The Role of Male Partners in Combating Adolescent Pregnancy

by

REBECCA MOTLATLA

Submitted in fulfilment of the requirement for the degree of

MASTER OF ARTS IN NURSING SCIENCE

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. O.N. MAKHUBELA-NKONDO

JOINT SUPERVISOR: PROF. J.M. DREYER

NOVEMBER 2000

DEDICATION

I would like to dedicate this dissertation to my husband Steve Papa, my children Thabang, Masana and Naledi, and my parents Shadi and Richard Mabaso, for their love, support and encouragement, including the community that made this research project a success.

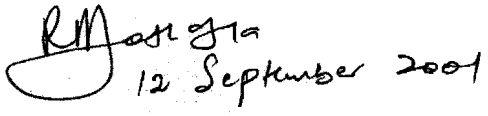
DECLARATION

I declare that:

THE ROLE OF MALE PARTNERS IN COMBATING ADOLESCENT PREGNANCY

is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

R. Motlatla



ACKNOWLEDGEMENTS

I wish to thank God for having given me the wisdom and courage to pursue this study. I wish to express my sincere appreciation to my family for the love, support, encouragement and patience throughout the research process.

All the respondents for co-operating and sharing some of the most sensitive experiences of their lives and having confidence in my ability to honor their privacy and confidentiality request. All the parents of the adolescent mothers who welcomed me at their homes, and gave me permission to interview their daughters.

My colleagues, Ms R Mohlabi, Ms B. Pooe-Monyemore, Ms L. Mangate, Dr F Kumalo and Ms Mampei Mabusela, for their support and assistance they provided me in shaping up the research process.

Ms Mapitso Ngwenyama, Ms Mmabo Moloi, Ms Grace Rapholo, Mr Abbey Lekalakala, and Ms Mankwana Ramodike for their continued advise and support at various stages of the research process.

Health managers of the Brits District Office, Ms M. Rakau and Ms D.L. Magano for having granted me the permission to conduct this research project in one of the district's Health Centres. Sincere thanks to all the personnel of Letlhabile Community Health Centre for their support and assistance in creating a conducive environment before and during the research process.

The manager of Eletsa Secondary School, Mr T Mojagi for having granted me the permission to conduct this research project and offered the school as a setting for data collection.

Sincere thanks to all the personnel of Eletsa Secondary School, particularly the Head of the Department: Ms T. Khumalo, and the Life-skills Educator: Ms Maduso, including all other school Prefects, and Mr. Aaron Diutlwileng, who assisted with the arrangements for interviews at times and places convenient for both the learners and the researcher.

Dr Jonathan Levin, of the Medical Research Council, for his valuable support and encouragement with the quantitative data analysis. Ms Mbali Thubisi for her patience, understanding and taking time to edit and finalise this dissertation for submission.

My promoters, Prof. Olga Makhubela-Nkondo and Prof. J.M. Dreyer for their confidence in assisting me to select this interesting topic, their continued support and motivation throughout the study.

The World Health Organization for the much needed fellowship support.

ABSTRACT

THE ROLE OF MALE PARTNERS IN COMBATING ADOLESCENT PREGNANCY

This study was intended to explore the role male partners play in preventing adolescent pregnancy in the Letlhabile area, of Brits district, which is located in the North West Province.

Adolescent males and females whose ages ranged between 13-20 years were included in the sample. The inclusion criteria was determined on the basis of the adolescents who were pregnant and non- pregnant, as well as males who had already became parents and those who hadn't experienced fatherhood.

Focus group discussions and individual in-depth interviews were conducted. Observations and the review of existing documents were triangulated to gather valid and reliable information. Quantitative and qualitative data analysis were blended. The findings revealed significant factors that ranged from the reaction of parents and/or partner to the announcement of pregnancy, to issues that impact on consequences of multiple sex partners. The recommendations of this project deal with aspects that include contraception, sexuality education, parental involvement among many relevant policy issues.

KEY TERMS

Youth

Adolescents

Teenager

Pregnancy

Contraceptives

Parental

HIV/AIDS

Sexually Transmitted Diseases

Male Partner

Sexual and Reproductive Health

DEFINITION OF TERMS

Adolescents - Adolescents refers to both male s and females between the ages of 13-19 years old for the purpose of this study.

Adolescent pregnancy - refers to pregnancy occurring between the age 10- 19 years of age.

Adolescent non-parent- refers to male partners who have not yet made a girl pregnant

Adolescent non-pregnant-refers to an adolescent mother of any age according to the definition of adolescent pregnancy.

Combating-used as in preventing and/or fighting.

Health Promotion is the process of enabling people to increase their control over and to improve their health.

"Ntasheta"- refers to a condition associated with pubic lice, and causing itching of the pubic area.

Male partners - refers to a male person who either has ever made a girl pregnant or have not yet made a girl pregnant.

Playing a "Number 5 Card"- refer to setting a scene for one who does not have the guards to initiate something

"Preventions" - refer to contraceptive methods

LIST OF ABBREVIATIONS

AIDS - Aquired Immuned Defficiency Syndrome

ANC- Ante-natal Clinic

CASE - Community Agency for Social Enquiry

CBD - Community Based Distribution

CEDAW - Convention on the Elimination of all forms of Discrimination Against Women

CEDPA - Centre for Development and Population Activities

CRC - Convention on the Rights of the Child

CRHCS - Commonwealth Regional Secretariat for East, Central and Southern Africa

DISH- Delivery of improved Services for Health

DOH – Department of Health

FGD – Focus Group Discussion

FWCW - Fourth World Conference on Women

HIV - Human Immune-deficiency Virus

ICPD - International Conference on Population and Development

IEC - Information, Education and Communication

KYIP- Kenya Youth Initiative Project

MRC – Medical Research Council

NPPHCN - National Progressive Primary Health Care Network

PPASA - Planned Parenthood Association of South Africa

STD - Sexually Transmitted Diseases

UNFPA - United Nations Population Fund

UNAIDS - United Nations Aids

WHO - World Health Organization

LIST OF TABLES

LIST OF FIGURES

ORGANISATION OF THE RESEARCH REPORT

CHAPTER 1

This chapter deals with the background to the research problem, the statement of the problem, the purpose and the significance of the study, research questions and statement of limitations to the study.

CHAPTER 2

In this chapter a wide range of literature related to the topic is reviewed from the context of South Africa, Africa and international perspective. The literature is structured in terms of sections which give insight to the research problem.

CHAPTER 3

This chapter covers the research methodology. It gives a description of the research design, ethical considerations, research setting, population and sampling processes, tools for data collection and methods of analyzing data.

CHAPTER 4

This chapter gives an analysis of the research findings. Quantitative data is presented numerically using graphs and tables, while qualitative data is presented using coding schemes, themes and categories. Narrative statements have been used to give personal accounts and thereby emphasizing the issue under discussion.

CHAPTER 5

This is the chapter which presents the interpretation of the research findings.

CHAPTER 6

This chapter summarises, concludes and suggests recommendations based on the findings of the research project, as well as drawing from other relevant literature reviewed about the topic.

REFERENCES

This section presents a list of literature that was referred to during the research process.

APPENDICES

This section displays all relevant information and documents utilized in the course of the research.

TABLE OF CONTENTS

CHAPTER THREE

CHAPTER FOUR

APPENDICES

CHAPTER ONE

OVERVIEW OF THE PROJECT

1.1 INTRODUCTION

Adolescent sexual and reproductive activities have far-reaching social, economic, educational moral, health and demographic effects (Commonwealth Regional Health Secretary for Eastern, Central and Southern Africa 1991: 3). Failure to meet the diverse reproductive needs of adolescents predispose them to unintended pregnancy, the risk of induced abortion (often in hazardous circumstances) sexually transmitted infections and the new menace of HIV infections leading to AIDS.

According to the National Survey of Youth in South Africa (SA) the consequences of adolescent pregnancy include dropping out of school, lower income jobs and low self esteem (Everatt and Orkin, 1993). This situation shows that unplanned adolescent pregnancies directly affect a woman's chances in life.

The report of the Statistics South Africa by Orkin (1998) revealed that pregnancy featured as a significant reasons among South African youth for dropping out of school. Adolescent pregnancy is cited in the Population Policy for SA (1998:11) as often the outcome of a lack of information and knowledge about sexuality and contraception.

Unequal power relations between men and women often play an important role. The risk to pregnant adolescents may be compounded by adolescents lack of experience,

resources, social and familial support, as compared to adult women. The health implications for the pregnant adolescent girl may include the following:

- Prolonged or obstructed labour resulting from an immature pelvis due to incomplete skeletal growth which may also cause damage or even death of both;

- An increased risk of unsafe induced abortion, STDs and even HIV/AIDS due to unprotected sexual behaviour;

- Too early pregnancy increases the risks of maternal and child morbidity and mortality as well as the likelihood of having too many children too close together;

There is evidence showing that children born to adolescent mothers are more likely to be premature, of low birth weight, and suffer the consequences of retarded fetal growth. A growing challenge facing women of child bearing age is that of mother to child transmission of HIV/AIDS virus, if the mother is HIV positive; Infant and childhood deaths are also higher among mothers under the age of 20.

Studies conducted throughout the world have shown that developing programs for women simply to improve sexual and reproductive health are inadequate. In many societies men still play the dominant role in almost every sphere of life and their role in the promotion of good sexual and reproductive health is crucial.

Often the role of men and their motivation in fertility decision-making have not been acknowledged, on the assumption that men are indifferent, unaware or unwilling to play an active role. The importance of involving men in sexual and reproductive health as a means to several ends was highlighted in the ratified International Conventions of the United Nation Conference on Population and Development (ICPD) in Cairo 1994, and the 1995 Conference on Women held in Beijing 1995 in which South Africa participated (IPPF 1995/2:4).

It is crucial that special efforts be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood and sexual and reproductive behaviour including options to prevent unwanted and high-risk pregnancies. This study intends to get the views of male partners as both potential and actual fathers, on their role in combating adolescent pregnancy in the community of Letlhabile, an area situated in the North East of North West Province, Brits District.

1.2 BACKGROUND OF THE PROBLEM

Letlhabile is situated in the Far Eastern region of North West Province. Letlhabile is in the Brits magisterial areas, located in the North East and about 25km from Brits town city centre. The farm areas of Mamogalieskraal and Kleinfontein as well as the villages of Maboloka and Rabokala (Odi District) border it.

The population of Letlhabile, according to the 1991 census, was estimated at 56 900. In terms of the 1996 population results of Brits Magisterial district in general, the racial breakdown is estimated as in table 1 below:

Table 1.1:

Showing Population of the Brits District by Race

RACE	TOTAL
African/Black	135 037
Coloured	1 831
Indians/Asians	1 141
Whites	26 166
Unspecified/other	165 414
TOTAL	**329 589**

(Statistics SA, 1996)

However, the current population of Letlhabile is estimated to be three fold the 1991 census by virtue of its growth in infrastructure (from Block A & B in 1985 to include Block C & D now lately). There is a rapidly growing surrounding informal settlement due to an influx of people from rural areas. A map showing the area of Letlhabile obtained from the Brits Transitional Local Authority is attached, see Appendix A.

Letlhabile is served by one health clinic whose hours of services is from 08: 00-16:00, five working days per week. A daily antenatal service is rendered to pregnant women and health education and counseling are provided.

According to clinic records for the period of January1998 to June 1999, an average of 25-65 pregnant women are examined daily, from which 5-10 clients are adolescents. However clinic health workers acknowledged discrepancies in their recording systems as reports do not tally with the given figures of the monthly statistics.

According to health workers of those adolescents who attended antenatal clinics in 1998, most reported in their second trimester of pregnancy. Those who reported in the third trimester of pregnancy gave excuses for reporting late. Some of the reasons given included the lack of knowledge about the pregnancy state, a desire to write exams first, manipulation by an adult male to engage in a sexual activity; contemplation of termination of pregnancy before parents find out, to mention but a few.

They elaborated that a few more pregnant adolescents showed up once or twice at the antenatal clinic and never returned for follow up care. This state of affairs is a course for concern, in terms of whether these pregnancies ended up with a live birth or death of one or both the adolescent mother and the baby. Other possibilities may be a missed opportunity to manage complications that might have happened as a result of the adolescent pregnancy.

Table 2:

Data of pregnant adolescents attending antenatal clinics at Letlhabile clinic obtained from clinic records for a period starting from 1 January 1998 - December 1998:

Month 1998	1st trimester	2nd trimester	3rd trimester	Total
January	3	6	2	11
February	4	5	-	11
March	3	5	1	9
April	5	5	2	12
May	6	7	1	14
June	6	10	3	19
July	4	6	-	10
August	6	6	2	14
September	7	3	1	11
October	3	4	-	7
November	7	6	1	15
December	1	2	-	3
TOTAL				136

However the given data does not give a clear picture of the extent of teenage pregnancy reported at Letlhabile antenatal clinic because of the poor recording systems Some of the gaps identified include lack of age specific data as reflected in some daily statistics records, particularly for the months of March, April, July, October and December 1998. However some pregnant adolescents who attended and/or are still attending antenatal clinics might have been missed due to this poor information system.

The age at which pregnant adolescents present themselves at Letlhabile antenatal clinic ranges from 15-18 years as shown in the 1998 annual data. Pregnant

adolescents are referred to the Brits District hospital for delivery when they are due or present with complications of pregnancy.

Many studies have been conducted around adolescent pregnancy and most programmes have specifically targeted only young women than young men. Evidence has shown that family planning programmes are one such example. Family Planning clinics in South Africa previously avoided serving men in the belief that many women need privacy and autonomy in reproductive health matters.

The assumptions of many health care providers that men are uninterested in taking responsibility for family planning has become self fulfilling prophecy and could be said to contribute to an increase in adolescents pregnancy. Although some studies included males, very few have examined male feelings, although when they have, the results indicated a positive outlook (Puri, 1996:27).

The study intends to reveal how to improve reproductive health by responding to the different identities and perceptions of pregnant adolescents and that of male partners. Religion, politics, economic conditions, the environment and education influence men and women's reproductive health differently.

Studies have shown that adolescent boys and girls are sometimes unequally provided with factual information by parents and teachers, particularly information on relationships and where to go for contraceptives.

1.3 STATEMENT OF THE PROBLEM

The role that male partners can play in combating adolescent pregnancy in Letlhabile is often not considered as a priority by health workers and the community at large. According to the South African Demographic and Health Survey (1998:26), 35% of all adolescents have been pregnant or have had a child. This figure represents a very high level of teenage fertility, a continuing course of concern to the government and researchers (refer to Appendix B).

1.4 SIGNIFICANCE OF THE PROBLEM

- In terms of findings, strategies will be proposed that will contribute to combating the problems of teenage pregnancy in Letlhabile through the recognition of male partners.

- Health promotion programme will be proposed for Letlhabile community, which is hoped to involve men in sexual and reproductive health.

- Strategies drawn up will be communicated with the Brits District health and Welfare office to contribute towards developing successful gender sensitive sexual and reproductive health programmes for youth and adolescents.

1.5 PURPOSE OF THE STUDY

Purpose of the study include the following:

- to explore male opinions on the problem of adolescent pregnancy;

- to assess their knowledge, attitudes and practices regarding contraception.
- to determine their role in reducing adolescents pregnancy.

1.6 RESEARCH QUESTIONS

The research process will be guided by the following questions:

- What is the extent of Adolescent pregnancy in Letlhabile?
- What are the risk factors and pregnancy outcomes among pregnant adolescents?
- What is the response of male partners to the increase in adolescent pregnancies?
- What is the role of male partners in reducing adolescent pregnancies?
- What is the level of knowledge of men about sexual and reproductive health issues?

1.7 LIMITATIONS OF THE STUDY

Since the study was limited to male and female adolescents in school and female adolescents accessing the clinic for ante-natal and post-natal services, the study findings will not be generalized to the entire population of youth in other parts of the country. The sample size was relatively small, comprising of 40 respondents of both sexes participating in the in-depth individual interview study, and 28 males and 28 females with seven participants per focus group discussion.

To get a representative sample among female respondents, some respondents who gave informed consent were followed and interviewed at their own homes by the

researcher. Due to the sensitivity of the topic, a sample was drawn from male adolescents in school, based on voluntary participation and on the criteria of being a father or a non-father. It was therefore not easy to find any male partner who is a father in any other setting e.g. workplace, community etc., hence the sample was limited to a school setting and/or a clinic setting.

There seem to be limited studies conducted on the role of male partners and adolescent pregnancy in the country. However, most of the literature gathered in this study is based on international evidence some of which may or may not compare with the prevailing situation experience by most South African males, such as, geographical factors, socialization, multi-culutral issues, rites of passage etc. Limitations due to interviewer bias during the qualitative data collection method was minimized by observing ethical consideration, the use of a tape recorder as well as a scriber and a facilitator during interviews.

1.8 SUMMARY

This chapter attempted to provide an overview of the research project. An outline of adolescent pregnancy as a social, economic, health and educational problem affecting most societies was discussed. The chapter further explored the health implications resulting from adolescent pregnancy and its relationship with other determinants of health, such as sexually transmitted diseases and HIV/AIDS.

Evidence was used to substantiate discussions, both from within the country and at an international level. Other areas covered in this chapter include the presentation of the background to the population under study. Justification of why adolescent

pregnancy is regarded as a problem in that area was presented in a table as well as the statement of what will be done with the information generated from the study. Research questions to guide the study were also done.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is a presentation of the literature that was collected and perused. There is abundant literature on teenage pregnancy. However, there is limited documentation on the role of male partners in this topic.

Several sources were consulted. Libraries, at the ministry of Health and UNISA were consulted. Several recent studies from the country's non-governmental organizations including the Reproductive Health Unit, Planned Parenthood Association, have been consulted to provide evidence in this subject matter. This section will include a review of literature relevant to the topic of adolescent pregnancy, linking various studies to the topic and other determinants of health impacting on the topic.

While it is now recognized that African men have been largely neglected in the family planning movement, perhaps an even more overlooked population is adolescent males in the continent. Where family planning efforts focus on adolescents, they focus primarily on females, largely excluding their male counterparts (Kiragu & Roberts, 1996).

2.2 YOUNG MEN'S KNOWLEDGE ABOUT SEXUAL AND REPRODUCTIVE HEALTH ISSUES

Studies have shown that most men are uninformed about sexual and reproductive health issues. Many young men do not have sufficient information about contraception, pregnancy prevention or STD prevention.

Knowledge of sex and reproduction are even more limited among adolescents, whether educated or not. Jejeebhoy (1996) in a study conducted in the slums of Bombay, found that 67% and less than half the boys reported that they knew nothing about married life and its sexual aspect.

In a study in the Ivory Coast found that many young men did not know how to use a condom, some took it off midway through intercourse and resume without protection (Deniud, 1994). In Uganda, boys were confused about the various types of condoms, wondering which could protect against HIV/AIDS and which could protect against pregnancy, and when it was better to wear two condoms together (DISH Project, 1996).

In Nigeria, Tauna and Hildebrand (1993) found that girls were more knowledgeable about reproductive health matters than boys. As confirmed in one Kenya study, authors found that while many adolescent men were using the safe time of the month as their method of birth control, less than 20 percent actually knew when in a menstrual cycle a woman was most likely to become pregnant (Kiragu and Roberts 1996).

Although young people are increasingly knowledgeable about contraception, serious questions exist about the depth and application of their knowledge. The statistics for young men closely parallel those for women in Sub-Saharan Africa. Both knowledge and use of contraceptives among young men is lower than that of older males.

The above study found that young men demonstrated a marked lack of knowledge about and disinterest in contraceptive use, and except for in Cote d'Ivoire, contraceptive use among adolescent males in less than half that of adults (Pathfinder International: Africa Regional Office, 1999).

In the African region overall, one third of girls aged 15 to 19 had premarital sex. The overall percentage of sub-Sahara Africa of young women up to age 24 who have had sex is 61%; clearly premarital sex is not a rare activity. Statistics on boys' sexual activities are more difficult to obtain (CEDPA / UNFPA, 1998)

In South Africa, a National Male Sexual and Reproductive Health Survey (1999), found that there was an increased level of knowledge about sexual and reproductive health issues. Seventy five percent (75%) of respondents disapproved of other men having multiple sex relationships, citing reasons of morals and that this practice promotes the spread of STDs.

However, some of these males were said to have admitted having more than one partner at the time of the interview. This state of affair shows that increased knowledge about sexual and reproductive issues does not necessarily change the behaviour of people to practice safe sex. Seventy seven percent (77%) of men objected to the use of contraceptives by their partners without their knowledge,

largely because they felt that it had to be a joint responsibility. Sixty nine percent (69%) said that they provided condoms in their relationships. Men identified a need for reproductive health information on STDs and HIV/AIDS, family planning, and male health education, while others indicated a need for information on female condoms, abortion and sexuality (Matidze, Beksinska, Rees&Mazibuko, 1999).

There is evidence showing that young men are usually the initiators of sexual contact, and frequently advise females on contraception. The fact that so many are misinformed suggests that much of the advice they disseminate is erroneous. These young men eventually become husbands, fathers, community leaders and policy makers, to extend that their misinformation carries on into adulthood demonstrates the urgency of early education.

The onset of the AIDS epidemic has also changed the contraceptive landscape, elevating the importance of condoms. This has made male collaboration in contraception even more essential than before.

2.3 THE IMPACT OF GENDER ON SEX ROLE AND STEREOTYPES

Most African cultures exert tremendous pressure on young men to become sexually active; tacitly approving sexual adventures and privately expressing concern at male abstinence. Virtually any African study that examines adolescent sexual behaviour by gender finds that males are more likely to be sexually active than females, that males have more sexual partners and that they commence their sexual careers at younger ages than females.

In Uganda nearly a third of boys interviewed felt that their friends would laugh at them if they were not sexually experienced (Lewicky and Wheeler, 1996). In some cases, having a STD is the ultimate proof of manhood and experience, although AIDS may have modified these aspirations.

Gender affects expectations regarding the sexual activity of boys and girls. For example, in a survey of factory workers in Thailand among ages 15 to 24, a majority of men said that premarital sex was expected of them, and that their peers ridiculed boys who had not had sex (Family Health International, 1997).

Sex roles and stereotypes, especially the masculinity and macho role, contribute to males' reluctance to obtain information about contraception. Many young men refuse condom preferring a body to body contact and, colloquially abbreviated as a BBC and in Uganda youth lingo (DISH Project, 1996) and flesh to flesh, in South Africa. As some Kenyan youth say, having sex with a condom is like eating candy with a wrapper on (KYIP, 1995). These are attitudes that reproductive health services need to address if they are to convert today's adolescent males into responsible contraceptors tomorrow. Macho stereotypes also distort the role of sex and devalue the women as the sexual object.

Research shows that many girls are forced into sexual action, by subtle pressure, coercion, or outright rape (Weiss & Muller, 1989) This was also confirmed by authors such as McCauley & Salter (1995).

In a desire to gain sexual experience, many boys will go as far as seeking prostitutes, hardly the relationship that promotes the sexual responsibility (Teka, 1993). Others

engage in sexual behaviour for material rewards, usually from sugar mummies (Glass et al, 1995).

These power-based relationships are likely to foster positive attitudes towards females and are unlikely to encourage contraceptive responsibility. For most African societies, double standards and macho attitudes among boys are reinforced by the example of adults. Rarely are young men shown positive examples of what male responsibility means, and rarely is sexual responsibility included in the definition of masculinity (McCauley and Salter, 1995).

Gender disparities exist in many indicators of human development. Those disparities reflect the generally lower status of women compared with men. Enrolment rates at primary, secondary and tertiary educational levels are estimated to be slightly higher for females (79.6%) than for males (77.1%), and adult literacy rates are almost equal for males and females. However, a high drop out rate is recorded for young women due to teenage pregnancies.

The maternal mortality rate of 230 per 100 000 deliveries reflect their poor reproductive health status. The incidence of violence against women and children is still high. Although the constitution guarantees equality between the sexes in all aspects of life, many administrative and cultural practices still discriminate against women.

Women are also experiencing heavy domestic and work burdens, and many can therefore not take advantage of such life enhancing opportunities in politics, education, community involvement or leisure. A large proportion of female rather than

male-headed households live in poverty because most female headed households are particularly disadvantaged with their income, about half that of male headed households in many instances (Population Policy for SA 1998:11).

2.4 THE EFFECT OF ADOLESCENT PREGNANCY AND SEXUAL RESPONSIBILITY

Most studies find that adolescents are poor contraceptive users. A study in Uganda found that only 13 percent of males were using condoms, although nearly half of them had had multiple partners (Agyei et al, 1993). In Zimbabwe, researchers found that only 34 percent of sexually active males were consistent condom users (Wilson and Lavelle, 1992). In Kenya, Kiragu and Zabin (1995) found that the only determinant of male contraception was if the female partners insisted a method be used.

According to Matidze, et al (1999) study findings, most men objected to termination of pregnancy and said that they would instead offer to support the child. Few African societies deal fairly with the consequences of sexual behaviour, and most of the burden is borne by the unfortunate girl. There is often little effort to enforce the financial, social or emotional responsibility of young men who impregnate girls, excusing males from the results of their actions (Weiss and Muller, 1989).

In many cases, impregnating a girl is seen as evidence of masculinity and a source of pride, with parenthood and childbearing frequently only fleeting considerations (McCauley and Salter, 1995). For the girl however, pregnancy usually means expulsion from school, abrupt termination of pregnancy and swift entry into the

uncertainties of motherhood. Few girls can never return to school, leaving them and their children in the vicious cycle of poverty and economic dependency. Thus early in life, young men are freed from the responsibility of contraception, while their female counterparts bear the scar for life.

This double standards eventually play out in adulthood - for example, African men are less likely to have a vasectomy, preferring that their wives undergo a tubal-ligation instead. Reaching young men with appropriate information while they are still young will go far towards balancing some of these responsibilities.

The WHO report of a Joint Meeting held in Senegal, April: 1993 revealed a major finding by the participants, that pregnancy to an adolescent girl diminishes her prospects for the future and this is often compounded by lack of support from the family and the society. In contrast, the young man's life is far less disrupted and, in a relatively short time, he continues to live as he had before been able to evade responsibilities with relative ease.

Teenage pregnancies increase the health risk to both mother and baby. Teenage pregnancies are often the outcome of a lack of knowledge about sexuality and contraception, and the unequal power relations between men and women. Many teenagers resort to illegal abortions or terminate pregnancies, which often results in medical complications, infertility and even death (Population Policy of SA 1998:26).

2.5 SEXUALLY TRANSMITTED DISEASES AND HIV\AIDS VULNERABILITY

Many young men do not see the need to use contraception, in part because they are not the ones who become pregnant. However, many of them do not consider themselves at risk for STDs and HIV/AIDS. For example in South Africa, a study of adolescent males in Durban showed that while nearly all had heard of HIV/AIDS, most perceived no personal threat to warrant behaviour change and when offered condoms, most refused (Preston- Whyte and Gcadinja, 1993).

While already high, STD infection rates among youth are on the rise, and detected rates of infection are much higher among young women than young men, as many studies show. A study in Lagos, Nigeria found that among those treated for STDs, 55.6% of women and 32.5% of men were less than 24 years old (Pathfinder International, 1999).

Even more tragic are viral STDs, especially HIV which lead to AIDS and is almost always fatal. Globally, at least half of those currently infected with HIV are younger than 25 years of age. In South Africa, the National Sero-Prevalence Survey of Ante-Natal Women attending Public Health Clinics found that the infection rate amongst adolescents has increased from 12% in 1997 to 21% (DOH, 1998).

The rate of increase amongst adolescents aged 15-19 years was highest (65%), in comparison to 32.5% and 47% among women in their twenties 20-24 and 25-29 year olds respectively.

In Djibouti, over half the sexual active adolescent males had never used condoms and 80 percent did not consider themselves at risk for HIV infection (Radier et al, 1993). Similar findings have been found in Zimbabwe by authors such as Nyachuru - Sihlangu and Ndlovu (1992). Young people, especially adolescent males, have a sense of invisibility and risk taking that is characteristic of this stage in life. Impressing on them early on of their risks may positively influence some to change.

2.6 LACK OF SERVICE FOR YOUNG MEN

Young men are largely alienated from the health care system because most reproductive health services are oriented towards a female audience. Adolescent males are therefore forced to depend on friends for contraceptive suppliers, or to purchase them on their own. In a study in Ghana conducted by Glass (1995) it was found that young men rarely obtain condoms from clinics (where they are usually free), getting them from chemists and shops (where they are for sale) instead. Limited access, compounded by the price of condoms, can discourage consistent contraception.

Making contraceptive services more available for men including adolescent males, and enhancing their image may increase the likelihood that contraceptives are used. For example, a study in Zimbabwe found that presence of a Community Based Distribution (CBD) of contraceptives increased the likelihood of the adolescent contraception.

Although service delivery for young men has not been comprehensively studied in Africa, one could argue that it is true that many health providers are not used to

serving young men. Young men are not likely however, to visit STD clinics and this could be suitable opportunities to introduce contraceptive methods and give age appropriate information on sexual and reproductive health and rights. Regardless the efforts so far, there is a need to improve service delivery specifically targeted at young men.

However, other small-scale efforts to provide services for men have had encouraging results. Community out-reach efforts in Cameroon, Ghana, Kenya, Mali and Swaziland have provided men with information and contraceptives in their homes and at their places of work. A program in Cameroon enlisted male community leaders in rural areas; after one year, knowledge of condoms among men in the project communities rose from 52% to 81% (Rosen & Conly, 56:1998).

In Ghana, an information campaign designed to encourage men to visit public health facilities was found to have increased discussion of family planning between men and their partners, as well as use of contraceptive methods. Male only clinics have also been tried in a few African countries, with mixed results. In spite of these efforts, family planning and reproductive health programs in the region for most part continue to ignore the needs of men. Most men lack good information on family planning and reproductive health; existing services are rarely geared towards meeting their needs. In the vast majority of clinics, men still feel neither welcome nor comfortable asking for family planning services.

2.7 ACCESS TO INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Young men also have limited access to formal reproductive information and education. While girls receive information from mothers or aunts, boys are less likely to talk to family members about sexual matters (Mc Cauley and Salter, 1995). The onset of menses for females serves as an obvious maker that a discussion is needed; males do not have such an obvious phenomenon. Therefore many opportunities that could broach the topic are geared for females (for example home economics classes in school).

Young males are therefore less likely to receive detailed information on puberty development, and are forced to depend on books, magazines, radio, television, videos and other mass media. Many boys in fact blame their sexual urges to the pornographic literature they exchange with each other (KYIP, 1995). Many mothers and fathers admit they do not often talk to their children, especially sons, about sexual matters.

For example, a study conducted in Zaire revealed that, while 50% of the mothers said they had spoken to their children about sex education, only 20% of the fathers had. Many parents preferred other family members or community members to take this role (AZBF and Population council, 1993). In South Africa, a study of university students found that only 40 percent had received contraceptive information from their mothers but fewer (20 percent) had received any from their fathers (Nicholas, 1993).

A study involving 5 599 male and female adolescents in Nigeria conducted by Makinwa- Adebusoye (1992) confirmed that parents were one of the least common

sources of information on sexuality (). In the North West Province of South Africa one study found that less than 40 percent of the boys aged 13 to 18 had ever discussed teenage pregnancy with their parents, although 78 percent were sexually active (Kau, 1991). This low parent-child communication is due to numerous factors including parental discomfort, parent lack of knowledge and parental apprehension about the reaction by the young person.

In addition, many young people do not like to discuss sexuality with parents. From the researchers own work experience in interacting with adolescents and parents, it has shown that in most instances, many parents assume that youth get the information from schools, so they do not see the need to communicate with them. In addition, many youth are more educated than their parents are and parents may feel unable to discuss these issues with them.

It is also likely that few parents themselves received discussions on sex education. Moreover, sexuality education in many African cultures was not the domain of parents; rather special guardians provided relevant instruction during initiation and puberty rites. The breakdown of these traditional structures has led to vacuum that parents are often unable to fill. The end results are an unfortunate cycle of silence, anxiety and helplessness both by parents and their adolescents.

2.8 YOUNG MEN AND RISKY BEHAVIOUR

Young men are heterogeneous group and programs should tailor themselves accordingly. Boys are more likely to become street youth, to be incarcerated, to become migrant workers, and to lead lifestyle that can make them less accessible to

reproductive health services. In Africa, it is estimated that there are 10 million street children, and most of these are boys.

Many are now vulnerable to conditions that were traditionally assumed to be female concerns for example prostitution and sexual exploitation. For example in Nigeria, many motor park boys are forced into sexual relations with long haul truck drivers, leaving them vulnerable to STDs (Nnoli, 1992).

Some authors such as Richter and Swart- Kruger (1995) reported that in South Africa, street boys report that their clients are often insistent on unprotected penetrative or oral, anal or vaginal intercourse. In some countries, young people, particularly women, face sexual abuse. Rape is the most common form, but abuse also includes sexual assault, incest, involuntary prostitution, and other harmful practices. These types of abuse can result in physical injuries, unintended pregnancy, STDs and HIV/AIDS and psychological trauma.

