ethekwini	Durban Metro	KwaXimba	16-Nov-11	74	44	118
Sisonke	Ingwe	Bulwer	17-Nov-11	101	23	124
Ilembe	Mandeni	Hlomendlini	18-Nov-11	104	34	138
Umkhanya-kude	Hlabisa	Makhowe	24-Nov-11	96	40	126
Zulululand	Phongolo	Ncotshana	19-Nov-11	N/A	N/A	110
Uthungulu	Mlalazi	Mbongolwane	21-Nov-11	89	53	142
Ugu	Umdoni	Amahlongwa	22-Nov-11	98	40	138
Umzinyathi	Nquthu	Kwanyezi	23-Nov-11	129	105	234
Umgungundlovu	Umsunduzi	Nhlazatshe	2011/11/23	92	45	137
Uthukela	Imbabazane	Moyeni	24-Nov-11	N/A	N/A	77
Amajuba	Newcastle	Mdadeni	25-Nov-11	N/A	N/A	500
Total				851	401	1929

Appendix C

'The Sugar Daddy Syndrome' – Young Girls in relationships with older men



Appendix D

Focus group guide

Research title: “ZAZI-Know Your Strength”- A Reception Analysis of young female learners’ perceptions on contraceptive knowledge and utilisation in Umnini, a rural area in KwaZulu-Natal

SECTION A – 15 minutes

Introduction (by facilitator)

1. Warm welcome to everyone and introduction of the facilitator to all the participants.
2. The facilitator asks each all the participants to briefly introduce themselves and a mention of one of their hobbies (ice breaker).
3. Purpose of the focus group stated by the facilitator

The purpose of this focus group discussion is to explore young women learners’ perceptions and knowledge of contraceptive methods in correlation to unplanned pregnancies. The ZAZI –Know Your Strength Campaign is one of the Health Communication strategies advocating for prevention and knowledge of HIV and AIDS among young women, along with other related issues like contraception use. Specifically, this focus group sets out to explore how the participants have received the ZAZI campaign, their reception of prevention strategies advocated by the campaign. The discussions from this focus group will be of great benefit to the developers of the campaign who would in time evaluate its influence on behaviour change.

4. Explaining of ground rules

It is encouraged that everyone be part of the discussions in a respectable manner; anyone can contribute after the previous speaker is done talking. Freedom of expression is acknowledged with the understanding that this may be exercised in a respectable manner; no one may make reference to individuals who are not present in the discussion. Everyone should express their opinion as there are no wrong or right answers. The focus group will have a duration of 2 to 3 hours with a break in-between for lunch.

5. Read out a consent form, and then participants may sign their consent forms.

SECTION B- 10 minutes

Recognition of the problem and the need for contraception and a preventative method to unplanned and unwanted pregnancies.

1. The problem: a brief explanation of the fact that young women between the ages 15-24 are the most vulnerable to HIV infection and unplanned pregnancies.

- a) An introduction to the different contraceptive methods available to prevent pregnancy.
2. Facilitator presents a chart of the different contraceptive methods to the participants to check for their level of knowledge of the different available methods.

SECTION C- 20 minutes

Discussion on HIV prevention

1. What do you think has caused young women to be more vulnerable to HIV?
2. Do you think young woman are in control of protecting themselves from sexually transmitted diseases including HIV?
 - a) Do you think men are in control of safe sex practices?
 - b) Do you think women have sufficient resources of protecting themselves against HIV infection?
3. Currently male condoms are the most commonly used methods of HIV and pregnancy prevention available to both male and females. Do you think the male condom is an adequate means of protection for women?
 - a) Why do you think many women do not use a male condom for protection?
 - b) What are your personal views of the male condom?
4. As a female learner in KwaZulu-Natal, do you think you are at risk of HIV infection?

SECTION D- 20 minutes

Discussion on Pregnancy Prevention

1. What is pregnancy?
2. What are your perceptions of teenage pregnancy
3. How does a young woman get pregnant?
4. What do you think has caused high rates of unplanned and unwanted pregnancies among young women?
5. Do you think young women should use contraception as a preventative method when engaging in sex?

Lunch Break: 20minutes

SECTION E – 15 Minutes

Discussion on Knowledge of Contraception

1. Do you know what contraception is?

2. What are the different types of contraceptive methods do you know?
3. Do you think young women should use contraception as a preventative method when engaging in sex?
4. Do you think there is a lack of knowledge about contraception?
5. Do you think that the lack of knowledge has influenced the high rates of unplanned pregnancies?
6. Are there sufficient access points, for example, clinics where contraceptive methods are available?
7. What do you think that there is a lack of contraceptive use among young women?

SECTION F 15 Minutes

Discussion on the reception of ZAZI-Know Your Strength

1. What do you understand the campaign?
2. Where did you hear about the ZAZI campaign? Did you hear about it through the television advert, the radio advert or the ZAZI song?
3. Which mode of media communication of the campaign did you like the most?
4. Which of these do you think it was able to communicate the ZAZI message well?
5. Your involvement in the ZAZI campaign, has it had an effect in your life and behaviour in any way?

Conclusion: Thank you for your participation in the discussion, if you have any questions please ask me and I will answer to the best of my ability.

Appendix E

Interview Structure for the educators

Name	
Age	
Occupation	
Gender	
Highest Education	
Ethnic background	
Place of living/ location	
Marital Status	

1. What is your understanding of the ZAZI campaign?
2. Has the ZAZI campaign succeeded in achieving its aims with the peer group in your school?
3. Has there been a difference in attitudes and behaviour change among the learners who have been part of the ZAZI peer group, in comparison to the learners who are in the same school but are not part of the peer group?