Studies have shown that those who have suffered from sexual abuse are more prone to low self- esteem, earlier consensual sexual activity, and high-risk behaviors, such as multiple partners and substance abuse (Family Health International, 1998).

Young men are also more likely to engage in behaviors that can cloud their judgement, for example drinking and using drugs (Flisher: unpublished). Misuse of alcohol and other drugs was cited in other studies as reasons for violence amongst most men. Interventions addressing young men need to recognise these emerging populations and be able to respond to their unique needs.

In South Africa, violence within sexual relationship, in the form of physical assault and forced sex, is an important area of concern. According to Wood & Jewkes, (1998:6), recent research has contributed towards understanding the nature and extent of male violent practices among youth.

A qualitative study conducted among pregnant teenagers in Khayelitsha, Cape Town (Wood and Jewkes 1998, in press) showed violence to be a consistent feature of teenage sexual relationships and the primary means by which pervasive male control over female partners was enforced.

The authors therefore argue that from a public health perspective, such violence and coercion limit young women's capacity to protect themselves against unwanted sexual intercourse, pregnancy, and STDs including HIV/AIDS. The mental health effects of abuse of women are recognised but have been poorly documented in Africa. They include loss of self-esteem, depression, anxiety disorders and suicide.

2.9 THE ROLE OF MALE PARTNERS IN COMBATING ADOLESCENT PREGNANCY

2.9.1 Male reproductive health issues

Family planning is listening to what people want, not telling them what to do. And it works best when we begin with where people are in their social lives (socialization), not where we sometimes wish to be. Without doubt, some men treat women abominably. But most men most of the time, want the best for their families. Surveys from around the world commonly show little difference in desired family size between

men and women. Some women say they cannot use contraceptive methods because their partners object, but fortunately the number is usually small (IPPF, 1996:2).

In Iran in the 1960s an alert psychologist called Siassi noted that only 12% of women who began taking oral contraceptives were still using them six months later. Instead of blaming the consumer for these disappointing results, he changed the distribution system. He gathered together the partners of the same group of women, told them how pills worked and distributed the contraceptives to the men to pass on to their wives. The continuation rate at six months jumped over 80%. Clearly Iranian men were comfortable seeing their wives use contraceptives if they could be directly involved, but threatened if the women appeared to act unilaterally. Helping couples avoid unintended pregnancy was seen as immediate and real liberation for women (IPPF, 1996:2).

A number of goals could be served by changes in patriarchal male-female dynamics: social justice objectives of increasing equality, the demographic objective of lowering population growth rates and the public health goal of reducing disease, especially STDs and HIV/AIDS. Greater participation by men could thus contribute to the goal of reproductive health in a variety of ways (IPPF, 1996).

However, she noted that there is as yet no generally accepted understanding of what men's involvement actually means. Often it has been defined as the importance of increasing the popularity and prevalence of vasectomy or condoms. She therefore argues that the seemingly simple phrase "male involvement" still hides a variety of different meanings or philosophies. This assertion suggests a clear definition of the above phrase using gender analysis to enable men to play a significant role in

society.

Other interventions suggested above include improving communication between partners which is likely to increase the correct use of contraception and decrease both disease transmission and unintended pregnancies. In a study of 76 sexually active young men and women in Denver in the United States, it was found that male motivation to use contraceptives, particularly condoms, was high because they wished to prevent pregnancy and the spread of STDs and HIV/AIDS (IPPF, 1996:27).

2.9.2 Female reproductive health issues

The extent of reproductive health problems among adolescents is a matter of increasing concern, but also a matter of debate. Cultural obstacles to open inquiry into the sexual lives of married and unmarried adolescents impede most researchers' ability to collect data in this area. Prevalence data on sexually transmitted diseases (STDs) are rare, particularly on population based samples, and data broken down by age groups are even more rare. According to a review of the epidemiological data, when STD levels for girls are reported by age, rates are higher among 15-24 yrs; however, most of this data are collected from family planning and ante-natal clinics, and girls who attend such clinics are unlikely to be representative of active adolescents (Mensch, Bruce & Greene 1998:43).

Mensch at,al (1998) further argues that for biological and social reasons, adolescent girls are vulnerable to more reproductive health problems than boys. Consider their risk of pregnancy related morbidity and mortality, and are more vulnerable to certain problems that affect both sexes, such as HIV infection. To illustrate, two population-

based surveys in areas of Tanzania and Uganda revealed that 13%-17% of females aged 15-24 yrs were HIV positive compared to only 5% of males in the same age group.

Mc Cauley and Salter in Mensch et al (1998:52) state that whether adolescents' knowledge of reproductive biology and health has been studied; data indicate that adolescents have a minimal grasp of this biology and a limited understanding of how to prevent pregnancy and reproductive health problems. Therefore the girls' knowledge of reproductive biology and health is critical to their ability to protect themselves from unwanted reproductive outcomes.

Intervention should target both girls and boys at early ages educate them at the very least, about human sexuality including issues of how pregnancy happens, how STDs are spread, and what unwanted pregnancy and sexually transmitted infections including HIV/AIDS. Interventions that focus on promoting abstinence, providing life skills education and access to services should target both groups of adolescent who are sexually active and those who are not yet sexually active. The role of peer education should not be under-estimated.

In Namibia, the Strengthening Male Involvement in Reproductive Health Project trains cadres of peer educators to conduct ongoing educational sessions for other young men within the defense and police forces. While in Ghana, the Red Cross and the Scout Association have organized a peer education programme to provide training in negotiating safer sex and refusal and assertive skills (Focus on Young Adult 1998:2).

2.10 SUMMARY

This chapter gave a review of literature relevant to the study of male partners in combating adolescent pregnancy. The literature was drawn to highlight the perception, attitudes, behaviour and practices of male partners from gender and reproductive health perspectives.

CHAPTER THREE

RESEARCH DESIGN

3.1 INTRODUCTION

The previous chapter was based on review of relevant literature related to the role of male partners in combating adolescent pregnancy, from the South African, African and international contexts. The purpose of this chapter is to discuss methods used to answer the research questions.

The study was qualitative, using exploratory study design to understand the phenomenon under study through exploring perceptions, opinions and feelings of both males and female adolescents about adolescent pregnancy as a problem and the role of males. Data analysis as described in this chapter involves the blending of both qualitative and quantitative data. Various tools are triangulated to validate data and give more meaning to the study.

3.2 DESCRIPTION OF RESEARCH DESIGN

The phenomenon of interest in this study has been the "role of male partners in combating adolescent pregnancy. An exploratory study has been conducted to identify factors contributing to adolescent pregnancy and the part various male partners could play in combating adolescent pregnancy in the area of Letlhabile. Polit and Hungler (1995:11) explains that explanatory research begins with some phenomenon of interest to explore its dimensions, the manner in which it is

manifested and other factors which may be related.

An exploratory study has been considered for this inquiry because the available literature and existing knowledge base about the topic is poor as many studies suggest. Male involvement in reproductive health is a new area of focus particularly in Africa. Although studies around adolescent pregnancy have been conducted the major focus has been on the female adolescent than the male partner.

Qualitative data gathering was used through the design of unstructured questions using a questionnaire guide to be able to gather as much data as possible about the topic. For analysis of the collected data both qualitative and quantitative methods were used.

Because of the complexity and sensitivity of the topic, a qualitative study was preferred than quantitative study. While quantitative method would have reflected numerical data to explain the phenomenon, qualitative method required the researcher's maximum involvement in the data collection process to explore to respondents' actual feelings and opinions about the phenomenon under study and observe some behaviors during discussions through narratives.

In the analysis of data the study was able to integrate both qualitative and quantitative methods. Some of the qualitative data was translated into schemes to quantify responses and attaching numerical qualities, and also to identifying the effect such variables may have on responses given, such as contraceptive use and religious affiliation, for example.

Two types of variables were identified to make data quantifiable, that is continuous variables of age, sex and family setting, discreet variables of religious affiliation, number of children, employment, etc. The above approach of data analysis is supported by Polit and Hungler (1995: 520) who asserted that an understanding of human behaviors, problems, characteristics is best advanced by the judicious use of both quantitative and qualitative data.

3.3 THE RESEARCH SETTING AND NEGOTIATING ENTRY

Various research settings were undertaken to collect data from the respondents. Both naturalistic (home) and quasi-natural settings (school and clinic) were used to access information from respondents sampled for the study. Because the population comprised of all adolescents who were pregnant and those adolescent mothers who attended the clinic at Letlhabile Clinic, the following were identified as research settings:

- Two focus group discussions with adolescent mothers who were attending school, were conducted.

- Two focus group discussions with pregnant adolescents were conducted at the clinic.

- Four focus group discussions with the in-school adolescent fathers, and those who were not fathers were conducted.

- All individual interviews with male respondents were conducted at the school, while two of the ten individual interviews with pregnant adolescents were conducted at their homes by the researcher. Three other female respondents who had delivered babies at the time of the study were followed up at their homes for interviews.

In all the above cases arrangements were made with the clinic and the school management through letters of permission and consultations by the researcher. The researcher worked with relevant officials (Life-skills Teacher and the Health Care Worker of the Maternity Unit) identified for this research project, to select a purposeful sample from the population under study.

Since participation in the study was voluntary, respondents were given informed consent both at school and at the clinic. There was no disruption of lessons at school as interviews were held after school and were coordinated by the Life-skills Teacher. While at the clinic, a conducive environment was created to interview respondents after ante-natal care.

With regard to home visits, a letter of permission to parents/guardians, with a clinic stamp followed by appointments and confirmations by telephone where applicable was done. All such appointments were done with the clinic health worker who also provided the contact details of these respondents. Clinic records served as primary source of information for this exercise.

The researcher always observed cultural rituals with regard to pregnancy and delivery. These included among others, the fact that strangers are restricted from

holding a new born baby for fear of causing a delay in the healing process of the umbilical area. An observation was made during the research process, that one of the adolescent mothers was found to be staying alone during the day when parents had gone to work, but the environment did not seem to appear poor. While two other respondents were seen supported by their mothers who were housewives.

One of these adolescent mothers was already attending school as the baby had turned two months old and looked after by its grandmother. The clinic confirmed that male adolescent do not utilize the clinic except for condom use for some young people. Another observation made by the researcher was that the category of males that attended the clinic on several days that she has been conducting interviews, comprised mainly of adult and elderly males.

Of all adolescents who were consulted for the study, only three pregnant adolescents said that their parents refused to give consent for the interviews, and they were excluded from the study. Their exclusion did not influence the number of participants.

3.4 ETHICAL CONSIDERATIONS

3.4.1 Informed consent

Various channels of informed consent were explored with parents of respondents as well as significant others, e.g. teachers who are secondary caregivers during school hours. Respondents who were 18 and above were given a written informed consent, and verbal explanation to participate in the study.

In both focus group discussions and individual in depth interviews, content areas of the informed consent included the following details:

- That the data collected is solely for the purpose of the study and not for any other purpose.

- That the purpose of the study was to explore and describe the views of male partners in combating the problem of adolescent pregnancy.

- That data collection involves focus group discussion and an in-depth interview.

- That the process of interviewing will take about 2 hours.

- That they were selected on the basis of purposive sampling because they have certain characteristics that not all other learners have for the purpose of this study.

- That their names will not be quoted anywhere in the study but only responses will be referred to in several discussions

- That they are assured of their safety of the environment, and that the researcher will terminate the study at any time should there be anything that threatens their safety and comfort, such as, labour or complications associated, with the pregnancy, or any emergency on the male respondent.

- That snacks and drinks will be served during the interviews and respondents should feel free to have some.

- That they are assured of the maintenance of privacy at all times throughout the interview and all information will be treated as confidential as possible, that under no circumstances will their names be quoted. Hence use of numbers to refer to their responses will be maintained.

- That they should feel free to withdraw from the study at any given time. Respondents were told that they have a right to refuse to divulge any personal information about their experiences if they deem so. They were also assured that there is no right or wrong answer and thus freedom of expression is promoted and their views will be respected Polit & Hungler (1995: 119 –127).

3.4.2 Other ethical considerations

A written letter of permission was handed to the Health and Education Authorities of Brits District. An approval letter was granted from the Health and Education Authorities to undertake a study in the proposed area. Further consultations were made with the local clinic authorities and as well as the school authorities to discuss the purpose of the study, its significance and benefit to the study population and the community in general and the methodology.

A meeting was held with a team of health workers at Lehlabile clinic in February 2000 to discuss the above issues and with two Life Skills (guidance) teachers at Eletsa high school. A contact person to work with the researcher throughout the process

was identified in both settings, the clinic and the school.

While at the school some of the learners who were at the age of 18 and 19 years had consent to take part in the study, informed consent had to be obtained from the two Life Skills teachers and voluntary participation in the study was promoted. However it was not difficult to get the cooperation of learners in the study as the researcher was told that HIV/AIDS life skills education has been incorporated into the school curriculum and the school supports the study. Ethical considerations were observed throughout the study.

3.5 POPULATION AND THE SAMPLING PROCESS

The study population comprised of all adolescent males and female in school and those who utilize the clinic for services. In order to access the target population the local clinic, as the primary service provider of this population was visited. In addition the local school was also visited to include some of the target population who were less likely to use the clinic for their pre and postnatal care. The two institutions were targeted as they provide services for the population under study. The sample was drawn from the following category of the adolescent population:

Adolescents of both sex between the ages of 10 –19 years, with the following characteristics:

- 7 per focus group of those that were pregnant (pregnant)
- 7 per focus group of those that were mothers (non-pregnant)
- 7 per focus group of those that were fathers (fathers)
- 7 per focus group of those that had not made any girl pregnant (non-fathers)

The clinic and the school were found to be relevant settings to gain access to a purposeful sample for the data collection. Given the sensitivity of this topic, it would not have been easy to interview any of the above sample, say by convenience or randomly as the study would not achieve its objective.

This approach is supported by Polit & Hungler; (1995: 230), who assert that, the accessible population is the aggregate of cases that conform to the designated criteria and that are accessible to the researcher as a pool of subjects for a study. Consequently in order to access the target population of teenage mothers, fathers and currently pregnant teenagers and their partners, the clinic and the school provided the necessary information.

In the 1990s a perspective on sampling qualitative research approach discounted probability and convenience sampling. For authors such as Paton (1990), purposive sampling seemed the most appropriate. Authors Bickman and Rog (1994) who believe in purposive or judgmental sampling reiterated the above information.

3.6 TOOLS FOR DATA COLLECTION

Both focus group discussions and individual in-depth interviews were used to collect data. The two tools for data collection were preferred for the following reasons:

- Little is known about the topic and where studies are available, emphasis is on female adolescent from which interventions drawn pay less attention to male involvement. These data collection tools intend to further explore the feelings and opinions of males in this area of adolescent pregnancy.

- When conducting the main study, these data collection tools have shown to be applicable to various settings including the homes, the school and the clinic. These settings did not seem to affect the consistency of the questions asked

- Since the study was conducted at the same nearby location by one investigator, no elaborate tools or equipments were required, and less cost implications were incurred. (Royce, Singleton, Bruce et al 1993: 316-320)

An interview guide was prepared for use in focus group discussions of both respondent types and a questionnaire guide for both respondent types in individual in-depth interviews. The structure of the questionnaire guide contained both structured and unstructured questions.

Same questions were asked to both groups but with gender variation. Structured questions allowed for some data to be analyzed quantitatively, while unstructured questions, which were used to gather more deeper and thoughtful responses that formed most of the narrative statements in the analysis of data. The researcher conducted all of the individual in-depth interviews.

During interviews the researcher was able to observe and record certain behaviors of the respondents as well as environmental conditions in other settings to compare with verbal responses on questions asked. This process is supported by authors such as Royce et al, (1993:343), who state that in a field research "the primary sources of data are the words and actions of the people", you are observing, listening to, and entering into conversations with.

The observer will have to rely on listening and observing, while the participant has access to the broadest range of data. This assertion however supports the approach undertaken to collect data. To manage and record data, the researcher used a tape recorder in all focus group discussions to record all what was said and jotted down some notes on key words, emphasis statements, and observations made that could not be captured by the tape recorder during the interview. Transcripts were made for analysis of qualitative data.

3.7 METHODS OF ANALYSIS ARE ELABORATED ON:

3.7.1 Validity process

To ensure validity of the instrument the following was done:

- A small-scale pilot study was conducted to pretest the questionnaire. The questionnaire was presented at a district hospital involving male respondents who had made girls pregnant and those who have not; pregnant adolescents attending antenatal clinic as well as adolescent mothers who had delivered at the hospital.

- Data was triangulated from using various tools of data collection, including a focus group discussion, an in-depth interview, document review and observation. This process is important as it increases reliability and content validity of information gathered. Triangulation process followed in this study is discussed further below.

- Before the main study was conducted the improved questionnaire was discussed with a statistician to determine whether the questions are relevant to the research problem and the feasibility of the study. To ensure representativity of the sample, the male adolescent fathers aged 14–18 were selected to compare with adolescent males aged 15–20 who were not fathers.

- Among the category male fathers there were those males who were fathers to be or already has babies while those that were not fathers some were sexually active while others were not.

- The female sample comprised of pregnant adolescents between ages 13–18 to compare with adolescent mothers (non-pregnant) aged between 14–18 years. All respondent types were interviewed either one of the following settings, including the school and the clinic, while the home setting was also used for some female respondents.

- Most of the female respondents were in school while some were out of school due to pregnancy. Almost all-male respondents were in school. The same questionnaire was administered to all respondents with variation on some sex and gender questions.

- The nature of the sample itself (non-probability), does not guarantees that there is a probability that each element has been included, and that every element usually does not have a chance for inclusion. (Polit and Hungler, 1995:231). Therefore the study will not be generalized to the entire population of adolescents in the North West Province.

- The researcher made use of the service of an independent assessor who had no interest in the study to critique and give meaning to data through out the study.

3.7.2 Triangulation of data

The study focused on various methods for data collection. The following data collection tools were used to gather information about the subject matter:

- Focus Group Discussion,
- Individual In-depth Interview
- Observation
- Review of Documents relevant to the topic

Through the use of different tools for data collection, various themes, categories and patterns emerged to confirm the extend of the problem in almost all discussions to determine how resorts converge. These trends led to a better understanding of the question from all the tools used.

In analyzing data, the process of triangulation gave substance and credibility to the study and is seen to have increased the reliability of the observations. While on a study courses in Malawi in 1999 March and in Washington DC in November 1999, the researcher was able to share the research proposal with some course facilitators with research knowledge. Through their involvement the researcher received guidance in constructing a questionnaire for this study to answer questions asked by the topic. The researcher was also introduced to the concept of triangulation of data

in all the above courses she attended.

3.7.3 Reliability process

There was consistency in the response from both respondent types as the same instrument was used to gather data. The results of a pretest contributed to the restructuring of the questionnaires to include more relevant questions.

The same questionnaire guide was administered to both female respondent types and was able to yield the same responses to the research question. There were no significant differences in response to questions by pregnant or non-pregnant respondent. This also applied to male respondent. Triangulation of data has also ensured reliability of the instruments used for data collection.

3.8 GENERALISABILITY

Findings of this study are specific to the segment of the population Letlhabile, a community of the District of Brits in the North West Province. Since the sample was relatively small, the study can therefore not be generalized to the entire district of Brits nor the Province.

However, the significance of the study findings (strategies) and lessons learned may influence the development of effective health promotion models in other communities, districts/regions and also in other provinces. Other communities with the similar geographic, social, health and other characteristics may benefit through other means including replication of this study.

3.9 PILOT STUDY

3.9.1 The setting

A pilot study was conducted in July 1999 at Letlhabile, Brits District in the North West Province. The aim of the pilot study was to determine the clarity and effectiveness of the questions, and to determine relevance of the data collection technique, as pointed out by Polit and Hungler, 1995. The pilot study was done at Brits Hospital. The questionnaire was administered to four male respondents, of whom two were fathers and the other two were non-fathers. Four female respondents were also interviewed, two were pregnant and the other two had recently delivered babies and were interviewed from the maternity ward.

3.9.2 Target groups

Those who were fathers were aged 17 and 21 years old, while non-fathers were aged between 16 and 18 years old. However, pregnant adolescents were in the age category of 15 and 17 years old, while adolescent mothers were 14 and16 years old. One noticed that female respondents were quite younger than male respondents interviewed. Each interview took place for fifteen minutes.

3.9.3 Findings

The pilot study found that:

- Contraceptive knowledge is high among male and female respondents. All male respondents indicated that they use condoms. The reason for using

this contraceptive method for most respondents was not for the prevention of pregnancy as stated, but for purposes of protection against diseases.

This was also based on the fact that most males felt that condoms were effective to protect one from promiscuous partners, including issues related to lack of trust, protection from contaminated blood and sexual fluid during sex.

- All respondents knew about where to get information and services about condoms, STDs and HIV/AIDS. However, it was revealed that most males compared to females prefer to get information and services from sources outside the clinic, some indicated the chemist and private doctors for more privacy and confidentiality.

- While two females indicated that they get contraceptives from the clinic, the other two did not use contraceptives

- The above statement may imply that, as long as there is a threat of HIV/AIDS there will be an indirect health benefit between HIV and Pregnancy in terms of the decline. There will certainly be a correlation between condom use and decline in adolescent pregnancy.

This does not necessary mean that the public awareness campaign has succeeded in raising awareness of male about the need to participate in reducing teenage pregnancy.

- Most males indicated that they do not talk about sex and child spacing with their partners only one said he does most frequently. Most males compared to females, felt that women should not initiate sex nor condom use.

- It was found that there were still misconceptions associated with condom use and the rights of women to initiate sex among male respondent. Among females interviewed some indicated that they lacked information on sexuality issues at the time of their pregnancy.

- There seemed to be an agreement among most males and all females that both partners have to take equal responsibility for contraceptive use and child support, while one respondent felt that it is a women's responsibility, and the other one felt that it's the men's responsibility.

- This situation shows that women do not have the right to negotiate when and how to have children and always relied on men to make them pregnant. There seem to be lower level of awareness among males about the Sexual and Reproductive Rights of women as seen above.

This pilot study informed the researcher's modification of questions that did not yield appropriate information. The researcher was able to establish rapport with relevant authorities and gained the skill of interviewing respondents.

3.10 DATA ANALYSIS

The analysis focused on personal accounts related to the problem of adolescent pregnancy and how it could be prevented. Semi-structured interviews were conducted. The transcripts from all the respondents were collated. Qualitative data was analyzed using a coding scheme from the transcripts that were combined. The themes emerged, including condom prevent against diseases; sources of information about contraceptives and HIV/AIDS; and the role of male partners in preventing adolescent pregnancy.

Quantitative data was analyzed through the assistance of a statistician and using an Epi-Info computer program.

3.11 SUMMARY

The above chapter dealt with research methodology describing the type of study undertaken, and explored other methods used to gain access to the research settings including the use of various tools to collect data for validity purposes. Data analysis and ethical considerations were also covered. This is an important chapter because research methodology is seen as the backbone of the research process and determines whether or not the objectives of the study will be met.

CHAPTER FOUR

DATA ANALYSIS

4.1 INTRODUCTION

The previous chapter dealt with the research methodology. This section will address the specifics of quantitative and qualitative data analysis. First, the quantitative data analysis will be discussed. It will be followed by the qualitative data analysis, using the coding scheme as suggested by Polit & Hungler 1995.

4.2 QUANTITATIVE DATA ANALYSIS

This section will address numerical data analysis. The following table summarizes the ages for both male and female respondents who participated in this study. An analysis of demographic data of respondents' reveals the differences between the groups.

4.2.1 Demographic Data

Table 4.1:

Age distribution of all respondents (N=106) males: N= 48; females: N= 48

GROUP	MINIMUM	MEAN	MEDIAN	STD DEVIATION	MODE	MAXIMUM
Father	14.000	16.200	16.500	1.398	15.000	18.000
Non father	15.000	17.100	17.000	1.449	16.000	20.000
Pregnant	13.000	15.600	15.000	1.430	15.000	18.000
Non pregnant	14.000	16.700	17.000	1.252	16.000	18.000

The sample procedure yielded a representative target group. However, given the research setting, the ethnic and racial demographics were not adequately represented.

The mean ages are slightly higher for non-fathers and for non-pregnant (mothers), than for those who were pregnant and those who were fathers. The standard deviations are relatively small, showing that the ages were not very variable.

Table 4.2: Family setting of male respondents (N=20)

FAMILY SETTING	FREQUENCY	PERCENTAGE
Nuclear	10	50%
Extended	1	5%
Single parent	6	30%
Other	3	15%
TOTAL	**20**	**100%**

Table 4.3: Family setting of female respondents (N=20)

FAMILY SETTING	FREQUENCY	PERCENTAGE
Nuclear	8	40%
Extended	3	15%
Single parent	6	30%
Other	3	15%
TOTAL	**20**	**100%**

Table 4.3. shows family settings of both male and female respondents. Approximately half of respondents interviewed came from a nuclear type of a family 10 (50%) males and family 8 (40%) females. There is no difference between males and females from single parent families 6 (30%).

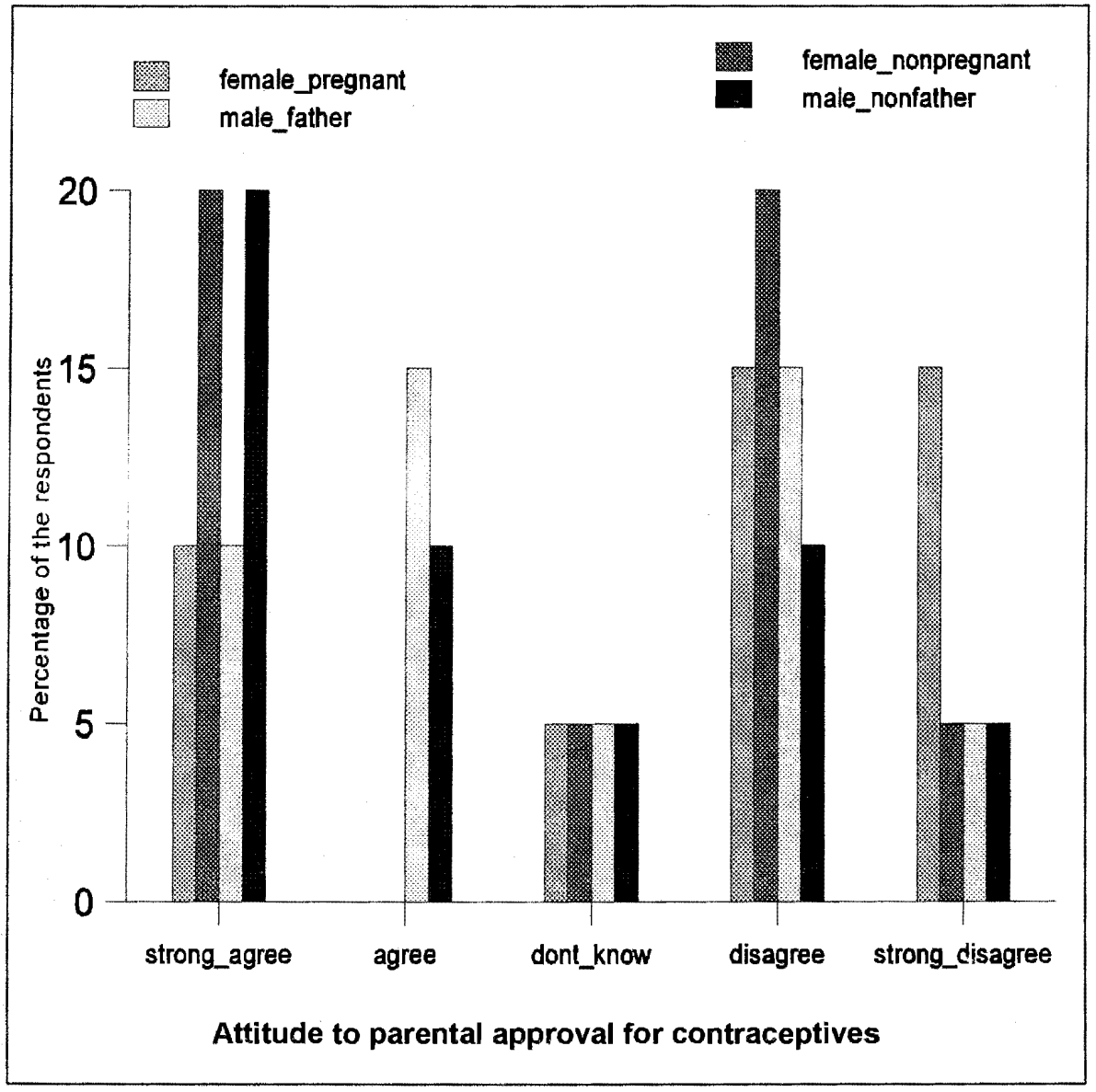
Similar features are also seen "Other" types of settings where about 3 (15%) of all respondents males and females indicated that they come from. About 3 (15%) of female respondents indicated that they come from extended families compared to only 1 (5%) of all male respondents.

4.2.2 Sexuality and contraceptive use

Responses to attitude to sexuality and contraceptives were gathered and analysed using three graphs. A Likert Scale was used to determine the attitude of respondents on several sexuality issues and responses are captured in figures below.

Figure 4.1:

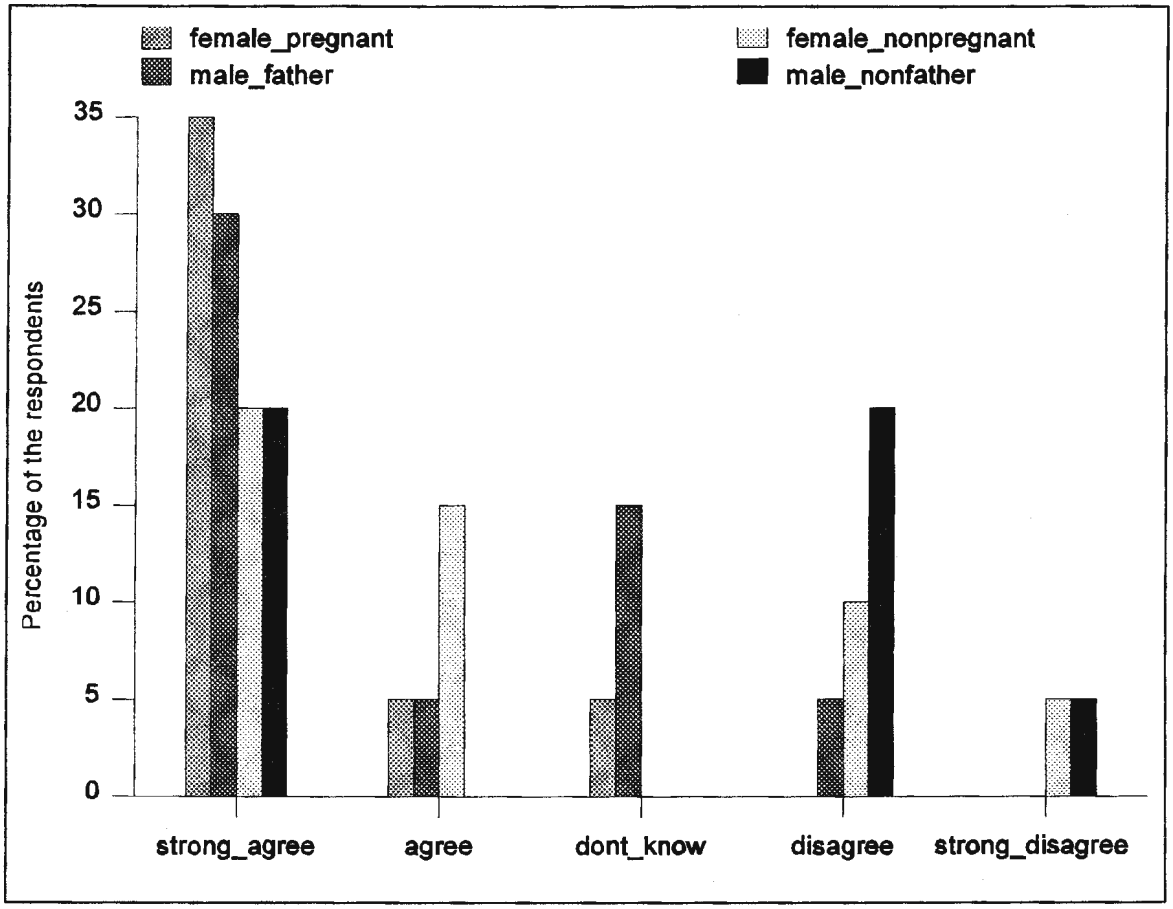
The attitude to parental approval for contraceptives (N = 40)



There is a difference between males and females. Overall males are more likely either to agree or strongly agree (55% males versus 30% females), while females are more likely to either disagree or strongly disagree (55% females versus 35% males).

Figure 4.2:

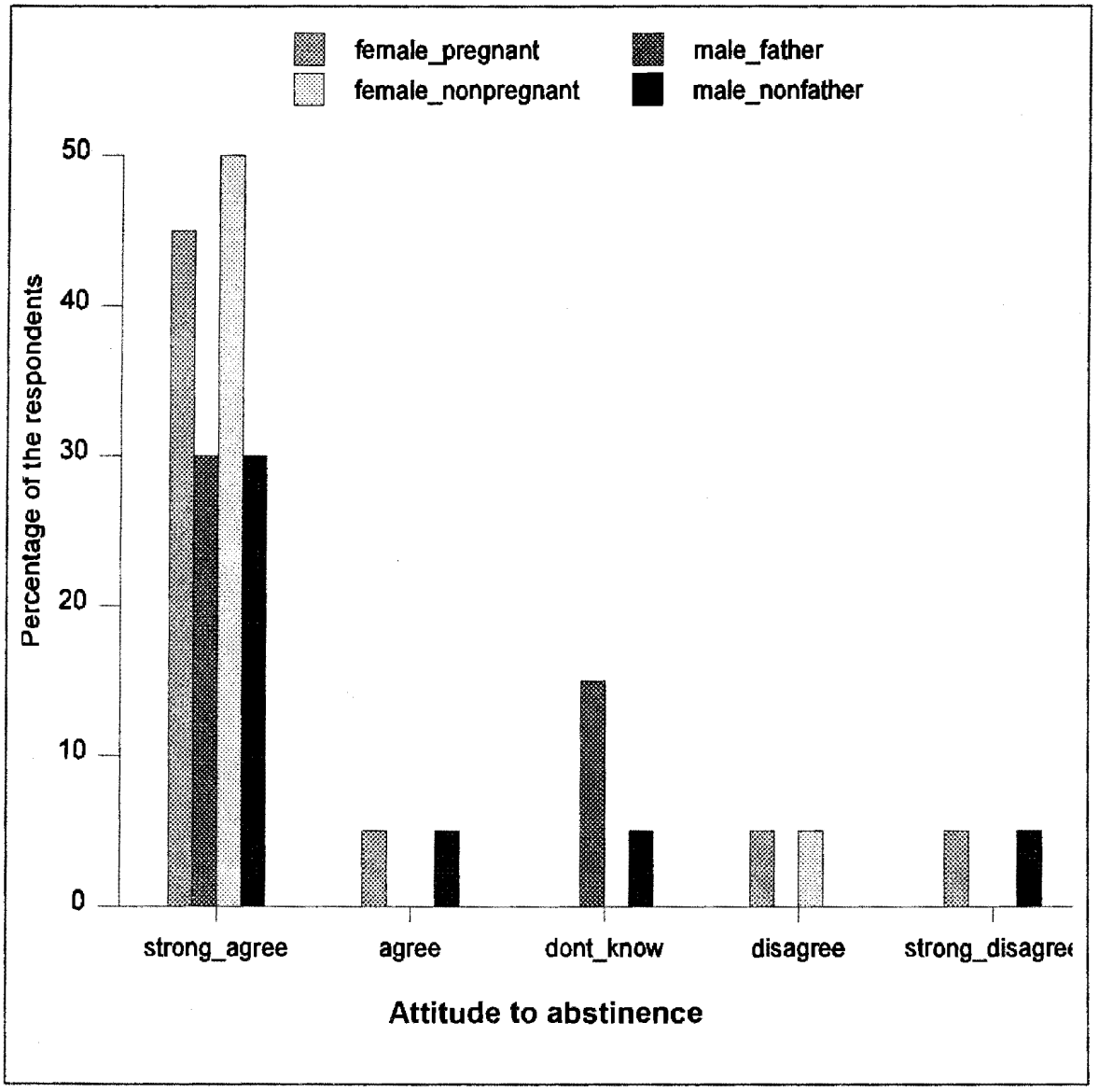
The attitude to access to contraceptives without parental approval (N = 40)



There are differences between males and females responses. Overall females are more likely either to agree or strongly agree (75% females versus 55% males), while males are more likely to either disagree or strongly disagree (40% males versus 5% females). However, 4 (20%) other females felt that they don't know whether sexually active adolescents should or should not access contraceptives without parental approval.

Figure 4.3:

The attitude to abstinence (N = 40)



A significant number of all respondents (85% males and 80% females) tend to support abstinence. All adolescent fathers seemed to strongly agree compared to 9 (45%) of females who are pregnant. The same pattern of responses was observed, with both non-pregnant females, and non-fathers.

Figure 4.4:

The attitude to delaying sex

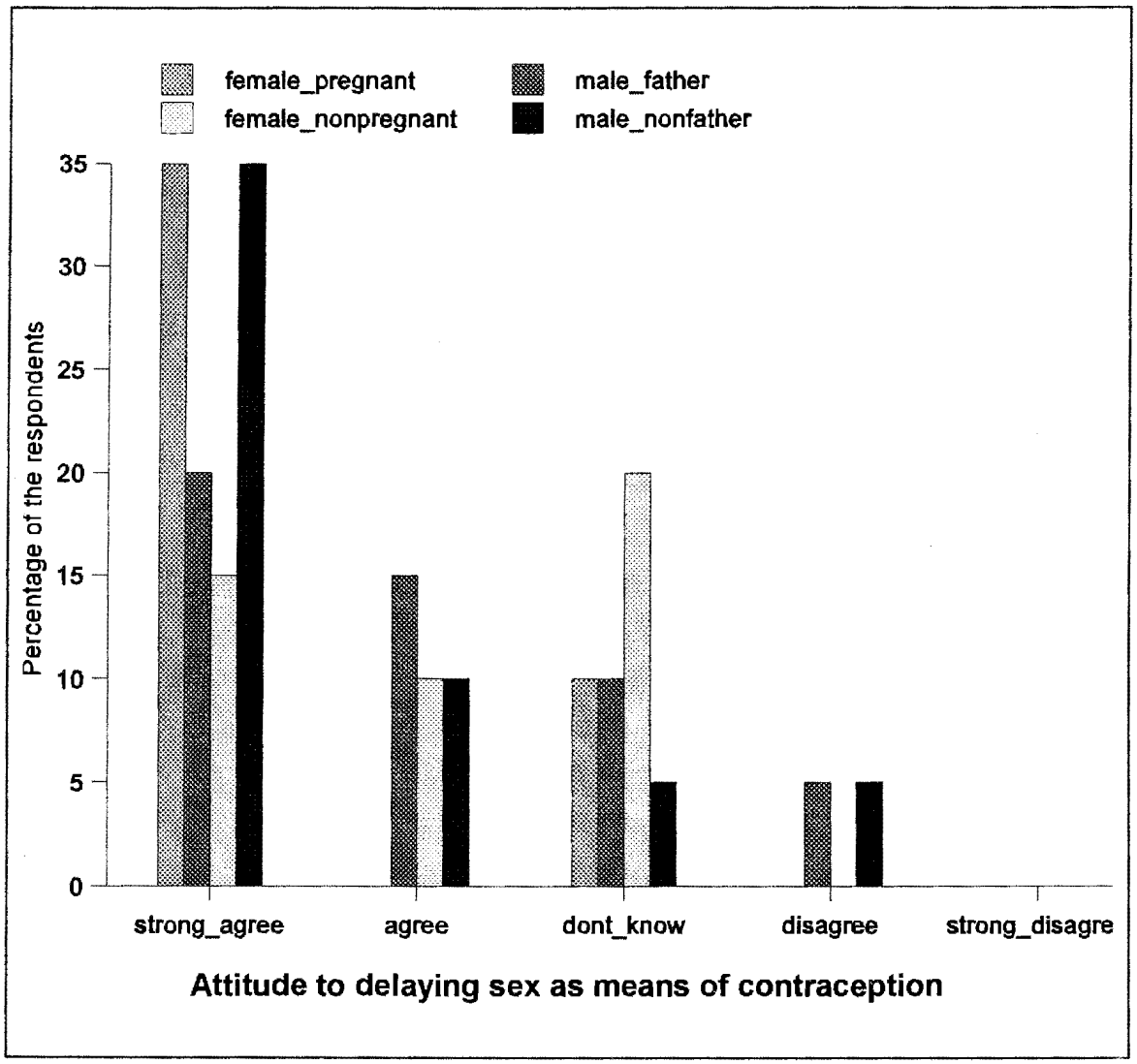


Figure 4.4. shows the attitude to delaying sex. Overall both females and males are more likely either to agree or strongly agree (80% females versus 60% males), while some males and females are likely show lack of knowledge about delaying sex (20% females versus 25% males).

Figure 4.5:

Age at first sexual activity (N=40)

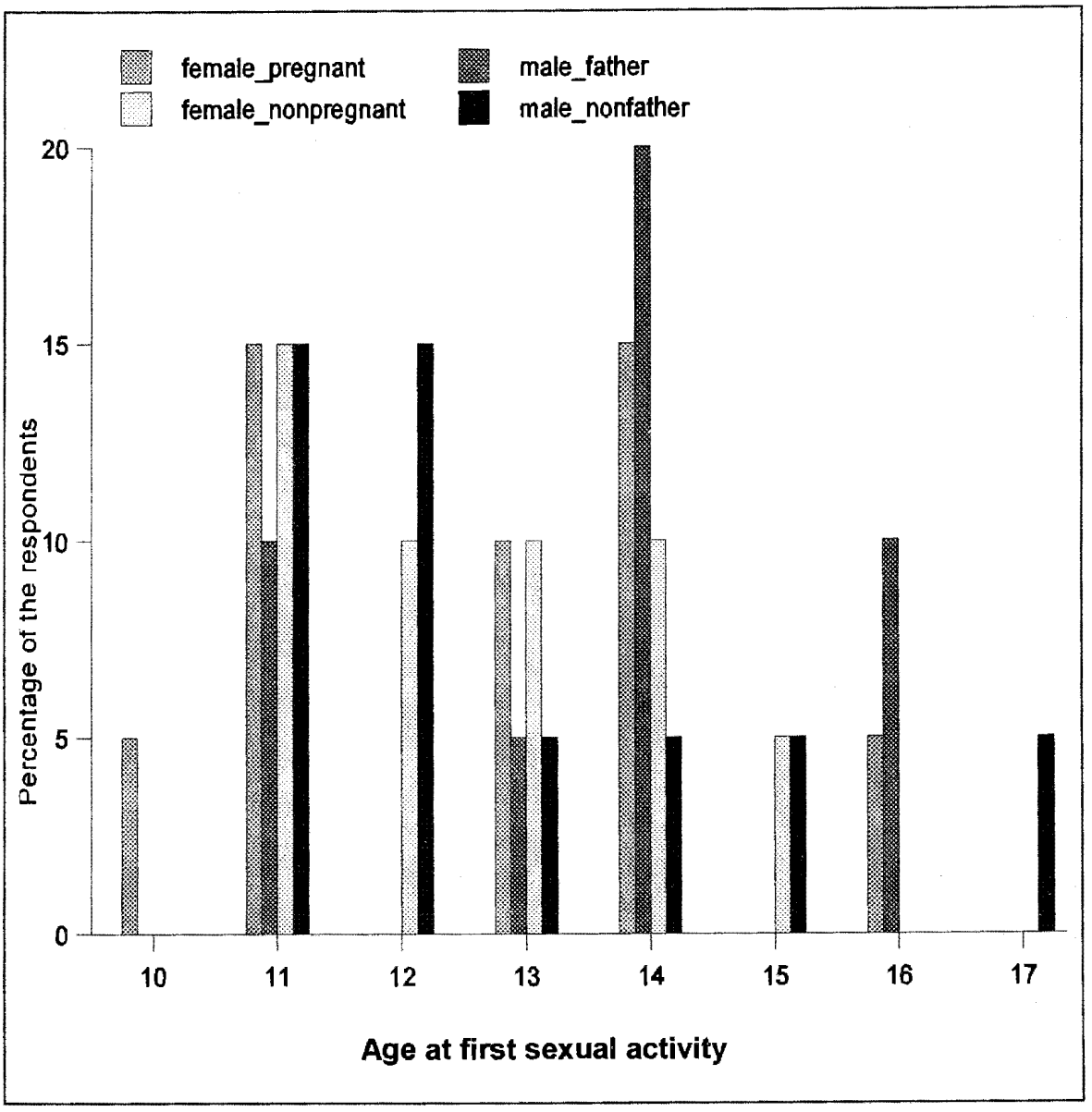


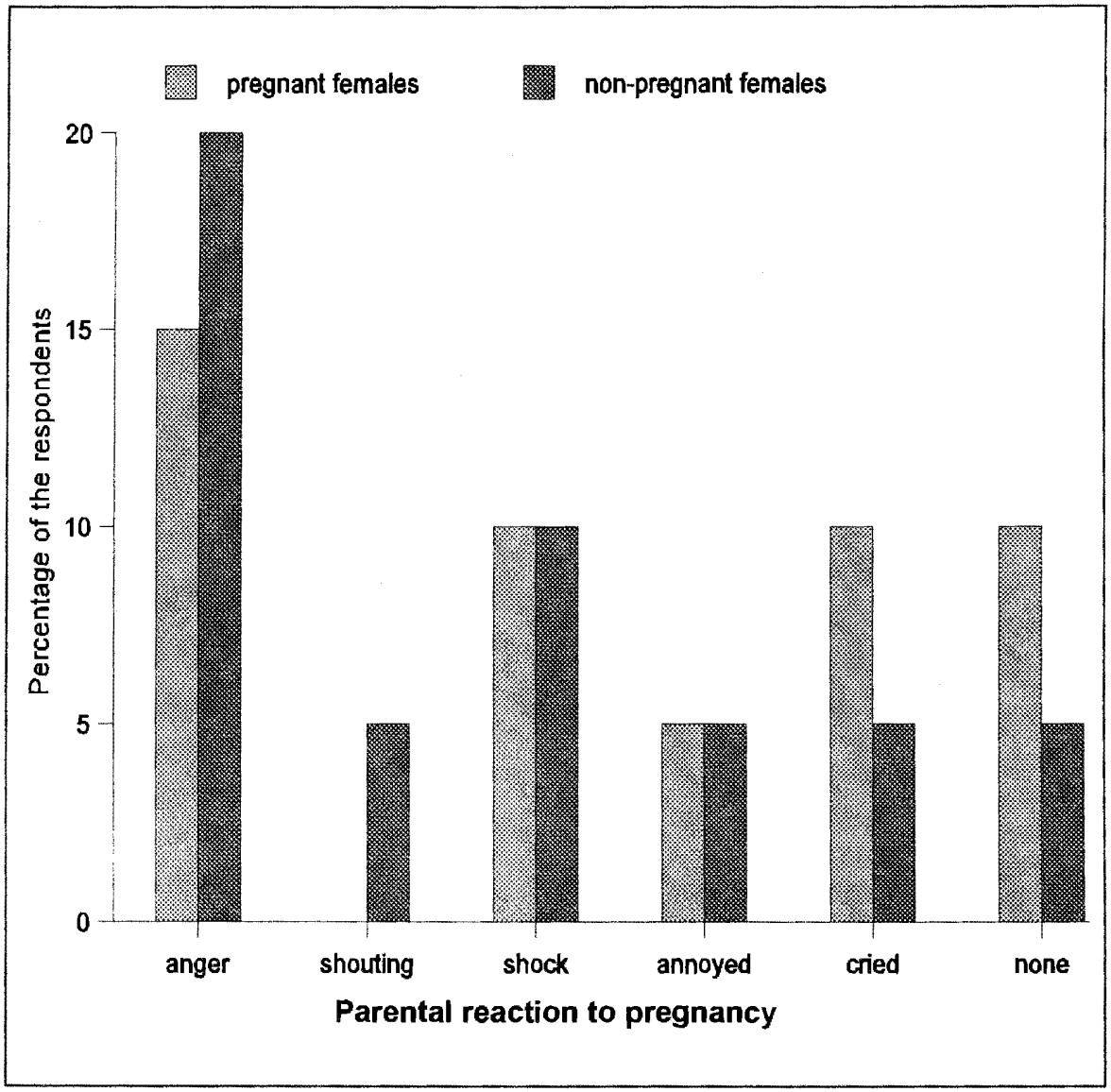
Figure 4.5 shows age at first sexual activity as low among pregnant respondents than in all respondent types, as supported by statistics of the mean ages below:

- Fathers mean age = 12.6
- Non-fathers mean age = 12.4
- Pregnant mean age = 12.6
- Non-pregnant mean age = 11.7

The above findings indicate a pattern of the commencement of sexual activity almost at the same time among all respondents.

Figure 4.6:

Reaction of parents to pregnancy by female respondents (N=20)

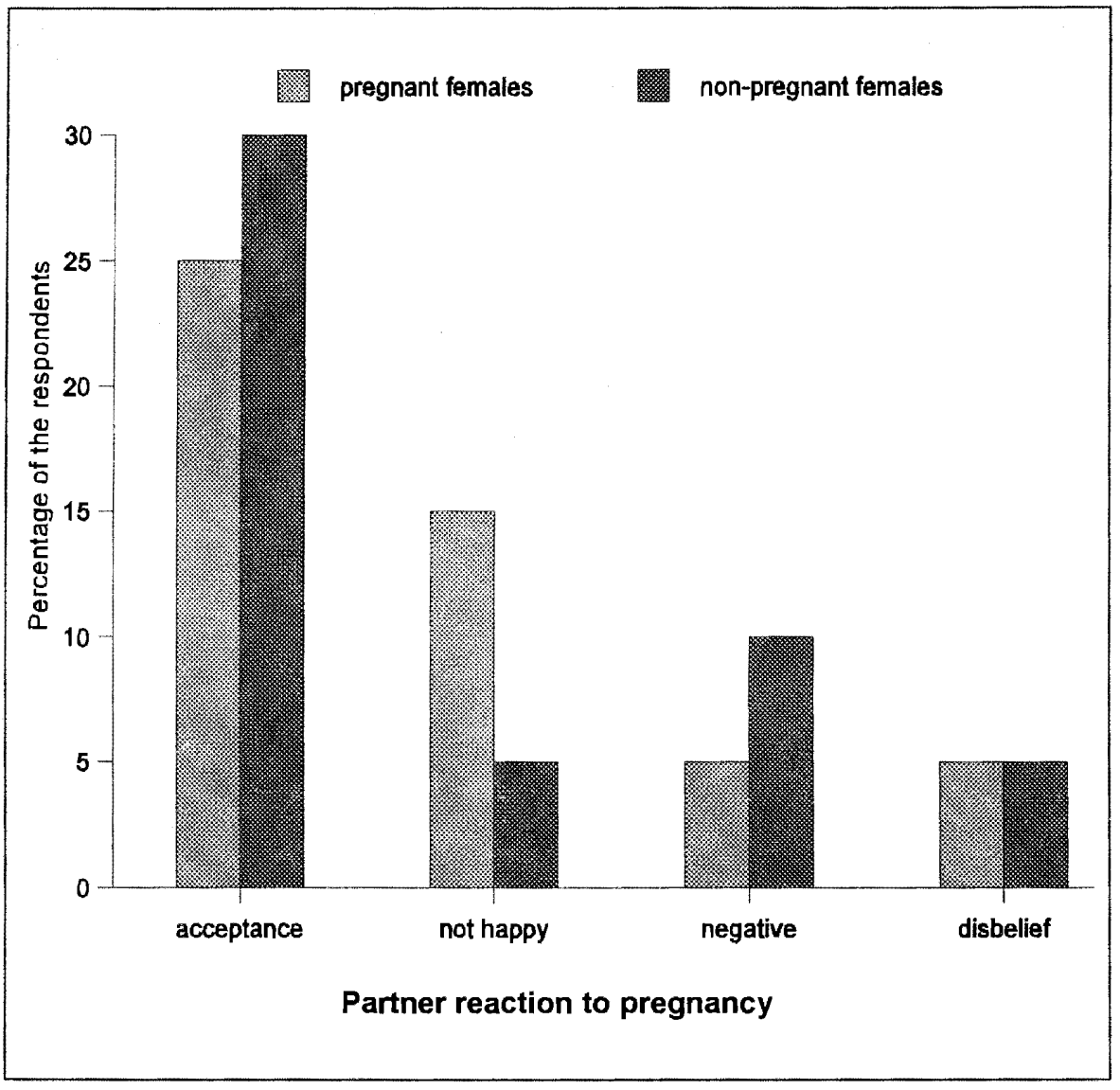


Overall parents are more likely to feel bad about the announcement of pregnancy. Various emotions were expressed ranging from anger 35%, shouting/annoyed 20%, shock 20%, and 15% parents cried.

These reactions seem to be natural emotional expressions of most people when confronted with experiences such as the problem being addressed, from the view that most parents have wishes and ideals for future of their adolescents.

Figure 4.7:

Reaction of partner to pregnancy (N = 20)



On average, most partners (55% male partners) tended to have accepted the responsibility for the pregnancy, compared to 45% partners who were reported not to be happy, negative and disbelief.

Figure 4.8:

The attitude to abortion by male respondents (N = 20)

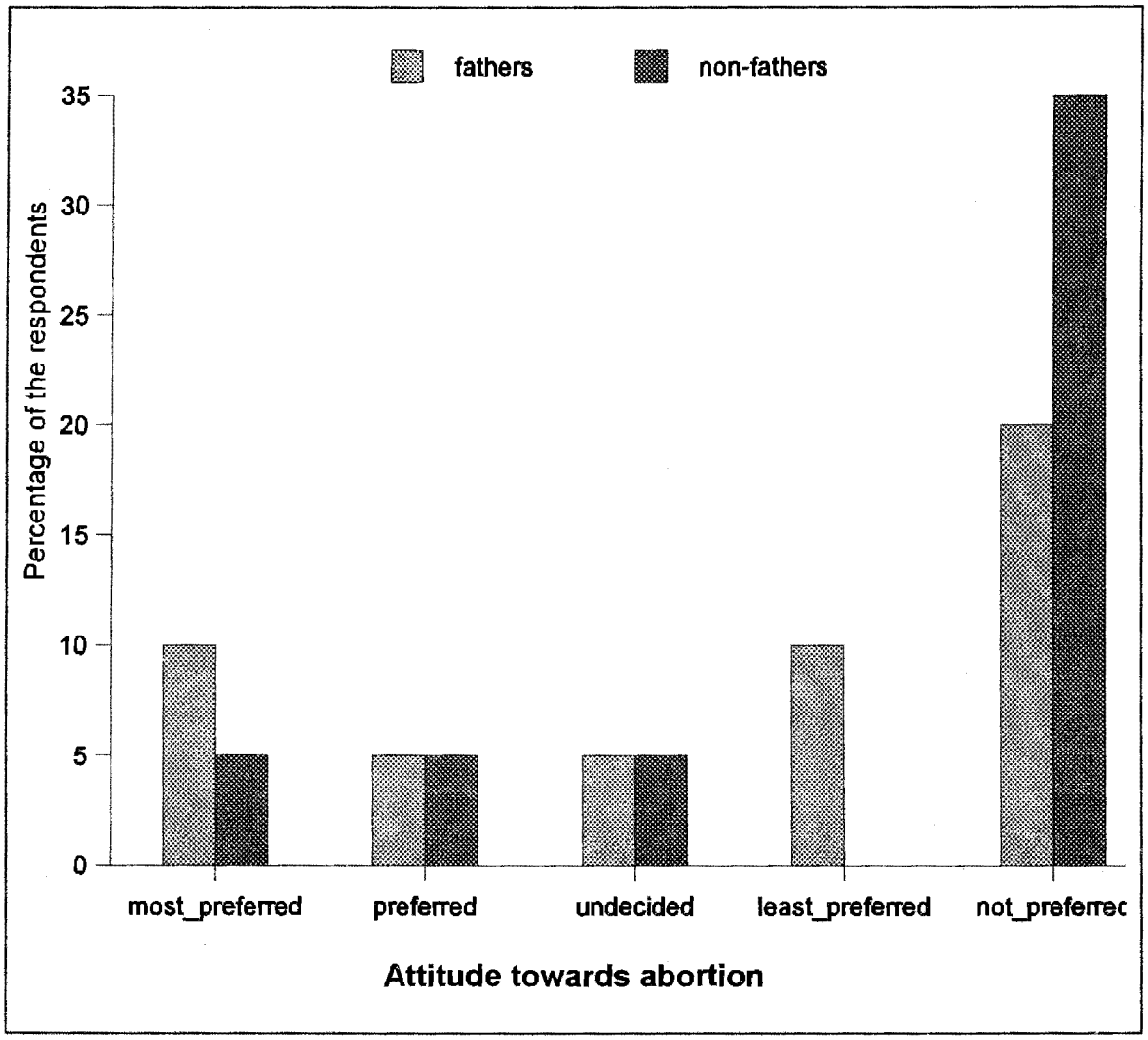
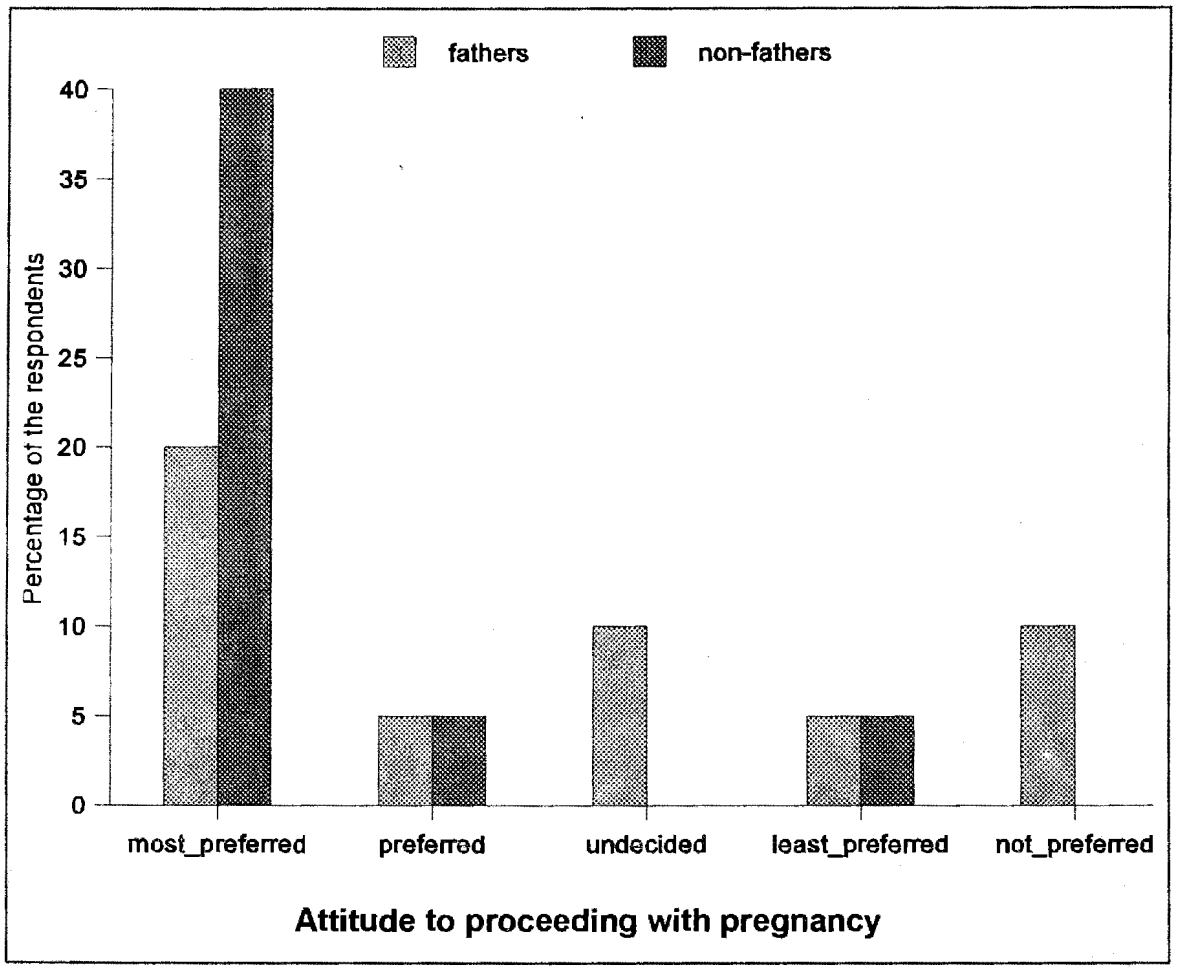


Figure 4.8 above and figure 4.9 below seem to yield similar of responses. A significant number of males 11 (55%) are more likely not to prefer abortion compared to 3 (15%) who are more likely to most prefer abortion. A preliminary report of a study

conducted by Matidze, Beksinska, Rees and Mazibuko (1999:4) confirms the above finding. This survey revealed that most men objected to termination of pregnancy (TOP) and said that they would instead offer to support the child when it is born.

Figure 4.9:

The attitude to proceeding with pregnancy by male respondents (N = 20)



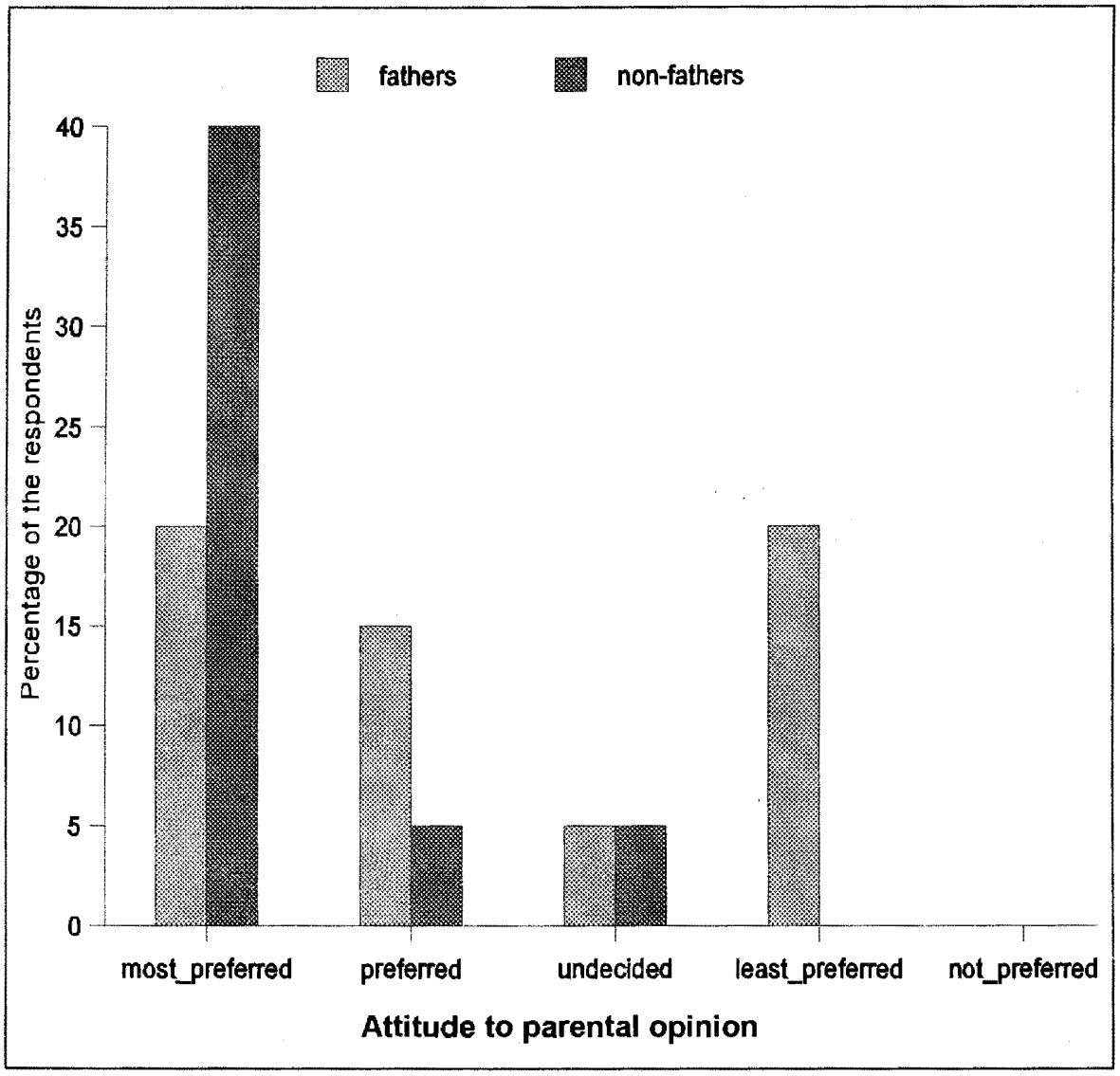
There seems to be similarities in responses as shown in figure 4.9, which seem to validate the findings of figure 4.8 above.

These findings reveal that 16 (60%) of all males are more likely to mostly prefer that their partners should continue with pregnancy, compared to 2 (10%) who are more

likely not to prefer that their partners should continue with pregnancy.

Figure 4.10:

The attitude to parental opinion by male respondents (N = 20)



While figure 4.10 shows that 12 (60%) of all males are more likely to mostly prefer to parental opinion about pregnancy options, only 4 (20%) are more likely to state that they least preferred parental opinion about pregnancy options.

Table 4.4:

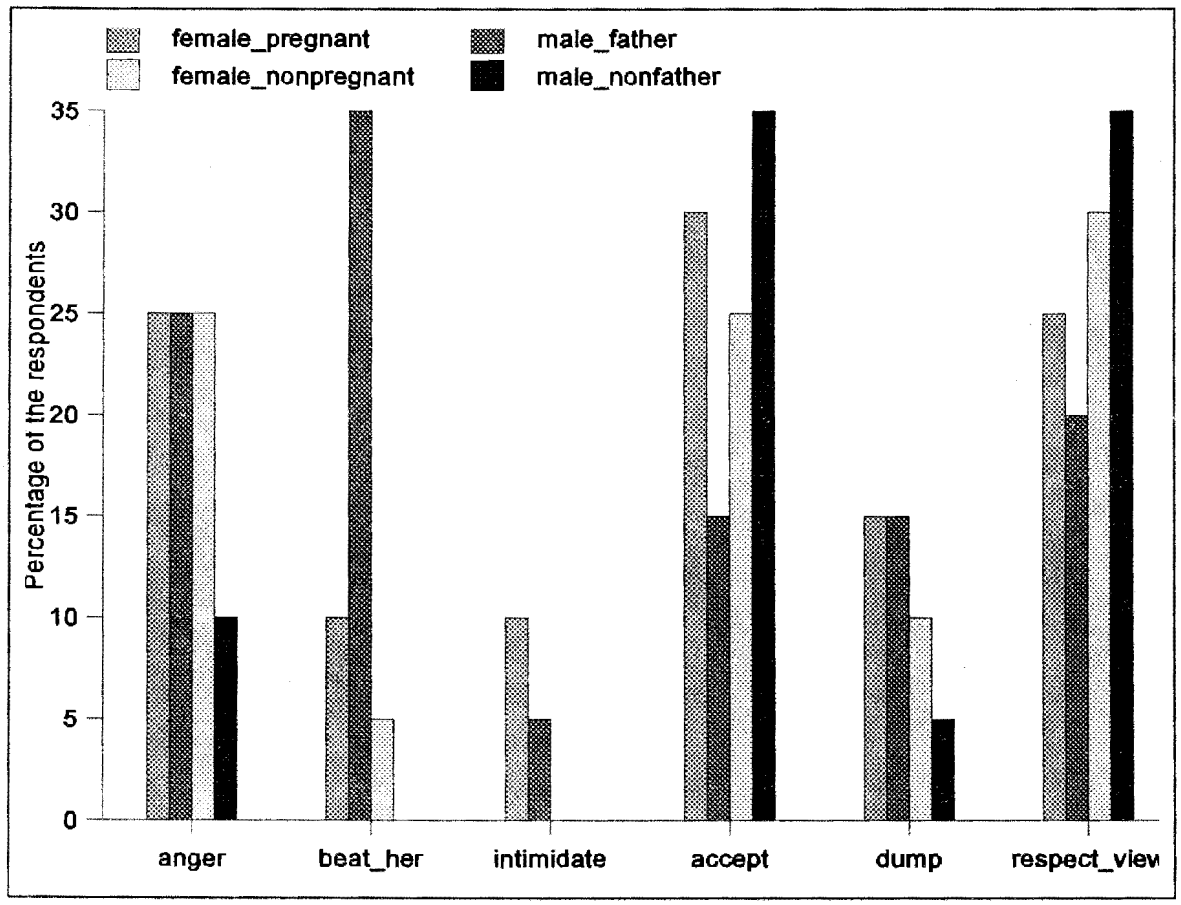
The options in pregnancy from female respondents (N=20)

PREGNANCY OPTION	PERCENTAGE
1. abortion thoughts	45%
2. never thought about abortion	50%
3. partner advise for abortion	5%
TOTAL	100%

Of all females 9 (45%) are more likely to prefer abortion compared to half 10 (50%) who are more likely not to think about abortion as an option. 1 (5%) female reported that her partner wanted abortion.

Figure 4.11:

Male partner reaction to the rejection of sexual advances by a female (N = 40)



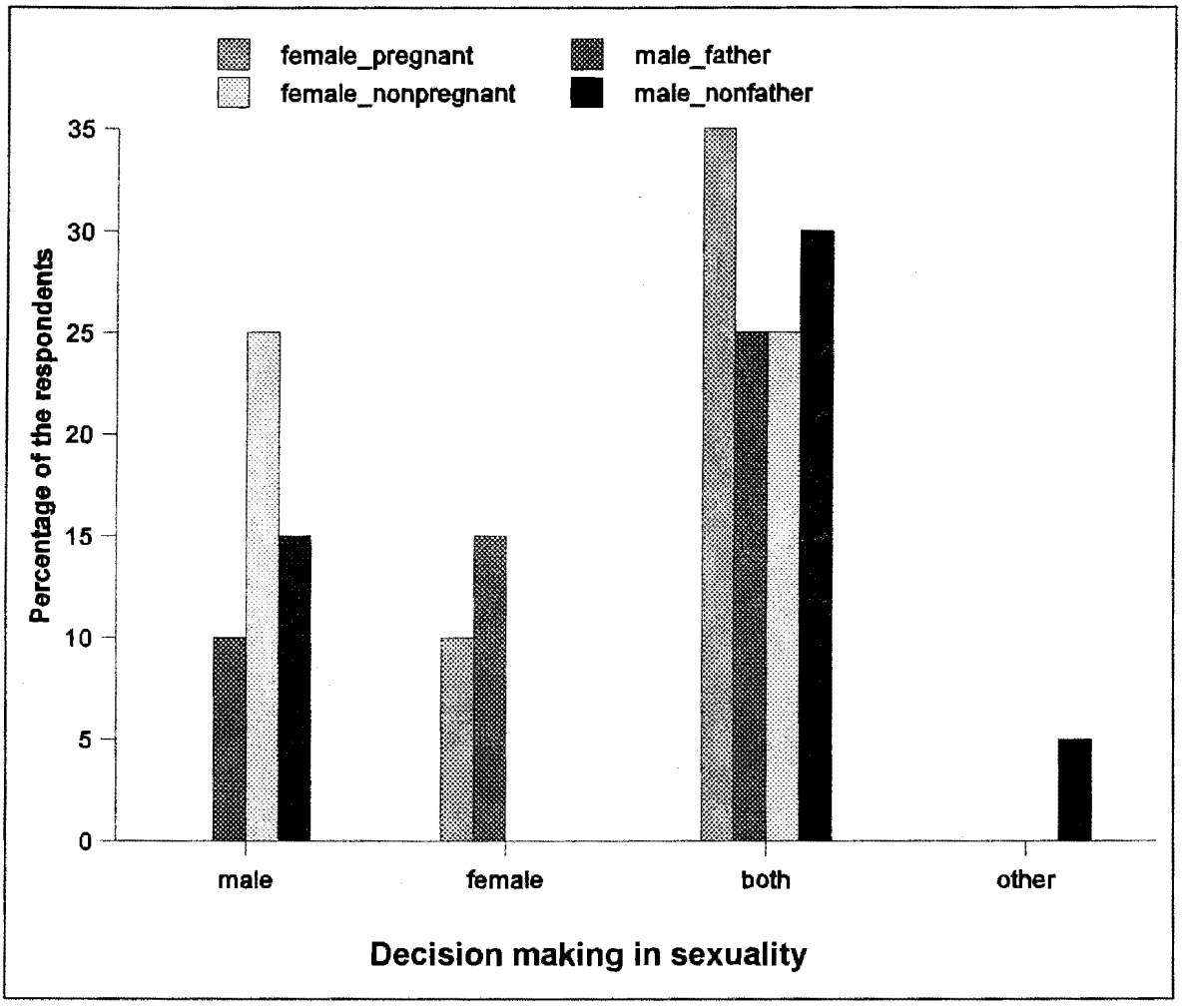
Various reactions both positive and negative are likely to be expressed by different males as shown above. Almost half 10 (50%) of all females stated that males show anger; 9 (45%) said that men tend to beat them up; 6 (30%) dump them and some 2 (10%) said that they will intimidate them.

However, a similar pattern emerged from 9 (45%) females respondents who said that males are likely to accept the rejection, with those who said that males are likely to respect their views for rejecting sexual advances.

About 13 (65%) of males are found to be more likely to respect the views of females, and 12 (60%) are more likely to accept when a female says 'no' to sexual advances. However, 7 (35%) of males will tend to express anger; 3 (15%) males are likely to dump their girls; 2 (10%) will intimidate them, and 1 (5%) will tend to beat them up.

Figure 4.12:

Decision making in sexuality issues for both sexes (N = 40)



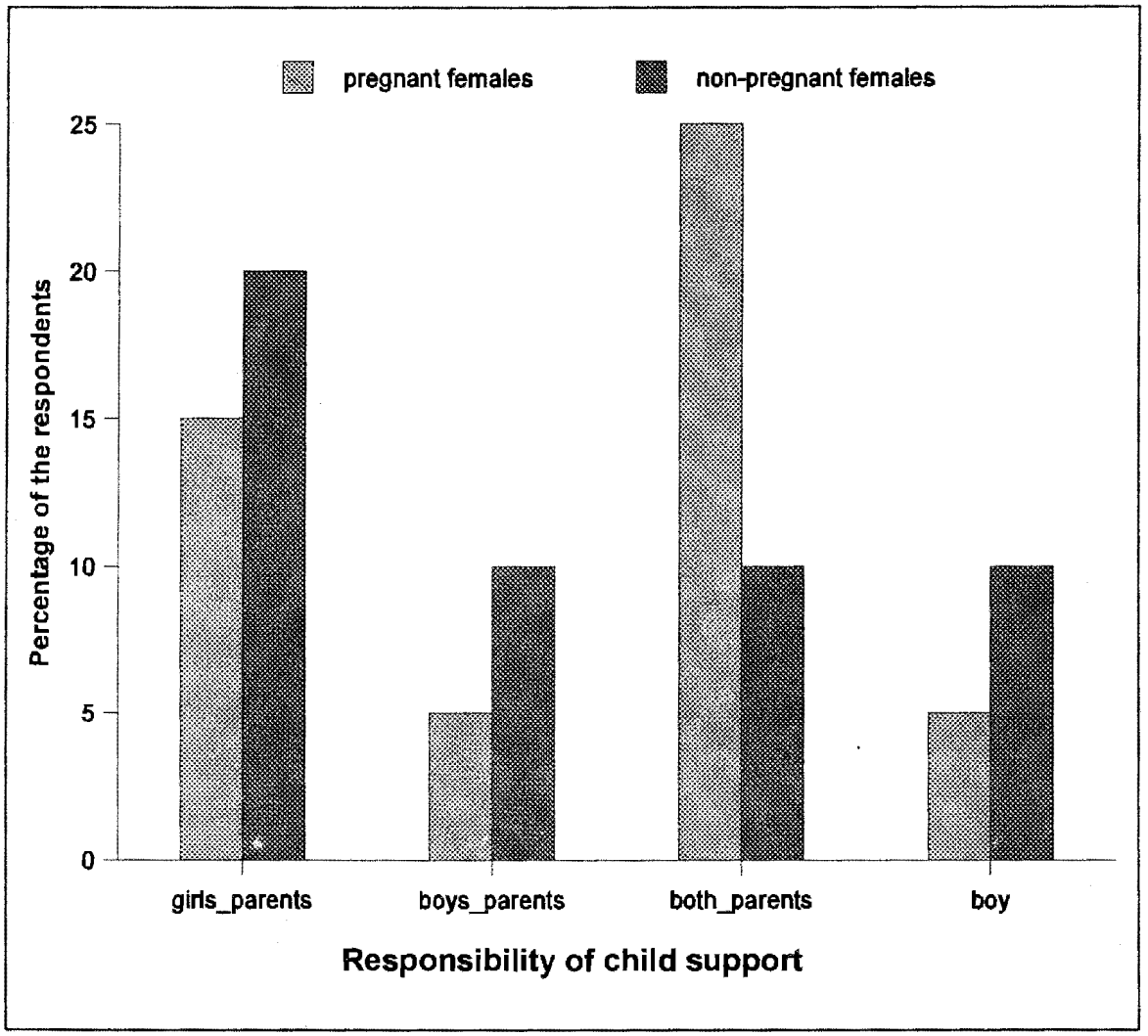
There is a difference between males and females. Overall females are more likely to agree (65% vis 55%) that it is the responsibility of both partners to make decisions about sexuality issues. Eight (40%) of male respondents felt that males should make decisions about sexuality issues, and this statement was supported by only 2 (10%) of the female non-pregnant respondents.

While none of the male respondents supported that a female partner has a responsibility to make decisions about sexuality issues, 5 (25%) out of all female respondents felt strongly so. Only 1 (5%) of all male respondents (non-father) said

that persons other than any of the partners can make decisions about both partners' sexuality issues.

Figure 4.13:

The responsibility for child support from female respondents



A similar pattern emerged in these findings where 7 (35%) females said that both parents are responsible for child support and the same number 7 (35%) of responses emerged from those who said that it is the responsibility of the girls' parents. Only 3 (15%) are likely to put the responsibility to the boy, while the same 3 (15%) female respondents are likely to put the responsibility to the boy's parents.

4.3 QUALITATIVE DATA ANALYSIS

4.3.1 Introduction

According to Miles and Huberman (1994:34) data analysis involves three phases, namely: data display; data reduction and data interpretation. Transcripts were made after interviews. This process was followed by use of coding scheme and categorization of data as a method of data reduction. Four focus group discussions comprising of seven participants each were held for each of the respondent types (four with males and four with female). Focus group discussions comprised of the following sample:

- Adolescent males: non fathers aged 13-18 years old
- Adolescent males: fathers aged 16-19 years old
- Adolescent females: pregnant aged 13-18 years old
- Adolescent females: mothers (non pregnant) aged 14-18

Focus group discussions were conducted in two settings, the school in which seven focus group discussions (four male groups and three female groups) were conducted involving the Grade eight to eleven learners, and at the clinic in which discussants comprised of pregnant adolescents attending antenatal clinic in one focus group. Data analysis for male respondents will be discussed below, then followed by that of female respondents.

4.3.2 Qualitative data analysis of male respondents

4.3.2.1 Perceptions on Recreational Facilities

- **Availability**

The discussion started by asking them if there are any recreational facilities in their community. All indicated that recreational facilities are available. However some discussants in two focus groups mentioned that recreational facilities are inadequate to cater for all the youth in the community, as captured below:

> "We have two main sport grounds for many activities including soccer, volley ball and netball, that are not in good order. The community hall is not even accessible as one has to hire it at an unaffordable cost for us youth"

- **Limited facilities**

Discussants identified a range of activities that most youth people are engaged in, which included soccer, which appears to be the main sport as compared to other activities including volleyball, basketball, softball and netball for girls. It was mentioned that some adolescents of both sexes spent their time in taverns/shebeens drinking alcohol and watching television.

However some respondents in one focus group raised concerns of limited facilities for other activities such as the cinema, swimming pools and dancing activities. The

following narrative is relevant:

> "Most activities are taking place outside our location, where we are expected to travel distances to get a cinema or exposure to dancing opportunities, for instance because of limited facilities"

4.3.2.2 Knowledge of Contraceptives

When asked about contraceptive use, most discussants in the four focus group discussions reported that they use condoms. On probing about the consistent use of condoms, it was found that most discussants were not consistent in the use of condoms, some used them once, while others twice only, if condoms are readily available.

Similar patterns of response emerged in all focus groups to the question of consistency as captured in the narratives below:

Most discussants supported the view that:

> "I seldom use them because I only have one girlfriend"

Some supported the view that:

> "I use them always to protect myself from diseases"

While others supported the view that:

> "I don't use condoms, they are not "cool" for me, but I know that they are OK" laughter.

Discussants who stated not using condoms, also said that they disapprove if their partners initiate condom use. Myths related to "condom disappearing inside the woman's vagina", as well as "destroying sexual feelings" were heard. Most discussants knew about other contraceptive methods particularly used by their partners, like pills and injections.

All discussants knew of the clinic as the main source of information and service for contraceptives. Other sources and distribution sites were mentioned to include the private practitioner, shop school, chemist. The above responses show that there is a gap between knowledge and practice of condom use in particular.

Even if discussants knew that free condoms were obtained from the clinic, they mentioned that they would prefer to buy them at the chemist or get them anywhere else for fear of interrogation by health workers. While another discussant identified the church and another one parents as sources of information about sexuality issues.

4.3.2.3 Perceptions about contraceptives

Discussants were asked whether they think condoms are effective in the prevention against diseases and the following responses were gathered:

- **Prevention against diseases**

All respondents interviewed agreed that condoms are effective in the prevention of pregnancy, STDs and HIV/AIDS. The following narrative statement is relevant:

> "Contraceptives are essential since I'm not ready to have any child. It's also necessary to use contraception especially a condom to avoid diseases like HIV"

The narrative is indicative of the fact that the male adolescent is sexually active and uses contraceptives (condoms) to prevent unwanted pregnancy and sexually transmitted diseases.

However, different opinions were gathered from some respondents in all focus group discussions about the quality of condoms that they are not 100% safe and can burst during the process of sexual activity. The researcher probed to find out whether respondents knew how to apply a condom properly or not.

Of the four focus groups only eight discussants were able to explain the technique of condom application using a male condom. However, a similar trend confirms the above findings as seen in a survey conducted by Matidze, Beksinska, Rees and Mazibuko (1999:4). Their investigation revealed that male respondents in general indicated high confidence about the effectiveness of condoms in the prevention of STDs and HIV/AIDS.

The risks associated with unsafe sexual practices by girls with adult males were also highlighted in two focus groups. Discussants also felt that this practices put them at risk of getting infections from their partners at school as stated in the follows narrative:

> "Sometimes it happens that girls fall in love with adult males who are working. These adults give them money and buy them things and alcohol in exchange for sex. The risk can be associated with sex without a condom in such a relationship of power. Some males deliberately refuse to use a condom especially if they know that they are infected with STD or HIV".

It has been noted that some males intentionally make girls pregnant or infect them with STD and HIV/AIDS.

The following narrative is relevant:

> "Some men can pretend to their partners that they are having sex with a condom, only to find that the condom has a hole on it. They use pins to do that"

4.3.2.4 Relationship of contraceptives, STDs and HIV/AIDS

Almost all discussants interviewed seemed to be aware that there is a link between condom use, STDs and HIV/AIDS. Most of the respondents knew about the mode of

spread of STDs. The following narrative statement bears witness:

> "An STD is a disease one gets through having sex with an infected person and we call it "drop" in our community"

The common type of STDs known by all was HIV/AIDS and "drop". It was quiet interesting to learn that pubic lice, also known as "ntasheta" is also classified as sexually transmitted diseases by most discussants in all focus groups.

The researcher observed that when discussants described "ntasheta" they all looked at one another as some were demonstrating where the name was derived from, (through scratching of pubic area) and all burst into a laughter. On probing, the researcher was told that itching of the pubic area was the most common type prevailing in the community among young sexual partners.

4.3.2.5 Prevention of pregnancy, STDs and HIV/AIDS

All discussants agreed that consistent use of condoms prevents one from getting infected with STDs and HIV/AIDS. Most mentioned other options to include abstinence, and faithfulness to one partner. However it appeared that abstinence was seen as a challenging option. The following narrative was captured from two discussants:

> "We do want to abstain from sex but it is difficult to do so, especially when you are already sexually active"

One group of discussants described the treatment of pubic lice which was shared by a friend who suffered from that before, as shaving of pubic hair followed by the use of "Dip" (Jeye's Fluid) until he was treated. It was not established whether the chemicals contained in the Jeye's Fluid had an effect on the pubic hair area and the penis and also possibilities of the recurrence of pubic lice.

However, some discussants mentioned that one of the preventive measures for HIV/AIDS include going for voluntary HIV/AIDS testing before marriage with a girl partner use of condoms prior to marriages as captured in one discussion group below:

> "I always tell myself to have sex with a condom until I'm about to marry her, then we go for HIV blood test before marriage to avoid problems"

Some discussants argued that young people, especially males are often too impatient to postpone sex in case where condoms are not available and sex is unprotected. It was noted in discussions that power relations are prevalent even in adolescent relationships and often result in coercive sexual behaviour.

4.3.2.6 Multiple sex relationships

All discussants described multiple sex relationship as a high risk behaviour that puts the young males and females at risk of contracting pregnancy, STDs and HIV/AIDS.

The following table shows categories of responses with narrative statements were captured from discussions to relate to the issue of multiple sex relationship and the link with STDs and HIV/AIDS

Table 4.5:

Categories and narrative statements of male respondents on multiple sex relationships

CATEGORY	NARRATIVE STATEMENTS
1. Not using condoms	"Yes multiple sex relationship is a risk factor, more especially to some of us who are not using condoms"
2. Fear of being infected	"Multiple sex relationship is not safe particularly to sexually active partners, as you can have a partner who has multiple partners and she can infect you as well"
3. Fear of the HIV/AIDS disease itself	"I sometimes think about if I can discover that I'm HIV positive, what will I do? But I always tell myself that I wont get it. To tell the honest truth I do not have one girlfriend . What I know is that all my girlfriends trust me. I try to build confidence in them. But I know that this is wrong"
4. Religious beliefs	" Multiple sex relationship is a sin according to the bible"
5. Contributes to the speed of HIV/AIDS	"A male partner who has many other partners, can make all girls pregnant at the same period and infect them with AIDS, and this is bad"

During the research process it was revealed that two male discussants had children with more than one female partner. In both instances discussants took responsibility

for child support, while both still being at school and parents are presently supporting both babies. On probing it was understood that their second incidences of pregnancies to girls were actually "mistakes" and that there is no intention to marry the mother of the baby.

4.3.2.7 Power relations and contraceptive use

Discussants were asked what they would do if a female partner suggests condom use during sex. The researcher observed that there was a sudden silence followed by giggle in three discussion groups. Most discussants said that they would demand an explanation from the girl especially if it's the first time they initiate condom use.

Some said that they would welcome the idea because girls are usually shy to initiate sex anyway. However, both the focus groups of non-fathers, two different responses were captured that included extreme suspicion that the girl may be "two timing", while some said that will not respond. Of those who said that they did not wish to respond, some indicated lack of knowledge about the issue, while others said that they were not yet sexually active and hence lack the skills to deal with the issue.

Discussants were also asked about their reactions if a girl refuses to have sex with them. While most discussants said that they will respect the girl's view, others did not seem to support the above statement, as one discussant puts it:

> "Most girls are often shy to refuse to have sex because they fear that we will drop them"

Other responses raised included feelings of suspicious that the girl may be cheating. However the researcher also noticed that there was a discrepancy in how some respondents verbally expressed their positive attitude towards the decision and their actual non-verbal communication they displayed.

For example, of those who said that they respect the views of the girls to decline sexual advances, some also supported those who said that they will express disappointment, suspicious and that they will attempt to convince the girl to agree to have sex. Almost all discussants knew about child abuse and agreed that it is a problem in their community.

It was found that most discussants felt that the girl has the right to say "no" to sex and that it is violation of their right to force a girl to have sex against her will. However, one discussant commented that:

> "Much as she has the right, it must not always that gives excuses not to have sex".

4.3.2.8 Perception about religious principles and contraceptive use

Discussants were asked about which religious principles about contraception do they aspire. Most discussants said that religion is an important factor that has an influence on contraceptive use and marriage. Various religious principles were identified which varied from one religious organization to another. One discussant said that:

> "Some churches like the "Born Agains" other religious

organizations to promote abstinence, and preaches that there should be no sex before marriage"

Another discussant said that:

"Catholic churches discourage the use of 'preventions' by adolescents and unmarried couple"

Whereas in another focus group discussants said that:

"men are regarded as heads of families inmost churches"

It was also found that, some churches encourage that youth of the same denomination form relationships with one another to maintain the culture of the church. However, most respondents have explained that even if these principles exist, there is lack of support mechanisms in place to promote implementation of such principles.

The following narrative bears witness:

"Another problem is that our churches do not promote the implementation of such principles. They do not promote that people should come and talk about the "prevention" (contraceptives) and condoms".

Among the discussants there was an indication that religion did not seem to deter adolescents from sexual activity. Some of these discussants confessed that they are aware of these church principles but could not follow them.

Therefore one discussant in one focus group discussion recommended that:

> "We believe that people from the health sector should be invited to our churches to give us information about health issues. This will improve communication between parents and youth, this is happening in some churches though "

Therefore sexual activity was seen to prevail even among adolescents in settings like the church, where morality is expected to be the guiding principle for adolescent behaviour.

4.3.2.9 Perceptions about pregnancy

- **Age at first intercourse**

Of all male discussants, seven commenced sexual activity at the age of 14, five at 15, five at 13, four at 12, four at 11, two at 10 and one at 17. The above ages give a picture that most adolescent boys started their sexual activity as early as 15 years of age while the least number was at 10 years and 17 years old. Of these males, most stated that they were not coerced into having sex with a girl.

Some also explained they have seen sex scenes in the media (TV), and in magazines. Others said that it was due to pressure from friends as it was explained in their narrative:

> "Ya, I once coerced the girl to have sex with me. It happened when I was 14 years old. I was experiencing pressure from a friend who actually set up a scene for me to have sex with this girl. I was inexperienced"

Another discussant explained that:

> "My friends played number 5 card on my behalf and I was challenged to please them, so that I can be accepted in the group. I actually had a problem of convincing this girl, she was refusing and I had to hit her. I regretted and that was the last time I hit a girl"

- **Reasons for pregnancy**

When asked about why girls become pregnant most discussants said that some girls were careless and stubborn about their bodies. Some said that girls lack information about sex issues and how to prevent themselves from falling pregnant. While others said that some girls wanted to upset their parents who are too strict, some said that girls fall pregnant due to peer pressure and others said that some girls want to retain boyfriends using the child.

One discussant asserted that:

> "I really do not understand why girls become pregnant when there are "preventions" (contraceptives) available at the clinic, and obviously no guy wants to be a father at this age of 16yrs"

One other respondent mentioned the issue of ignorance. However most discussants blamed parents for not giving the necessary care to their girls. This statement was supported in this narrative:

"Girls become pregnant because they lack parental care"

- **Options in pregnancy**

Most discussants who made girls pregnant stated that they would have never advised their partners to terminate the pregnancy, because they believe it is wrong, even if the pregnancy was unplanned. However discussants in one focus group said that boys who advises their girlfriends to terminate pregnancies do not love them.

In circumstances where pregnant girls suggest their intentions to terminate a pregnancy, the researcher observed expressions of shock and anger from discussants. However, one discussant elaborate by saying that it can be accepted on the basis that the girl want to continue with education. Other discussants cited peer pressure, as one of the reasons why one or both partners may wasn't to terminate a pregnancy.

In one focus group one angrily responded that:

> "If I can know who helped my girlfriend with abortion, I will strangle that person"

Various responses were gathered from debates that transpired in this discussions and such information was categorized in narrative statements as pro-choice and pro-life to capture all responses, as shown in table 4.6. Below:

Table 4.6: Pro-choice versus Pro-life responses of male respondents

PRO-CHOICE	PRO-LIFE
"It will depend on the person's choice and home situations. The girl's father may be strict and at home there can be no financial resource to raise the coming baby"	"I will refuse that she does it because why does she secretly want to kill the baby"
"Most gents in our community are saying that they would advise their girlfriends to do an abortion to keep them out of the responsibility. I will advice her to opt for abortion because it is legal in South Africa and because I do not want a baby."	"I will advice her not to terminate the pregnancy and to give the baby away after birth to needy parents, because there are many people who cannot have children"
"The choice may be as a result of some form of pressure from parents who do not want to be embarrassed of from friends who may persuade you to do it, you see"	"In my opinion boys who encourage girls to terminate pregnancies do not love them. And abortion is not right even if its legal, its still has disadvantages and advantages. Anything can happen and the girl may not fall pregnant again in the future"

- **Prevention of abortion and future recurrence**

Parents were identified by all discussants that they are the main role players in the prevention of the prevalence of abortion. The following discussion took place:

- It was explained that parents should use a positive approach to target both girls and boys and give the factual information on the life skills.
- Parents should be open to their children so that those children can be able to share their problems.

- Parents should give first hand information because if that opportunity is missed children will get misleading information from friends. If one has received factual information from parents, one will be able to make informed decisions about whether or not to engage in sex and other risk taking behaviours.

- Parents should accept the changing culture, that needs of adolescents differ from theirs, as it has been described by one discussant:

" Our parents should accept that today's lifestyle is different from that of the 1950's and 1960's. They should accept that the lifestyles have changed. We want them to sit down with us especially those of us who have already made mistake (made a girl pregnant) and guide us to overcome the mistakes"

- Because parents are often too busy and strict to talk to their adolescent daughters and sons. The adolescents then tend to seek information on issues of sexuality and options outside home, which can be misleading and wrong. Therefore parents should have skills to deal with their children.

- Sexually active girls should be allowed to use contraceptives without the permission of their parents who may or may not approve.

- Health workers and teachers should teach adolescents about sex issues that may lead to drastic consequences.

4.3.2.10 Roles and responsibilities

- **Partner reaction to pregnancy**

Discussants were asked how will they feel if their partners announce that they are pregnant. Both personal experiences from those are fathers and those who have not yet experienced the issue. The table below gives the narrative statements gathered from discussions:

Table 4.7: Partner reaction to pregnancy

Male respondents (fathers)	Male respondents (non father)
"I accepted the responsibility because she was the person I loved. For somebody else it could have been different"	"I'll be shocked"
	"I will have disappointed my parents"
"Ya, when she told me that she was pregnant I accepted responsibility, but I felt shocked at first because I did not expect that to happen. Finally I accepted that it has happened and that I should be accountable for it because I did it"	"I'll weigh the situation"
	"It will have happened"
	"I'll accept the baby since I will be the one who made it"
I accepted the responsibility but "Well, the challenge is we are both still at school and not financially secure to can raise the baby. I think that if parents can give us the necessary support until we are adults enough we will be able to take care of the baby"	"I'll advise her to go for an abortion as I'm not ready to be a father yet"

- **Parental reaction**

Of those respondents who has ever made adolescent girls pregnant, some discussants said that their parents did not have a problem to accept the news from either the boy or the girl's family and they offered support to their adolescent father

to be. Other discussants reported that parents said nothing, while most discussants said that their parents told them that they will be fathers soon and has to act responsibly.

On the average, most discussants said that their parents expressed shock at first, which some managed to overcome later. Another discussant confided that he approached his parents through his sister who was able to convince them that he had made a mistake. The father expressed anger and almost withdrew the boy from school. He then accepted that the boy made a mistake and approved that he continues with his education.

In one focus group a discussant told of his experience that he said nearly affected his future, as he explains below:

> "I was actually advised by my parent (mother) to decline responsibility for the pregnancy of a girl whom I loved so much in 1998, because both families were not in good terms. I was actually prevented to see the girl and the baby and felt very bad about it. We are still seeing each other outside our parent's boundaries"

- **Child rearing practices: Adult parents / Adolescent parents**

In comparing child-rearing practices of adult parents to those of adolescent parents, all discussants said that adult parents are more likely to raise their children in a more healthy mature way because of their physical and psychological readiness to have

children.

They have the ability to plan their families because of their socio-economic status. Adolescent parents were described by all respondents as lacking experience adult parents have because of the age at which most of them fall pregnant. This will interfere with both partner's education, growing up, relating with friends and peers. One discussant (17years old) shared his personal experience about lack of experience:

> "Our parents are always warning us about the danger of making babies, while we are still children. It is true because I think we lack the experience about child rearing and about the needs of a child. With my baby who is eight months now, if ever I have to buy something for her, I always need the company of my sister or mother to help me about where and what to buy"

- **The role of peers**

Information, Education and Communication

All discussants felt that they and their peers are the most appropriate people to educate other youth in the community about issues of sexuality because they share the same culture. Peer education is therefore seen as an important aspect of disseminating information to adolescents and youth in the community of Lethlabile. It was also explained that such resources are lacking in this community.

Whereas in another focus group discussants suggested that youth should be given a chance to organize community events on health issues, with the support of knowledgeable adults form health and education sectors. They also talked about the use of youth and culture in such events and awareness campaigns will be important.

However some discussants stated that they are committed to share information with other youth in the community but often lack confidence, skills and knowledge about sexual and reproductive issues, including HIV/AIDS. Most discussants mentioned that access health services is a constraining factors and viewed health workers at the clinic as too busy to offer them support. The following narrative supports the assertion:

> "It will be difficult for us to participate in programs that are taking place in our clinics unless the clinic is willing to share with us their daily schedule that in such and such a day such activities will be taking place. Then we will offer our contribution"

All discussants also recommended the support of youth from other areas outside their community to share experiences and learn from them. Most of the discussants confessed that they only use clinics to get condoms. While some stated that they are shy to go to the clinic for condoms because of the embarrassment by health workers who will ask them what are they using condoms for, and others said that they never use the clinic at all.

- **The role of Parents**

Parents were seen by all discussants as primary educators of children about life issues in general and about sexuality issues. All supported the above statement, citing reasons to include the following:

- Both parents brought children in the world, and that parents are legally responsible for guiding them into healthy development.

- Most adolescents are concerned about lack of communication between them and the parents which result in them getting misleading information from their friends or other adults who may also abuse them. The following narrative supports this assertion:

> "In most instances we do not get the right information from parents. There is too much of 'don't do this' and too little of 'do that' from most parents. They should change their attitude of being strict to that one of becoming informative, and giving options and guidance"

- **The role of Health Workers**

Almost all discussants felt that health workers plays an important role in providing information and services for young people in the community and in schools.

Emphasis was put on the value of experience they poses in addressing health

issues. However some discussants mentioned that the clinic is "a no go area" for most youth because of judgemental attitudes of some health workers.

- **The role of teachers**

Teachers were described as secondary parents in one focus group, and their role was seen as crucial and superceding that of parents as argued by some discussants:

> I agree that parents brought us into this world and should guide us, but there is a saying that "bringing up a child is the responsibility of the whole nation". I think that teachers have an important role to play here because they are knowledgeable about most issues than some parents who may have outdated information some of which may be based on culture which may not be applicable today. We need to know culture as well as real issues, gents!"

Another discussant said:

> "I think that I'm more free to ask questions at school than at home even if parents are able to talk openly but its not easy for them to start a conversation, say about sex".

- **The role of Religious leaders**

Most of the discussants have acknowledged the role of religious organizations in

promoting information about sexual and reproductive health issues particularly in the area of HIV/AIDS. Of these respondents, some confessed that they have heard about HIV/AIDS prevention messages in their respective church sessions.

Other discussants indicated that they are not attending any church at all but would encourage churches to address issues of sexuality and pregnancy and HIV/AIDS openly because most youth spend much time at church. However other discussants indicated that in some churches these issues are still not discussed. This implies that churches should recognize adolescents are a distinct group with diverse needs, and plan relevant youth clubs that respond to these needs and that are run by the youth.

4.3.3 Qualitative data analysis of female respondents

4.3.3.1 Recreational facilities

Discussants were asked if there are recreational facilities in their community. All discussants knew about the available recreational facilities and they mentioned the sport ground as the main facility available in their community, and the Community Hall. Some mentioned the church and the school as places where young people usually spend their spare time. The same as with male discussants, other discussants identified the taverns / shebeens, as found in one focus group discussion below by this narration:

> " Some girls usually go to "taverns" to drink alcohol and dance with guys"

However it was interesting to hear that some adolescents stay at home while others go to the community parks to relax. Of those discussants who said that they prefer to stay at home, some were adolescent mothers who stated that sometimes they fear to be ridiculed and labeled by peers and other families.

Other recreational activities identified were similar to that of male discussants. The study did not establish the level of participation of most youth in these ranges of activities. Some discussants mentioned that recreation for boys often differ with that for girls. Boys are allowed to play outside home till late at night, while girls are expected to play up to a certain period of time and to do domestic work, e.g., prepare dinner for the family.

From the researcher's point of view most parents tend to be more protective and concerned about adolescents who goes out to social gatherings, those who hangs around with friends/peers and those who participates in the community than those who are not so active in the community. On the other hand, recreation was regarded by some discussants as a deterrent from sexual activity. It was stated that young people who engage in recreational activities are kept busy by those activities so that they do not have time to think about sex and other high risk behaviour.

4.3.3.2 Knowledge of contraceptives

Discussants were asked if they ever used contraceptives. Of all 28 discussants, 21 said that they used a form of contraceptive. Seven said that they have never used contraceptives. Of those who said that they ever used contraceptives, some were current contraceptive users, while others had stopped due to pregnancy.

Most discussants used an injection, some used pills, while others used male condoms as contraceptive methods and others used condoms and pills for safety. However one discussant mentioned that she used a traditional method as contraception by wearing a belt around her waist.

Of those who were not using contraceptives, three mentioned that they were abstaining from sex until they reach maturity and educational attainment. Two mentioned that they are not sexually active, while another two discussants said that they fell pregnant before using contraceptives. Most discussants said that they received contraceptives from the clinic, others got them from general practitioners, while others said that they bought them from the chemist especially condoms.

It was noted that one discussant have heard from a friend about emergency contraceptive pill. She elaborated that she overheard a health worker at the family planning clinic saying that emergency contraceptive pills are not yet introduced in their clinic. Of those who used condoms all confessed about inconsistent use citing lack of control for condom use as captured below:

> "It is difficult to convince a boyfriend to use a condom always because these condoms are for males, and you cannot force him to wear it if he does not want to"

In comparison with male discussants contraceptive knowledge and use, female discussants seem to have more knowledge of a range of contraceptives, while most male's knowledge of contraceptives was limited to condoms. Some males discussants also confirmed that they don't use condoms at all, which predisposes

many girls to diseases like, STDs and HIV/AIDS, according to the above narrative statement.

4.3.3.3 Perceptions about contraceptives

Almost all discussants regarded contraceptives as effective to prevent pregnancy, STDs and HIV/AIDS. Most discussants identified condoms as most effective contraceptive method for all problems mentioned above, with pills and injections seen by some as only preventing pregnancy.

However, some discussants stated that compliance to contraceptive use is often problematic for most adolescents. This has been captured in one focus group discussion with pregnant discussants who asserted that:

> "Most of the girls often changes from injection to pill, because sometimes we do miss the appointment date for injection and some girls complains of lack of menses, and that the injection makes one sick, hence we are forced to stop for a while or use another method"

Some discussants stated that once they had defaulted from taking contraceptive pills, they either had to share pills with their peers or visit other clinics to start as new family planning clients for fear of being scolded by some health workers.

4.3.3.4 Relationship of Contraceptives, STDs and HIV/AIDS

- **Condom use**

Discussants were asked to give their views on whether condoms were effective in preventing adolescent pregnancy. Most respondents have agreed that condoms are effective in preventing pregnancy, STDs and HIV/AIDS. Reasons given in support of the above statement included the following:

- that most condoms are strong and of good quality
- a strong believe by some discussants that the male condom seem to be more practical, easy and convenient than the female condom

However some discussants raised concerns about the quality of condoms, the size of some condoms which according to their partners are said to be small, and that some partners tend to use sharp objects to make holes on condoms deliberately to make girls pregnant. One observation made when the respondents talked about this issue there was expressions of concerns noticed through a moment of silence that was shared by most discussants in one group and an observed expressions of fear.

The following are narrative statements supports the above:

> "Yes we agree that condoms are effective, but as long as boys do not make holes in them before they have sex with girls. And some boys are in the mission to spread diseases like HIV, and make girls pregnant".

Another discussant said:

> "I don't think that condoms are effective because one can get pregnant while using condoms it happened to me"

Another discussant said that she has heard from friends that condoms tend to burst easily, as a result they are not 100% safe. A similar observation was made in focus groups with male discussants on the issue of making holes on condoms. This is an area of concern that, according to the researcher works against of STDs, HIV/AIDS and pregnancy prevention programs.

This situation can be linked with lack of information and skills of how to apply a condom and the myths associated with condom use from peers. When a sample of a female condom (femidom) was shared with all groups, all discussant said that although they have heard about it in the media and the clinic, it was the first time they saw it.

Most discussants commented that the size and shape of the female condom is too big as compared to the male condom, and that the female condom is made for adults than for adolescents given its size. One discussant commented as follows:

> "This thing (femidom) is too fatty and it looks like a "Parachute" Oh it is huge"

The above comments justify the unfamiliarity of the female condom to most adolescents and youth in the community, and it could therefore argue that the issue

of aesthetics shape of the femidom strongly influence the utilization of this contraceptive method. However, other discussants, particularly adolescent mothers, welcomed the female condom and some said that they see it as an option for girls whose partners refuses to use male condom.

- **STDs and HIV/AIDS**

There seemed to be increased knowledge of how STDs and HIV/AIDS is contracted among all discussants. HIV/AIDS was mentioned as one of the STDs commonly known by all discussants. Some discussants elaborated that having sex with an infected partner and without a condom puts one at risk of STDs and HIV/AIDS. The most common type of STDs known to most discussants was "Drop", syphilis and Gonorrhoea. Some discussants mentioned cauliflower as another sign of STD.

In terms of sources of information and services for STDs and HIV/AIDS, all discussants identified the clinic, private doctors, the hospital and the school as the main sources of information and services. Some said that they get information from the churches and from friends. While others said that they get information from magazine, television and radio programmes.

However, in one focus group a discussant reported that she gets information from awareness campaigns like World Aids Day and other community events of such a nature, and from people wearing red ribbons. Another discussant said that some people go to traditional healers for treatment of STDs and HIV/AIDS and she was not sure whether they get cured or not. It can be argued that among all identified STDs by both male and female discussants, there seems to be some that are

unique to each discussant type.

Male discussants, for instance identified pubic lice as sexually transmitted, while female discussants identified cauliflower. As another symptom of an STD common to women. Almost all discussants were aware that there is a link between pregnancy, STDs and HIV.AIDS. When asked about risk factors, almost all discussants admitted that most girls of their age are at risk of unplanned/unintended pregnancy, STDs and HIV/AIDS. Most discussants said that adolescents are put at risk by the following factors:

- Exposure to unprotected sex, early commencement of sexual activity
- Multiple sex relationship
- Rape / forced sex by a partner/stranger or a person known to the victim
- Substance use/abuse e.g., under the influence of alcohol and/or drugs

Involvement of young girls with adult males for financial reasons as stated below by a 14 years old discussant:

> "There are some young girls of my age choose to go out with adult males for the sake of money and this exposes them to unprotected sex and diseases"

One discussant stated that girls who commence sexual activity early tend to become careless with their bodies and this lead to child prostitution.

4.3.3.5 Prevention of pregnancy, STDs and HIV/AIDS

In terms of opinion on the prevention of pregnancy STDs and HIV/AIDS similar responses raised by male discussants earlier were gathered with female discussants. Prevention was seen by all discussants to include regular use of condoms. Some mentioned abstinence, while others said that faithful monogamous relationship should be encouraged. Some discussants recommended that both male and female adolescents should receive information and education about HIV/AIDS issues so that they can learn to protect themselves and respect their bodies.

Others suggested that all sexually active adolescents should go for blood test to know about their HIV/AIDS status with partners and also go for regular checkups. While one discussant warned that young girls should avoid sleeping around especially with adult men and sexually active adolescents should use contraceptives, insisting on condoms. There seemed to be increased knowledge about the relationship between pregnancy STDs and HIV/AIDS.

4.3.3.6 Perceptions about pregnancy

- **Age at first sexual activity**

Discussants were asked at what age they started sexual activity. Of all discussants six said that they started at 12years, four started at 13years, four started at 14years, two started at 15years, three started at 16years and one at 17years. One discussant could not recall at what age, while seven said that they have not yet started having sex. Most discussants agreed that there are problems associated with early

pregnancy, particularly between the ages of 10 and 18 years. One discussant from a focus group of pregnant adolescents said that:

> "The younger age group of 10 - 17 years have more problems with pregnancy and delivery ,and it becomes worse if the father is not known as compared to our mothers and sisters. Some of us still do not have information about what is going to happen when we give birth, instead we are only told about myths by friends and some parents."

From the above statement one could ague that the level of pregnancy in a given population is in an immediate sense, the result of sexual activity and the extent to which contraceptives are used by those who are sexually active.

- **Reasons for pregnancy**

When asked about reasons why young girls fall pregnant, most of the discussants cited peer pressure as a contributing factor to adolescent pregnancy. Some discussants said that some of the girls intentionally become pregnant as an attempt to keep the partner.

Almost all of the respondents in all groups cited reasons of lack of information which often result in mistakes being made, lack of respect for one's body, experimenting with sex. Other discussants said that some girls are involved with adult men for financial reasons and even due to poverty at home. This was captured in one focus group discussion where the discussant (14 years old) said:

"Some girls of our age become involved with adult males for financial gain not knowing that they are exposing themselves to pregnancy and diseases. And most of these girls do not use contraceptives".

Similar findings were found in a study conducted by de Castro et al (1996:XV) which revealed that some reasons for adolescent pregnancy include unexpected sex; forced sex; taking risks; feelings of invincibility, deliberate impregnation by a jealous partner.

Contraceptive use has once more been linked to pregnancy rate among adolescent girls. Of those respondents who ever used contraceptives 14 felt that lack of contraceptive use, as well as inconsistent use predisposes most young girls to pregnancy. It was also emphasised by respondents in the three other focus group discussions.

Whereas in the one focus group discussion some discussants went further to explain that girls often stop using contraceptives because of side effects that are often unbearable. The negative attitude of some health care workers made these girls to stay away from health services.

However one discussant blamed contraceptive method failure as the reason for her pregnancy. She stated that she and her partner were using condoms, as captured below:

"I don't know how I fell pregnant because my boyfriend and I were using condoms, I really don't know"

This statement may suggest the possibility of either a condom was defective or inconsistent use of condoms or even faulty application of the condom that have resulted in method failure. Rape, was also mentioned by one discussant in one focus group discussions as the reason why most young girls fall pregnant.

This reason was further linked to the issue of coercive sex usually happening to "innocent" young girls as elaborated by one discussant below:

> "I was actually robbed, you know! I think I did not understand what love really meant. It happened to me when my boyfriend asked me to accompany him to his home, and when we arrived there, he suddenly locked the door telling me to have sex with him as a sign of love. He threaten not to let me out until unless I agree to have sex with him. Realising that it was getting dark, I then gave up and we had sex, that's how I fell pregnant."

Although some discussants said that they were coerced to engage in sex at the time of first sexual encounter with boys, six said that they fell pregnant after the first sexual encounter with partners. Of all discussants four stated that they were coerced to have sex.

During this discussion the researcher observed a debate among discussants about coercive sex. Two discussants felt strongly that coercive sex is disturbing and constitutes rape, which should be reported to the parents and the police. However, others felt that reporting the incident to the parents and the police is not always easy

because of their judgmental attitudes. This narrative by one discussant supports the assertion:

> "Girls should be taught to say "NO" and boys must understand that "NO" means "NO" to sex"

Most discussants said that the experience of sexual coercion involves physical force especially if the girl says "no" to sexual advances (sex). And some girls confessed that they ultimately had to give up for fear of losing a partner. According to the researchers opinion power relation between men and women seems to starts early in life, through differentiation in the socialisation of boys and girls.

It shows that most young women lack the skill to negotiate safe sex with partners in a relationship and for those who are able to negotiate sex they tend to be overpowered by their sex partner. Violence against children and young women is another problem, which needs to be further explored.

- **Experiences of pregnancy**

Discussants were asked about the information they got about pregnancy and sexuality, most stated that they did not have prior information about sex issues from parents, teachers and health workers at the time of their pregnancy.

Of these discussants some said that they did not know that they were pregnant until physical changes were noticeable, which included, breast and weight changes, including missed period and morning sickness. Of these discussants, ten said that

they discussed with parents about the issue, while three respondents discussed with sisters and one respondent with her partner. Others discussants were informed by parents, family and neighbours that their bodies were undergoing change (pregnancy).

Of these discussants some were as young as 13 years old while others were 14 years old. About two of the older discussants aged 17 and 19 years said that they have received prior information about sex issues from health workers at the clinic. All discussants agreed that pregnancies were unplanned and that they were not ready to carry and raise children.

- **Pregnancy options**

When asked about pregnancy options, half of the discussants said that they thought of an abortion at first before their families and the community noticed them. However, as pregnancy progressed they had to reconsider their thoughts to continue with the pregnancy. The other half said that they did not think about abortion at all.

Discussants cited the following constraining factors to access abortion services:

- fear of parental reaction regarding abortion as an option;
- lack of financial resources to seek abortion services;
- lack of knowledge of abortion services;
- fear of dying during the procedure;
- fear of losing the only "God given" baby, and
- choice to keep the baby.

Of the discussants said that they did not think about an abortion as an option, some cited reasons of strong support systems in their families and or those of their partners. While others said that peer and partner pressure played a major role.

One discussant said that she was advised by her partner to go for abortion, and she declined to take the option. Another discussant said that:

> "I was actually accompanied by a friend who had an abortion previously, to seek abortion services at the Private Doctor. But we returned halfway to the Doctors surgery because I feared that if my parents can know this, I will be in trouble".

Two of these discussants said that social pressure also contributes to adolescent seeking abortion services. Social pressures include rejection by parents and boyfriends, discrimination by peers, the school and the community. One respondent gave a pro-choice statement that:

> "One may not be ready to raise a child because she is also a child and intends to go back to school"

Other discussants said that in the case of rape it becomes imperative that an abortion should be performed because one will be carrying a child whose father is not known. While another one gave a pro-life statement that:

> "No, I think it is not right to kill a baby, what if you also die or, the baby that you kill was your only child"

Similar findings were also gathered in the male focus group discussion. According to de Castro, et al, literature review on teenage pregnancy revealed that issues of adoption, abortion and keeping the baby are not easy options for pregnant teenagers. The above findings also confirm that discussants gave various challenges they were faced with on whether or not to terminate a pregnancy.

4.3.3.7 Prevention of future termination of pregnancy

When asked about what can young girls do to prevent future terminations of pregnancy, all discussants agreed that provision of information about sexuality issues, improved communication with parents, teachers and health workers, and about services for abortion is needed.

Most discussants said that parents should be open to their children about issues related to sex, menstruation, pregnancy abortion and relationships. One discussant said that:

> "Parents have a tendency to be more protective and always focus on our mistakes and not on our strengths. We always get into trouble because we lack their support"

Another discussant said:

> We should have somewhere to turn to If we encounter problems to get Information so that we can act responsibly"

However, it was picked up in another focus group that some discussants knew of some parents who forced their daughters to go for abortion, because pregnancy could bring shame to the family. One discussant angrily commented that:

> "Such parents should be exposed to the television and radio, and be locked up in prison because she failed to show her child the right way of living and now she wants to kill her"

Access to contraceptive services and information to sexually active adolescents was seen by most discussants as important to prevent future abortions. Other discussants said that younger adolescents should be targeted by interventions to help them understand their bodies and avoid getting into trouble of sexual and reproductive nature, including pregnancy, abortions, STDs and HIV/AIDS. However, in another focus group it was heard that young people should stop sleeping around and exposing themselves to unprotected sex.

4.3.3.8 Knowledge about Sexual Rights

Respondents were asked about what happens when a girl refuses to have sex with a male partner. Of all discussants, most said that some partners tend to become angry and resort to beat them up. Moreover, some discussants specified that often girls are afraid to say "no" to sex for fear of losing their partners.

Some explained that there are some male partners who intimidate girls because they refuse to have sex with them by passing negative remarks about girls in the presence of their peers. One respondent gave an asserted that:

"most boys find it become difficult to understand that "no" means "no", and they will intimidate you for that"

Discussants in one focus group discussion seemed concerned about the issue of coercive sex, and as witnessed below:

"Boys should learn to accept what girl's feelings and respect our view"

However, three said that they have never had problems to express their views about whether sex has to happen or not. Most discussants however emphasised the need for girls to decide whether or not sex should happen. Others elaborated that girls also have the right to enjoy sex and should not be forced onto it.

It was also observed that some discussants in a focus group with pregnant adolescents seemed shy to contribute to this topic. For others there was a noticeable amount of anger which was reflected in their expressions that girls who are in abusive relationships should take measures to inform the police and parents. The following narrative statement bears witness to the discussion:

"When a girl is forced to have sex by a boy against her will, she should learn how to fight back if she can, you know" (laughter)"

As Woods and Jewkes (1998:2) put it, that violence within youth sexual relationships, in the form of physical assault and forced sex, has been identified by several authors.

One of the key finding of their study was that physical assault and rape or coercive sex was reported and discussed by many female respondents.

Violence was found to be used by boys as a way of imposing the "rules" of the relationship and particularly associated with girl's rejection of "proposals for love"; their attempt to end the relationship; their refusal of sex, etc. When discussing the question of who should initiate sex in a relationship, most discussants said that it should be the responsibility of both partners because they are sharing a relationship. One respondent gave an asserted that:

> "Both of us can only enjoy sex if we feel safe and maybe use condoms as well. Yes, because we are often told that not all days are safe for sex to happen"

Some said that females should initiate sex so that they can take care of their own bodies. The following statement supports this assertion:

> "I think that we girls should take control of sex in a relationship because that can help us as we are the "victims" here".

Four felt that males should initiate sex. However, one discussant said that it depends on who initiates first. However, some discussants felt that males should initiate sex citing tradition and culture as some of the reasons and the perception that some girls are often shy to initiate sex. This was explained in one focus group discussion:

"I think that boys should initiate sex because in most instances if a girl does so, her partner will suspect her of cheating on him"

The above statement shows that some adolescents still lack information about sexual rights leading to low self-esteem and self-confidence. According to the Centre for Development and Population Activities (1996:7), Lack of control in sexual relations makes women more vulnerable to sexually transmitted diseases, including HIV/AIDS.

4.3.3.9 Roles and responsibilities

In line with the topic, discussants were asked to give their experiences of pregnancy from the perspective self, parents/guardians, partner, as well as the roles and responsibilities various organisations and the community can play to reduce adolescent pregnancy. Some personal accounts of experiences with the pregnancy are shared below to paint a picture for guiding interventions.

- **Parent reaction to pregnancy**

With regard to parents reaction when news were broken about the pregnancy, all discussants said that parents expressed various emotions at ranging from anger, shouting depression, shock, immediate acceptance. One 13 year old pregnant discussants said:

"My mother was very concerned about my age that she burst into tears when she first heard that I'm pregnant"

However two discussants explained that their parent (mothers) expressed happiness when they heard about the pregnancy and said that they were looking forward to the grandchild. These confessions sounded very strange to other discussants for the fact that of two discussants one was pregnant (14years) and another was a mother attending school (15years). As a result of the reaction of other discussants the researcher was therefore unable to probe further about the family setting and educational cultural and other factors that may share light into the statement.

The study also established that almost all parents and guardians of discussants were able to accept and supported their adolescents throughout the pregnancy and after delivery. The following narrative supports this assertion:

> "My mom was angry at first and I felt so guilty, but now she has dealt it. Now she constantly asks me how her grandchild is growing inside me and this makes me feel good and wanted"

- **Partner reaction to pregnancy**

As far as partner's reaction to pregnancy is concerned, of all discussants, twelve said that their partners accepted responsibility without hesitance. Fourteen of the discussants said that their partners were not happy. Some said that their partners expressed negative feelings, saying that they were not ready yet to take the responsibility as a father; and some said that babies bring problems; and others said that they were not impressed and expressed shock. Two other discussants did not say anything.

Two other discussants confessed that their partners were working, and while other partners were said to be in school, and two were said to be out of school. Of all these discussants, seven said that their relationships ended at the announcement of pregnancy to their partners, and they had to go though their pregnancies without partners, two discussants said that they were actually informed by their partners that they appear pregnant. One discussant that:

> "I was actually told by him that I was pregnant, before realise myself, then I went to the clinic for confirmation and it was true"

- **Responsibility for the child support**

When asked about who is responsible for support for the baby, most discussants said that both parents were responsible, while some said that the girl's parents are responsible and other two discussants said that their partners are working and are currently responsible for child support.

However, one discussant said that her partner is unemployed, his father is a pensioner hence it is difficult to raise the baby without financial resources. Similarly, another discussant confessed that she is struggling to survive and to raise the baby who is seven months old because her family is poor and parents are doing casual work. However one other discussant said that her father raises her and other siblings after her mother died. She said that she received support from her father and maternal-grandmother throughout pregnancy and birth. Another discussant said that her partner's parent (mother) is taking responsibility since the partner is still at

school.

- **Information, Education and Communication**

Discussants were asked to give their opinions about who should take the responsibility to teach children and adolescents sex education the following people were identified: parents, health workers, teachers, the Church, the media, peers and males.

- **The role of parents**

Like male discussants, all female discussants regarded parents as primary educators for their children's in terms of sex education and other issues. Almost all discussants parents should provide factual information about growth and development and moral issues.

Some discussants described parents as strict, rigid, incompetent, old fashioned and outdated, while others described some parents as overprotective and biased in the way they raise their girl children as compared to boy children. One discussant actually said that:

> "The reason why we girls fall into troubles of pregnancy and diseases is that our parents are shy to talk to us about sex and menstruation. And instead parents quite often blame and threaten us not to associate with boys without information"

The mother figure was seen as more important than the father figure in the family by all discussants because they said mothers are good carers. Some discussants identified the role of the father as that of educating the male child and adolescent to deal with aggressive behaviour and to respect girls and women. Most discussants also said that parents should share their individual experiences of childhood with their own adolescents of both sexes so that many problems can be prevented.

Most discussants said that parents should develop the skill of talking to their children and work closely with the clinic and the school. South Africa also experiences the same situation. While many cultures and religions still regard sex as a sensitive issue, the media is promoting sex as pleasurable and romantic and this leave children and adolescents some form of identity crisis.

- **The role of health workers**

All the discussants who said that parents play a major role in the education of their children about sex education, also identified health workers as equally important. Most respondents felt that health workers have the necessary knowledge, including resources to deal with such issues.

All discussants agreed that the problem is that some health workers lack commitment and skills to serve adolescents, just like most parents. Some respondents suggested that clinics should be staffed with male health workers to attract adolescent boys who may feel comfortable to be served by such cadre of health workers.

In one focus group discussion discussants remarked that health workers used to visit schools to provide health assessment and in the past three years but they are no longer coming. One discussant could recall that the last time visited their school was a while ago when she was at primary during immunisation campaigns.

Almost all groups recommended that health workers should develop adolescent clinic programmes and Community Health Programmes, and involve adolescents who are interested in promoting health messages to be part of the programme. This narrative supports the above assertion:

> "Such programmes should target adolescents through various channels such as sports activities, theatre, music and other places where young people hang around to help them change behaviour"

- **The role of teachers**

Most discussants said that the school should also take responsibility for sex education because children spent most of their time at school. All of them knew about resources available in most school in the form of guidance and life skills teachers, some of which were seen to be non-judgmental in their approach to adolescents and youth at school and as important.

However other guidance and life skills teachers were seen by some discussants to be acting like strict parents. Most discussants suggested that the guidance life skills period at school should be given more priority and inform adolescents of both sexes

about sexuality, pregnancy prevention and HIV/AIDS.

- **The role of the Church**

Religious organisations were identified by most discussants as important intervention settings for the promotion of issues related particularly to, positive moral values based on the reality of adolescent sexual and reproductive health experiences, most communities are faced with.

Some discussants said that the fact that some priests and church elders are predominantly men, is a disadvantage to most female children and adolescents because they tend to be treated like their mothers in youth clubs of various churches. One discussant commented that:

> "Some church rules and practices are unfair to women and girls than for males We are expected to behave in a particular way, eg, to cover our hair whenever we attend church sermons but it is not the same with men"

Most discussants recommended that church elders and priests should be provided with skills to be able to help children and adolescents deal with issues of sexuality and to incorporate Christian values to promote responsible growth and development.

Others said that there is a need for most religions to recognise that both men and women play an important role in the church and should be treated equally.

- **The role of the media**

Some discussants identified the media, both radio and television, magazines, posters and others as important channels to communicate messages about sexuality and the promotion of healthy development, particularly with regard to younger adolescents who have not started sexual activity to help them know and respect their bodies.

They also saw media to facilitate age and culture specific targeted messages, if only these messages are properly screened for their relevance and benefits to adolescents. However, one discussant complained about the impact of the media to the adolescent of the present day, with regard its portrayal of sexual activity and its consequences as "cool", as reflected in some "television soapies".

- **The role of peers**

All discussants said that they equally have the responsibility to teach their peers about sexuality issues because it is through their peers that they often receive what may be good or harmful to their health. Of these discussants, some said that often adolescents lack the skills and the necessary support from adults to work in programs, which target them.

While others said that, health workers, social workers and teachers tend to plan interventions for adolescents without involving the youth, some only involve them as tokens in the implementation of programmes. Some discussants complained that, most adults who should help young people are not approachable, and hence should work with and support them in youth programs. Peer workers should be guided to

initiate community projects on health promotion.

- **The role of males**

Of all discussants most felt that there is a need for programmes that target males in clinics and in the community on sexuality issues and on reproductive health and these programs should not be limited to condom use only so that men can understand women better. Some discussants emphasised the need for males to avoid multiple sex relationships, raping children and adolescents, to learn to respect the opinion of girl partners.

Some discussants said that male partners should accompany their girl partners to the clinic for both contraceptives and if the partner is pregnant for antenatal care so that they can share responsibility and get information to prevent future occurrences. Other discussants said that male partner should learn to have one faithful partner. This was supported in one group discussion when a respondent said that:

> "Males should visit clinic to find out about clinic programmes. The clinic must not only be there for women's service" but as a community service"

4.4 SUMMARY

This chapter dealt with the specifics of qualitative and quantitative data analysis. Quantitative data was analysed statistically using a computer programme and was present in graphs and tables, showing frequencies and percentages. Qualitative data

was then analysed using a coding scheme.

Themes that emerged from discussions with both male and female respondents were categorised and narrative statements were also used to justify personal accounts and perceptions towards the issue under discussion. Study findings identified similarities and differences in responses between same and different sexes, which provided more insight into research questions raised earlier in the study.

CHAPTER FIVE

INTERPRETATION OF RESEARCH FINDINGS

5.1 INTRODUCTION

The previous chapter dealt with quantitative and qualitative data analysis, which painted a picture to try and arrive at answers to the research questions of this topic. This chapter will interpret the findings of the research study, also referring to the supporting theories of other relevant studies done in the area of adolescent pregnancy and reproductive health.

5.2 SEXUALITY AND CONTRACEPTIVE USE

Responses to attitude to sexuality and contraceptives were gathered and analysed using three graphs. A Lickert scale was used to determine the attitude of respondents on several sexuality issues and responses are captured in the previous chapter as shown in all figures discussed under 4.2.

It was found that, given the problem of lack of or poor communication between parents and children, most sexually active female adolescents do not feel comfortable discussing the subject of contraception with parents. Even if the law exists that requests for parental approval, on minors (>14 years according to the Child Care Act, 1996) to access contraceptives, experience has shown that some minors tend to increase their date of birth in order to access the contraceptive services.

Other factors that may affect access to contraceptive use by sexually active adolescents include peer pressure, experiences of rape / sexual abuse, the issue of rights and responsibility of adolescents to have free access to contraceptives without parents. The fact that most parents tend to associate contraceptive use with promiscuity and often leads to misconceptions about agreeing to contraceptive use.

To support the above findings, a qualitative study on Adolescent Sex and Contraceptive Experiences in the Northern Province revealed that, first contraceptive use was commonly initiated by mothers, once daughters started to menstruate. While for some adolescents first contraceptive use was motivated by the perception that sexual initiation was eminent and often because their peers used contraceptives (Wood, Maepa and Jewkes; 1998:2).

Other findings confirmed that females are more likely to use contraceptives without parental approval. According to the Demographic and Health Survey (1998:19) contraceptive use is high among sexually active women in their teens and 20s. One in four teenagers are currently using a modern type of contraception and among sexually active teenagers, the injectable contraceptive is the most popular, with half of sexually active women currently using it. Other findings of the same study indicated that condom use was low among all teenagers.

With regard to findings on attitude to abstinence, there seemed to be the similar responses from both male and female respondents, particularly (adolescent fathers and those who were mothers) those who went through the experience of adolescent pregnancy. Some may have had about abstinence before but were not motivated to abstain from sex until they made mistakes.

The study did not establish whether non-fathers who agreed on abstinence ever practised that as a method of choice, and what role would the church play in promoting abstinence among adolescents. Promoting abstinence among young people, however, receives particular emphasis. Focus on family's James Dobson preached the point that " no one has ever been hurt by refraining from sexual expression".

The emphasis on Christian purity for teenagers, is in part a response to the threat of HIV/AIDS and several sexual implications. This is accompanied by changes in social mores and the media representation of sexual activity (Rudy 1997:46-7). However, the Baseline Survey into HIV/AIDS Knowledge, Attitude and Related Life-skills revealed that more students in the Northern Cape, Western Cape and Kwazulu-Natal reported having had any sexual encounter. On average, over 60% of students in these provinces had never had sex, compared to an average of 47% in the other provinces (Kushlick & Rapholo , 1999:vii).

The literature review revealed that in one study in Uganda, nearly a third of boys interviewed had experienced peer pressure as a reason to engage in sexual activity with girls. Sex for young men is seen as a conquest, a rite of passage and means of achieving peer respect.

Given the sensitivity of the issue, the challenge would be to investigate the practice of abstinence so that more valid results can be found for promotional programs.

The study revealed that in terms of attitude to delaying sex, overall most adolescent seem to show lack of knowledge about delaying sex as one of the options of

contraception. Although this area did not seem to interest respondents that much, as observed by the researcher, some studies have shown that relationships between girls and boys during adolescence are based on the notion that sex is the only indication of love for most adolescents.

While kissing, hugging, for example, is regarded as "childish" by some and as arousing sexual feelings by others. This area needs to be explored much further to investigate the existing myths and misconceptions about various methods used to delay sex and develop strategies to promote this option particularly among this target group.

5.3 AGE AT FIRST SEXUAL ACTIVITY

Overall age at first sexual activity is lower among pregnant respondents than in all the non-pregnant as well as in male respondent types. Early start of sexual activity amongst adolescents of both sexes could be attributed to many factors.

Sexual abuse of children and adolescents is a growing problem in many countries of the world including South Africa. A number of issues contribute to sexual abuse of children. Patriarchy on the other hand contributes to gender discrimination, further separating the role of boys and girls. Traditional cultural practices that promote right of passage for girls and boys through initiation schools have been experienced by some adolescents as the time for sexual activity as documented in some studies.

There is a growing tendency among adolescents to desire or need to be accepted by other people or to be like them in order to gain their approval. For some

adolescents first sexual encounter can result from peer pressure, while others may pick that up from movies and soapies they watch in the media especially without parental or adult supervision. Adolescents may also lack factual information about sexuality issues from parents, teachers, religious leaders, health workers and rely on their peers for information.

In itself this need is not all bad because people will make informed choices. For example, an adolescent can compare herself with an identified group of adolescents of the same age or older who practice abstinence as a method of choice, by joining the group. Studies show that many of the girls become pregnant and few will continue on to complete high school.

Far too many end up on public assistance and begin a cycle of dependency from one generation to another, thus creating and perpetuating at-risk families. Given the problem of HIV/AIDS epidemic, it is true to add that sexually active adolescents are at risk of dying from AIDS.

However according to Matshidze, Beksiska, Rees and Mazibuko report on the National Male Sexual and Reproductive Health Survey (1999:2), age at first sexual activity was found to be lower in the youngest age group (mean 14years) compared to the older age group (mean 18years).

It can be argued that while the above findings give a general picture about sexual behaviour and practices of males, some small scale studies reveal that age at first sexual activity can be found to be the lowest in the younger age group, as confirmed by the present study. Studies complement one another.

Based on data from this research project, early start of sexual activity can have the following implications:

- Health implications include the risk of contracting sexually transmitted infections, like STD and HIV/AIDS due to unprotected sex;

  Early and repeated pregnancies which may result in complications of labour and unsafe abortion; high risk for cancer of the cervix have been shown to be associated with early start of sexual activity.

- Socio-economic implications include societal value system, how the society view its young people depends on many factors, such as socialisation of children in the family, the school, the church, the community, role models, abuse, poverty, unemployment, sexuality and life-skills education, availability of services in the community.

- The impact of the above stated factors will put strains on government resources to deal with issues of street children; child prostitutes/ commercial sex workers, pregnant adolescents and adolescent mothers; unemployment; low/unskilled youth because of school-drop-out rate, resources to care and support people living with HIV/AIDS both infected and affected; child marriage.

5.4 REACTION OF PARENTS AND MALE PARTNERS TO PREGNANCY

Findings revealed that overall parents are more likely to feel bad about the announcement of pregnancy. For socio-economic reasons some parents who are

Bread-winners, who are single, having a big family, unemployed or live in poverty this can be devastating. Societal stigmatisation on the pregnant adolescent and the family further complicates the issue.

However, some respondents reported non-response from their parents. This response may suggest various factors contribute to that assertion. Parents may encourage their adolescents to fall pregnant to fit into a particular culture because it is acceptable. Some parents may sell their adolescents in exchange for money either as child sex workers or as arranged marriages to elderly men for economic reasons.

Adolescent pregnancy may not be seen as a problem but as a familial birth order or a pattern. Poor parental control may be the course due to alcohol and substance abuse in the family. Alternatively some parents may choose to keep calm at the break of the news to think more positive ways to manage the situation.

A report by Pathfinder International (1999:14) confirms that over 25% of births occur to young people especially before marriage. It further states that although union often follows, some cultures require that young people prove their fecundity before marriage.

Findings on the reactions of partner to pregnancy, on average most partners tended to have accepted the responsibility for the pregnancy, compared to some who were reported not to be happy, negative and disbelief. Acceptance of pregnancy by a partner may imply a sense of maturity from the male partner who may perhaps be an adult, or an adolescent recognising his responsibility beyond a mistake that has

occurred. While negative response may be an expression of shock, feeling of guilt unexpected outcome or an intentional practice by the male partner.

Findings of de Castro et al (1996:20) supports the above. The study revealed that there was consensus across all groups interviewed that most teenage fathers frequently do not take responsibility for fathering a child; they may blame the girl, run away or simply deny it is their child. It is not clear whether most teenage boys are aware that sexual activity may result in pregnancy or not as this was not asked in this study, and is indicative as an area for further exploration.

5.5 OPTIONS IN PREGNANCY

These findings reveal that most of all males are more likely to prefer that their partners should continue with pregnancy, and seem to be against abortion. More male respondents are likely to prefer to parental opinion about pregnancy options. The above findings give a picture that most males seem to be against abortion. One would suggest a further to look into reasons behind these feelings.

Findings should compare the suggested study with reasons of the need for abortion by females. It was found that most males encourage parental input and seem to show positive attitude for females to continue with pregnancy. With regard to female respondents, many seemed not to think about abortion as an option, while only on finding revealed that the partner wanted abortion. Among reasons given for preferring abortion, issues such as health reasons, including health risks associated with backyard abortion; socio/cultural reasons (family embarrassment).

Other reasons included peer/partner pressure, stigma; rape/abuse/violence and broken down family; educational reasons, such as the need to proceed with school; economic reasons, such as poor family background, single parent household where the sole parent is unemployed and does not have enough support. According to information gathered in focus groups in Ethiopia, Kenya, Tanzania, and Uganda, almost all young women knew about induced abortion, and friends or partners were usually the ones to arrange for the procedure (Pathfinder International Africa Region, 1999:18).

One can argue that the present legislative measure (Choice on Termination of Pregnancy Act, 1996), which has increased access to abortion services for women and adolescents, is confronted with implementation challenges often of ethical and moral nature. Evidence has shown that women will turn to abortion as a method of coping with unwanted pregnancy whether or not it is legally available, and for various reasons, adolescents may even, more apt than adults to seek illegal abortion.

5.6 REACTION OF PARTNER IF A GIRL REJECTS SEXUAL ADVANCES

On average, negative expressions were raised with regard to responses from most males to the question of what if a female partner rejects sexual advances to range from anger; beatings, dumping the girl, intimidation.

However, positive expressions included a comparison of those females respondents who said that males are likely to accept the rejection, with those who said that males are likely to respect their views for rejecting sexual advances. Responses were found to be similar from both questions.

Most males were found to be more likely to respect the views of females and to accept when a female says 'no' to sexual advances. However, some indicated that most males tend to express anger, to dump their girls; to intimidate them, and few will beat their girls up. There is a difference between males and females. Overall males have shown to accept and respect the views of females compared to what females said males would react in the same circumstances. On the contrary, female respondents seem to report negative reaction on the part of male partners, more than male respondents.

This situation poses some questions to be explored further:

- Does it mean that individual female respondents felt free to articulate their own experiences as well as those of others in the questionnaire?

- What would the response have been if the same question was asked in a heterogeneous focus group discussion?

- Whether it means that adolescents of today are becoming aware of their sexual rights?

Three studies throw light on this issue. In a study conducted among adolescents in Umtata, Eastern Cape, Wood and Jewkes (1998:2) found that boys used violence as a way of imposing the rules of the relationship. This violent behaviour was particularly associated with issues including; the girl's rejection of 'proposals' of love, their attempts to end the relationship, and their refusals of sex.

The study also found that boys used physical coercion against girls in order to maintain their fantasies of power. Girls were restricted in their ability to resist violent men for fear of losing a relationship of 'status' and, whilst characterising men as 'irresponsible' and 'deceitful', were eager accomplices in acts of 'deceit' against other women when these increased their power and position within the female peer group.

The findings on the personal power in another national study conducted by Kushlick and Rapholo (1999:40), among the South African Secondary School Learners revealed that, 20% of males were highly empowered and felt they could make their own choices, particularly with regard to their sexual relations, as opposed to only17% of females. These findings reflect that men felt more empowered than females.

Similarly, de Castro et al (1996:94) reported that 67%of respondents said that their partners could refuse sex, and only 41% of these were boys. The authors therefore recommended a need for education concerning sexual rights and mutual respect between the sexes to be incorporated into sex education programs.

5.7 DECISION MAKING ON SEXUALITY

On the question about decision making in sexuality issues, overall females were found to be more likely to agree compared to some males that it is the responsibility of both partners to make decisions about sexuality issues. While some male responses felt that males should make decisions about sexuality issues, only two of the female non-pregnant respondents supported the same statement.

Only female respondents felt that the female partner has a responsibility to make

decisions about sexuality issues, and no males felt the same. Only one male respondent (non-father) said that persons other than any of the partners can make decisions about sex issues. These findings gives an impression that most adolescents are increasingly becoming aware of the need for joint decision making in sexuality issues in relationships. However, the challenge lies in the actual practice whether these decisions are ever respected, especially when initiated by a female partner.

This area still needs to be explored. It has been found that males are more likely than females to agree that the responsibility to make decisions about sexuality issues rests with male partners. This means that power relations continues to exist and affect the socialisation of most adolescents. Many other factors contribute to gender relation issues particularly in areas including the following: the roles of the media; the school; the church; the parents and guardians; the society and the government.

Evidence have shown that there are common expectations and pressures on men that affect sexual health for both men and women. These expectations and pressures differ in intensity and presence among nations, and they include the following:

- men are expected to be strong and are discouraged from expressing pain, fear and insecurity;

- men should always take the initiative for sex;

- men exert pressure on each other to drink alcohol together to create a shared social space, a practice often associated in the literature with unsafe sex

practices. The study found that some people feel that significant others can make responsible decisions for partners. This could refer to parents, friends, teachers, religious leaders and other;

- men should always be active, and never passive, with the corollary that women should not express desire. She goes further to state that these behavioural expectations play an important role in certain instances of sexual coercion, especially within the context of courtship and dating (Puri, 1996:14).

In another study conducted by Kushlick and Rapholo (1999:13) it was found that 61% of students felt that their decision to engage in sex or not was made jointly, while 67% felt that both they and their partners were responsible for practising safe sex. 58% believed that females had the right to refuse sex. Another finding was that in a quarter of respondents in Natal-Kwazulu, the opinions of male partners prevailed in family planning decision-making.

The use of condoms touches on core elements of negotiating power in hetero-sexual relationships through constructions of female sexuality. One study found that, although most men interviewed in that study admitted that young men commonly "sleep around" even if they are in a steady relationship. Few felt that this could be the reason for a woman to want to use a condom.

This study also found that where male promiscuity is an acceptable part of the dominant masculinity, the young men felt they had no reason to use condoms, because they are widely associated with morally and socially illegitimate sexual relations. Therefore, a young woman who asks for a condom must have "done

something wrong". Hence the projection of female unfaithfulness which, unlike male promiscuity, is generally shunned (Everatt 2000:63).

5.8 RESPONSIBILITY FOR CHILD SUPPORT

The study found that a similar pattern emerged between those female respondents who said that both parents are responsible for child support and those said that it is the responsibility of the girls' parents. Few thought that it is the responsibility to the boy, while the same number puts the responsibility to the boy's parents.

In situations where both parents take responsibility for child support this may imply that these parents have a common understanding of their adolescents' mistakes, and the need to give them opportunities to go back to school while they share the responsibility for child support. One would ague that it is a common practice in most African cultures that the girls' parents tend to bear the burden for child support, even in cases where the father has accepted responsibility for pregnancy.

However, these findings have shown that boys' parents are less likely to take the same burden as girls' parents. Adolescent females who are in a relationship with males who are employed are likely to say that their male partners are responsible for child support. Again this will depend on whether the partner accepts responsibility or not and how responsible the partner is.

To support the above findings, the following study is cited. de Castro et al, (1996:88), confirms in one study that there was consensus across all groups that teenage fathers frequently take the responsibility for fathering the child; they may blame the

girl, run away or simply deny it is their child.

Most respondents in this study felt that the responsibility lay with parents of the pregnant girl and/or the pregnant girl herself. A few respondents mentioned adolescent parents or the adolescent father.

5.9 PERCEPTIONS ON RECREATIONAL FACILITIES

Given the fact of limited facilities in the area, it is interesting to note that most discussants regard going to tarvens/shebeens as a form of recreation for some youth. From one's own point of view and some existing evidence, the natures of South Africa's socio-economic and cultural history have served to create not only diversity but also considerable complexity in recreation as a concept and experience, and consequently in recreation patterns and activities.

It would not be hard to postulate, for instance, that the pressures brought to bear on adolescents of today, whose deeper values still reflect socio-cultural values, yet whose daily life is the experience of western values form which they barely benefit. These adolescents are bound to feel (express) conflict in identification of desirable recreation.

5.10 KNOWLEDGE OF CONTRACEPTIVES

Discussants who stated not using condoms, also said that they disapprove if their partners initiate condom use. Myths related to "condom disappearing inside the woman's vagina", as well as "destroying sexual feelings" were heard.

Most discussants knew about other contraceptive methods particularly used by their partners, like, pills and injections.

All discussants knew of the clinic as the main source of information and service for contraceptives. Other sources and distribution sites were mentioned to include the private practitioner, shop school, chemist. The above responses show that there is a gap between knowledge and practice of condom use in particular. Even if discussants knew that free condoms were obtained from the clinic, they mentioned that they would prefer to buy them at the chemist or get them anywhere else for fear of interrogation by health workers. While another discussant identified the church and another one parents as sources of information about sexuality issues.

It is encouraging to note that in recent studies from developing countries show that a high percentage of men know at least one method of fertility regulation. Among male methods, awareness about condoms is high, but condom use is low even in those countries like South Africa, that are affected by the AIDS pandemic, and where prevention campaigns by government and non-governmental organizations are in existence.

5.11 PERCEPTIONS ABOUT CONTRACEPTIVES

All respondents interviewed agreed that condoms are effective in the prevention of pregnancy, STDs and HIV/AIDS. However, different opinions were gathered from some respondents in all focus group discussions about the quality of condoms that they are not 100% safe and can burst during the process of sexual activity. The researcher probed to find out whether respondents knew how to apply a condom

properly or not.

The study found that there is lack of knowledge about condom application, even if awareness is increased. However, a similar trend confirms the above findings as seen in a survey conducted by Matidze, Beksinska, Rees and Mazibuko (1999:4) which revealed that male respondents in general indicated high confidence about the effectiveness of condoms in the prevention of STDs and HIV/AIDS. Unsafe sexual practices by some school going girls who engage in relationships with adult males was seen as a practice that put most men at risk of getting infections. It has been found that some males intentionally make girls pregnant or infect them with STD and HIV/AIDS.

It is argued that the acceptance of a contraceptive method is not only influenced by the potential user's desire to prevent a pregnancy, but by gender dynamics. Therefore men have a duty to share contraceptive responsibility and its associated burdens (Puri, 1996:9).

5.11.1 Relationship of contraceptives, STDs and HIV/AIDS

Almost all discussants interviewed seemed to be aware that there is a link between condom use, STDs and HIV/AIDS. Multiple sex relationship was seen as a high risk behavior that puts the young males and females at risk of contracting pregnancy, STDs and HIV/AIDS.

Most of the respondents knew about the mode of spread of STDs. The common type of STDs known by all was HIV/AIDS and "drop". It was found that the pubic lice, also

known as "ntasheta" is also classified as sexually transmitted diseases by most discussants in all focus groups. The researcher observed that when the male discussants described "ntasheta" they all looked at one another as some were demonstrating where the name was derived from, (through scratching of pubic area) and all burst into a laughter.

Social norms that require female passivity and economic dependence often lead to early sexual initiation for women to insist on contraceptive use or mutual fidelity, and make women vulnerable to violence (Centre for Development and Population Activities, 1996:7).

- **Prevention**

This means that young people know that abstinence is the best option in the prevention against pregnancy, STDs and HIV/AIDS but it becomes a challenge to those who are already having sex to practice abstinence. Even to those who choose to abstain after they had engaged in relationships and had sex, they are often pressurized by their own peers to engaged in sex.

In another study of Wood, Mafora and Jewkes (1997:8) revealed that as a consequence of peer exclusion, many teenagers reported that their first knowledge about sex derived from sexual initiation by men, a pattern reported among teenagers elsewhere.

5.11.2 Multiple sex relationships

The categories and narratives on perceptions about multiple sex relationships discussed in chapter four indicate the relationship between the number of partners, contraceptives, e.g., morality and the spread of STDs and HIV/AIDS. Other findings included lack of information about sexual and reproductive issues, existing myths and misconceptions, peer pressure and gender power relations. Wood and Jewkes (1998:20), confirms that multiple sexual partners, by all accounts virtually universal among boys, seemed to be an important defining feature of "being a man".

During the research process it was revealed that two male discussants had children with more than one female partner. In both instances discussants took responsibility for child support, while both still being at school and parents are presently supporting both babies. On probing it was understood that the latter pregnancies were actually "mistakes" and that there is no intention to marry the mother of the baby.

Given the sensitivity of the topic and ethical issues concerned, it has not been possible to interview the female concerned, to get their perceptions about the issue. It is perhaps necessary to investigate further as to whether adolescent female who are aware of the multiple sex of relationships would take more precautions.

The categories and narratives discussed under a section on multiple sex relationship show a picture of the relationship between the number of partners, contraceptives use and knowledge levels with regard to, morality issues and the spread of STDs and HIV/AIDS. Some responses are indicative of lack of information about sexual and reproductive issues, existing myths and misconceptions, peer pressure and gender

power relations.

5.11.3 Power relations and contraceptive use

With regard to discussants on what they would do if a female partner suggest condom use during sex. The researcher observed that there was a sudden silence followed by giggle in three discussion groups. Responses included demand an explanation from the girl especially if it's the first time they initiate condom use, suspicion that the girl may be "two timing", not likely not to respond. Some said that they would welcome the idea because girls are usually shy to initiate sex anyway.

One can argue that those who do not know are not yet sexually active and lack the skills to deal with the issue. While those discussants who have shown some emotions to the issue (suspicious) became challenged due to gender power relations. A qualitative study conducted by de Castro, Gulati, Mosai and Everrat (1996:xiv), revealed the following findings:

- The patriarchal nature of South African society has meant that gender oppression is a real and negative feature of society. This has implications for contraceptive use: young women find it difficult to initiate condom use and make reproductive choices. There is a perception by some male teenagers that the prevention of pregnancy is not their responsibility.

The above argument confirms that the negotiation of safe sexual practice challenges the culturally constructed notions of femininity and masculinity, from which most children become socialized into.

About discussions on their reactions if a girl refuses to have sex with them, it was captured that most discussants will respect the girl's view. Other responses raised included feelings of suspicious that the girl may be cheating. However the researcher also noticed that there was a discrepancy in how some respondents verbally expressed their positive attitude towards the decision and their actual non-verbal communication they displayed.

For example, of those who said that they will respect the views of the girls to decline sexual advances, some also supported those who said that they will express disappointment, suspicious and that they will attempt to convince the girl to agree to have sex. Almost all discussants knew about child abuse and agreed that it is a problem in their community.

It was observed that most discussants felt that the girl has the right to say "no" to sex and that it is violation of their right to force a girl to have sex against her will. According to the researcher, the above statement denies the girl sexual rights and may predispose her to sexual violence, for example, coercive sex, rape and abuse. Some discussants identified the right of a girl to drop the guy who treats her badly (abuses her).

This imply that some discussants are aware of the existing laws, eg Domestic Violence Act, and other laws that protects one against violation of human rights or they were not aware of such laws. It seemed as though the respondents either were reluctant to enter into legal issues associated with violence or that they were not informed about these issues.

5.11.4 Perception about religious principles and contraceptive use

Discussants seemed to have a level of knowledge about religious principles that impacts on contraception. Religion was regarded by most discussants as an important factor that has an influence on contraceptive use and marriage. This did not mean that most of these discussants belonged to these religious organizations. Various religious principles were identified which varied from one religious organization to another.

It was also heard that, some churches encourage that youth of the same denomination form relationships with one another to maintain the culture of the church. However, most respondents have explained that even if these principles exist, there is lack of support mechanisms in place to promote implementation of such principles. Among the discussants there was an indication that religion did not seem to deter adolescents from sexual activity. Some of these discussants confessed that they are aware of these church principles but could not follow them.

de Castro, Gulati, Mosai and Everatt (1996:87) note that religious practices can affect contraceptive use and attitudes towards pregnancy. Religious taboos deter many women from using contraception. Many religions are patriarchal in nature and this frequently means men make decisions about women's reproductive health.

From the discussion one could say that most youth are sexually active and that while most religions advocate for abstinence, other options should also be promoted for sexually active adolescents and young people to prevent pregnancy, STDs and HIV/AIDS. Implications are that issues of sexuality and contraception are still

regarded by most religions as sensitive.

While on the contrary, Ministers of Religions are engaged in addressing issues related to these in their daily lives through counseling, the sick and troubled families and couples in relationships, marriages, suicidal attempts, diseases and other issues.

5.12 PERCEPTIONS ABOUT PREGNANCY

Reasons for pregnancy for males included that some girls were careless and stubborn about their bodies; lack information about sex issues of ignorance, and how to prevent themselves from falling pregnant. Some reasons included willing to upset their parents who are too strict; pregnancy was as a result of peer pressure; blame on parents for not giving the necessary care to their girls and to retain boyfriends by getting pregnant.

- **Options to pregnancy**

Most discussants who made girls pregnant stated that they would have never advised their partners to terminate the pregnancy, because they believe it is wrong, even if the pregnancy was unplanned. However discussants in one focus group said that boys who advises their girlfriends to terminate pregnancies do not love them.

In circumstances where pregnant girls suggest their intentions to terminate the pregnancy, all discussants expressed feelings of shock and an expression of anger, was observed by the researcher. However, one discussant elaborate by saying that

it can be accepted on the basis that the girl want to continue with education. Other discussants cited peer pressure as one of the reasons why one or both partners may want to terminate a pregnancy.

All discussants agreed that consistent use of condoms prevents one from getting infected with STDs and HIV/AIDS. Most mentioned other options to include abstinence, and faithfulness to one partner.

However it was interesting to note that abstinence was seen as a challenging option. This means that young people know that abstinence is the best option in the prevention against pregnancy, STDs and HIV/AIDS but it becomes a challenge to those who are already having sex to practice abstinence. Even to those who choose to abstain after they had engaged in relationships and had sex, they are often pressurized by their own peers to engaged in sex.

It was found in discussions that respondents lacked knowledge of the signs and symptoms of pubic lice, hence some referred to treating the symptoms with Jeye's fluid. It was not clear whether people affected by pubic lice do get cured or not as the stories shared were referring to the third person.

It was interesting to note that some discussants mentioned that one of the preventive measures for HIV/AIDS include going for voluntary HIV/AIDS testing before marriage with a girl partner use of condoms prior to marriages.

Impatience on the part of some males to postpone sex in case where condoms are not available and sex is unprotected was identified as a problem. It was picked up in

discussions that power relations are prevalent even in adolescent relationships and often result in coercive sexual behaviour. This situation is indicative of gender power relations, which often result in violent behavior by a male partner. Some literature revealed the pro choice versus the pro life debates.

The proponents of the Right to Life such as Cameron & Sethurajan et al (1989), Willis (1993), Kelly et al (1998) argue that termination of pregnancy is a moral violation. They use the excerpts of the Vatican to substantiate their opposition to termination of pregnancy.

5.13 PREVENTION OF ABORTION AND FUTURE RECURRENCE

The study found that parents play an important role in the prevention of abortion and the following reasons were derived from most respondents of males and females:

- It was explained that parents should use a positive approach to target both girls and boys and give the factual information on the life skills.

- Parents should be open to their children so that those children can be able to share their problems.

- Their children tend get misleading information from friends. If one has received factual information from parents, one will be able to make informed decisions about whether or not to engage in sex and other risk taking behaviours.

- Parents should accept the changing culture, that needs of adolescents differ from theirs,

- Because parents are often too busy and strict to talk to their adolescent daughters and sons. The adolescents then tend to seek information on issues of sexuality and options outside home, which can be misleading and wrong. Therefore parents should have skills to deal with their children.

- Sexually active girls should be allowed to use contraceptives without the permission of their parents who may or may not approve.

- Health workers and teachers should teach adolescents about sex issues that may lead to drastic consequences.

5.14 ROLES AND RESPONSIBILITIES

Discussants were asked how would they feel if their partners announce that they are pregnant. Responses were classified according those who were fathers and have experienced the issue with those who have not yet experienced that.

5.14.1 Parental reaction to pregnancy

Of those respondents who has ever made adolescent girls pregnant, some discussants said that their parents did not have a problem to accept the news from either the boy or the girl's family and they offered support to their adolescent father to be. Other discussants reported that parents said nothing, while most discussants

said that their parents told them that they will-be fathers soon and has to act responsibly. On the average, most discussants said that their parents expressed shock at first, which some managed to overcome later.

Another discussant confided that he approached his parents through his sister who was able to convince them that he had made a mistake. The father expressed anger and almost withdrew the boy from school. He then accepted that the boy made a mistake and approved that he continues with his education.

5.14.2 Child rearing practices: Adult parents / Adolescent parents

In comparing child-rearing practices of adult parents to those of adolescent parents, All discussants said that adult parents are more likely to raise their children in a more healthy mature way because of their physical and psychological readiness to have children. They have the ability to plan their families because of their socio-economic status.

Adolescent parents were described by all respondents as lacking experience adult parents have because of the age at which most of them fall pregnant. This will interfere both partner's education, growing up, relating with friends and peers. One discussant (17years old) shared his personal experience about lack of experience

5.14.3 The role of peers

- **Information, Education and Communication (IEC)**

All discussants felt that they and their peers are the most appropriate people to educate other youth in the community about issues of sexuality because they share the same culture. Peer education is therefore seen as important aspect of disseminating information to adolescents and youth in the community of Lethlabile. It was also explained that such resources are lacking in this community.

Whereas in another focus group discussants suggested that youth should be given a chance to organize community events on health issues, with the support of knowledgeable adults form health and education sectors. They also talked about the use of youth and culture in such events and awareness campaigns will be important.

However some discussants stated that they are committed to share information with other youth in the community but often lack confidence, skills and knowledge about sexual and reproductive issues, including HIV/AIDS.

- They raised constraining factors to access a health service that quiet often health workers at the clinic seem too busy to offer support.

- All discussants also recommended the support of youth from other areas outside their community to share experiences and learn from them.

Most of the discussants confessed that they only use clinic to access condoms. While some stated that they are shy to go to the clinic for condoms because of the embarrassment by health workers who will ask them what are they using condoms for, and others said that they never use the clinic at all.

5.14.4 The role of Parents

Parents were seen by all discussants as primary educators of children about life issues in general and about sexuality issues. All supported the above statement, citing reasons to include the following:

- Both parents brought children in the world, and that parents are legally responsible for guiding them into healthy development.

Most adolescents are concerned about lack of communication between them and the parents which result in them getting misleading information from their friends or other adults who may also abuse them

5.14.5 The role of Health Workers

Almost all discussants felt that health workers plays an important role in providing information and services for young people in the community and in schools. Emphasis was put on the value of experience they poses in addressing health issues. However some discussants mentioned that the clinic is "a no go area" for most youth because of judgmental attitudes of some health workers.

5.14.6 The role of teachers

Teachers were described as secondary parents in one focus group, and their role was seen as crucial and superceding that of parents as argued by some discussants:

5.14.7 The role of Religious leaders

Most of the discussants have acknowledged the role of religious organizations in promoting information about sexual and reproductive health issues particularly in the area of HIV/AIDS. Of these respondents, some confessed that they have heard about HIV/AIDS prevention messages in their respective church sessions.

Other discussants indicated that they are not attending any church at all but would encourage churches to address issues of sexuality and pregnancy and HIV/AIDS openly because most youth spend much time at church.

However other discussants indicated that in some churches these issues are still not discussed. This implies churches should recognize adolescents a distinct group with diverse needs, and plan relevant youth clubs that respond to these needs and that are run by the youth.

5.15 SUMMARY

This chapter provided an interpretation of research findings explained in chapter four previously. A cross reference to the available literature around major findings was done as a means to identify trends, similarities and gaps in research. Interpretation

of findings provided direction to drawing conclusions and recommending actions to be taken to answer research questions. This will be discussed in the next chapter.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter is a presentation of the summary of research findings, conclusions as well as recommendations intended to decrease the rate of teenage pregnancy. The recommendations include policy issues, strategies to reinforce existing structures, education and training initiatives, and preventative measures for the control of preventative measures against sexually transmitted diseases as well as HIV/AIDS, given their close correlation with adolescent pregnancy.

The purposes of this research project, entitled: The roles of male partners in combating adolescent pregnancy are three fold and include the following:

- to explore male opinions on the problem of adolescent pregnancy.
- to assess their knowledge, attitudes and practices regarding contraception.
- to determine their role in reducing adolescents pregnancy.

6.2 CONCEPTUAL FRAMEWORK

6.2.1 Introduction

This section is very important to help link the research problem, literature review and the research design. It is a section that will discuss the interdependence of concepts

that are relevant for the investigation of the role of male partners in combating adolescent pregnancy. At this point it is appropriate to assess the description of a conceptual framework as presented by Polit and Hungler (1995:433). The conceptual framework is described also as a theoretical framework by the same author.

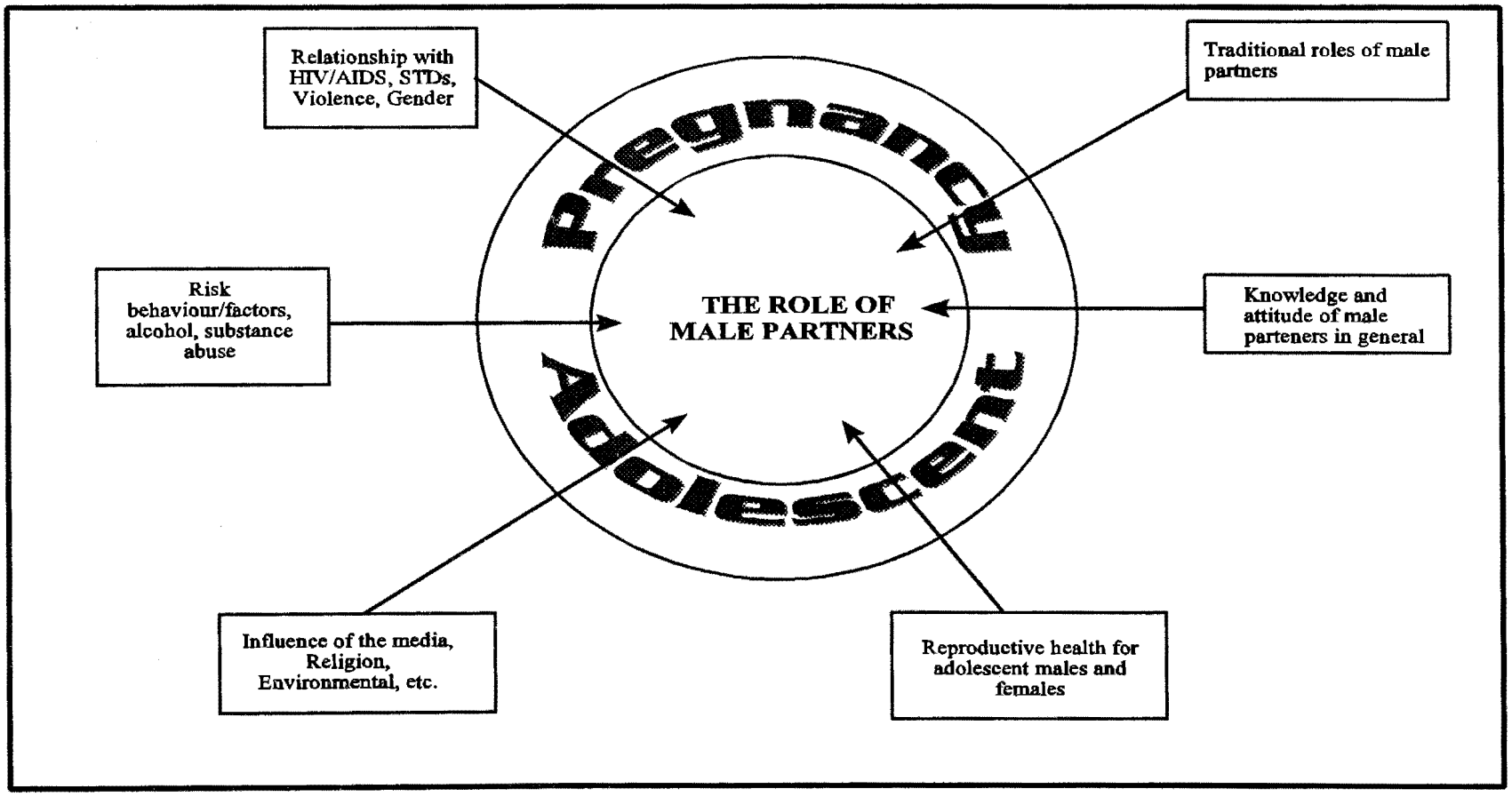
The conceptual framework is intended to give a frame of reference. The frame will then serve as a basis for:

- defining related concepts;
- providing a frame of reference that is a base for observations;
- guiding the research designs;
- determining interpretations;
- addressing potential generalizations.

DIAGRAM 6.1

CONCEPTUAL FRAMEWORK

"THE ROLE OF MALE PARTNERS IN COMBATING ADOLESCENT PREGNANCY



6.2.2 Discussion of the framework

Collective and interpersonal effort is one of the most important factors to be taken into consideration in the presence of adolescent pregnancy. Some of these factors include the following as shown in diagram 1- however the list is not limited to these:

- reproductive health services for adolescent male and female
- general knowledge and attitude of male partners on issues related to sexual and reproductive health and life skills
- risk behaviours e.g. substance abuse, alcohol, smoking etc.
- relationship of adolescent pregnancy with other social determinants of health e.g. STDs, HIV/AIDS, violence and gender inequality
- traditional roles of males partners e.g. socialisation

From the above factors, it is crucial that strategic interventions targeting male partners in sexual and reproductive health should consider the comprehensive nature of the relationship between a single issue for example, adolescent pregnancy with other relevant variables e.g. violence, HIV/AIDS, STDs etc, that affect that issue.

Some of the most problematic aspect of adolescent pregnancy relate to child rearing practices where male off springs are not informed of their responsibilities (socialisation). The disruption of local economies will result in the problem of poverty that may result in children engaging in sexual activity to generate funds.

Separation from family members has also resulted in children not having role models to guide them. While other societal changes have resulted in the increase of

adolescent pregnancy. Of these, the greatest threat has been the relationship between adolescent pregnancy and the increase in HIV/AIDS infections.

New policies and programmes such as education in schools and life skills are aimed at raising awareness as far as adolescent pregnancy is concerned. Most of these measures are seen as modest but may be effective strategies to reduce adolescent pregnancy. National initiatives are also developed to deal with this problem.

All these other efforts have to be systematically developed and implemented. Furthermore it is beneficial to help particularly the male child to be involved in the reduction of pregnancy to make sure that potential manpower is harnessed and developed. Prevention of adolescent pregnancy also demands gender equality. The main aim has been to repeal loss that denied women their rights. Community education to stress respect for all especially women, violence against women also to prevent and reduce adolescent pregnancy.

Health services need to be sensitive to the needs of male and female adolescents. Provision of access to information and services for counseling and contraception are crucial. Peer education remains important to providing adolescents of both sexes with skills that will empower them to deal with issues of sexual and reproductive health. That is, male adolescent should not only be taught about condom usage, but they should be exposed to a whole range of issues related to sexuality and responsibility.

Nonetheless, the conceptual framework will be refined as the research proceeds. Further details will be furnished. Existing programmes on national and community levels should be reviewed to incorporate males into all aspects involving sexual and

reproductive health, and thereby increasing their awareness. Such programmes should be build on the foundations of activities in which males are actively involved in e.g. sport and recreation.

6.3 ROLE OF MALE ADOLESCENTS IN ADOLESCENT PREGNANCY

The role of male partners has been overlooked in most reproductive health and family planning programs. The boys have been ignored or were not in the past given attention given the fact that females were expected to protect themselves. They tended to regard pregnancy-related issues exclusively in the women's domain.

6.4 REPRODUCTIVE HEALTH RIGHTS

The sexual and reproductive health rights were not adequately integrated into the socio-cultural and political system of most countries.

6.5 REGIONAL DIFFERENCES

Although other countries have incorporated sex education in their school curriculum, some have not. Thus adolescent males continue to be poorly informed regarding reproductive health in countries that do not provide sex education at schools.

6.6 INTER-MINISTERIAL INTERVENTIONS

In South Africa, the Ministry of Health has called upon policy makers and educators to consider introducing sexuality education in schools as a response to the HIV/AIDS

pandemic as well as the current problem of teenage parents. It is important to note that the HIV/AIDS Life Skills' Programme is being implemented in most schools.

The primary and secondary schools in South Africa are expected implement Life Skills Programme since the beginning of 1998. This is a joint initiative by the Ministry of Health and Education. It is intended to promote HIV/AIDS education among scholars.

Other Inter-Ministerial initiatives include and not limited to the following designing and implementation of peer-education strategies, revival of School Health Services, implementing and sustaining Health Promoting Schools environments, integrated plan for children infected and affected by HIV/AIDS and Child Labour Inter-sectoral groups, National Plan of Action for Children in South Africa.

6.7 PARENTAL ROLE

Most literature revealed the incapacity of parents to inform their sons about sexuality issues. Some believe that parents lack the appropriate language to provide the necessary information. Others regard parents as unprepared in sharing sensitive information with their off-springs.

However, mothers are said to be providing some form of information to their children as part of their child rearing activity and because they spend more time with their children than fathers do. Studies have shown that various factors have a bearing on child rearing practices and contributes to positive or negative behavior in adolescents.

6.8 GENDER SENSITIVITY

Most boys tend to be unprepared in matters of sexuality because of the perception that men than women in most relationships control sexual issues. It is not surprising to note that throughout the main study, gender inequality seem to have dominated most discussions.

This indicate the need for programs of adolescents to focus attention on 'gender-sensitive' interventions that acknowledge both the reality and also the undesirability of the inequalities between women and men, including unequal division of labour and power.

This approach will lead to inculcation of positive gender norms in the socialization of children and adolescents, preparing them to deal with most social (peer pressure), traditional (Gender inequality between boys and girls through socialization in the family) challenges in life.

6.9 CONCLUSIONS AND RECOMMENDATIONS

In many of the discussions in the previous chapter (four), conclusions were drawn by the respondents in some areas, which were accompanied by the implicit or explicit recommendation that adolescent pregnancy prevention is an inter-play of many social factors that requires the involvement of various role players.

6.9.1 Conclusions

It is important to revisit the research questions so as to substantiate on the compatibility of the research questions with the research findings. Here are the research questions that had to be explored:

6.9.1.1 What is the extent of adolescent pregnancy in Letlhabile?

The demographic profile of both respondents painted the following picture about the extent of adolescent pregnancy:

- Younger and younger adolescent girls are falling pregnant in the absence of support structures. Younger male adolescents are becoming fathers early enough to know their bodies and responsibilities (see table 1);

- Various family structures and different child rearing practices affect the future of both male and female adolescent (see table 2&3)

- Findings of qualitative data have shown that male respondents were concerned about the extent of adolescent pregnancy in the community of Letlhabile. Some sources stated that approximately 5-8 girls from lower grades in school become pregnant every year, and most of them experience school disruption.

6.9.1.2 What are the risk factors and pregnancy outcomes among pregnant adolescents?

Almost all male respondents, particularly those who were fathers were able to identify several risk factors and pregnancy outcomes. There was increased knowledge of the relationship between adolescent pregnancy and other factors including, multiple sex relationships, forced sex, violence, substance abuse, STDs and HIV/AIDS.

The study found that most male respondents compared to females seemed to be against abortion and citing the risk of complications that may happen during the procedure, especially in the absence of experienced persons (figure 4.8). Other risk factors identified included rape, poor child rearing practices, poor communication between parents and children and lack of access to information about sexuality, and services for counseling, contraception and recreation.

Most males felt that girls lack the skill to say "no" to sex, but when they were asked how they respond to this, findings have shown varied responses ranging from acceptance, dropping partner, beating them up, including anger (figure 4.11).

6.9.1.3 What is the response of male partners to the increase in adolescent pregnancies?

What is the role of male partners in reducing adolescent pregnancies?

Several questions were asked to get the views of male respondents about

adolescent pregnancy and their role in reducing adolescent pregnancy. Responses to both the above questions were interrelated and have thus the following conclusions are drawn from the discussions. Amongst reasons stated as to why girls fall pregnant most males felt strongly that lack of information about sexuality issues, lack of life skills education in schools, lack of communication between parents and daughters and too much emphasis on culture were contributing factors to the increase in adolescent pregnancy.

Sexual relationships with adult males for financial gains due to poverty was cited as a course for concern by most male respondents because not only does such relationships result in pregnancy, but also put partners at risk of contracting STDs and HIV/AIDS. The study found that for most male partners, an announcement of pregnancy by a female partner often brings mixed feelings showing that most pregnancies are unplanned and unintended. For those male adolescents who indicated accepting responsibility for child support, the provision of resources to care for the baby should be incurred by other people including parents, guardians, the government in terms of support grants and only male partners who are financially independent.

The study findings also conclude that there is a need to involve adolescents and youth in sexual and reproductive health, with the focus on both younger males and female target groups. This statement implies that young people needs to be considered as assets and not as liabilities, and hence their capabilities has to be considered by program planners.

However, the study findings have shown that men in general have an important role to play in combating not only adolescent pregnancy, but in all aspects of sexual and reproductive health. Strategies suggested include specialized services for young men; integrating male services into existing reproductive health interventions, such as contraceptive services and expanding contraceptive method choice for males (condom distribution) to include more information about sexuality;

Study findings of both qualitative and quantitative data highlighted many of the responsibilities and challenges that face various people involved in the adolescent health promotion programmes, at various level of care including the individual, family, community and policy level. Most males identified the role played by parents, teachers, health workers and religious leaders as crucial to their acquiring life skills, and sexual and reproductive health information.

6.9.1.4 What is the level of knowledge of men about sexual and reproductive health issues?

The study findings found that there was increased knowledge about contraception and condom use, STDs, HIV/AIDS, and Violence among male respondents. However, this knowledge did not seem to be influencing behaviour change as found in some related questions to explore of own views and opinions. Such questions included saying "no" to sex; reaction to pregnancy, prevention of adolescent pregnancy, STDs and HIV/AIDS and condom use.

Contraception is still seen as a female issue by most males. Although male respondents have indicated that they are willing to participate in reproductive health

programmes, but actual activities are limited to condom distribution and provision of information to their own peers and does not include participation in Clinic Management Boards, for instance. As evidenced in the findings on qualitative and quantitative data analysis, some of the determinants of pregnancy, such as age at first sex, it has shown that most adolescents start sexual activity early. Similar findings were confirmed by various other studies.

Although some male respondents have confessed that they do not go the clinic, evidence have shown that males tend to receive better service in health services than their female counterparts. For instance, a male adolescent seeking condoms in a clinic will be served differently from a female adolescent seeking a contraceptive method. However, most males felt that health services should involve them in clinic activities and provide them with information, knowledge and skills for participation.

Recreation has been seen to yield positive reproductive health outcomes as evidenced by its relationship with issues such as delay in sexual activities, and enhancement of better education opportunities for those adolescents who engage in recreational activities. The study found that most males were active in recreational activities than females.

For a number of issues, including contraception and condom use, sexual rights, sexuality, multiple sex relationship, pregnancy, abortion, STDs and HIV/AIDS, there was a strong sense that intervention strategies should target both male and female adolescents using a gender lens approach.

The findings of the study have shown that adolescents of both sex have unique reproductive health needs that constitute a problem in many ways. Other findings are that although many girls said that they know about sexual rights, many of them, particularly those who are sexually active, still fail to obtain protection and assistance in matters of reproductive health.

Gender inequality, lack of parental guidance, lack of community support structures (religious, recreational, social), and lack of access to correct information and health services have been identified by all as major constraining factors to healthy development of adolescents.

Although the above issues were discussed in the study, gender inequality seem to have had a major impact in almost all sections discussed, for example, family settings, religion, sexuality issues. Age at first sex, reaction of partner/parent to pregnancy, pregnancy options, decision making and responsibility for child support. One would argue that gender inequity affected women from those early ages more than males of the same age group, as the study confirmed.

6.9.2 Recommendations

The following section highlights future actions to address the unmet needs of adolescent males with emphasis placed on adolescent pregnancy prevention and other related programmes e.g. HIV/AIDS, STDs, substance abuse etc, which will involve males as part of the solution to problems.

6.9.2.1 Policy and legislation

With the growing recognition of adolescents and youth as a distinct group, there has been international recognition to promote the health of this target group. Various International Instruments protecting the health and rights of adolescents exist and many countries of the world including South Africa have ratified these conventions. These International Instruments/Agreements include the following:

The International Conference on Population and Development (ICPD), Cairo, 1994 and the Fourth World Conference on Women (FWCW), Beijing, 1995, highlighted the importance of involving men as a means to several important ends. Focus areas include improving gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.

The Convention on the Rights of the Child save guard the rights of adolescents to access to health service, information and informed consent, confidentiality, privacy and respect, with the support and guidance of parents.

Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), December 1979, which highlights elimination of all barriers that impede on the schooling of pregnant adolescents and young mothers, including providing affordable child care facilities, other support services and parental education.

There are also South African National frameworks specific to adolescents and youth protecting their right These include the country's Constitution the RSA, the existing departmental youth policies, various Acts, including Choice on Termination of Pregnancy and the Domestic Violence Act.

For adolescents and youth to get to know and apply these frameworks that impact on their health the following is recommended:

Review of existing legislation and policies to incorporate male unmet needs. programme managers of youth programs should understand these frameworks, and use them to inform them in and implementing gender sensitive youth programmes. Advocate for action in the community involving young males to promote the rights of adolescents particularly sexual and reproductive rights.

Through advocacy, policies will be linked to programmes and this action will achieve improvement in quality, accessibility and acceptability by providing information, education, and skills building, counselling and health services for adolescents.

Programmes should focus on comprehensive approaches rather than a single approach to solve problems. That is pregnancy prevention interventions should be linked with other interventions such as HIV/AIDS, Substance Abuse, Life-skills and be gender sensitive. Intervention programmes should be sensitive to the health and developmental needs and capacities of males. Such programmes should also build on assets of males than on problems.

Various communication channels can be used to target the male population in many settings , to include the following:

- Conducting workshops and awareness campaigns with adolescent males and females, targeting both homogeneous and heterogeneous groups, should be arranged to inform and educate adolescents about the implementation of policies.

International and National days for youth (youth day, human rights day, etc) should be designated, during which the health needs of young males and females will be discussed and action by and for youth will be recognised.

6.9.2.2 Reproductive Health Services

Services for adolescents should have an integrated, comprehensive and youth friendly approach. These services should take a health promotion perspective to empower adolescent males and females to take control of their own health throughout their life. Such programs should take into consideration the diverse needs of adolescent males and females, with regard to the following:

Providing age and gender specific Information, education and communication, and counselling skills in all settings of adolescents and youth through the use of youth culture is essential. Providing services for younger adolescent males and females (less than 10 years olds) to respond to their physical growth and development. More importantly to those who are not yet sexually active, to provide them with life-skills to abstain from sex, to delay sex and to give them sexual and reproductive health

options. Greater attention should be given to gender differences. Services should target both in and out of school male adolescents. A health services should also implement an outreach program to adolescents who may not be able to access the facility.

Issues of quality of care have to be maintained in a health facility that serves adolescents. These include privacy, confidentiality, respect acceptable waiting periods at the clinic, convenient hours. Some of these recommendations emanated from discussions with male respondents in the study.

Male programmes should go beyond condom use and distribution to include life skills, and sexual and reproductive health interventions. Males should also be involved in planning, implementation and evaluation of services, to ensure that action is effective and appropriate to local culture.

The health service should be able to identify and work with other organisations that have males as partners/ male involvement programmes to build coalition and collaborate on issues of common interest. This collaboration will strengthen program objectives and prevent fragmentation and duplication of services.

There is a need for a service linkage with the school and other community outreach initiatives which is seen as crucial for strengthening sexuality education and life-skills education services.

For example, programmes with a community development focus can work together to incorporate health messages, say on pregnancy prevention for a Boy Scout

organisation, for instance, or even with a young male or female income generating Community Development project.

Programmes for adolescent mothers and fathers should be implemented, to add to the existing ones of antenatal and abortion and contraceptive services. These services should be accessible and offer information and support to both partner though counselling and proper referral for further treatment.

Any program for men should be designed with user-friendly marketed approach, creating an acceptable environment which aim and addresses their perspectives and needs. Young women and men believe services for men should have the following features:

- They should cover a wide spectrum of health related issues, not just contraception and family planning.

- They should not come under the same umbrella as family planning because of the perceived stigma. Male adolescents should be empowered to participate in community events and be able to hold workshops, seminars and meetings to share information with their peers and the community.

- There is a great need for career paving for those committed males to encourage them to establish and sustain their own community projects; linking them with relevant partners in and outside the country.

- They should not be completely separate as this would encourage segregation of responsibility

6.9.2.3 Gender and Empowerment

All programmes should incorporate gender perspective and strive to address gender inequalities among boys and girls. Parents should also be targeted so that they should learn the skill to raise their children in a gender sensitive manner particularly during socialisation , early in life.

Managing the vulnerability of young women in sexual health and HIV education may mean also addressing young men and the notion of gender and sexual identity through which they understand their experiences. Education must seek to engage the gender system and not just women. The following recommendations are stated:

- Health services should plan and conduct gender training, to be included as part of service delivery programs, including reproductive health services targeting adolescents and youth.

- Conduct gender awareness campaigns to educate adolescent population about gender stereotypes.

- Develop gender sensitive health messages.

- Involve adolescents of both sexes in clinic programs to plan, implement, monitor and evaluate service achievement of goals.

- Programmes should seek to include both partners in counselling and service delivery. To help them make informed decisions about sexual responsibility.

- When recommending contraceptive use to sexually active adolescents, encourage use of "dual method use" so that men and women should share contraceptive responsibility, with men using condoms as protection against STDs and HIV/AIDS and women using more effective methods to protect against pregnancy.

- The involvement of men should be linked to local realities and be responsive to expressed desires of communities. This can be achieved by having consultations with the community before an intervention, while respecting social and cultural issues of that community.

- Programmes should focus of the positive values of adolescents building on their capabilities and skills than on the negatives and problems.

6.9.2.4 Parents and communities

Parents remain the greatest influence for good or ill in their children's lives. However, both respondent types have recommended it extensively in discussions that parents too need information to make right decisions and give good guidance.

Health services should work with the community and educate parents, guardian and other relevant people who impact on the health of adolescents. Parents, teachers and religious leaders also require knowledge of life skills to be able to deal with

adolescent males and females.

By involving other partners training programmes and or workshops and meetings for the community can be co-ordinated, and resources can be shared. For example, such workshops can be arranged through a religious organisation and conducted on a Sunday for parents in that congregation.

Another venue can be a school whereby parents will be invited and also in a social gathering. Some parents could be invited to share information about their own experiences of adolescence or any other innovative ideas.

6.9.2.5 Research Implications

Given the need to create and provide recreational opportunities and facilities which are rural and urban based, there is a considerable need for good research into recreation experiences and needs for adolescents and youth.

There is, an urgent need to involve adolescents males and females in research, planning, implementation which will secure suitable recreational opportunities for them, and minimise the likelihood of error in identifying and providing for recreation their needs.

The following recommendations have been drawn from the study findings to include:

- Conduct a study to review possible work on male involvement in gender perspective. This study will guide programme planners to implement

successful interventions for males.

- While information on men's views of condoms can be contradictory or incomplete, it is even less clear what young women think about their partners' use of condoms. A gender analysis would examine these and other aspect of a couple's relationship by taking the desires and behaviour of both partners into account.

- The present study attempted to examine some of these aspects with a consideration on gender differentiation and other stereotypes, but some gaps do exist.

Some issues did not come out clearly, such as, how men are actually involved as responsible fathers, pre adolescent orientation and education about sexuality issues, which will warrant a need for further investigation.

More gender studies should be conducted to focus on the process that shift and construct the differences between masculinities to achieve gender equality. There is a need to conduct more intervention studies that will inform programs for adolescents to take a behavioural change approach. Most of the studies available seem to be descriptive which often lead to interventions which aim at providing information and education than persuading people (youth) to change behaviour.

Peer educators should be able to generate data from the information and counselling service which they provide, and to use the data to inform policy change and programme improvement.

6.9.2.6 Information Education and Communication

Various disciplines including health workers, teachers religious organisations and parents should be actively involved in providing information to adolescents of both sexes, especially about sex issues healthy development, abstinence and contraception, pregnancy, termination of pregnancy and STDs, HIV/AIDS in particular to promote sexual health of adolescent. Sexuality education both in and out of school is necessary.

Strengthening of programs for social marketing might help to make condoms more popular with men. Suggesting other innovative approaches to reach out to men in various settings can also complement this. Drawing from other relevant studies, one way could be to recognise the context that men live in, address their fears and desires, and encourage responsibility, communication with their partners and respect for others.

Male partners can generate innovative ideas to develop relevant messages to combat adolescent pregnancy from a male perspective. Research studies can help most males come up with innovative strategies only if they participate in such studies.

6.10 SUMMARY

This chapter was intended to give the summary of the research findings, conclusions and recommendations research for action to be taken to reduce the problem of adolescent pregnancy by acknowledging the role of male partners in sexual and

reproductive health.

Firstly, the conceptual framework was discussed with the aim to highlight the relationships between other relevant variables and concepts including the age, sex, religion, HIV/AIDS, STDs, abortion, multiple sex relationships, and the study topic of adolescent pregnancy and the role of male partners.

Conclusions drawn were based on the picture painted in the conceptual framework, which highlight that problems are perceived and dealt with in their inter-relatedness and not as single issues. Finally, recommendations drawn suggested actions to be taken from the perspectives of policy research programme implementation.
Specific action to get the male partners more involved in the prevention of adolescent pregnancy included peer education programmes, youth friendly services, the role of parent and the communities, addressing issues of gender equality and involving males in developing information, education and communication that are relevant.

BIBLIOGRAPHY

Ageyi, W. A., Epema, E. & Lubega, M.: (1993). *Teenage Life.* Sex Education Should Start Early. Africa Woman and Health. 1(4): 15-12.

AVSC International. (1997). Programming for Male Involvement in Reproductive Health. *A practical guide for managers.* New York, Men as Partners(MAP),(p 1-5).

AZBF and Population Council. (1993): *Survey of Parents' Ability to Answer Questions on Family Life.* In: Operations Research Family Planning Database Project Summaries. New York: The Population Council, 2: pp 2AI-16.

Bassett, M., Herman, J., Charles, S., Chiwesha, B. et al (1993): *Adolescent Sexual Behaviour and HIV Prevention.* Washington, DC :International Center for Research on Women (ICRW), Women and AIDS Research Program.

Brink, P.J & Wood, M.J. (1998). *Basic Steps in Planning Nursing Research: from question to proposal.* Boston: Jones & Bartlett.

Burns, N. & Grove, S. K. (1993) *The Practice of Nursing Research Conduct: Critique & Utilisation.* Philadelphia: W. B. Saunders.

Cameron, N.M. de S. & Sethurajan, C. (1989) *Sexuality and fertility: Christian ethical perpectives.* Edinburgh: Rutherford House Books.

Centre for Development and Population Activities (1996). *Gender Equity: Concepts and tools for Development.* Washington DC: CEDPA. Vol. Number 3: 5-12.

Centre for Development and Population Activities (1996). *Gender and Development.* Washington DC: The CEDPA Training Manual Series, Vol. Number 3:10.

Centre for Development and Population Activities (CEDPA) & United Nations Population Fund, 1998. *From Challenges to Consensus: Adolescent Reproductive Health in Africa.*: Washington DC: CEDPA, pp 4-5.

Child care amendment Act of 1996.

Choice on Termination of Pregnancy Act 92 of 1996.

Commonwealth Regional Health Secretariat for East, Central and Southern Africa (CRHCS) (1991). *Improving Teenage Reproductive Health in Tanzania.* Summary of Intervention Study on Selected Aspects of Teenage Reproductive Health with Policy and Program Implications. Arusha: Tanzania: CRHCS: 3, 6-16.

Convention on the Elimination of all Forms of Discrimination Against Women (Cedaw), December 1979.

Convention in the Rights of the Child (CRC), November 1989.

De Castro, Gulati Mosai and Everrat (1996). *An Evaluation of the Crossover Television series: The facts of life.* Johannesburg: CASE.

Delivery of Improved Services for Health (DISH) Project, (November 1996) Uganda: HIV/AIDS and Adolescents. Preliminary Results from the Evaluation of the HIV/AIDS Youth Campaign.

Denuid, F. (1994): *Premature Removal of Condoms by Young Men in Abidjan.* Cote D'Ivoire: An Example of an AIDS Prevention Dilemma. AIDS 8(1):140.

Department of Health, (1998) *National HIV Sero-Prevalence Survey of Women Attending Public Antenatal Clinics in South Africa. Summary Report.* Health Systems Research and Epidemiology: Pretoria: DOH: 5-6.

Department of Health (1998). *South Africa Demographic and Health Survey.* Preliminary Report. Pretoria: DOH, MRC: 26-27.

Department of Welfare, (1998). *Population Policy for South Africa.* Ministry for Welfare and Population Development: Pretoria: DOW.

Dispatches. *Tracking Teen Troubles.* Dispatches, Volume3, Number1, October 1993. Baltimore: John Hopkins University Center for Communication Programs.

Everrat D. (2000), *The Dead Decade? Youth in the Post Apartheid South Africa July (2000).* Development Update. Quarterly Journal of the South African National NGO Coalition and INTERFUND. Volume 3, Number 2: 5-7 Braamfontein: JHB.

Family Health International (1997). *Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Diseases.* Contraceptive Technology Update series. Family Health International: North Carolina.

Fee, N & Youssef M (1993). *Young People, AIDS and STD Prevention: Experiences of peer approach in Developing Countries.* Global Program on. Geneva: *A Draft Copy WHO.*

Flisher, A. J. Unpublished. *High Risk Groups – Adolescents.* Chapter for proposed book: *Urbanisation and Health in South Africa* edited by John Seager and Charles Parry. Revised version. New York: Columbia University.

Focus on Young Adult. (1998). *Reaching Young Men with Health Programs.* Tulane University School of Public Health and Tropical Medicine: Pathfinder International & Futuregroup International.

Fourth World Conference on Women in Beijing, 1995.

Friedman, H. L. & Edstorm , K. G. (1983). *Adolescent Reproductive Health . An Approach to Planning Health Service Research.* Geneva: WHO pp. 3–5.

Glass, B. S. (1996): *The Results of the Ghana Tracking Study.* Paper presented at the Ghana Adolescent Reproductive Health Summit, Accra, Ghana, Novotel Hotel.

Glass, B. S., Gamurorwa, A., Loganathan, R. & Lettenmaier, C. (1995): *Family Planning and HIV/AIDS Knowledge, Attitudes and Practices in 6 Districts in Uganda.* Uganda: Delivery of Improved Services for Health (DISH) Project.

Hebert, L. (1994). *The key to the future.* Paper prepared for the global Commission of Women's Health No.3, No.6.

Herdman, C. S. (1999). *Serving the Future.* An Update on Adolescent Reproductive and Sexual Health Programs in Developing Countries. Washington DC: International Division Advocates for Youth (p 21-29).

Huysamen, G. K (1996). *Introductory Statistics and Research Design for the Behavioural Sciences.* Volume 1 Number 2, Cape Town: Academica.

International Planned Parenthood Federation (IPPF) (1995). *Sexual and Reproductive Health. Family Planning Puts Promises into Practice.* Vision 2000. London: IPPF.

International Women's Health Coalition. *Women's sexual and Reproductive Rights and Health. Action Sheets.* Health Empowerment Rights Accountability. New York USA: HERA.

Jejeebhoy, S. (1993). *Adolescent Sexual and Reproductive Behavior.* A review of the Evidence from India. ICRW Working Paper No. 3. Washington DC: International Centre for Research on Women pp16-19.

Kau, M. (1991): *Sexual Behaviour and Knowledge of Adolescent Males in the Molopo Region of Bophuthatswana.* Curations, 14(1): 37-40.

Kelly, K.T. (1998). *New directions in sexual ethics: moral theology and the challenge of AIDS.* London: Washington.

Kgosidintsi, B. N. & Mugabe, M. (1994). Botswana Males and Family Planning. *Surveys on Households and Institutions 1990-1991.* Gaborone: University of Botswana.

Kiragu, K & Roberts, P.W (1996). Young Men Too. *Africa Regional Conference on Men's Participation in Family Planning and Reproductive Health.* 2-6 December Zimbabwe: Harare, pp 1-5.

Kiragu, K. and Zabin, L. S. (1995): *Contraceptive Use Among High School Students in Kenya.* International Family Planning Perspectives, 21(3).

Klugman, B, Stevens, M. Van Den Heever, A, & Federl, M. (1998). *From Words to Action: Sexual and Reproductive Rights, Health Policies and Progamming in South Africa 1994-1998*: University of Witwatersrand Department of Community Health: Women's Health Project.

Kushlick, A & Rapholo, G. (1999). *Baseline Survey into HIV/AIDS Knowledge, Attitudes and Related Life-skills.* Braamfontein: Community Agency for Social Enquiry (CASE).

KYIP (1995): *Parents and Youth Speak*: Are we listening? Nairobi, Kenya: Kenya Youth Intiative Project (KYIP). Johns Hopkins University Population Communication Services.

Letlhabile Clinic, (1998). *Annual data on antenatal visits obtained from Clinic Record.* Brits District: Letlhabile.

Lewicky, N. and Wheeler, M (1996): *HIV/AIDS and Adolescents.* Key Findings from the HIV/AIDS Baseline Survey in 7 Districts in Uganda. Kampala, Uganda: Delivery of Improved Services for Health (DISH) Project.

Lofland, J and Lofland, L.H (1984). *Analysing Social Settings* : A Guide to Quality Observation and Analysis (2nd edition) Belmont, CA : Wadsworth.

Makinwa-Adebusoye, P. (1992). *Sexual Behavior, Reproductive Knowledge and Contraceptive Use Among Young Urban Nigerians.* International Family Planning Perspectives, 18(2), pp66-70.

Matidze, P. Beksinska, M. Rees, H. & Mazibuko, S. (1999). *National Male Sexual and Reproductive Health Survey.* A Preliminary Report. Chris Hani Baragwanath Hospital Reproductive Health Research Unit.

McCauley, A. M. and Salter, C. L. (1995): *Meeting the Needs of Young Adults.* Population Repots, Series J-41. Johns Hopkins University School of Hygiene and Public Health. Baltimore: Population Reports.

Mensch, B. Bruce, J. & Greene, M. E. (1998). *The Uncharted Passage.* Girl's Adolescence in the Developing World USA: Population Council.

Miles, M.B and Huberman, A.M (1994). *An Expanded Sourcebook Quality Data Analysis* (2nd edition) London: Sage Publications.

Morton-Young, T. (1995). *After-school and parent education programs for at-risk youth and their families:* a guide to organizing and operating a community-based center for basic educational skills reinforcement, homework assistance, cultural

enrichment, and a parent involvement focus. Springfield, ILL: C.C. Thomas.

National Progressive Primary Health Care Network (1996). *Youth Speak Out for your Future:* A Study of youth sexuality, Johannesburg: NPPHCN.

Network (1998), *Men and Reproductive health.* Family Health International. Volume 18 Number 3: 4-7.

Network (1998). *Family Planning and Women lives.* Family Health International, Volume 18, Number 4: 6-10. WHO, 1995. Adolescent Health and Development.

Nicholas, L. 1993. *Intra-familial Communication About Contraception – A Survey of Black South African Freshmen.* International Journal for the Advancement of Counseling, 16(4), pp291-300.

Nnoli, C. (1992): *Motor-park People Shift Gear.* World AIDS, 19: pp10.

Nyachuru-Shilangu, R. H. and Ndlovu, J. (1992): *Factual Knowledge About AIDS and Other Dating Practices Among High School Students from Selected Schools.* Central African Journal of Medicine, 38(6): 225-233.

Orkin, M. (1998). *Report on women and men in South Africa.* Pretoria: Statistics South Africa.

Paxma, J. M, Zuckerman R. J. (1987). *Laws and Policies Affecting Adolescent Health* 1987: Geneva: World Health Organization.

Pathfinder International Africa Regional Office (1999). *Adolescent Reproductive Health in Africa: Path into the Next Century.* A Programatic Strategy for addressing Reproductive Health Needs OF Young People in Sub-Sahara Africa 1999-2003. Nairobi, Kenya: Path, pp. 12-20.

Path (1997) *Involving Young Men in Reproductive Health.* Outlook 14 (3):7.

Polit, D. F & Hungler, B. P. (1995). *Nursing Research.* Principles and Methods. Philadelphia: LIPPINCO TT Company.

Polit, D. F & Hungler, B. P. (1997). *Nursing Research.* Principles and Methods. Philadelphia: LIPPINCO TT Company.

Population Action International (PAI) (1994). Youth at Risk: Meeting the Sexual Health Needs of Adolescents. *Abstracts and Excerpts.* Washington DC: PAI, pp. 1-3.

Preston-Whyte, E. and Gcadinja, M. (1993): *Condoms: Who Makes the Decision?* AIDS Bulletin, 2(3).

Puri, S. Planned Parenthood Challenges (1996). *Mens needs and responsibilities.* Dialogue, Challenges, Overview, and responses. London: International Planned Parenthood Federation (IPPF) pp. 3-44.

Radier, G.R , Morand, J.J, Olson J.S (1993). *HIV Infection Among Secondary School Students in Djibouti, Horn of Africa. Knowledge, Exposure and Prevalence.* East Africa Medical Journal 70(7), pp414-7.

Richter, L.M and Swart-Kruger, J. (1995). *Risk Among Street Children and Youth.* Implications for Intervention. South African Journal of Psychology, 25(1), pp31-8.

Rosen J. E. & Conly, S. (1998). Africa's Population Challenge. *Accelerating Progress in Reproductive Health. Country Study.* Series Number 4. Washington DC: Population Action International. pp3-6, 21, 54-55.

Roudi, F. & Ashford, L. (1996). *Men and Family Planning in Africa.* Washington DC. Population Reference Bureau. Pp. 6-14.

Rudy, K (1997). Sex and the Church. *Gender, Homosexuality and the Transformation of Christian Ethics.* Massachusetts,Boston: Beacon Press.

Senderowitz, J. (1999). Making Reproductive Health Services Youth Friendly. *Research, Program and Policy Series Focus on Young Adults.* Washington DC: Pathfinder International pp. 1-35.

Senderowitz, J September (1998). Involving Youth in Reproductive Health Projects. *Research, Progarm and Policy Series Focus on Young Adults.* Washington DC: Pathfinder International, pp.1-33.

Singleton, R, (1993). *Approaches to social research* 2nd ed. New York: Oxford University Press.

Tauna, B. T. and Hildebrand, V. L. (1993): *Reproductive Health Knowledge and Implications:* A Study in Nigeria. Early Child Development and Care, 87: pp 83-92.

Teka, T. (1993): *College Students's Attitude and Knowledge of AIDS.* Ethiopian Medical Journal, 31(4): pp. 233-37.

Toledo-Dreves, V. Zabin, L.S.and Emerson, MR. (1995). *Duration of adolescent sexual relationship before and after conception.* John Hopkins School of Hygiene and Public Health, Baltimore, USA. Journal of Adolescent Health, 17(3), pp163-72.

United Nations Population Fund (UNFPA) (1998). Report of the Round Table on Adolescent Sexual and Reproductive Health. ICPD+5. *Key to Future Actions.* New York: UNFPA. pp. 19-29.

Veal, A. J. (1993). *Leisure and the future.* Boston, London: Allen an Unwin.

Weiss, P. and Muller, U. (1989): *Unwanted Pregnancies in Unmarried Young Woman in Rwanda.* In: Family Planning for Life: Experiences and Challenges for the 1990s. Paper presented at the Conference on Management of Family Planning Programs, Harare, Zimbabwe, October 1-7. (Conference proceedings edited by M. Bouzidi and R. Korte, IPPF London, 1990).

Wilson, D and Lavelle, S. (1992). *Psssychosocial Predictors of Intended Condom Use Among Zimbabwean Adolescents.* Health Education Research. Theory and Practice, 7(1), pp55-68.

WHO (1989). The Reproductive Health of Adolescents. *A strategy for action.* Geneva, Switzerland: A joint WHO/ UNFPA/ UNICEF Statement.

WHO. (1998). Emergency Contraception. *A guide for service delivery.* Geneva: WHO.

WHO. (1993). Adolescent Sexual Behavior and Reproductive Health. *From Research to Action.* The Narrative Research Method. Report of a Joint Meeting 22-26 April 1993. Dakar: Senegal, pp. 6-10.

WHO. (1993). The Health of Young People: *a Challenge and a Promise.* Geneva: WHO.

Willis, M.V. (1993). *Reclaiming teenage morality: Christian ethics vs. modern ethics:* a guide for adolescents and unmarried young adults: an excellent resource for parents, teachers, pastors, youth ministers, religious education coordinators, Christian couselors, and home schools. Vero Beach, FL: Ocean East Pub.

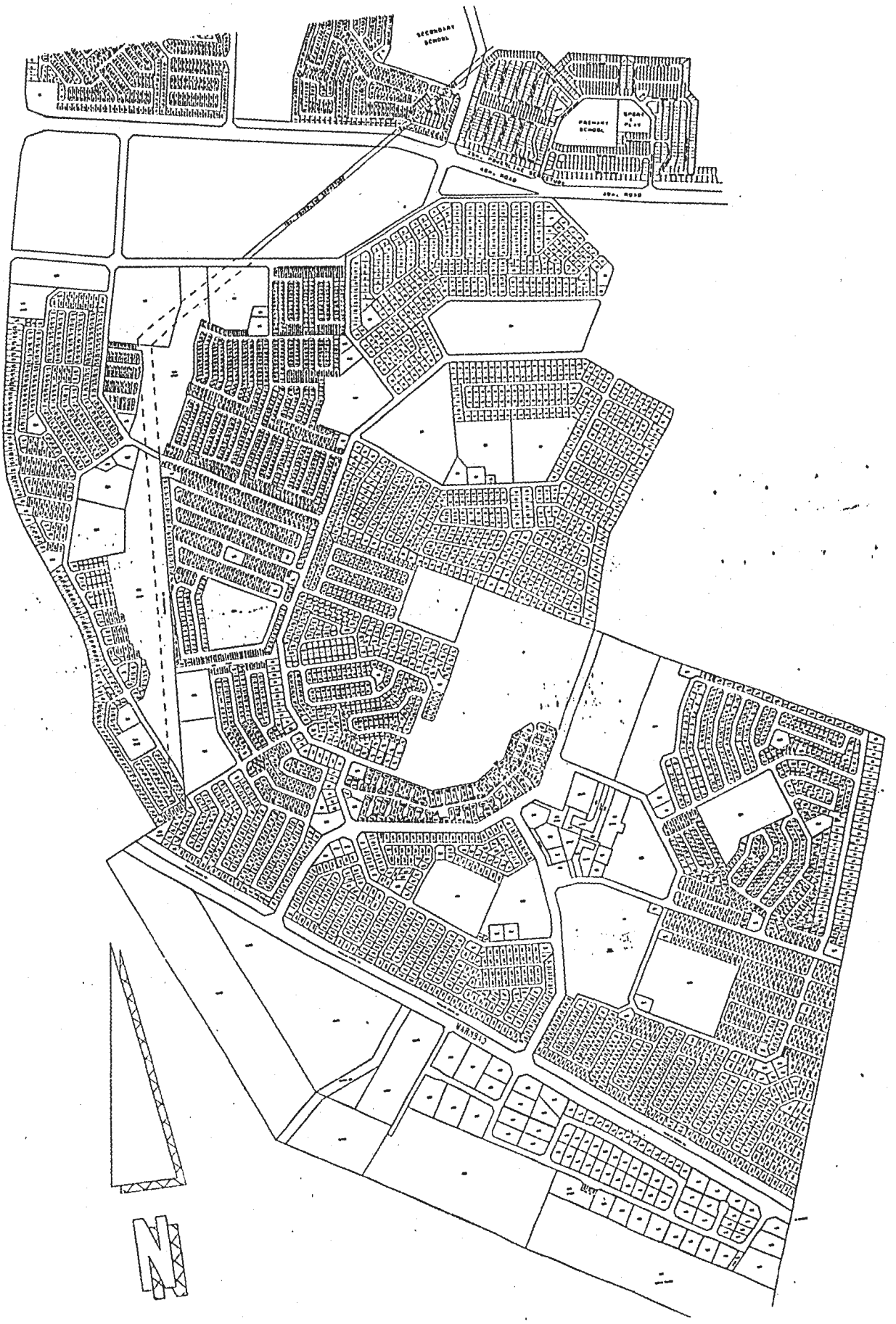
Wood, K. & Jewkes, R (1998). 'Love is a dangerous thing': *Micro – dynamics of violence in sexual relationships of young people in Umtata.* Pretoria: Medical Research Council.

Wood K, Maepa, J & Jewkes, R (1997). *Adolescent sex and contraceptive experiences: perspectives of teenagers and clinic nurses in the Northern Province.* Pretoria: Medical Research Council.

Wood K, Mafora, F & Jewkes, R (1998). " *He forced me to love him": Putting violence on adolescent sexual health agenda.* Social Science and Medicine, 47, pp 233-242.

APPENDICES

APPENDIX A – LETLHABILE MAP



APPENDIX B – ADOLESCENT PREGNANCY AND MOTHERHOOD PERCENTAGE OF WOMEN AGED 15–19 YRS WHO ARE MOTHERS OR WHO HAVE BEEN PREGNANT. BACKGROUND CHARACTERISTICS; SOUTH AFRICA 1998

Table 16 Adolescent pregnancy and motherhood

Percentage of women aged 15-19 who are mothers or who have been pregnant by background characteristics, South Africa 1998

Background characteristic	Percentage who are: Mothers	Ever pregnant	Number of women
Age			
15	2.0	2.4	468
16	5.2	7.9	458
17	10.7	14.2	444
18	19.8	24.6	474
19	30.2	35.1	406
Residence			
Urban	10.5	12.5	1,197
Non-urban	16.3	20.9	1,052
Province			
Western Cape	13.7	16.4	195
Eastern Cape	14.8	18.2	369
Northern Cape	15.2	18.0	44
Free State	8.4	12.6	136
KwaZulu Natal	13.8	16.7	457
North West	11.0	13.4	164
Gauteng	8.9	9.5	377
Mpumalanga	18.8	25.2	190
Northern	14.9	20.0	318
Education			
No education	34.4	34.4	19
Sub A - Std 3	24.7	29.2	114
Std 4 - Std 5	13.8	17.4	336
Std 6 - Std 9	12.9	16.3	1,542
Std 10	7.9	10.1	177
Higher	4.0	4.0	60
Population Group			
African	14.2	17.8	1,802
Afr. urban	11.6	13.7	812
Afr. non-urban	16.4	21.1	990
Coloured	15.7	19.3	208
White	2.2	2.2	162
Asian	2.9	4.3	66
Total	13.2	16.4	2,249

SOURCE: SOUTH AFRICA DEMOGRAPHIC AND HEALTH SURVEY 1998: A PRELIMINARY REPORT

APPENDIX C – REQUEST LETTER TO UNDERTAKE A STUDY

Po Box 2455
Rooihuiskraal
Centurion
0254

The District Manager
Brits District Health and Developmental Welfare
Brits
0250

REQUEST FOR PERMISSION TO UNDERTAKE A STUDY AT LETLHABILE CLINIC: "THE ROLE OF MALE PARTNERS IN COMBATTING ADOLESCENT PREGNANCY"

Dear Mrs Rakau

Adolescent sexual and reproductive activities have far reaching social, economic, educational, moral, health and demographic effects. Failure to meet these diverse needs predispose this target group to unintended pregnancy, the risk of termination of pregnancy sexually transmitted diseases and the new menace of HIV\AIDS.

My study - towards a Masters degree - attempts to find ways of emphasizing men's shared responsibility and to promote their involvement in responsible parenthood and sexual and reproductive behaviour, including options to prevent unwanted and high risk pregnancies.

The purpose of the study is to explore and describe the views of male counterparts as both potential and actual fathers on their role in reducing adolescents pregnancy in Letlhabile. The significance of the proposed problem will benefit the community of Letlhabile in the following :

- In terms of findings, strategies will be proposed that will contribute to combatting the problems associated with adolescent pregnancy in Letlhabile through the recognition of males as partners in reproductive health. These strategies will also contribute to the development of a model for sexual and reproductive health of youth and adolescents in the area.

In order to achieve the objectives of the study, experts and relevant information is needed through interviews with the health workers in the Community Health Centre under study, the target population of adolescents attending ante and post natal clinics and male counterparts in the community. This process will commence with pretesting of the research instrument which is planned for July 1999, until the final process is completed hopefully in the year 2000.

Hoping that my request will be accepted and that the study will make a contribution in improving the sexual and reproductive health needs of young people in the Brits District.

Kind Regards.

RM Motlatla

Mrs Rebecca Motlatla

99. 07. 05.

APPENDIX D – PERMISSION LETTER TO UNDERTAKE THE STUDY

NORTH WEST DEPARTMENT OF HEALTH AND DEVELOPMENTAL SOCIAL WELFARE
BRITS DISTRICT

Developmental Social Welfare
Private Bag X5084
BRITS
0250

TEL: (012) 2523766/7/8

FAX: (012) 2523769

ENQUIRIES: Ms. DL Magano

DATE: 4 August 1999

Attention: Mrs Rebecca Motlatla
P.O Box 2455
ROOIHUISKRAAL
CENTURION
0254

RE: PERMISSION TO UNDERTAKE A STUDY AT LETLHABILE CLINIC

This office is granting you permission to pursue the above venture. We hope that the District will benefit from your project.

Once more congratulations and Good Luck.

Thank you.

MS. M.E. RAKAU
DISTRICT MANAGER

APPENDIX E – REQUEST TO CONDUCT A STUDY AT ELETSA HIGH SCHOOL

Po Box 2455
Rooihuiskraal
Centurion
0254

The School Manager
Eletsa High School
Letlhabile
0264

REQUEST TO UNDERTAKE A STUDY AT ELETSA HIGH SCHOOL: "THE ROLE OF MALE PARTNERS IN COMBATING ADOLESCENT PREGNANCY"

Dear Mr Mojagi,

Adolescent sexual and reproductive activities have far reaching social, economic, educational, moral, health and demographic effects. Failure to meet these diverse needs predispose this target group to unintended pregnancy, the risk of termination of pregnancy sexually transmitted diseases and the new menace of HIV\AIDS.

My study - towards a Masters degree - attempts to find ways to emphasize men's shared responsibility and to promote their involvement in responsible parenthood and sexual and reproductive behaviour, including options to prevent unwanted and high risk pregnancies.

The purpose of the study is to explore and describe the views of male counterparts as both potential and actual fathers on their role in reducing adolescent pregnancy in Letlhabile. The significance of the proposed problem will benefit the community of Letlhabile in the following :

☛ In terms of findings, strategies will be proposed that will contribute to combating problems associated with adolescent pregnancy in Letlhabile, through the recognition of males as partners in reproductive health. These strategies will also contribute to the development of a model for sexual and reproductive health of youth and adolescents in the area.

In order to achieve the objectives of the study, relevant information is needed through interviews with the in-school adolescents and youth of both sexes. Your school has selected to participate in the study.

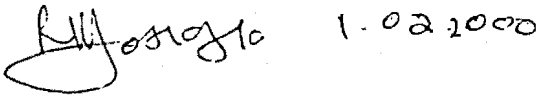
The methodology to be used will include two focus group discussions and five individual indepth interviews with female youth who have experienced adolescent pregnancy (A group of 6-8 participants) and those who have no children; young males who have impregnated a girl as well as those who have not.

Each interview will be conducted for about two hours, and for convenience, interviews will be conducted after school. Ethical consideration will be adhered to at all times. The proposed date for data collection at your school shall be the 29 January 2000 to 2 February 2000.

Hoping that my request will be accepted and that the study will make a contribution in improving the sexual and reproductive health needs of young people in the Brits District.

Kind Regards.

Mrs Rebecca Motlatla



APPENDIX F – FUNDING LETTER – WHO FELLOWSHIP AWARD

WORLD HEALTH ORGANISATION ORGANISATION MONDIALE DE LA SANTE

LIAISON OFFICE
SOUTH AFRICA

7th FLOOR METROPARK BUILDING
351 SCHOEMAN STREET
PRETORIA (0002)
TEL.: 27 (12) 338-5204

P.O. BOX 13113
TRAMSHED
PRETORIA (0126)
FAX: 27 (12) 320-1503

17.07.00

Ms. Rebecca Motlatla
P O Box 2455
ROOIHUISKRAAL
0254

Our Ref.: FEL/PSN/SOA

Dear Ms. Motlatla:

Subject: WHO FELLOWSHIP AWARD

We are pleased to inform you that you have been awarded a WHO Fellowship for the period beginning 01.07.2000 - 30.11.2000. Attached is your Letter of Award and WHO Fellowships booklet.

If you have any queries on your award, please contact Ms. Fortunate Mendlula at this office.

Best wishes.

Yours sincerely

Dr. Vincent Agu
Administrative Officer

APPENDIX G – FEMALE INTERVIEW GUIDE: FGD

FEMALE RESPONDENT FOCUS GROUP DISCUSSION

1.Are there any recreational facilities for adolescents in your community?

2.What activities are adolescents and youth engaged in?

2. CONTRACEPTION

1. Let us discuss about contraception. Have you and used contraceptives?

If YES, Which contraceptive methods have you ever used?
If NO, Why not?

Which other contraceptive methods did you have access to?

2 Please indicate your feelings about the following statements.

1. strongly agree	2. Agree	3.don't know	4. Disagree	5.Strongly

Sexually active adolescents should use contraceptives.
Adolescents should abstain from sex.
Sexually active adolescents should get the approval of parents to use contraceptives
Sexually active adolescents should have access to contraceptive without the consent of parents
Adolescents should delay sexual activity until they are adults by exploring other means like, kissing, masturbation etc

What is your perception about contraceptives? Please explain briefly.

What is emergency contraception?

RELIGION AND CONTRACEPTIVE USE

What is you opinion about religious principles on contraceptives?
In your opinion who should control contraceptive use?
Why should it be so?

CONDOM USE

Have you ever used a condom?
If YES, Please explain how often did you use them?
If NO, please explain why not?

SOURCES OF INFORMATION

Where do you get information about condoms from?
Where do you get condoms from?
Do you think that condoms are effective in preventing one against pregnancy, STDS and HIV\AIDS?
Please explain why.
What would you say if your partner suggests that you should use a condom? Please explain.
What programs exists in your community that target men as partners in reproductive health?

3. SEXUAL REPRODUCTIVE HEALTH ISSUES

- SEXUALLY TRANSMITTED DISEASES

Let's talk about sexually transmitted diseases

What do you understand about the term sexually transmitted diseases?
What are the common sexually transmitted diseases in your community?
Where do people go when you when they get sexually transmitted diseases?
What would one do to avoid getting infected with sexually transmitted diseases?

- HIV/AIDS

Are women of your age group at risk of getting HIV\AIDS

If YES,
What do you think puts them at risk?
What precautions need to be taken to prevent those risks?
What is your opinion about openness about one's HIV/AIDS status
Do you think that people should talk openly about their their HIV status?
To what extend do you think HIV/AIDS is discussed

RESOURCE CENTRES
Where do young people usually receive information about HIV?AIDS from?

HIGH RISK FACTORS
How do you perceive multiple partners in the relationships among adolescents?
How does the number of sex partners influence the need to combat adolescent pregnancy? (Impact)
How does the number of sex partners influence the spread of HIV/AIDS ? (Impact)

- ADOLESCENT PREGNANCY

What does adolescent pregnancy mean to you ?
Why do you think girls become pregnant ?

How different are rearing practices of adolescent parents from those of adults ?

How did your partner react the first time you told him you were pregnant?

- TERMINATION OF PREGNANCY

Which options did you consider when you found out that you were pregnant?
Do you think that termination of pregnancy is the best option?

In your opinion what can be done to prevent future termination of pregnancy among young people?

- VIOLENCE AGAINST WOMEN AND CHILDREN

What do you understand by the term Child abuse?
Please describe the types of abuse that you know of?
How old were you when you had your first sexual encounter?
Were you coerced into engaging in sexual intercourse?
Do you and your friends ever discuss about issues of coercive sex?
What happens a girl refuses to have sex with her partner?
What do you know about sexual rights?

5. RESPONSIBILITY

In your opinion who should makes decision on sex issues in a relationship?
Who are the other whom you think plays a major role in the prevention of adolescent pregnancy?
What is their role?
Who do you think is responsible for teaching children about sexuality issues?
Please give reasons why?
What would you recommend that males of your age should do to prevent adolescent pregnancy and STDs\ HIV\AIDS?
What are your intentions about your future?
How should males be involved in reproductive health issues in your community?

APPENDIX H – MALE INTERVIEW GUIDE: FGD

TOPIC: THE ROLE OF MALE PARTNERS IN COMBATTING ADOLESCENT PREGNANCY

MALE RESPONDENT: FGD

What recreational facilities are there in your community?

What activities are adolescent and youth engaged in?

2. LET US TALK ABOUT CONTRACEPTIONS

Do you and your partner use contraceptives?

If YES, Which contraceptive methods have you ever used?
If NO, Why not?

Which other contraceptive methods did you have access to

4. Please indicate your feelings about the following statements.

1. strongly agree	2. Agree	3.don't know	4. Disagree	5.Strongly

Sexually active adolescents should use contraceptives.
Adolescents should abstain from sex.
Sexually active adolescents should get the approval of parents to use contraceptives
Sexually active adolescents should have access to contraceptive without the consent of parents
Adolescents should delay sexual activity until they are adults by exploring other means like, kissing, masturbation etc

What is your perception about contraceptives? Please explain briefly.

Religion and contraceptive use: religious principles on contraception do you aspire?

Please give reasons why you aspire to them.

In your opinion who should control contraceptive use?
Why should it be so?

CONDOM USE
Have you ever used a condom?

If YES, Please explain how often did you use them?

If NO, please explain why not?

Where do you get information about condoms?
Where do you get condoms?
Do you think that condoms are effective in preventing one against pregnancy, STDS and HIV\AIDS?
Please explain why.
What would you say if your partner suggests that you should use a condom? Please explain.
What programs exist in your community that targets men as partners in reproductive health?

SEXUAL REPRODUCTIVE HEALTH ISSUES

- **SEXUALLY TRANSMITTED DISEASES**

What do you understand about the term sexually transmitted diseases?

What are the common sexually transmitted diseases in your community?

Where do people go when you when they get sexually transmitted diseases?

What would one do to avoid getting infected with sexually transmitted diseases?

- **HIV/AIDS**

Are men of your age group at risk of getting HIV\AIDS

If YES,
What do you think puts them at risk?

What precautions need to be taken to prevent those risks?

What is your opinion about openness about one's HIV/AIDS status?

Do you think that people should talk openly about their HIV status?

To what extend do you think HIV/AIDS is discussed in your community?

Where do young people usually receive information about HIV/AIDS?

Which of the persons mentioned above are most effective in disseminating the message on HIV/AIDS? Please indicate.

How do you perceive multiple partners in the relationships among adolescents?

How does the number of partners influence the need to combat adolescent pregnancy? (Impact)

How does the number of partners influence the spread of HIV/AIDS? (Impact)

- **ADOLESCENT PREGNANCY**

What does the term adolescent pregnancy mean to you?

Why do you think girls become pregnant?

Which of the following steps would you pursue if your partner falls pregnant?

Why do boys of your age choose to become fathers early?

How different are rearing practices of adolescent parents from those of adults? Please explain.

Please indicate what you would do if your partner said she had missed a period?

Please explain what you would do if your partner said that she was pregnant?

- **TERMINATION OF PREGNANCY**

If your partner reported that she was pregnant, which of the following options would you suggest?

In your opinion, why do some pregnant girls choose to terminate pregnancy?

What in your opinion could be done to prevent this?

- **VIOLENCE AGAINST WOMEN AND CHILDREN**

What do you understand by the term Child abuse?

Please describe the types of abuse that you know of?

How old were you when you had your first sexual encounter?

Were you coerced into engaging in sexual intercourse?

Do you and your friends ever discuss about issues of coercive sex?

How would you react if a girl says no to your sexual advances?
Please explain your reactions.

What do you think are the rights of a partner in a relationship?

5. RESPONSIBILITY

In your opinion who do you think should makes decision on sex issues in a relationship?

In your opinion which persons in your community plays a major role in the prevention of adolescent pregnancy?
What is their actual role in this regard ?

Who do you think is responsible for teaching children about sexuality issues?
Please give reasons why?

What would you recommend that males of your age should do to prevent adolescent pregnancy and STDs\ HIV\AIDS?

How should males be involved in reproductive health issues in your community?

APPENDIX I – QUESTIONNAIRE GUIDE: INDIVIDUAL FEMALE INTERVIEWS

Rebecca

Female questionnaire questnum __

Type of respondent resptype _ (1=pregnant 2=nonpregnant)

Demographic data

1.1 age __ exact age in years

1.3 family setting d3 _ 1=nuclear 2=extended 3=single parent 4=other

1.5 religious affiliation d5 _ 1=rhema 2=apostolic 3=anglican 4=luthe 5=zcc 6=nazarene 7=faith_mission 8=oth

1.7 are you in school d7 _ 1=primary 2=secondary 3=tertiary 4=other

1.8 highest qualification d8 __ (years of education)

Recreational facilities

1. are there any facilities [rf1 _ (1=yes 0=no)

2. What activities are youth engaged in

sports	rf2a	_	(1=yes 0=no)
drinking	rf2b	_	(1=yes 0=no)
choirs	rf2c	_	(1=yes 0=no)
dancing	rf2d	_	(1=yes 0=no)
movies	rf2e	_	(1=yes 0=no)
watch TV	rf2f	_	(1=yes 0=no)
hang on street	rf2g	_	(1=yes 0=no)

Contraception

have you ever used contraceptives con1 _ (1=yes 0=no)

Which methods :

injection	con2a	_	1=yes 0=no
pills	con2b	_	1=yes 0=no
condoms	con2c	_	1=yes 0=no

)ther contraceptive methods heard of :

traditional methods	con3a	_	1=yes 0=no
IUD	con3b	_	1=yes 0=no
emergency pill	con3c	_	1=yes 0=no

'eelings on statements on sexuality

=strongly agree 2=agree 3=dont know 4=disagree 5=strongly disagree

sexually active adolescents should use contraceptives sex1 _

adolescents should abstain from sex sex2 _

active should get approval from parents for contraceptives sex3 _

active should have access to contraceptives without parents sex4 _

adolescnts should delay and explore alternatives sex5 _

Have you ever used a condom con4 _ 1=yes 0=no

Information about condoms

Clinic	con5a	_	1=yes 0=no
hospital	con5b	_	1=yes 0=no
chemist	con5c	_	1=yes 0=no
private GP	con5d	_	1=yes 0=no
school	con5e	_	1=yes 0=no
shop	con5f	_	1=yes 0=no

Where did they get condoms

Clinic	con6a	_	1=yes 0=no
hospital	con6b	_	1=yes 0=no
chemist	con6c	_	1=yes 0=no
private GP	con6d	_	1=yes 0=no
school	con6e	_	1=yes 0=no
shop	con6f	_	1=yes 0=no

Sexual reproductive health issues

Precautions to prevent risk of hiv

Condom use hiv1 _ 1=yes 0=no

one partner hiv2 _ 1=yes 0=no

faithful partner hiv3 _ 1=yes 0=no

abstinence hiv4 _ 1=yes 0=no

stop loving old men hiv5 _ 1=yes 0=no

avoid going to taverns hiv6 _ 1=yes 0=no

what extent is HIV/aids discussed hiv7 _ 1=greater 2=lesser 3=never

HIV information from which groups

peers hiv8a _ 1=yes 0=no

health workers hiv8b _ 1=yes 0=no

teachers hiv8c _ 1=yes 0=no

parents hiv8d _ 1=yes 0=no

priests hiv8e _ 1=yes 0=no

from people with ribbons hiv8f _ 1=yes 0=no

TV and other media hiv8g _ 1=yes 0=no

Adolescent pregnancy

Age at first sexual activity preg1 __ years

first person discussed preg2 _

1=parents 2=partner 3=neighbour 4=sister 5=nobody

how did you find out that you were pregnant

breast and weight changes preg3a _ 1=yes 0=no

morning sickness preg3b _ 1=yes 0=no

missed period preg3c _ 1=yes 0=no

suspected by parents preg3d _ 1=yes 0=no

told by boyfriend preg3e _ 1=yes 0=no

parent reaction at first preg4 _ 1=anger 2=shouting 3=shock 4=annoyed 5=cried 6=none

partner reaction preg5 _ 1=acceptance 2=not happy 3=negative 4=disbelief

who will support preg6 _ 1=girls parent 2=boys parent 3=both parents 4=boy

Termination of pregnancy

What are options in pregnancy top1 _

1=abortion 2=didn't think about abortion
3=TOP for rape 4=boyfriend want TOP

Violence against women

how does a male react if a girl says no to advances

anger	viol1a	_	1=yes 0=no
beat her up	viol1b	_	1=yes 0=no
intimidate	viol1c	_	1=yes 0=no
accept	viol1d	_	1=yes 0=no

drop her	viol1e	_	1=yes 0=no
respect her view	viol1f	_	1=yes 0=no

who should make decisions on sex issues respo1 _ 1=male 2=female
3=both 4=other

APPENDIX J – QUESTIONNAIRE GUIDE: INDIVIDUAL MALE INTERVIEWS

Rebecca

Male questionnaire questnum __

Type of respondent resptype _ (1=father 2=nonfather)

Demographic data

1.1 age __ exact age in years

1.3 family setting d3 _ 1=nuclear 2=extended 3=single parent 4=other

1.5 religious affiliation d5 _ 1=rhema 2=apostolic 3=anglican 4=lut 5=zcc 6=nazarene 7=faith_mission 8=c

1.7 are you in school d7 _ 1=primary 2=secondary 3=tertiary 4=other

1.8 highest qualification d8 __ (years of education)

Recreational facilities

1. are there any facilities dq _ (1=yes 0=no)

2. What activities are youth engaged in

sports	rf2a	_	(1=yes 0=no)
drinking	rf2b	_	(1=yes 0=no)
choirs	rf2c	_	(1=yes 0=no)
dancing	rf2d	_	(1=yes 0=no)
movies	rf2e	_	(1=yes 0=no)
watch TV	rf2f	_	(1=yes 0=no)
hang on street	rf2g	_	(1=yes 0=no)

Contraception

have you ever used contraceptives con1 _ (1=yes 0=no)

Which methods :

injection	con2a	_	1=yes 0=no
pills	con2b	_	1=yes 0=no
condoms	con2c	_	1=yes 0=no

Other contraceptive methods heard of :

traditional methods	con3a	_	1=yes 0=no
IUD	con3b	_	1=yes 0=no
emergency pill	con3c	_	1=yes 0=no

elings on statements on sexuality

=strongly agree 2=agree 3=dont know 4=disagree 5=strongly disagree

xually active adolescents should use contraceptives {sex1} #

olescents should abstain from sex {sex2} #

ive should get approval from parents for contraceptives {sex3} #

ye should have access to contrac[illegible]

adolescents should delay and explore alternatives {sex5} #

Have you ever used a condom {con4} # 1=yes 0=no

Information about condoms

Clinic	{con5a}	#	1=yes 0=no
hospital	{con5b}	#	1=yes 0=no
chemist	{con5c}	#	1=yes 0=no
private GP	{con5d}	#	1=yes 0=no
school	{con5e}	#	1=yes 0=no
shop	{con5f}	#	1=yes 0=no

Where did they get condoms

Clinic	{con6a}	#	1=yes 0=no
hospital	{con6b}	#	1=yes 0=no
chemist	{con6c}	#	1=yes 0=no
private GP	{con6d}	#	1=yes 0=no
school	{con6e}	#	1=yes 0=no
shop	{con6f}	#	1=yes 0=no

Sexual reproductive health issues

Precautions to prevent risk of hiv

Condom use {hiv1} # 1=yes 0=no

one partner {hiv2} # 1=yes 0=no

faithful partner {hiv3} # 1=yes 0=no

abstinence {hiv4} # 1=yes 0=no

stop loving old men {hiv5} # 1=yes 0=no

avoid going to taverns {hiv6} # 1=yes 0=no

what extent is HIV/aids discussed {hiv7} # 1=greater 2=lesser 3=never

HIV information from which groups

peers {hiv8a} # 1=yes 0=no

health workers {hiv8b} # 1=yes 0=no

teachers {hiv8c} # 1=yes 0=no

parents {hiv8d} # 1=yes 0=no

priests {hiv8e} # 1=yes 0=no

from people with ribbons {hiv8f} # 1=yes 0=no

TV and other media {hiv8g} # 1=yes 0=no

Adolescent pregnancy

Age at first sexual activity preg1 __ years

what if partner preg preg6 _ 1=see doctor 2=abandon her 3=seek adult advice 4=consult friends 5= call HIV/AIDS hotline

emotion if partner preg preg7 _ 1=anger 2=support/comfort/accept 3=flee/deny 4=happy/elated 5=offer solution 6=announce to parent 7=announce to friends 8=seek pastoral

Termination of pregnancy

What are options in pregnancy

abortion top1a _ 1=most pref 2=pref 3=undecided 4=least pref 5=not

proceed with preg top1b _ ditto

institutionalize top1c _ ditto

crisis centre top1d _ ditto

consult physician top1e _ dditto

commence antenatal care top1f _ ditto

ask parental opinion top1g _ ditto

abandon school top1h _ ditto

seek employment top1i _ ditto

Violence against women

How do you react if a girl says no to advances

anger	viol1a	_	1=yes 0=no
beat her up	viol1b	_	1=yes 0=no
intimidate	viol1c	_	1=yes 0=no
accept	viol1d	_	1=yes 0=no
drop her	viol1e	_	1=yes 0=no
respect her view	viol1f	_	1=yes 0=no

who should make decisions on sex issues respo1 __ 1=male 2=female 3=both 4=other